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**Achieving Oral Health Equity through P-5 PATH
Prenatal to 5 Years, Patient Activation Towards Health
A Practical Toolkit for Implementation in Pediatric Health Homes**

Achieving Oral Health Equity through P-5 PATH
A Practical Toolkit for Implementation in Pediatric Health Homes

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About Neighborhood Health Center: Neighborhood Health Center (NHC) is a not-for-profit healthcare organization providing services to underserved and at-risk residents of Washington and Clackamas counties in the Portland area situated in northwestern Oregon.

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1. Background and Program Overview

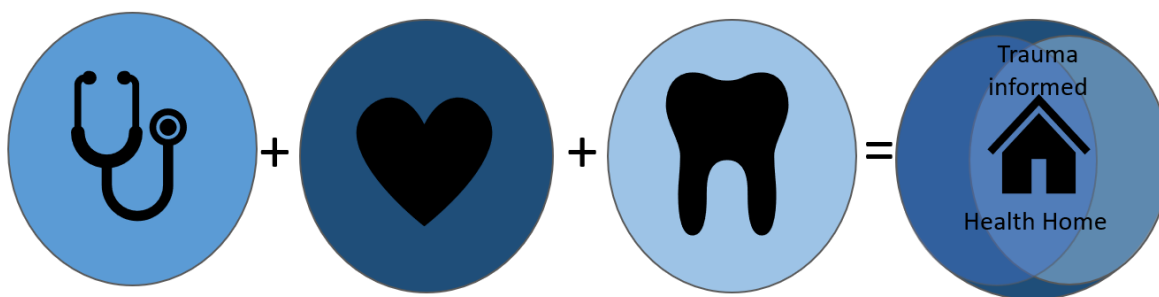
WHO IS THIS TOOLKIT FOR?

This manual is designed to guide pediatric and family Health Home organizations, who endeavor to move towards integrated preventative dental, medical and behavioral health services for their young patients using care teams which include a pediatric occupational therapist. Our program is ideal for clinics interested in upstream interventions for patients and with co-located medical and dental services, though it can be modified for use in stand-alone medical and dental clinics. It is written specifically with Neighborhood Health Center (NHC) clinics in mind, but most elements of the manual are transferable to other systems.

WHAT IS P-5 PATH

Prenatal to age 5 Patient Activation Towards Health (P-5 PATH) at NHC is a multidimensional and transdisciplinary life-course initiative to improve engagement with preventative health care and daily health promoting home routines for our community's most vulnerable families. The P-5 PATH team utilizes a coordinated Health Home approach to integrate primary care with behavioral and dental care. This includes reforming the structure and culture of care delivery to pregnant mothers and children 0-5 within our Tanasbourne Dental and Medical clinic.

Figure 1. Trauma informed health home



This novel programming, led by an Occupational Therapist embedded within medical and dental care teams, identifies areas of patient health risk and addresses a family's skills and environment using an occupational science-informed patient activation centered approach. Our integrated Care Team recognizes self-management of health and accessing health care as a complex process that includes a family's functional and social determinants. We provide upstream efforts including comprehensive risk assessment, risk-based care pathways, and direct intervention for our highest risk patients, delivered at the earliest point of care. Intervention is integrated into Dental visits and Well Child Care (WCC) as well as within stand-alone OT visits within the Health Home to increase care seeking and health promoting behaviors during early childhood.

PROGRAM THEORY AND MOTIVATION FOR IMPLEMENTATION

Chronic illness significantly impacts quality of life for millions of Americans. Six in ten American adults have at least one chronic condition; four in ten Americans have more than one (Buttorff,

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Ruder, & Bauman, 2017). Addressing and treating chronic conditions imposes a substantial physical and mental health burden on patients as well as an economic burden on our healthcare system, making upstream preventative efforts an essential aspect of achieving the Quadruple Aim (Bodenheimer & Sinsky, 2014). It is widely accepted that habits and health patterns established in childhood tend to follow individuals into adulthood (Bjerregaard et al, 2018; Mikkila et al, 2007; Kelder, et al, 1994) suggesting that interventions which support the establishment of health promoting daily routines and habits in childhood may have far reaching effects on an individual's lifetime health and on our healthcare system.

Traditional WCC services are designed to screen and support physical health, growth, development and safety. Historically, there is a lack of screening for certain elements of health, such as dental health, mental health, or functional engagement of the child and family in self-management of health, despite our understanding of the substantial impact these areas have on a child's health. Preventative dental education and services are frequently disconnected from WCC services even though evidence suggests that participation in routine dental care can have a significant positive impact on development and whole-body health and wellness (American Academy of Pediatric Dentistry, 2019). Unfortunately, even when dental, mental and functional health risk or needs are identified within WCC visits the intervention and referral pathways are often unclear.

Well Child Care visits are the most consistent health-related touchpoints for families with children and are, along with preventative dental visits, optimal vehicles for upstream, family-focused preventative intervention efforts (Leslie et al, 2016). Preventative efforts in these settings have long centered around dissemination of verbal education and advice. Evidence suggests that despite knowing current recommendations, parents struggle to follow through with this advice at home (American Academy of Pediatric Dentistry, 2019), implying the need for more structured interventions which include practice of skills to assist families in carrying over and contextualizing recommendations from primary care and dental visits.

P-5 PATH was developed through grant-based funding to improve collaboration and interdisciplinary care between medical and dental programs, as well as to integrate Occupational Therapy (OT) within perinatal, WCC, and dental visits for families of children aged 0-5 at a Federally Qualified Health Center (FQHC) serving underserved patients in Oregon. The goal of this model is to increase value to the patient and system at a reduced cost, as compared to traditional delivery models. The P-5 PATH model embeds OT into dental and medical visits to engage, screen, risk stratify and provide intervention for patients who present with functional deficits regardless of diagnosis. The significance of OT in pediatric primary care and dental services is wellness and prevention across all domains: physical, mental, behavioral and dental health as described through the lens of occupational engagement.

Occupational therapists have demonstrated value addressing health management, wellness and prevention within primary care (Halle et. al 2018) and dental care (Cermak, et al, 2015). OT within primary care and dental settings aligns strongly with the Quadruple Aim of healthcare (Rogers et. al, 2016) and is "client-centered, achieves positive outcomes, and is cost-effective"

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(AOTA, 2016). Further, OT adds distinct value in addressing and modifying patient's lifestyle factors (Clark et al, 1997, 2001, 2012; Pyatak et al., 2019) which are primary targets of pediatric medical and dental anticipatory guidance. As a habilitative discipline, OT supports patients with development of physical, cognitive and social-emotional skills to support optimal function in daily life occupations (Case-Smith, Frolek Clark, & Schlabach, 2013; Case-Smith, 2013; Arbesman, Bazyk, & Nochajski 2013).

Occupational therapists provide services to infants, toddlers, children, young adults and their families aimed at increasing or improving participation in health promoting, meaningful daily activities. Occupational therapists work to identify, ameliorate and compensate for delays or difficulties in development and participation in daily occupations such as eating, sleeping, brushing teeth, playing, going to school, etc. With the goal being function in necessary daily activities, occupational therapist address both the underlying component barriers (such as coordination, fine motor skills, cognition, or self-regulation, for example) as well as the environmental barriers which may impact skill development and full participation. OT is family centered, strengths-based and contextual, which supports clients with taking general anticipatory guidance and applying it in meaningful ways within their daily lives.

P-5 PATH GOALS & OBJECTIVES

P-5 PATH can be reduced to 3 main objectives which lead us to our overarching goal of achieving the quadruple aim.

1. **SYSTEM REDESIGN:**
 - a. Move from co-located medical and dental departments towards integrated care.
 - b. Change the culture of our services by educating and training our providers to deliver care that is trauma informed and patient activation focused.
 - c. Change the culture and structure of our services by creating interdisciplinary care teams which specifically include occupational therapists.
2. **RISK STRATIFICATION & RISK INFORMED CARE PATHWAYS:**
 - a. Create a more robust screening protocol to be used in dental and medical visits which includes screening for social needs and familial mental health in addition to the child's physical health and development.
 - b. Augment the quality of the care we provide using the risk information to create risk informed care pathways that acknowledge that some children and families need more support than others.
3. **TARGETED INTERVENTION:**
 - a. Ensure that those care pathways include direct intervention services to build our patients' skills and their parents' skills for improving, managing and maintaining optimal health through daily habits.
 - b. Lead by connecting families with social needs to concrete resources, ensuring foundational safety and wellness before attempting to build skill.
 - c. Emphasize skills which support patient activation and self-management of health.
 - d. Focus on activities of daily living that are habitual and which can be deeply health promoting.

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Figure 2. P-5 PATH Overview



P-5 PATH EXPECTED OUTCOMES

By implementing this initiative, we expected to see the following outcomes in our patients:

- Increase appropriate engagement in healthcare: including going to all or most WCC visits between birth and 5 years old, engaging in preventable dental services bi-annually from time of first tooth appearance and seeking primary care services (rather than accessing emergency room care) for non-emergent issues in a timely manner to address illnesses before they become emergencies.
- Improved parental satisfaction and feelings of efficacy with care, parenting and individual level of health.
- Reduce risk of developing preventable diseases, injuries and negative experiences of childhood and beyond: including developmental delay, caries, child abuse, Adverse Childhood Experiences (ACEs), behavioral concerns, depression/anxiety, asthma, Attention-Deficit/ Hyperactivity Disorder (ADHD), type 2 diabetes, etc.
- Cost savings to clinic and health care system: reduced no show rates, reduced preventable Emergency Department (ED) visits, reduce patient leakage or loss.
- Improved provider wellness and satisfaction: increased feelings of efficacy and connection to a team of experts; reduced stress, feelings of isolation and work burden.

MANUAL OVERVIEW

In this manual, we will review what we have found to be essential components of implementing an occupational therapist led P-5 PATH initiative, which provides activation focused intervention and integrated care within a health home.

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The way we have structured this manual is to review each component of successful program implementation and outline the core functions within each component. Throughout the text we also give examples of how these core functions were fulfilled within our pilot program. We encourage the reader to follow the examples when appropriate, but feel free to make adaptations as long as they address the underlying core function.

In each chapter, there are checklists to help guide you. For example, the objectives for this chapter:

- Learn about the **background** of P-5 PATH for pediatric primary care and dental care in a Health Home.
- Determine **appropriateness** of P-5 PATH for your organization and clinic.

We have also compiled a master checklist of all chapter objectives in Appendix A.

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2. Legend & Abbreviations

❑ Understand key symbols and common abbreviations which will be used throughout this tool kit.

Throughout our manual you will find acronyms, abbreviations and symbols which we have used to support brevity and ease of identification of key components. You will need to review these before continuing through this manual. You can return to this legend as needed to help recall what each abbreviation or symbol represents.

Table 1: Legend




	This symbol will be used to highlight ideas and tips which we have found useful in launching and implementing P-5 PATH.
	This symbol is used in areas where we discuss workflow ideas and suggestions.
	This symbol indicates “lessons learned” where our team improved our process over time through quality improvement efforts and team feedback, OR areas where we will be continuing our efforts to refine and improve our work over the next few years.

Table 2: Commonly used abbreviations

ACEs	Adverse Childhood Experiences
ASQ	Ages and Stages Questionnaire
AVS	After-Visit Summary
DA	Dental Assistant
DH	Dental Hygienist
EDPS	Edinburgh Postnatal Depression Screen
EI	Early Intervention
FQHC	Federally Qualified Health Center
MA	Medical Assistant
NHC	Neighborhood Health Center
OT	Occupational Therapy
P-5 PATH	Prenatal to 5 years, Patient Activation Towards Health
PCP	Primary Care Physician
SWYC	Survey of Well Being of Young Children
WCC	Well Child Care

3. Defining Your Program

- Determine your organizational and clinical limitations.
- Identify which components of P-5 PATH will be implemented in your clinic and which sections of this manual you may be able to skip.

Before getting into implementation details it is important to point out that we will be introducing the program as we designed and implemented at one clinic. We lead with this to acknowledge that every organization and clinic is unique. We will discuss elements to the program which are essential and those that can and should be adjusted prior to the launch at your facility in order to meet the needs, limitations and goals of your organization.

WHO WE ARE

As noted above, NHC is an FQHC. We serve a variety of patients, but we predominantly serve patients who experience many of the sequela of poverty. Our patients primarily are Medicaid/Medicare insured, or uninsured. We serve both adults and children and we emphasize family-based medicine and care where possible.

Prior to launching P-5 PATH, the NHC clinic where P-5 PATH runs already housed a medical and dental department in the same building, on the same floor. The medical and dental clinic has a joint front desk and the clinic space is separated only by a hallway. Our medical department employs a variety of practitioners including Family Medicine Physicians, Family Nurse Practitioners, Physician Assistants and Pediatricians who provide primary care services. Each medical provider works in tandem with a Certified Medical Assistant. Our medical department has support from a small team of Registered Nurses and a Behaviorist. NHC does not provide obstetric services, though our family medicine physicians and nurse practitioners do provide primary care services to pregnant and post-partum mothers. Our dental department has Dentists on staff who see patients of all ages. Our dentists are supported by several Dental Assistants and a small team of Expanded Practice Dental Hygienists. We currently do not have any pediatric dentists on staff.

Given the demographic we already serve, our P-5 PATH initiative chose to include pregnant mothers in addition to 0-5-year-old patients (as well as the child's parents even if the parent was not a current NHC patient). We included on our team all medical and dental practitioners who were comfortable working with 0-5-year-olds and/or pregnant mothers. We hired two additional full-time staff members at the outset of the program: the Occupational Therapist and the Coordinator.

WHO ARE YOU?

As we mentioned in Chapter I. Background and Program Overview, P-5 PATH is ideal for clinics with co-located medical and dental services which serve pregnant women and young children 0-5 years old for primary care. It is unrealistic to assume all organizations have a similar set up and offer the same services. With that in mind, P-5 PATH can be modified to meet a variety of needs and most elements of the manual are transferable to other systems. More likely than not,

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if you are reading this manual, you already have a sense of what you are looking for and which elements will not apply to your setting. We encourage you to take time to continue to consider which program elements do not apply to your needs and skip the corresponding chapters. Table 3 (below) can serve as a guide for knowing which chapters may not apply to your needs.

Table 3: Considering Your Needs When Using This Manual

<p>If your clinic only has primary care services and no dental department in the same location:</p>	<ul style="list-style-type: none"> • Skip Chapter 5. Clinical Systems Integration & Logistics • Skip Chapter 16. Personnel Specific Sections, sections C (Dentist), D (Dental Assistant), and E (Dental Hygienist) • Skip Chapter 17. Visit Specific Sections, sections A (Well Dental Visits) and E (Group Dental Education Visits)
<p>If your clinic does not provide primary care for pregnant mothers:</p>	<ul style="list-style-type: none"> • Skip Chapter 17. Visit Specific Sections, section G (Pregnant Women Primary Care Visits)
<p>If your clinic does not expect to hire a Coordinator:</p>	<ul style="list-style-type: none"> • Identify key staff who can fill all or pieces of the Coordinator role, as outlined in Chapter 16. Personnel Specific Sections, section A (P-5 PATH Coordinator)
<p>If your clinic is a stand-alone dental clinic and is seeking information on how to integrate OT in dental visits for screening and support:</p>	<ul style="list-style-type: none"> • You will find the bulk of what you are looking for in Chapter 17. Visit Specific Sections, sections A (Well Dental Visits) and E (Group Dental Education Visits)

4. Organizational and Clinic Readiness

In this chapter, we will assess organizational and clinic readiness for implementation of P-5 PATH. We present key players that are needed to plan and implement the program, as well as considerations for communication and meeting logistics.

- Assess **organizational readiness** for P-5 PATH implementation using Key Questions to Assess Organizational Readiness.
- Define **key organizational players** and the **functions** they serve.
- Decide on **meeting logistics** for steering committee.
 - Attendance
 - Facilitation & agenda setting
 - Meeting frequency, time, and space
 - Meeting communications methods
- Identify location and space for P-5 PATH program.
- Assess **clinic's readiness** for P-5 PATH implementation using Key Questions to Assess Clinic Readiness.

ORGANIZATIONAL READINESS

For an effective implementation, it is vital for the system -- whether it is a primary care clinic or a health system -- to have organizational capacity, organizational climate, staff capacity, and an implementation plan. To that end, we have included a brief list of *Key Questions to Assess Organizational Readiness*, (see Appendix B) to help you identify any barriers to program implementation early in the process. These Key Questions should be answered by stakeholders at the organizational level during the preparation phase to assess readiness to progress towards your program launch.

STEERING COMMITTEE

Having a steering committee to get the program off the ground is valuable and may include the occupational therapist, the Chief Medical Officer, the Chief Dental Officer, a program manager and any other key stakeholders who can speak to the mission and vision of the organization. Early identification of a program or project manager on the administrative team is important, as this person will most likely organize key players, prioritize implementation steps, drive progress, set meeting agendas and track what has been accomplished as well as what is still needed.

The frequency and duration of meetings should accommodate your organizational capacity and needs. In our experience, meeting weekly for one hour in the preparation and launching phases facilitated an open discussion of systems level supports needed and allowed for organizational level brainstorming and troubleshooting to occur. Meetings may need to be shorter and/or less frequent during the maintenance phase. We did find, though, that a return to weekly meetings after a time allowed for program assessment and quality improvement efforts to help streamline the program to meet the evolving needs of our clinic and organization.

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Having a structured meeting agenda template can be helpful (see Appendix C) to support team meeting productivity and can support tracking of meeting minutes in a consistent manner. We recommend a template which tracks decisions made and action items generated. The meeting facilitator (often the program manager) should send the meeting minutes out after each meeting to remind key players of action items and decisions made to make sure everyone is on the same page. In the first meeting, establish your primary methods of communication outside of meetings: for example, through email with individual tracking, or another office communication tool, such as Microsoft Teams, which can track action items that are viewable by all team members, send reminder emails and act as a centralized location for meeting minute files to be uploaded.


CLINIC READINESS

With organizational buy-in established, it is imperative to determine interest and capacity at the clinical level. This is where you may find our *Key Questions to Assess Clinic Readiness* (see Appendix B) particularly helpful to starting a conversation with clinical team leadership and potential players. This list of questions can help you identify program champions as well as potential pitfalls and resistance before you move towards program launch.

CLINICAL TEAM MEETINGS

Depending on clinic structure (decision-making authority in clinic operations) you will most likely want the occupational therapist, medical champion, dental champion, your coordinator, and the clinic manager present for these meetings. While the *Key Questions to Assess clinic Readiness* can identify interested parties, the leadership team and clinic manager can help decide the key players who should attend these meetings as well as the frequency.

The frequency and duration of meetings should accommodate your clinic's needs.

 In our experience, meeting monthly for one hour in the preparation and launching phases facilitates an open discussion of clinic operations and troubleshooting of issues that arise.

Similar to the Leadership team meetings, clinical team meetings should include an identified facilitator (possibly the coordinator, the occupational therapist, or the clinic manager). This individual sets the agenda, keeps meeting minutes, tracks decisions and action items generated and sends meeting minutes out after each meeting to make sure everyone is on the same page. (See Appendix C for a sample Agenda Template.)

SPACE

Identification of clinic space is an essential component of this program because you will be incorporating an additional 1-2 staff members- an occupational therapist and a coordinator (see Chapter 7: Personnel Overview for details). Each of these staff will need a small desk/charting space that can accommodate a computer and files. Additionally, we strongly encourage you to consider designating a room (not a medical or dental suite) that can be child-proofed to be used as an intervention space for the occupational therapist. We will discuss this in further detail in Chapters 11 and 12: Logistics- Time, Space, & Tools.

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INTEGRATION

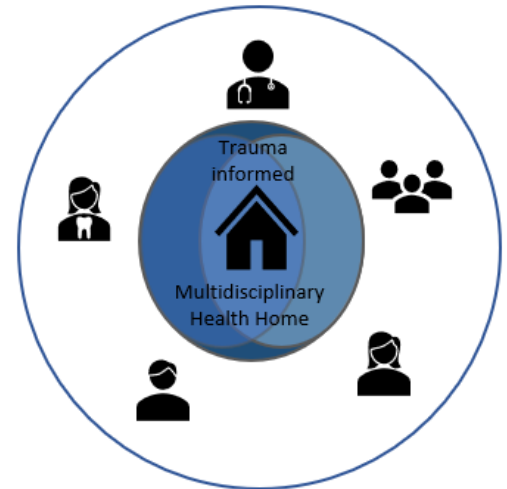
Phase I of our P-5 PATH project involved taking our clinic from co-located medical and dental services to an integrated practice (for our 0-5-year-olds) before integrating our occupational therapist and the OT intervention into the health home. While it is possible to integrate Occupational Therapy and the P-5 PATH program into a stand-alone medical or dental clinic, this program is designed for full integration into a practice that offers both medical and dental care under one roof with the goal of holistic health habit development. If your clinic includes co-located medical and dental services continue to Chapter 5: Clinical Systems Integration & Logistics. If your clinic is a stand-alone dental or medical practice skip Chapter 5 and move on to Chapter 6: Determining & Tracking Clinical Outcomes.

5. Clinical Systems Integration & Logistics

If your organization and clinic seek to move from a co-located medical/dental clinic to a more integrated health home continue reading this chapter on how to begin taking steps towards integration.

Figure 3. Integration Efforts

- Assess **meeting structure** for P-5 PATH clinical team and determine areas of possibility for integration efforts.
- Assess **the feasibility of physical space sharing** between medical and dental teams for P-5 PATH clinical team and determine areas of possibility for integration efforts.
- Assess readiness to move towards **integrated registration and intake paperwork** for medical and dental visits.
- Determine staff capacity to learn and implement **new workflows around intake, insurance verification, and scheduling** of medical and dental patients.




Prior to launch phase, systems should be examined which support or hinder integration efforts between medical care, dental care and occupational (functional) care. This includes an examination of your clinic's:

- Meetings
- Physical space sharing
- Tools & Equipment
- Front desk workflows

If these bulleted items above are separate and distinctly different between your medical and dental departments, we recommend starting here with a mix of introduction of new tools and workflow implementation to support integrated care delivery.

MEETINGS

Create a standing interdisciplinary joint meeting to get your key players in the same room communicating. We encourage this to happen at the administrative level and at the clinical level. Staff meetings were historically separate between our medical and dental clinics. While our clinic was not ready for integrated all staff meetings, we were able to obtain buy-in to initiate interdisciplinary clinical team meetings for those specifically involved in P-5 PATH.

 Our interdisciplinary clinical team meetings occur monthly, from 11-12pm, on the first Monday of the month. It brings together dental (lead dental provider, dental assistant, dental hygienist), medical (family medicine practitioner or pediatrician and medical assistant), behavioral health (occupational therapist as the P-5 representative of the behavioral health model) and the coordinator to identify areas and tools of need, create workflows, complete training and refine our work.

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As our work progressed and workflows solidified, we identified a need to adapt these clinical team meetings to include a “high risk” patient discussion. We are in the process of transitioning the monthly clinical team meeting focus from a systems focus to a patient care focus.

PHYSICAL SPACE SHARING

Consider using the physical environment as a strategy to unite your team and support new workflows. Bringing different disciplines into the same space daily or weekly will increase opportunities for communication and rapport building and is strongly encouraged. Within our clinic, the dental and medical departments are separated by a hallway which is enough to prevent our teams from interacting as frequently as might be expected for having a co-located clinic.

Within our P-5 PATH model we integrated a dental hygienist into the medical department initially for two one-hour blocks, two days per week (4 hours total). However, we found this model to be challenging given the time constraints of patients arriving late, appointments that may run long and the time needed for traveling between the dental and medical spaces.



Our second iteration of dental staff integration into medical visits consolidated the blocks down to one 4-hour block, one day per week, which reduced “misses” and time wasted for our dental hygienist and increased the number of patients she was able to see.

Under this second model, the dental hygienist has a well-defined block of time in the medical department for assessment and treatment, which was not only more efficient for our hygienist, but also increased her visibility to the rest of the team, increasing everyone’s familiarity and ability to communicate. The hygienist’s assessment and treatment took place within the medical suite being used for the WCC visit using a knee to knee position or the medical exam table. This model allows our patients and medical staff to have increased familiarity with the dental hygienist who was able to receive a warm hand-off from the medical team and establish a relationship with the patient and family before the first dental visit within the dental suite. See Chapter 16: Personnel Specific Sections, Section F: Dental Hygienist for details on this aspect of P-5 PATH.

TOOLS AND EQUIPMENT

1. *Integrated intake paperwork*- One of the most vital tools in your integration efforts is your integrated intake paperwork. If your clinic has not already included integrated intake paperwork into the workflow, we strongly recommend modifying existing registration and intake paperwork to create one set of fully integrated intake paperwork which can be given to all new patients, regardless of whether they are seen for a medical or dental visit. (See example of this in Appendix D). Consider integrating forms such as:

- New Patient Registration
- Health History
- Release of Information (ROI)

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Another helpful tool is working with the front desk staff and any pertinent individuals on creating your workflows and trainings surrounding the integrated paperwork including details such as:

- Electronic storage and printing
- Physical storage/accessibility for all departments
- Determining which patients should receive this paperwork and at which visits


(See Appendix E for example of NHC workflows to support details of storage and printing of integrated intake paperwork across pediatric medical and dental departments.)

2. *Dental supplies*- In addition to integrating the dental hygienist into WCC, we took steps to integrate other dental related interventions into WCC using medical staff. Our clinic was already offering fluoride varnish in WCC visits, though this was being placed inconsistently. We targeted our current systems to improve application rates. We additionally made toothbrushes, paste, and floss available to be given out in medical visits to support our education efforts. Your team must assess where these items should be stored. It is also helpful to consider that items stored close to where they will be used (in medical suite vs hallways outside medical suites, for example) support efficiency and follow-through.

For simplicity, our dental department ordered extra supplies based on our current 0-5-year-old engagement rates and the OT and the MA decided where supplies would be stored within the medical department.

- | |
|---|
|  We store bulk boxes of supplies in a hallway cabinet as close to the pediatric specific medical suites as we can get. |
|  When items run low the OT or coordinator informs the dental team so that an order can be placed. |

3. *Handouts*- Integrated parent handouts can improve provider efficiency and consistency with educating families on certain common topics. These handouts can be stored in both medical and dental spaces for ease of access. Our handouts were created primarily by the OT based on team feedback on which topics were needed and commonly addressed with our patient population. The focus of the handouts was a mix of education with active engagement when possible. See Appendix F for examples of some of NHC's most commonly used handouts.


- | |
|---|
|  Our coordinator keeps these handouts stocked by checking in once a month to print more when supplies run low. If we run out of a handout before the end of the month, an email can be sent to the coordinator to print more. If a particular handout is needed in the moment, it is accessible to staff, as all handouts are stored on a share drive for accessibility to all staff for printing. |
|---|

4. *Shared EHR*- Consider investing in a shared electronic health record. A shared EHR between dental and medical supports interdisciplinary communication and patient management. A shared EHR means that all staff can access the same records in real time. While this was not a

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direct component of our grant, our organization invested in purchasing, training and implementation of a shared EHR prior to the launch of P-5 PATH.

 We use OCHIN Epic and Epic Wisdom as our shared EHR platform. We found this system supports much of the integrated work we do. While there is always room for improvement in tools which communicate seamlessly between different departments and also meet the distinct needs of each department, this platform works well for our needs.


FRONT DESK WORKFLOWS

Within our clinic, despite sharing one front desk check in space, we had separate medical and dental front desk staff with different workflows. This was because the Dental front desk staff was not cross trained to check-in or assist medical patients and the medical front desk staff was not cross trained to check-in or assist dental patients. This issue was identified by our administrative and clinical team as an area to target to support integration efforts.

We determined that front desk and/or call center staff must be informed of and appropriately trained on new workflows regarding:

- Identification of shared patients between medical and dental clinics
- Verification of medical and/or dental insurance
- Integrated registration and intake paperwork, including:
 - Dissemination of paperwork
 - Who enters the paperwork into the EHR
 - Where completed paperwork can be found by the team seeing the patient today
 - How often it must be updated
- Scheduling

Cross training of all front desk staff and any medical and dental staff who may cover at front desk should occur. This allows for any staff who need to check in patients the ability to check in medical or dental patients. They are also able to find and distribute the appropriate paperwork, verify the medical and/or dental insurance, and schedule patients for medical and/or dental appointments following appropriate scheduling guidelines for both departments.

 We recommend creating visual workflows and printable “cheat sheets” to be posted at front desk and if needed within the call center for the first few months of integration efforts to remind staff of new workflows and support efficient recall of details to integrated patient registration, intake and scheduling. (See Appendix E for an example of NHC integrated front desk workflows and printable cheat sheets to support front desk and call center staff.)

6. Determining & Tracking Clinical Outcomes

- Collect and examine clinic level data** surrounding current functioning.
- Identify **clinical priorities and outcomes** which will guide your program towards an envisioned future state.
- Set measurable and achievable outcomes** based on your clinic's baseline functioning and desired state.

IDENTIFYING CLINICAL OUTCOMES

Once you know what elements of P-5 PATH you will use, it is worth taking time within your administrative team to discuss organizational priorities and clinical outcomes which support those priorities. The goal of these discussions is to identify standardized outcomes for your clinic or patients which can assess your program's effectiveness. These may include clinical workflow improvements, staff satisfaction, or increased interdisciplinary collaboration, as well as client health outcomes, health-related quality of life, improvements in mental health, and frequency of self-care behaviors. To this end, it should be noted that some assessments that are already part of routine care within PCP visits (e.g. the ASQ) may provide adequate information to track program success. Where this is the case, duplication of assessments should be avoided when possible, with data extracted from patients' medical records.

Primary considerations:

- What is feasible within regular workflow (what assessments are already being collected, who is doing it, how long does it take?)
- How important are these outcomes to the clinic?
- How do they match with the current clinic outcomes being tracked?

Possible clinical outcomes:

- Increase expected engagement in healthcare.
- Improved parental satisfaction and feelings of efficacy.
- Reduce risk of developing preventable diseases, injuries, and negative experiences of childhood and beyond.
- Cost savings to clinic and health care system.
- Improved provider wellness and satisfaction.

We will define possible avenues for quantifying these outcomes in this chapter. As part of the process of determining the details of your program's roll out, we recommend gathering baseline data which can tell you about where your clinic is starting and what are the primary areas of need within your clinic.

Examples of baseline data (ideally pulled from your clinic's electronic records for the previous 2-3 years prior to the launch of P-5 PATH on your 0-5-year-old patients) which might be useful prior to launching your program:

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- The percentage of patients who attended all expected WCC visits between 0-3 years.
- Average number of WCC visits attended out of the expected 15 AAP recommended visit between 0-5 years.
- The number of patients who engage in preventative dental services at your clinic in a calendar year.
- The number of patients who are shared between your medical and dental departments in a calendar year.
- The number of referrals placed from your medical team for dental care.
- The percentage of dental patients seen in the first half of the year who engaged bi-annually in dental visits by the end of a calendar year.
- The number of patients seen in the ED for 2 or more visits in a calendar year.
- The number of children who were screened at least once using a standardized developmental assessment tool before their 1st, 2nd, and/or 3rd birthday.
- Number of children who were identified as having developmental delay based on screening with or without a standardized assessment tool.
- Number of patients referred out to support services secondary to developmental or behavioral concerns.
- The average no show rate for this population.
- The average number of patients who transferred or were lost to care per year.
- The number of pregnant patients who screen positive for depression.
- The number of pregnant patients who report completing a dental visit during their pregnancy.

We used a mix of clinical assessment tools and EHR collected data to track our progress and determine success.

Specifically our metrics looked at:

- The number of 0-5-year-old patients who established care with our dental department following a WCC visit.
- Improvements in Parent Patient Activation (PPAM) scores over time.
- Decreases in caries risk score for our 0-5-year-old patients over time.
- Increases in instances of outreach to 0-5-year-old patients who missed dental appointments.
- Increases in collaboration between our medical and dental teams evidenced by shared goals, collaboratively managed between our medical and dental teams.

See Table 4 for options for additional data which may be collected to demonstrate improved clinical outcomes for patients and a strong return on investment for the clinic/organization.

Table 4: Tracking Clinical Outcomes

Increase appropriate engagement in healthcare:	
Our metric:	<ul style="list-style-type: none"> ● Increase the number of 0-5-year-old patients who established care with the dental department following a WCC visit by 20% in 1 year (then 30% by 18 months, then 40% from baseline in 2 years). <ul style="list-style-type: none"> ○ Tracked by placing a “Flag” in Epic chart of all 0-5 year-olds seen by P-5 PATH team in a WCC visit, plus a referral code by medical team for all children referred to dental, and new patient visit code by dental team after visit is completed. ○ <i>Our recommendation:</i> more reasonable benchmarks might be 10% in year 1, 15% by 18 months, and 20% by end of year 2. ● 50% of Health Home patients 0-5 or their parents with a missed dental appointment will be outreached to in order to understand and address barriers to care <ul style="list-style-type: none"> ○ Tracked through caller entering a phone encounter for “Missed appointment” in EHR.
Other possible metrics:	<ul style="list-style-type: none"> ● Increasing the number of your 0-5-year-old patients who attend all expected WCC visits in a year by 10% over 1 year and 15% over 2 years. ● Increasing the average percentage of WCC visits attended out of the expected 8 AAP recommended visits between 0-1 from [current percentage] to [higher percentage]. ● Increasing the number of patients who engage in preventable dental services at your clinic by 10% over 1 year and 15% over 2 years. ● Increasing the number of patients seen for a follow up visit within 6-8 months of a previous visit from [current number] to [higher number]. ● Decreasing the number of patients seen in the ED for 2 or more visits in a year by the end of the 2nd year following P-5 PATH implementation by 5%.
Improved parental satisfaction and feelings of efficacy:	
Our metric:	<ul style="list-style-type: none"> ● Parents of children 0-5 who receive an intervention will demonstrate increased activation from baseline screening, i.e. improved knowledge, skills and confidence to proactively manage child’s health, (by 20%, 30% then 40% by end of year 2) as evidenced by the Parent-Patient Activation Measure (P-PAM) and reported through EHR reporting. <ul style="list-style-type: none"> ○ Metric assessed using Parent Patient Activation Measure tool. ○ PPAMs completed at key WCC visits as part of intake paperwork. ○ We tracked through the creation of a flowsheet in Epic to document PPAM score and level. ○ This information was pulled every 3 months by our data team.

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Other possible metrics:	<ul style="list-style-type: none"> ● Gathering subjective accounts from parents regarding parenting satisfaction on a scale of 1-10 with 10 being highly satisfied. <ul style="list-style-type: none"> ○ This question could be added to intake paperwork and tracked over time through a flowsheet. ○ Similar to PPAM scores, improvements can be tracked over time.
Reduce risk of developing preventable diseases, injuries, and negative experiences of childhood and beyond:	
Our metric:	<ul style="list-style-type: none"> ● Children 0-5 who receive an intervention will demonstrate decreased caries risk on at least one indicator, as evidenced by decreased caries risk assessment score from their baseline and captured through EHR reporting. <ul style="list-style-type: none"> ○ Metric assessed using a quantifiable Caries Risk Assessment tool. We used the Oregon Oral Health Coalition (OROHC) Caries Risk Assessment Tool, completed at every WCC visit starting at 9mo old. ● 50% of parents of children 0-5 who receive an intervention through this model will receive a social determinants of health (SDOH) screening. <ul style="list-style-type: none"> ○ SDOH screen entered into Epic flowsheet, with this data pulled every 3 months by our data team.
Other possible metrics:	<ul style="list-style-type: none"> ● Increase over time in the number of children who were screened at least once using a standardized developmental assessment tool before their 1st, 2nd, and/or 3rd birthday. ● Gathering information from parents on frequency of engagement in healthy behaviors which can be tracked over time to determine improvement. For example, The number of days per week: <ul style="list-style-type: none"> ○ where fruits & vegetables were served at all meals. ○ the child was read to. ○ the family engaged in at least 1 family meal with the child. ○ the child engaged in at least 30 minutes of outdoor physical exercise. ○ a sugary beverage was served to the child. ○ the child spent more than 2 hours watching screens.
Improved interdisciplinary collaboration:	
Our metric:	<ul style="list-style-type: none"> ● Patients cared for by the P-5 PATH team of primary care and dental providers will have shared self-management goals documented in the EHR, for 30% of patients by end of year 1 and 40% of patients by end of year 2. <ul style="list-style-type: none"> ○ Goals were documented in the “Goal” section of “Care Management” tab in Epic, which is available to both medical and dental providers.
Other possible metrics:	<ul style="list-style-type: none"> ● Increased feelings of efficacy and connection to a team of experts, reduced stress, feelings of isolation, and work burden. <ul style="list-style-type: none"> ○ These outcomes could be assessed through provider interviews and rating scales at launch of program and end of year 1 and 2.

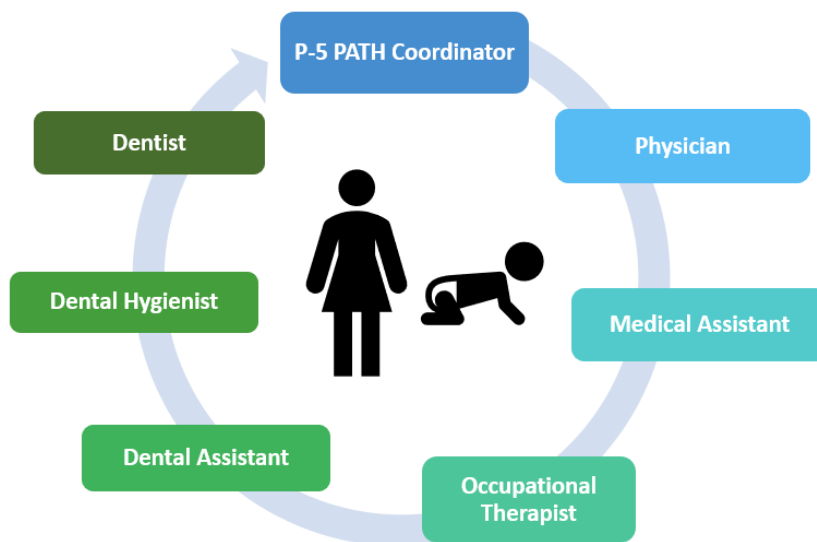
7. Personnel Overview

- ❑ Define **key clinical players** and the **functions** they serve.
- ❑ **Discuss** roles and expectations **individually** and as a **team**.
- ❑ Ensure appropriate **credentials** and system access.

PERSONNEL

The ideal staffing model for this program is comprised of:

Figure 4. P-5 PATH Clinical Team



1. **Occupational therapist** with clinical experience in pediatrics
2. **Coordinator** with clinical background (we recommend an MA, separate from the MA who is dedicated to the PCP)
3. **Primary care provider**, such as a Pediatrician, a Family Medicine Physician, or a Family Nurse Practitioner
4. **Certified medical assistant**
5. **Dentist** who is comfortable working with toddlers and young children
6. **Dental hygienist and/or dental assistant**

However, this program can and does fit into a variety of staffing configurations. You have options. We found that ideally, these are the key players who allow this program to run seamlessly.

The key components to this program that are not flexible are the occupational therapist and a provider (either a medical or dental provider). P-5 PATH is not stand-alone outpatient OT services. P-5 PATH is a model which embeds OT services in WCC visits and/or dental


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visits, which is why a medical or dental provider who sees patients for wellness-oriented, preventative visits is an essential component. Support staff such as the coordinator, MA, DA, and a dental hygienist are all ideal components and help to expand and broaden the reach of your program.

Components of this program can be set aside until a later date, such as the addition of a coordinator, or discarded all together, such as in the case of clinics which do not have integrated medical and dental departments. As an example, in a scenario where a stand-alone pediatric medical clinic endeavors to launch P-5 PATH, it is not necessary to hire dental staff. In this scenario, forging community partnerships with local dental offices who will see your referred clients is sufficient.

At NHC, in preparation for program launch, and recognizing the limitations of existing staff, the occupational therapist and a coordinator were hired. The PCP, MA, Dentist, DA, and DH were existing staff already engaged in daily patient care, though out of our existing staff pool, specific staff members were identified based on interest, expertise, and availability to be “key players.” If hiring additional staff is not feasible outside of the occupational therapist, existing staff can be used, depending on their capacity. In this scenario you will most likely be omitting the coordinator role and disseminating the coordinator responsibilities to existing staff. Your team will need to look through Chapter 16: Personnel Specific Sections, section a. P-5 PATH Coordinator, and determine if existing staff have the bandwidth to incorporate these additional tasks into their workday or if time will need to be carved out in their day by off-loading other duties in order to manage additional duties of P-5 PATH.

 In our program, the P-5 PATH Coordinator was a trained and certified MA. However, the coordinator did not room patients or complete clinical care. The PCP/MA team already in place in the clinic prior to launching P-5 PATH remained intake for standard WCC workflows, and the coordinator role was supportive of panel management, community partnerships, clerical work, and patient outreach.

Please see Table 5 for a list of personnel and core functions needed. Additional staff members may be involved as needed to address the core functions.

Table 5: Personnel and core functions needed to start P-5 PATH in primary care

Profession	Core Functions
Occupational Therapist	<ul style="list-style-type: none"> ● Joins primary care, WCC and dental visits to support developmental and functional engagement screening of pregnant mothers and young children. ● Provides family-centered occupational therapy services (evaluation, intervention, coordination) for the pediatric 0-5 age population, pregnant mothers, and parents.

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	<ul style="list-style-type: none"> ● Services focus on wellness, prevention, and habilitation, emphasizing skill development and a parent coaching model. ● Must have clinical experience/background in child development and mental health. ● In the state of Oregon, it can be helpful for the OT to have a behavioral health license. ● Attends and participates in integrated team meetings.
<p>Coordinator</p>	<ul style="list-style-type: none"> ● Completes panel coordination duties including combing charts and outreaching as needed to families who are due or overdue for medical or dental care. ● Provides support for the following: <ul style="list-style-type: none"> a. Scheduling b. Reminders (phone and/or or letters) c. Follow-up on no-shows d. Delivery of baseline and follow-up screening ● Tracks patients' needs to support patients and team with closed-loop referrals and care plans. ● Updates team with key information around insurance changes or lapses. ● Screens for and follows up with patients or families regarding social needs and referrals to community supports. ● Provides parent coaching to support goal setting and implementation intentions for accessing care. ● Attends and participates in integrated team meetings.
<p>PCP, most commonly a Pediatrician, Family Medicine Physician, or a Family Medicine Nurse Practitioner.</p>	<ul style="list-style-type: none"> ● Completes standard PCP duties. ● Helps facilitate integration of OT within the health home. ● Communicate the role of OT to the rest of the medical staff. ● Refers to the OT in situations where there is a patient need. ● Helps determine patient risk level. ● Helps determine need for augmented WCC schedule or frequency of follow up. ● Integrates dental health into WCC visits, collaborates with goals set by dental colleagues, and refers appropriate patients for dental care.

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	<ul style="list-style-type: none"> ● Attends and participates in integrated team meetings.
<p>Medical support staff (e.g. a CMA or clerk)</p>	<ul style="list-style-type: none"> ● Completes standard MA rooming duties. ● Coordinates and directs the flow of the WCC visit by informing PCP and OT when patient is ready to be seen. ● Reaches out to OT if needed and not already present for visit to add patient to OT’s schedule and complete warm handoff if possible. ● Is familiar with and able to score and enter results of screening tools used in intake paperwork into Epic flowsheets. ● Provides vaccinations for patient under the guidance of the PCP. ● Schedules patient for next WCC visit and dental visit and provides the After-Visit Summary to the patient. ● Attends and participates in integrated team meetings.
<p>Dentist</p>	<ul style="list-style-type: none"> ● Completes standard dentist duties. ● Helps facilitate integration of OT within the health home. ● Communicates the role of the OT to the rest of the dental staff. ● Refers to the OT in situations where there is a patient need. ● Helps determine patient risk level. ● Helps determine need for augmented frequency of follow up. ● Integrates holistic health into dental visits, collaborates with goals set by medical colleagues, and refers appropriate patients for medical care. ● Attends and participates in integrated team meetings.
<p>Dental support staff (DH and DA)</p>	<ul style="list-style-type: none"> ● Completed routine DA/DH patient rooming duties. ● Coordinates and directs the flow of the dental visit by informing Dentist and OT when patient is ready to be seen. ● Reaches out to OT if needed and not already present for visit to add patient to OT’s schedule and complete warm handoff if possible.

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	<ul style="list-style-type: none">● Is familiar with and able to score and enter results of screening tools used in intake paperwork into Epic flowsheets.● Supports dentist in setting and documenting self-management of health goal then provides the After-Visit Summary (AVS) to the patient.● Attends and participates in integrated team meetings.
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FOR NEW STAFF

As a first step, all new staff should complete required site-specific trainings and health clearances prior to starting in the clinic. Depending on the site, onboarding and clearances required to work in the clinic may take some time. It is helpful to familiarize yourself with the names and roles of all clinic staff, as well as the EHR documentation process and any other clinic-wide systems you may be using.

We recommend:

- 1-2 training sessions if possible, on use of your EHR for chart combing, scheduling, documenting, and potentially for billing and/or entering orders.
- 1 week of time spent shadowing pertinent staff, such as PCP, MA, Dentist, DA, DH, and front office.
- Time spent familiarizing yourself with the roles outlined in Chapter 16: Personnel Specific Sections depending on your role and any tools associated with that role.

8. Interprofessional Roles and Collaboration

A vital component of a successful program implementation is the creation of your interdisciplinary team. This includes the integration of dental practitioners into primary care workflows, the integration of holistic health screening and intervention into dental visit workflows, and the integration of the occupational therapist within the Health Home as part of clinic operations and workflows. Communicating with staff the purpose of the program, the proposed new workflows, the process of referral, and individual role expectations, is essential and will support the development of effective professional relationships amongst clinic staff.

- Gather your interdisciplinary clinical team** to introduce and discuss P-5 PATH.
- Introduce** occupational therapy to the clinic.
- Find reminder **touchpoints** for providers.
- Identify **methods of communication** with staff.
- Troubleshoot **role clarification**.
- Set a plan for **ongoing training and feedback** regarding barriers and successes.

INTRODUCING P-5 PATH

As mentioned in Chapter 4: Organizational and Clinic Readiness, measuring interest level of existing staff, and establishing clinical champions and core clinical team is an important early step. Make sure all existing staff are familiar with the background and purpose of P-5 PATH and that all staff have read through their role expectations in Chapter 7: Personnel Overview. We recommend a presentation as part of an all staff meeting. See Appendix G for our presentation titled, “What is P to 5 PATH.”

INTRODUCING OT

As P-5 PATH is getting off the ground, it is critical to let the rest of the clinic staff know what Occupational Therapy is, what the occupational therapist does, that OT services exists through various touchpoints, and what the referral pathway looks like. We have included a couple of strategies below, including print materials and an initial presentation. You will find these in Appendices H and I.

Initial Presentation

One strategy is to introduce occupational therapy through a presentation during a staff meeting. In Appendix I, you will find a sample slide deck that can be modified. Important components:

1. Introduce occupational therapist
2. What is OT
3. What OT will do in WCC Visits
4. What OT will do in Well Child Dental Visits
5. Referring to OT & Ideal Patient Candidates

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REMINDER TOUCHPOINTS

Remind providers and other clinic staff regularly at first about the why and how of referring to occupational therapy. The clinic manager is key in evaluating best practices for disseminating this information. We have highlighted a few touchpoints that have worked for our clinic:

Print materials

Posting visual reminders around the environment for staff members to read when they have time can help support early dissemination of information about who the occupational therapist is and what OT can do. Keeping these materials fresh with weekly changes can increase interest. These can be posted anywhere with high visibility. You may consider unorthodox locations, such as the break room or even the restrooms.

Email

Occupational therapist may consider using group email to send follow-up information on how to refer patients to P-5 PATH or to OT.

Morning Huddles

It can be helpful for the occupational therapist to attend morning huddles (if dental and medical teams have separate huddles, we recommend attending both initially, alternating the days). Attendance can help support integration of the occupational therapist into the care team and build rapport with other staff members and can be a useful venue to include reminders about P-5 PATH and OT. This can be another touchpoint to discuss who would benefit and how to refer to OT, or it can be used as a teaching moment, for the occupational therapist to disseminate education on a variety of topics.



We called these small teaching moments in morning huddles, led by the occupational therapist, The “Monday Minute.” Topics included:

- Core beliefs of OT.
- Provision of client-centered care.
- Common areas of occupation.
- Client factors or performance skills that OT can address.
- Contribution of occupation to mental health.
- Habit and routine formation.
- Engagement in preparatory methods to support self-regulation, attention, or positive mindset.

COMMUNICATING WITH OTHER PROVIDERS

Frequent communication between providers is an essential component of interdisciplinary collaboration. This should be a mix of face-to-face meetings (both formal and informal) and online communication to consult with and follow up with other providers. Joining team members in the break room for lunch or making a point to say hello in the morning is a great way to build rapport and to situate yourself as a member of the team. These can serve as opportunities for team members to ask questions that may have come up about P-5 PATH or about OT.

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Obtaining information from other providers

When the occupational therapist is first starting off, there is a lot of checking in with other providers involved in patient care (e.g. the dentist, the physician, the dental hygienist, the MA) to learn more about the patient, and what the providers hope that OT can help with. At NHC, this is often done informally, catching up with providers between clients if possible, or during their administrative time. Establishing boundaries and ground rules with your team members by asking one another when and how you each prefer to be communicated with, can be a useful way to avoid starting off on the wrong foot and can help demonstrate respect.

Providing information to other providers

When the occupational therapist works with patients and parents outside of WCC and dental visits, it can be helpful to communicate findings and plan of care to the referring provider.

- ◆↔● If your team and clinic space is small enough, this can be accomplished verbally.
- However, if you are unlikely to catch your team members face to face due to large clinic space and/or team size we recommend sending the evaluation report and a direct message through Epic messaging (or email if your EHR platform does not allow for direct messaging) to let the provider know the consultation was completed and report written, and to share key findings if appropriate.

Role clarification

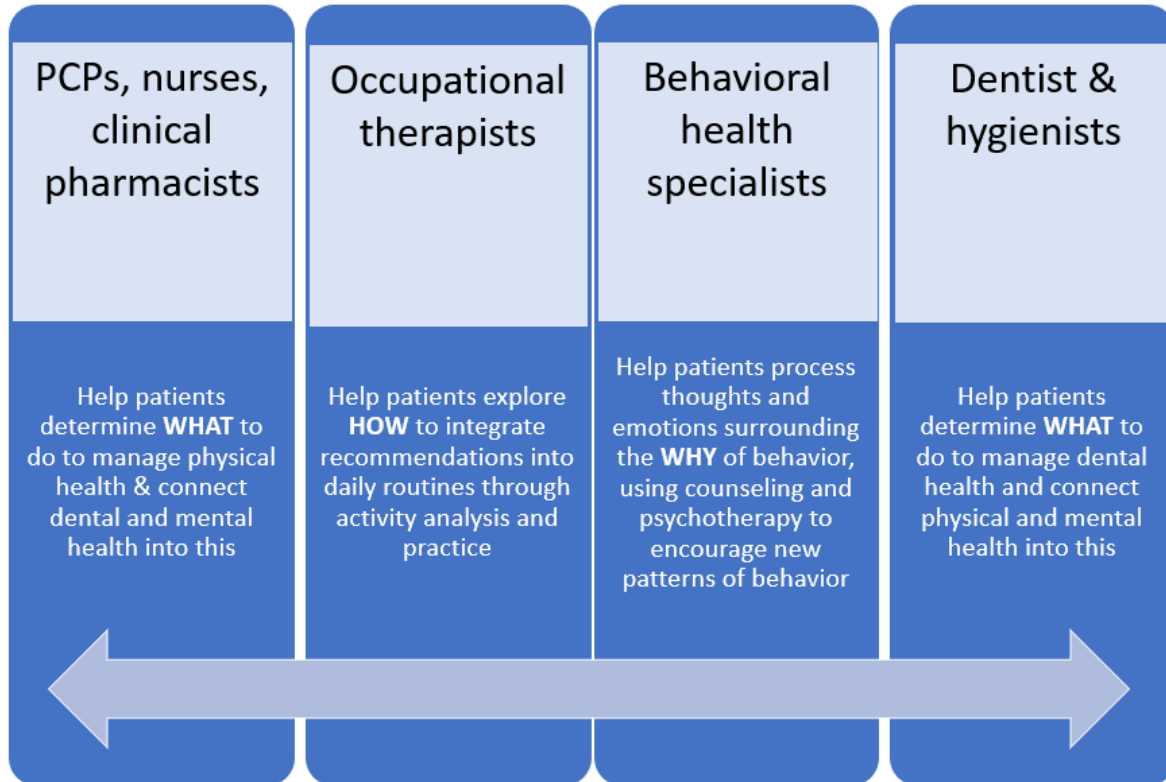
All team members should have a sense of the other (clinic-wide) providers' roles and how to refer appropriate referrals can be made using the correct process. It is also worth sharing with patients and families information about other resources and disciplines who might be available but not directly a part of the P-5 PATH team. For example, at NHC the Clinical Pharmacist was not a direct provider within P-5 PATH, yet the pharmacist was available if needed to support parents (i.e.- with smoking cessation or diabetes control). Making sure all team members know which resources are available will increase the likelihood of referrals being placed and with support interdisciplinary care.

As with any interdisciplinary team, there may be areas of overlap in focus or skill set. It is important to clarify each profession's roles within the primary care clinic. As a new discipline within the team, questions may arise regarding how OT's role differs from those of the primary care physician, behaviorist, clinical pharmacist, or community health worker. The primary distinction is this: PCP, nurses, dieticians, CHWs, etc. are focused on what to do to manage the patient's chronic conditions, while occupational therapists focus on how to integrate these activities into the patient's daily routines and build skills to help successfully do so.

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Figure 5. Role Delineation in P-5 PATH



We will offer, as an example, the case of Babygirl G and her mother, Mary (not their real names). Mary and Babygirl G were both patients at NHC. Mary was experiencing postpartum depression, marked with high anxiety throughout her day and Babygirl G was falling behind on meeting her developmental milestones and she scored high on the caries risk assessment even at 12 months old. The occupational therapist, PCP, behavioral health specialist, and dental team all worked with Mary and Babygirl G. The family medicine physician addressed the medical management of Mary's postpartum depression, prescribing medications, while the behavioral health specialist worked with mom, providing counselling and psychotherapy along with coping strategies to support her mental health. The occupational therapist worked with mom and Babygirl G on integrating those coping strategies into her daily life during stressful moments with her daughter, on determining activities to maximize Babygirl G's developmental skills, and on practice of these activities and mom's play skills to connect with her infant and support Babygirl G's development. The OT also worked directly with the dental team to make sure Babygirl G had a dental visit by 12 months and to support Mary with implementing brushing Babygirl G's teeth into their morning and nighttime routine.

Another example is the case of Lacy and her daughter Iris, who were both patients at NHC. Lacy was having difficulty managing her diabetes and was seeing the clinical pharmacist for support with this. Additionally, in her daughter's Well Child Care visit she reported concerns over her daughter's picky eating and reported Iris had not yet seen a dentist. The family

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medicine physician and clinical pharmacist worked with Lacy on identifying the right combination of medications for managing her diabetes while the occupational therapist worked with Lacy on ways to incorporate these strategies into her daily life based on Lacy's motivation to improve both her own and Iris' health and improve Iris' picky eating. For example, the occupational therapist helped Lacy set a flexible mealtime schedule for herself and Iris to make sure they were both eating regularly scheduled healthy meals, rather than skipping meals and snacking on sugary treats when they got hungry. The occupational therapist and Lacy also worked together to identify menu plans to use for family meals. The dental team completed a dental assessment and cleaning for Iris and Lacy and as follow up, both were able to attend a group dental class co-led by the dental hygienist and the occupational therapist, which connect Iris' picky eating to her oral health and where Lacy practiced the skills of reading food labels to choose snack options that were lower in sugar than some of their usual snacks. Attending the group further motivated mom to make changes to her and Iris' diet and supported mom in building her skill of choosing healthy, low sugar snacks to support their physical and dental health.



Interprofessional Collaborator Assessment Rubric (ICAR)- At the start of this work, our team planned to use the ICAR as a guide on our journey towards improved integration and interdisciplinary collaboration. Our clinical team realized quickly that this rubric, while useful, was too time consuming and cumbersome to be used by our team. We therefore settled on use of the Modified ICAR (see Appendix X) to guide team discussions on interdisciplinary collaboration, as well as to rate our team's capacity in 6 areas: communication, collaboration, roles and responsibilities, collaborative patient-family centered approach, team functioning, and conflict management/resolution. We used this tool every 3 months to check in with our progress and guide discussions around current level of function and areas for growth. While the language was helpful for guiding our discussions on the topic of interprofessional collaboration, likely in future we would not use the Modified ICAR as an assessment tool.

9. Key Tools

P-5 PATH requires some specific tools be integrated into your dental and/or medical practice. Based on our experience creating and launching P-5 PATH, our visit specific intake paperwork is a “best practice” which is an essential component to the program. The implementation of key questionnaires and screening tools at specific visits drives your team’s ability to implement risk stratification, risk stratified care pathways, and to effectively integrate the occupational therapist in an efficient and targeted manner.

- Understand** the difference between the 3 types of P-5 PATH paperwork to be integrated into Primary and Dental care for all 0-5-year-olds.
- Familiarize staff with each type** of paperwork and when to use.
- Complete **staff training** on use of these tools.

The primary tools which we created to facilitate this program are:

- Integrated, pediatric specific registration paperwork
- A set of age-specific intake paperwork for use in WCC visits
- A single 0-5-year-old intake paperwork for use in Well Dental visits

INTEGRATED, PEDIATRIC-SPECIFIC REGISTRATION PAPERWORK

This paperwork (also discussed in Chapter 5: Clinical Systems Integration and Logistics) includes all documentation that your clinic uses for onboarding new patients. For NHC, this includes the following forms: Patient Registration, HIPAA acknowledgement, Release of Information, Protected Health Information, Income Verification, and Health History. Because the forms contained in NHC’s intake packet were not specific to pediatric patients and were not the same between our medical and dental departments, our first step was to modify all existing forms to assure that they were:

1. Appropriate to be used with pediatric patients (omitting questions which were not pertinent to children, adding opportunities to collect information about caregivers) and
2. Able to be used by *both* our medical and dental teams. We have provided examples of these forms in Appendix D.

We strongly recommend using them to update your existing intake paperwork packet to meet the above criteria. See Chapter 10: Staff Training for details on training your front office and clinical staff on using new tools.

AGE SPECIFIC P-5 PATH INTAKE PAPERWORK FOR USE IN WCC VISITS


You can find these forms in Appendix K. This paperwork is a set of forms, delineated by age of the child at each American Academy of Pediatrics (AAP) recommended WCC visit between 0-5 years. There are 15 total forms to match the 15 AAP recommended WCC visits during that time frame. All forms follow a similar style, with the first page including several questions which are the same at every visit, plus a set of similar questions which progress based on the age of the child. Subsequent pages contain 1-3 additional screening tools. These tools were included at key visits to avoid overwhelming a family with paperwork and include:

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- Edinburg Postnatal Depression Screen (EPDS)
- Caries Risk Assessment
- Ages and Stages Questionnaire
- Survey of Well-Being of Young Children (SWYC)
- Parent Patient Activation Measure (PPAM)
- Parental ACEs screening
- Child ACEs screening
- M-CHAT Autism screen

All tools were selected to support the PCP identifying and prioritizing areas of need throughout the visit. The information allows the PCP and OT to determine how much support a family might need with adopting health habits and gathers a baseline for how frequently families are performing certain health promoting or detracting behaviors. Each form additionally contains one or more screening tools to match common concerns of that age and to guide the risk stratification process. (See Chapter 13: Risk Stratification and Chapter 14: Risk Stratified Care Pathways for additional information.)

 We print these forms in different colors to help delineate between them. Because there are too many to have them all be a different color, we simplify by making all forms for 0-6-month-olds blue, all forms for 9-30-month-olds purple, forms for 3-5-year-olds yellow.

P-5 PATH INTAKE PAPERWORK FOR USE IN WELL DENTAL VISITS

You can find these forms in Appendix K. This is a single form, which is used at every Well Dental visit for all children 0-5 years. This form mirrors the first page of the Age Specific Intake Paperwork for use in WCC visits and allows us to collect important information in the dental visit on the child's risk factors as well as current home behaviors to facilitate Dentist provided education and goal setting.

IMPLEMENTATION OF KEY TOOLS

Implementing these forms took consistent and on-going staff training as well as tracking to determine staff consistency with use, and problem solving to identify barriers and solutions to improve consistency. You can find more on this in Chapter 10: Staff Training for details on training your front office and clinical staff on using new tools.

We determined that the biggest barrier to implementing these tools was the front desk staff feeling overwhelmed and frequently forgetting to give out paperwork when patients arrive. Through discussion and problem solving, we determined that the best solution to this issue was for the coordinator (while scheduling) or occupational therapist (while combing the schedules) to document within the patient's appointment in the EHR, using an appointment "message" to remind front desk which paperwork was required for that visit. Appointment messages were already in use by the front office staff to remind themselves which paperwork was required for adult patients at each visit, so this was the obvious choice for NHC as it did not require the learning of a new workflow.

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Figure 6: Adding a “message” to patient appointments in Epic

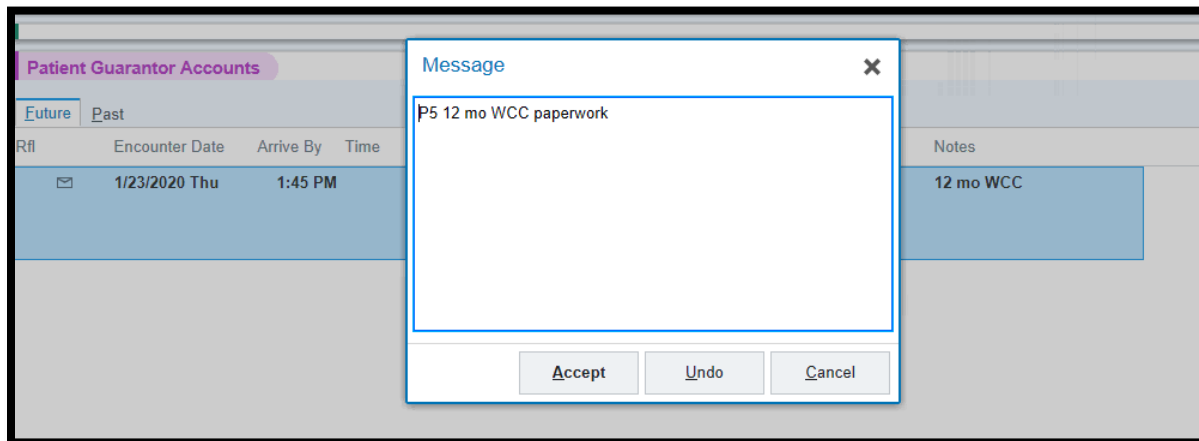


Figure 7: Back office view of appointment messages in Epic

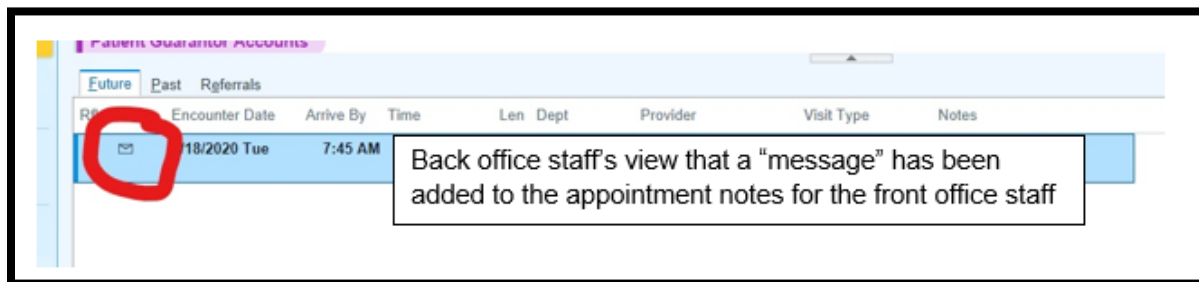


Figure 8: Front office staff view of appointment messages in Epic



◆←● Once our intake forms were approved by our Quality and Development team, they were
 ↓
 ●→■ converted to PDFs and housed along with our adult paperwork, on a share drive. The front office prints these forms as needed and keeps a file cabinet stocked with them for easy access for all front desk staff. All forms have been translated into Spanish.

These forms are used exclusively at Well Child and Well Dental visits. We do not use these forms for sick visits or follow up visits, unless the forms were not filled out at the last Well visit.


10. Staff Training

In order to get your team up and running using new methods, tools, and approaches as well as supporting everyone with learning and implementing new workflows, staff training will be a vital component of program launch. We recommend training all staff, including non-clinical staff in new workflows and on the overview of P-5 PATH to assure that they can support scheduling, answering patient questions, and marketing of the program to eligible patients.

Clinical and non-clinical staff will require on-going training, especially as new staff come on, for periodic refreshers or training on updates and modifications.

- Determine your model** for training non-clinical staff (identifying a champion vs training of all staff).
- Determine training schedule** for non-clinical staff on each vital topic and **obtain approval** to complete trainings.
- Determine who will lead trainings** for clinical and non-clinical staff.
- Determine the appropriate **pathway for scheduling and completing staff trainings for clinical staff.**
- Determine the appropriate **pathway for scheduling and completing staff trainings for non-clinical staff.**
- Set intermittent opportunities for **re-train** sessions on a quarterly to annual basis.
- Set a plan for **ways to gather feedback** regarding barriers and successes which indicate the need for updates or additional training.

Our primary staff training occurred over the first 6 months of program launch and was completed in phases. We completed general trainings for all staff as part of larger “all staff” meetings, then followed up with smaller, more focused trainings for those with key roles or on specific workflows that pertained to specific staff. We continued to incorporate “updates” and additional trainings as the program moved from preparation to launch phase and new workflows were tested and modified.

 We utilized a combination of direct training to all staff in a particular role (i.e.- all front desk staff) and also a “train the trainer” or staff champion model where we trained one key individual within a particular work area, who was in a position to disseminate the information to other staff in a similar role.

Phase 1: All staff training on program

Introduce OT and P-5 PATH program to your entire clinic. Again, this was accomplished at NHC initially through 10-15-minute in-services incorporated into “all staff” meetings in order to capture both clinical and non-clinical staff. See Chapter 8: Interprofessional Roles and Collaboration, and Appendices G, H, and I for further details and sample presentations.

Phase 2: Clinical staff training on theory and background

Topics include patient activation, motivational interviewing, and using a trauma informed approach in patient care. See Appendix L for a sample PowerPoint presentation on this topic.

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30 minutes was set aside to deliver this presentation to all clinical staff involved and new trainings were scheduled to support onboarding of new staff as well as re-train existing staff ~1 year after the initial training.

Phase 3: Non-clinical staff training on workflows

We recommend an initial training for all front desk and call center staff on these following topics:

Scheduling of patients with OT and co-scheduling OT with Well Child and Well Dental visits
Paperwork tools- stocking, disseminating, and collecting paperwork for P-5 patients in dental and medical visits. Specifically, we focused on the following areas for the paperwork:

- Where the file will be stored electronically- share drive pathway.
- Where each tool will be stored physically- identify one location and a filing system to delineate tools by age, language, and visit type.
- Who will print and restock these tools- our front desk lead does this as part of her weekly duties.
- Which patients should receive these tools and when- only 0-5-year-olds who are being seen for *Well* visits in dental or medical.
- How to make sure the right tool is distributed at the right time- look for the appointment note on the patient's appointment in the EHR. (See Chapter 9: Key Tools for more detail on this.)

Figure 9: Front desk filing cabinet with P-5 Paperwork



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Phase 4: Clinical staff training on workflows


This phase will be the most time consuming and, in our experience, was best accomplished over several training sessions with each topic below as its own training session.

For clinical support staff (MAs and DAs)-

- a. Understanding new paperwork and staff roles in collecting and entering into EHR.
- b. Scheduling patients for follow up visits.
- c. Connecting with the occupational therapist before or after patient visits.

For clinical staff (PCPs, Dentists, hygienists)-

- a. Documenting screening results and risk stratification score in the EHR.
- b. Reading and responding to issues identified on the paperwork.
- c. Providing activation focused intervention and parent coaching.
- d. Understanding and using the “risk stratification” tool for patient visits.
- e. Accessing and using available resources (clinic-based resources including handouts and support staff including and outside of the occupational therapist, and community-based resources available to patients).
- f. Incorporating occupational therapist into well child medical and dental visits, completing warm hand-offs, and accessing stand-alone OT visits.
- g. Finding and understanding the occupational therapist’s documentation.
- h. Supporting kids with negative “behaviors” in visits.

 The occupational therapist, who was the project lead, led most staff trainings on program details, theory, and workflows. We re-trained on a quarterly basis, to capture newly hired staff and update existing staff. We also created a PowerPoint presentation which gave a high-level overview of the program for new staff to be watched/listened to as part of general staff on-boarding procedures.

11. Logistics- Time, Space, & Tools for OT

We have provided our recommendations below on the logistics of embedding OT in primary care and dental visits, based on what worked within our setting. However, key considerations for this chapter include whether these logistics will fit within your organizations structure and whether each will positively impact patients' health and will be feasible for your patients.

- Set guidelines around **which** medical and dental visits the occupational therapist will be involved in on an automatic basis.
- Decide on **time** functions of OT follow up treatment - duration, frequency, & number of sessions.
- Find **space** for OT treatment to take place.
- Obtain **materials** needed for OT sessions.
- Create a plan (and template) for OT **documentation**
- Decide on **treatment model** for OT follow up with guidelines for who qualifies for which type of follow up intervention.

WHICH VISITS

One of the first questions to answer is “which visits” the occupational therapist should join (in the dental and medical setting). In our experience, as the program is first launching, the occupational therapist should join:

- all Well Child visits for children in your age range
- all new patient primary care visits for pregnant mothers
- all Well Dental visits for children in your age range
- stand-alone therapy visits
- group visits

This excludes any primary care sick visits and follow up dental intervention visits, *unless* the PCP, dentist, or occupational therapist agree that it would be helpful to have OT involved in one of these visits for a specific patient.

As your program grows, however, or if you are starting with too large a number of Well Child and Well Dental patient visits daily for one occupational therapist to see, we recommend using the following guidelines:

WELL DENTAL CARE

- 0-2 years- The occupational therapist should join all new patient dental visits for kids in this age range.
- 2.5-5 years- The occupational therapist should join new visits for patients in this age range based on caregiver response to the following screening question at time of scheduling: “Do you believe your child is scared of the dentist or will have trouble

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participating in the dental visit?” If the answer is yes, the scheduler should add the occupational therapist to the dental visit.

- For routine dental follow up visits or dental procedures- The occupational therapist will join the visit based on dentist referral and/or caregiver request.

WELL CHILD CARE

- Newborn – 2-month-olds- The occupational therapist should attempt to join at least one Well Child visit in this age range to introduce herself and the program and to support the PCP with screening and risk stratification of the patient.
- 4-9-month visits- the occupational therapist should attempt to join each of these visits for infants in this range to support parent knowledge and skill around establishing home-based daily health promoting habits for eating, sleeping, development, screen avoidance, and oral hygiene.
- 12-18 month visits- the occupational therapist should attempt to join at least one Well Child visit in this age range to further support the establishment of home-based, daily health promoting habits of family meals, sleep hygiene and routine use, developmental play, screen avoidance or reduction, and oral hygiene, as well as on-going engagement in preventative dental care.
- 24-60 months- the occupational therapist should attempt to join at least one Well Child visit in this age range to re-screen the patient and continue support around family meals, sleep hygiene, screen reduction, outdoor play, oral hygiene, self-regulation, kindergarten readiness, and on-going engagement in preventative dental care.
- LOW RISK patients should be followed by the occupational therapist at the frequency described above.
- LOW MODERATE RISK patients should be followed by the occupational therapist at the frequency described above and will get OT follow up visits via phone as needed, as well as invitations to join group classes.
- HIGH MODERATE RISK patients should be followed by the occupational therapist at the frequency described above and will get OT follow up visits via phone, individual in-office, or in group settings depending on the needs of the family.
- HIGH RISK patients should be followed by the occupational therapist at each Well Child visit between birth and five years and should also receive OT follow up via phone and individual in-office setting at least monthly until risk level reduces.
- New patient appointments of establishing patients beyond newborn age- the occupational therapist should join these visits if possible for warm handoff, to introduce herself and P-5 PATH, and to support PCP with screening and risk stratification.

TIME

It is important to assess whether the frequency, duration, and number of sessions is enough to have an impact on the patient’s health and is feasible for the clinic and the occupational therapist.

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As P-5 PATH is a wellness and health centered endeavor embedded in dental and primary care visits, the ideal OT treatment length will accommodate and compliment a Well Child or Well Dental visit.

DENTAL VISITS: For Well Dental care visits, we matched the current dental schedule of a 60-minute visit for the OT visit, which allowed the occupational therapist to be present throughout the dental visit to provide interventions which support engagement in the check up and cleaning, and interventions which target implementing the dental team's recommendations into the patient's daily life towards the end of the dental visit. This allowed patients to get individualized OT intervention at the same point of care as their Well Dental visit.

MEDICAL VISITS: OT visits as part of Well Child Care are 20 minutes in length and take place immediately following the doctor's appointment.



We initially utilized a 30-minute appointment time for OT visits in primary care and we situated them at the start of the Well Child Care or primary care visit for pregnant women. This was changed through quality improvement efforts to a 20-minute OT visit *at the end* of the Well Child Care visit, after the PCP had completed their portion of the visit.

20-minute OT appointments at the end of the doctor's visit allowed for the occupational therapist to follow up with the family on areas of concern identified by the PCP, but did not disrupt the PCP's schedule or delay their ability to stay on time with their patient visits. Additionally, this allowed families to get individualized OT intervention at the same point of care as their Well Child visit if they had time, but also accommodated families with time constraints to briefly meet the occupational therapist and schedule a follow up if needed, before leaving. Last, having the occupational therapist on a scheduling template of 20-minute appointments allowed the occupational therapist's schedule to stay in sync with the PCP schedule, which is also on 20-minute appointments.

FOLLOW UP OT SESSIONS: OT follow up sessions are typically 60 minutes in length for an evaluation, 20-40 minutes in length for phone or individual follow up intervention, and 60-minutes in length for group follow up.

TYPE

OT follow up sessions can be provided as either phone visits, individual in-office visits, or group follow ups. The type of follow up indicated was determined by the patient's risk level, parent motivation and availability, and Dentist/PCP input.

- **LOW RISK:** Patients who were identified to have "low risk" received no follow up unless the family or PCP specifically asked for support with a particular issue.
- **LOW MODERATE RISK:** Patients who were identified to have "low moderate risk" received phone and/or group follow up depending on parent motivation and availability and whether there was a specific issue to be managed at the time.

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- HIGH MODERATE RISK: Patients who were identified to have “high moderate risk” received group and/or individual in-office follow up, depending on parent motivation and availability, specific needs identified, and PCP input.
- HIGH RISK: Patients who were identified to have “high risk” received individual in-office follow ups with the OT on an on-going basis to address specific needs and to “check-in” with greater frequency than the traditional Well Child Care schedule dictates to both build capacity and to prevent concerns from compounding over time without being addressed between Well Child visits.

SPACE

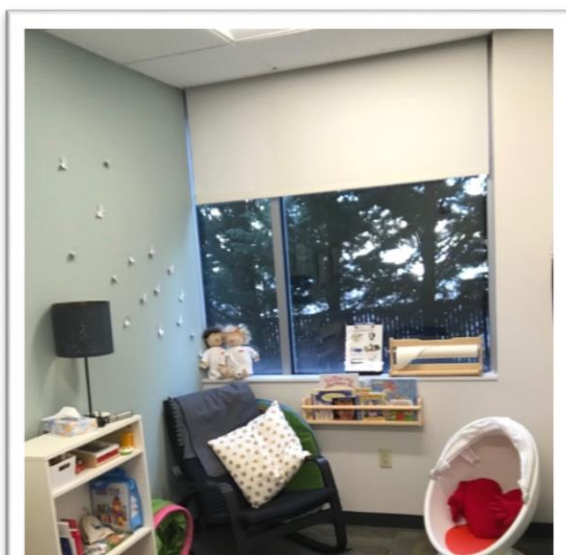
The occupational therapist should see patients in a room with floor space for playing and a supportive yet comfortable chair for the caregiver, who is often a pregnant or nursing mother or possibly a grandparent, to sit while engaging in discussion with the occupational therapist. Toys are necessary and if possible, a table for tabletop activities. This space is ideally not a dental or medical exam room though it should be within the primary clinic or as close as possible. Space should also include access to a computer or tablet with Internet access.

There should be storage space, ideally a filing cabinet within the clinic, for patient files and assessments, which include sensitive patient information and must be locked away for HIPAA compliance, as well as for OT treatment materials such as toys, dental hygiene supplies, and books. The treatment materials do not need to be locked but would ideally be close to the space where the occupational therapist is seeing patients.

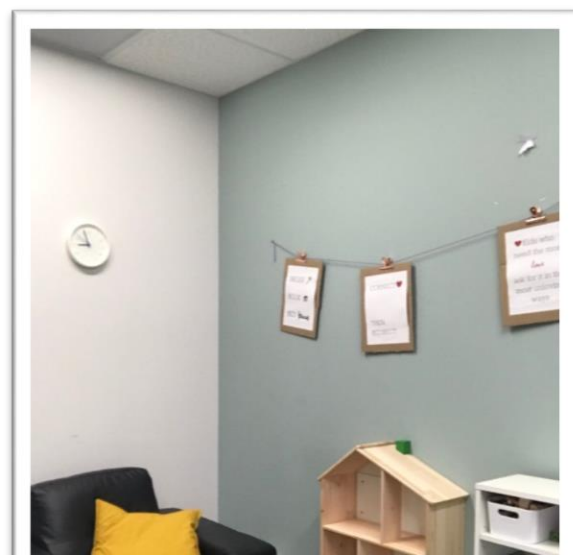
 We were able to designate a small treatment room, about the size of a medical exam room, as the OT room. This room contained one small bookshelf where books and toys were stored, 2 chairs for adults, 1 for a child, and a computer with internet and EHR access which could be used for either parent teaching or documentation.

When group visits launched, we recognized the need for additional space and in response, identified the staff conference room as an ideal location. This required removal and rearranging of current furniture in that room, which was not a problem because the existing tables and chairs were all on rollers. We were able to move these temporarily out of the way for group dental classes.

Figure 10: OT room for P-5 PATH



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MATERIALS

The OT typically will have a toolbox of various materials (e.g. toys for different developmental ages, craft supplies, whiteboards, markers, etc.).


Because many OT treatment activities are completed on paper, it is helpful to keep patient files (in a locked cabinet) with the patient's activities in progress (e.g. social stories, a Balance Wheel). It is also possible to photograph these worksheets for upload onto your EHR system.

The occupational therapist should have access to a printer and paper, as they will often print materials for the patients to use.

 Simple and inexpensive materials that are useful to launch your OT services on a budget include, construction paper, embroidery thread, markers, crayons, a roll of butcher paper, and a few key toys which can span multiple ages: balls, dolls, doll house, blocks, stacking cups or rings, shape or picture magnets, trucks/trains, a simple pretend medical and dental kit, and simple wooden puzzles. Securing dental specific toys, such as a large doll or stuffed animal with teeth that can be brushed is also useful. All items should be wipeable or washable.

For group classes, blankets are necessary to delineate a play space and a few foldable chairs for caregivers who are unable to sit on the floor. Additionally, we purchased a small collection of children's books on certain topics that were utilized in therapy visits and within group dental classes. These included:

- "Madison Goes to the Dentist" (which includes the same story in both English and Spanish)
- "Dora Goes to the Doctor/Dora Goes to the Dentist" (both stories in 1 book)
- "Brush, Brush, Brush"
- See Appendix T for details on dental group class activities and supplies

 We found it helpful to have a few grab-and-go bags packed with age specific toys, sensory tools and evaluation materials which could be carried into a medical or dental visit. This saved the OT time as she moved between visits. All materials were wiped down between visits when possible or were stored in a basket at the OT's desk after a visit to be cleaned at end of day if time did not allow between visit cleaning.

DOCUMENTATION

The occupational therapist should document initial evaluation and progress notes through the EHR (we use Epic) in-line with the way other allied health providers document. Prior to beginning treatment, the OT is expected to be proficient with using the clinic's EHR system—documenting, combing medical and dental records, using staff and patient messaging functions, and scheduling. It is ideal if the occupational therapist receives training in and becomes familiar with ways to create and modify documentation templates, including creation of short cuts as available (i.e. dot phrases and SmartLists in Epic), as standard primary care and dental

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templates are not appropriate for OT documentation and will generally not include appropriate OT lexicon.

In Appendix J we have also included templates for initial evaluation and progress notes as well as wellness screens that can be used in dental settings and well child visits. We use these templates as dot phrases which can be easily pulled into EHR documentation.

12. Logistics- Time, Space, & Tools for Dental Hygienist in Primary care

We have provided our recommendations below on the logistics of embedding a dental hygienist in Well Child visits for assessments and as a facilitator of group-based education and skills practice, based on what worked within our setting. Similar to the previous chapter, it is important to consider what will fit within your organization's structure and whether each will positively impact patients' health and will be feasible for your dental team.

- Set guidelines around which medical visits the hygienist will be involved in.
- Decide on **an ongoing date/time for hygienist to join Well Child visits.**
- Make sure that the hygienist schedule is blocked in an on-going manner for these visits.**
- Confirm outreach and scheduling protocol to fill primary care Well Child visits with patients who need dental care and have an insurance your dental clinic can accept on the days/times when hygienist is available.
- Find **space** for hygienist assessment and treatment to take place.
- Gather supplies and **tools** needed for hygienist's work in primary care.
- Create a plan (and template) for hygienist **documentation.**

Once again, an important question to answer is "which visits" the hygienist should join (in the medical setting). We recommend:

- all Well Child Care visits for children in the age range your clinic chooses to target, especially those that have a dental insurance accepted by the dental clinic.
- all new patient primary care visits for pregnant mothers.
- group wellness classes.

This excludes any primary care sick visits *unless* the PCP, hygienist, or occupational therapist agree that it would be helpful to have the hygienist involved in one of these visits for a specific patient.

TIME

The goal of embedding a hygienist in primary care visits for pregnant mothers and Well Child Care is to provide services to at risk patients who may otherwise not engage in preventative dental care. With this in mind, we recommend setting at least one 3-4-hour block of time per week when the hygienist's schedule can be blocked for exclusive coverage in Well Child Care visits.

- ◆←● Hygienist's visits as part of Well Child Care are 20 minutes in length and take place
- immediately following the doctor's appointment. The coordinator confirms with the family that they want a visit with the hygienist and the front desk confirms the dental insurance at the time of check in.

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The hygienist and OT enter the room immediately after the primary care provider completes their visit. The hygienist reviews the Caries Risk Assessment, performs an oral assessment, provides oral hygiene instruction and offers to apply fluoride varnish. The hygienist asks about home oral health practices and shows patients and caregivers how to brush thoroughly with a new toothbrush they will get to take home as well as tips such as how to position children who are uncooperative for brushing at home. The hygienist then excuses herself while the OT continues her visit with the patient.



We initially blocked four 1-hour time blocks on the hygienist schedule across two days per week to maximize access for children in primary care to receive dental services. However, we found this was not enough time for the hygienist to wrap up in the dental clinic, join primary care visits and complete her work before needing to return to the dental clinic to see her next dental patient. Because the timing of the PCP finishing their visit with patients can vary and the hygienist visit follows the PCP, the hygienist must have flexibility on when she is available to enter the medical exam room to see patients. We modified our hygienist's schedule to the current state of one 4-hour block in primary care on the hygienist's schedule one day per week to allow for the needed flexibility. We were also able to fit in 2-hour long group dental classes once per month during this block.

SPACE

The hygienist sees patients in the medical exam suite. The hygienist will position the child either in a knee-to-knee position or lying supine on the medical exam table. This allows for the hygienist to get a clear view of the patient's teeth, to show parents any concerns with the teeth and to demonstrate for parents how to perform brushing and flossing on their child.


The hygienist should also have a computer workstation outside the medical exam suites in the primary care provider work area to be able to access the EHR and perform documentation. Ideally, this station should be located among or close by the interprofessional care team members in primary care to be able to consult with care team members about patients prior to and after WCC visits.

Supplies should be brought weekly by the dental hygienist from the dental clinic over to the medical space, or preferably kept in a storage space in primary care close to the area where the hygienist will see patients in primary care. These supplies should be stored in an easily accessible location that can be brought in to visits as needed.

For the group dental classes, as we noted above in Chapter 11: Logistics: Time, Space, and Tools for OT, we designated times when the staff conference room was available and used this larger space which accommodated 5-6 families at a time once rolling furniture was removed.

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 We found it helpful to keep all the hygienist's supplies in a cabinet in primary care, and to prepare the supplies needed for each patient visit into discrete packets (small bags). The hygienist could grab a basket, add one of the prepared packets and a few additional supplies as needed to take to the medical exam room. This reduced the need to carry around a larger bucket full of supplies unnecessarily and helped promote infection control by preventing extra supplies from potentially getting contaminated.

Pre-preparation also helps make the visit efficient. Patients and families appreciate the value added by the hygienist visit, but also the respect shown in making the lengthened visit as efficient as possible.

MATERIALS

The hygienist brings a headlamp and a small basket of supplies to the medical exam room containing:


- Pre-prepared oral hygiene bag with a pediatric toothbrush, a small disposable mouth mirror, a small tube of toothpaste, and plastic-handled flossers
- Fluoride varnish packet

Other necessary supplies are stocked in the medical exam rooms, including:

- Masks
- Gloves
- Gauze
- Hand sanitizer
- Disinfecting wipes

For group classes, the hygienist brings:

- Pre-prepared oral hygiene bags as described above
- Education materials or handouts depending on activity selected (see Appendix T for details on dental group class activities and supplies)

 We learned that it is *very* important to do the oral assessment visit **prior** to the child receiving vaccinations! When the order is reversed, children are far less likely to be cooperative for a visit with the dental hygienist.

Additionally, parents often have questions about teeth eruption. It may be helpful to carry a laminated tool or have a handout available to give to parents on tooth eruption patterns. It may also be helpful to have handouts readily available on other topics, such as early childhood dental decay, breast and bottle feeding, and non-nutritive sucking, or provide information in an After-Visit Summary (AVS).

DOCUMENTATION

The dental hygienist should document the oral screening findings, oral hygiene and nutritional counseling given, and fluoride varnish application in the patient's chart through the EHR (NHC uses Epic). The hygienist has their own schedule and opens and documents an encounter, similar to documenting an encounter when in the dental clinic. A note template can be used to document oral health services provided in primary care. We tailored a note template that was already used in our dental clinics to fit the primary care setting.

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In Appendix J we have also included sample templates for documentation of oral care provided by the dental hygienist in Well Child Care visits. In Epic, these templates are easily pulled into the EHR documentation using dot phrases.

13. Risk Stratification

A key component to P-5 PATH is tailored care based on a child's current health *and* overall risk of developing health related issues developing over time. Our program acknowledges that certain life experiences, behaviors and daily habits either promote health or detract from a person's health in ways that are not always immediately apparent. Still other experiences, habits and behaviors have no immediate effects any may not ever lead to ill effects, but generally increase the odds that a child might get sick or struggle to function well later. Because of this, we re-framed our Well Child and Well Dental care visits to assure that our clinicians are gathering essential information on areas of risk and are discussing a child's health in the context of current health and risk for health issues over time. Next, we created a tool to differentiate "risk levels" and to standardize how we assign those "risk levels" to patients. Last, we formalized unique "care pathways" for each risk level to assure that those patients with higher risk receive quality care to support a reduction in risk and/or to manage current issues impacting health in a meaningful way.

- Familiarize your team** with the P-5 PATH risk stratification tool and how to score.
- Determine **who will be responsible for scoring** and assigning a risk level to your patients.
- Determine **where to document** this information within the EHR.

RISK STATIFICATION TOOL

Because there are not commonly available pediatric risk stratification tools currently available, we created our own. Our goal was to first create a list of possible experiences, behaviors, problems, etc. which we know impact:

- A child's current health
- A child's long-term health
- The likelihood that a child will develop an illness or functional impairment
- A parent's capacity to provide optimal conditions to support child development and overall health (this was not to determine if a parent was competent to raise a child—only to determine parents who may need more support to create or sustain developmentally optimal environments for their child to thrive.)

We used this list to inform which screening tools we needed in visits to gather the necessary patient and family specific information. Finally, we created a tool to supports our efforts to quantify those risks in a standardized way.

Our tool combines the social and medical complexity of the child and the family to provide a "risk level" assignment for each patient. The medical and social elements we chose were informed by literature on Adverse Childhood Experiences (Felitti, et al, 1998; Larkin, Shields, & Anda, 2012; Finkelhor, 2015) as well as local work by Dr. Joyce Liu of Kaiser Permanente and the Oregon Pediatric Improvement Partnership.

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Figure 11: P-5 PATH Pediatric Risk Stratification Tool


	CHILD	MATERNAL	FAMILIAL
MILD RISK FACTORS (Add all risk factors from each box in this row)	Growth concerns Developmental delay (at risks or mild) Behavioral concerns Feeding issues/Picky eater Sleep concerns Dental issues/caries Child ACEs score 1-2 Undervaccinated child Medical complexity (mild)	Mental illness (controlled) Learning disorder Low education level Low health literacy Parental language barriers Developmental disability "Harsh" parenting style H/o substance abuse (in remission) Parental ACEs score 1-3	Tense partner relationship Stress in home Lives below poverty level Incarcerated parent Smoking in the home Single parent household Multiple missed appointments
	CHILD	MATERNAL	FAMILIAL
SEVERE RISK FACTORS (Add all risk factors from each box in this row)	High medical complexity Prenatal drug/alcohol exposure Developmental delay (mod or severe) Hx physical, emotional, or sexual abuse History of neglect In foster care Child ACEs score 3 or more Frankl behavior or participation score 1-2	Teenage Low PPAM score Parental ACEs score 4 or more Disability or chronic illnesses Mental illness (uncontrolled) H/o substance abuse (active)	DHS involvement Domestic violence Food insecurity Housing instability Death of a parent
Level 1- Low Risk Care Pathway 0-2 "mild" risk factors AND 0 "severe" risk factors	Level 2- Low/Mod Risk Care Pathway 3-4 "mild" risk factors AND 0 "severe" risk factors	Level 3- High/Mod Risk Care Pathway 5-7 "mild" risk factors OR 1 "severe" risk factors	Level 4- High Risk Care Pathway 5-7 "mild" + 1 "severe" risk factor OR 8 or more "mild" risk factors OR 2 or more "severe" risk factors

Our Pediatric Risk Stratification tool focuses on “mild risk factors” and “severe risk factors” that a child, parent and family may experience. The “mild risk factors” are issues which are not profoundly detrimental to a developing brain, but which tend to negatively impact a child’s health if left unaddressed over time. The “severe risk factors” are experiences and issues which we know to have a more substantial impact on a child’s current and long-term health and/or which cause significant barriers to the parent’s ability to connect with and care for the child. Our tool hypothesizes that several “mild risk factors” can add up to a high degree of risk for illness and dysfunction in the same way that experiencing even a few of the “severe risk factors” can impact a child’s wellness. This tool is available to view in Appendix M, section 1.

While all factors can be assessed and added in both a medical and a dental visit, we found that it has taken more time, training and effort to integrate all the screening tools used in WCC into dental visits. Because of this, the primary trigger for risk level assignment in a dental visit is the child’s score on the Modified Frankl tool (which scores a child’s participation and behavior in that dental visit- See Appendix M, sections 2 and 3). A low score on the Modified Frankl tool is weighted as a “severe” risk factor in order to make sure that children who struggle to comfortably and functionally participate in dental visits are flagged to be seen by the occupational therapist in their next dental visit (and if needed) between dental visits for practice with remaining calm in the dental chair.

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 At this time, we have successfully implemented our risk tool in all WCC visits for 0-5-year-olds but with less consistency in dental visits. Moving forward, our goal is to further refine the tool to make it shorter, simpler to use, and integrated within the EHR (Epic & Wisdom) to automatically assign a risk score when factors are added to a patient's "Problem List."

HOW TO USE

1. Collect the necessary information on social, medical and dental health risk through your intake paperwork and through standard practice in WCC and Well Dental visits.
2. Next, count the number of factors from each column that the child, caregiver and family is experiencing which are listed in the "mild risk factors" row.

Figure 12: Mild Risk Factors

	CHILD	MATERNAL	FAMILIAL
<p>MILD RISK FACTORS</p> <p>(Add all risk factors from each box in this row)</p>	<ul style="list-style-type: none"> Growth concerns Developmental delay (at risks or mild) Behavioral concerns Feeding issues/Picky eater Sleep concerns Dental issues/caries Child ACEs score 1-2 Undervaccinated child Medical complexity (mild) 	<ul style="list-style-type: none"> Mental illness (controlled) Learning disorder Low education level Low health literacy Parental language barriers Developmental disability "Harsh" parenting style H/o substance abuse (in remission) Parental ACEs score 1-3 	<ul style="list-style-type: none"> Tense partner relationship Stress in home Lives below poverty level Incarcerated parent Smoking in the home Single parent household Multiple missed appointments
<div style="border: 1px solid black; display: inline-block; padding: 5px 20px;">TOTAL MILD RISK FACTORS =</div>			

3. Then you count the number of factors that the child, caregiver and family is experiencing which are listed in the "severe risk factors" row.

Figure 13: Severe Risk Factors

	CHILD	MATERNAL	FAMILIAL
<p>SEVERE RISK FACTORS</p> <p>(Add all risk factors from each box in this row)</p>	<ul style="list-style-type: none"> High medical complexity Prenatal drug/alcohol exposure Developmental delay (mod or severe) Hx physical, emotional, or sexual abuse History of neglect In foster care Child ACEs score 3 or more Frankl behavior or participation score 	<ul style="list-style-type: none"> Teenage Low PPAM score Parental ACEs score 4 or more Disability or chronic illness Mental illness (uncontrolled) H/o substance abuse (active) 	<ul style="list-style-type: none"> DHS involvement Domestic violence Food insecurity Housing instability Death of a parent
<div style="border: 1px solid black; display: inline-block; padding: 5px 20px;">TOTAL SEVERE RISK FACTORS =</div>			

4. Match this number up against the scoring section on the bottom of the Pediatric Risk Stratification tool to get a score for your patient.

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Figure 14: Assigning Risk Level

Level 1- Low Risk Care Pathway	Level 2- Low/Mod Risk Care Pathway	Level 3- High/Mod Risk Care Pathway	Level 4- High Risk Care Pathway
0-2 "mild" risk factors AND 0 "severe" risk factors	3-4 "mild" risk factors AND 0 "severe" risk factors	5-7 "mild" risk factors OR 1 "severe" risk factors	5-7 "mild" + 1 "severe" risk factor OR 8 or more "mild" risk factors OR 2 or more "severe" risk factors

Our tool differentiates between 4 risk levels:

- Low risk
- Low Moderate risk
- High Moderate risk
- High risk

HOW TO INTEGRATE RISK STRATIFICATION INTO WCC & WELL DENTAL VISITS

STEP ONE: Train staff on using the appropriate screening tools in key visits. Refer to Chapter 9: Key Tools, and Chapter 10: Staff Training for details on rolling out new visit paperwork which includes the appropriate screening tool at the correct visit. Train staff on how to respond to needs identified based on the use of screening tools/intake questionnaires. This takes education and practice of skills. See Appendix N1 and N2 for resources to support staff with responding to patient needs.

STEP TWO: Begin using P-5 PATH Age Specific Paperwork for WCC visits and P-5 PATH Intake Paperwork in Well Dental Visits by having front desk disseminate the correct paperwork for the child's specific visit. (i.e.- a 9-month-old child who is seen for a WCC visit would be given the P-5 PATH 9 Month WCC paperwork and a 15-month-old child who is seen for a Well Dental visit would be given the P-5 PATH Well Dental paperwork for 0-5-year-olds.)

STEP THREE: Track "misses" for 1-2 months. Then meet with appropriate staff to address any areas of concern or issues with consistency in giving out and collecting paperwork; reminding front desk of which paperwork to give, reminding front desk staff to look for "appointment message" reminders and handing out appropriate paperwork at each visit, and/or reminding the coordinator and occupational therapist to add these "appointment messages" to Epic appointments.

STEP FOUR: Schedule a follow up meeting with clinical staff in 1 month and again in 3-6 months to discuss any additional training needs or needs for resources, handouts and tools to support families with common issues identified for your patient population using the intake paperwork.

HOW TO DOCUMENT

Documenting the Risk Stratification score in the EHR is an important step to tracking patients over time and to using the risk informed care pathways that we will discuss in the next chapter, Chapter 14: Risk Stratified Care Pathways.

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- ◆←● The occupational therapist scores and documents the risk score in the EHR within the OT note at the top of each report (see Appendix J for example for where in the note this is documented or Figure 15 below). Then this score is added to the patient tracker tool managed by our P-5 PATH coordinator to track patients and make sure they are returning for care as prescribed.
- 💡 Some team members add the risk score to a “sticky note” in Epic so that it pops up for them whenever the patient’s chart is opened.

Figure 15: Documenting Risk score in EHR

OCCUPATIONAL THERAPY BRIEF WELLNESS SCREEN & INTERVENTION DURING WELL CHILD CARE VISIT

NAME: @NAME@
AGE: @AGE@
DOB: @DOB@
MRN: @MRN@

SNAPSHOT/SUMMARY:

Visit concerns: ***
Goal: ***
Risk Levels: {P5 Risk Level:27552}
Next steps: ***

- 🧠 As our work continues, our Epic team continues to investigate possible strategies or tools that will need to be created to support documenting risk scores for our pediatric patients in a more prominent and communal location within the chart.

Additionally, our team uses information gathered from the risk screening to populate the “Problem List” in the patient’s EHR.

Figure 16: Problems List in Epic EHR

← Snapshot Chart Review Care Everywhere Pre-Charting **Problems** FYI Demographics MyChart A...

Problem List

+ Care Coordination Note

Search for new problem + Add DxReference View Drug-Disease Interactions Show: Past Problems

New problems from outside sources

Problems need attention. Go Reconcile →

Diagnosis	Share w/ Pt	Resolved
-----------	-------------	----------

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Figure 17: Mild and Severe Risk Factor Diagnostic Codes

MILD RISK FACTORS		CODE	SEVERE RISK FACTORS		CODE
Growth concerns			Prematurity		
Poor feeding of newborn		R63.3	Prematurity of baby		P07.30
Poor weight gain of newborn		P92.6	Prenatal exposure to alcohol & drugs		
Developmental Delays			Fetal exposure to alcohol		P04.3
Risk for Developmental Delay		Z91.89	Neonatal abstinence syndrome		P96.1
Developmental delay, mild		R62.50	Maternal exposure to alcohol		O09.899
Behavioral concerns			Developmental Delay		
Child behavior problem		R46.89	Developmental Delay Moderate or Severe		R62.50
Behavior causing concern in adoptive or biological child		Z71.89	Delayed milestones in childhood		R62.0
Behavior causing concern in foster child		Z62.822	Unspecified intellectual disability		F79
Feeding Issues			History of Abuse		
Picky eater		R63.3	History of abuse in childhood		Z62.819
Breastfeeding problem in infant		R63.3	Sexual		Z62.81_
Breastfeeding problem in newborn		P92.5	Physical		Z62.81_
Does not latch		O92.70	Psychological		Z62.81_
Sleep concerns			Child Protection Services		
Infant sleeping problems		G47.9	Child protection team following patient		Z04.72
Dental Issues			In foster care		Z62.21
Dental caries in early childhood		K02.9			
Need for dental care		Z91.89			

A comprehensive list of the diagnostic codes we use for both mild and severe risk factors can be found in Appendix M, section 4.

RESPONDING IN THE MOMENT TO IDENTIFIED RISKS

One key element of implementing risk stratification screening, which includes using the P-5 PATH Age Specific Paperwork for WCC visits and P-5 PATH Intake Paperwork in Well Dental Visits is responding in the moment to social needs that may be identified through responses on the paperwork.

This includes identification of sensitive information, such as:

- Food insecurity
- Housing insecurity
- Parental mental health concerns
- Domestic violence
- Stress in the home/family life
- Smoking in the home
- Trauma history
- Incarcerated parent
- Parental drug and/or alcohol issues
- Neglect or abuse
- Social services involvement

Your care team (pediatricians and dentists) must be prepared to respond to these issues in a supportive and reassuring manner, with clearly spelled out next steps for patients. This means that you must complete training to help your pediatricians, family medicine physicians and dentists understand their role, build skills in having these conversations and know where to find resources to help a family with each of these concerns.

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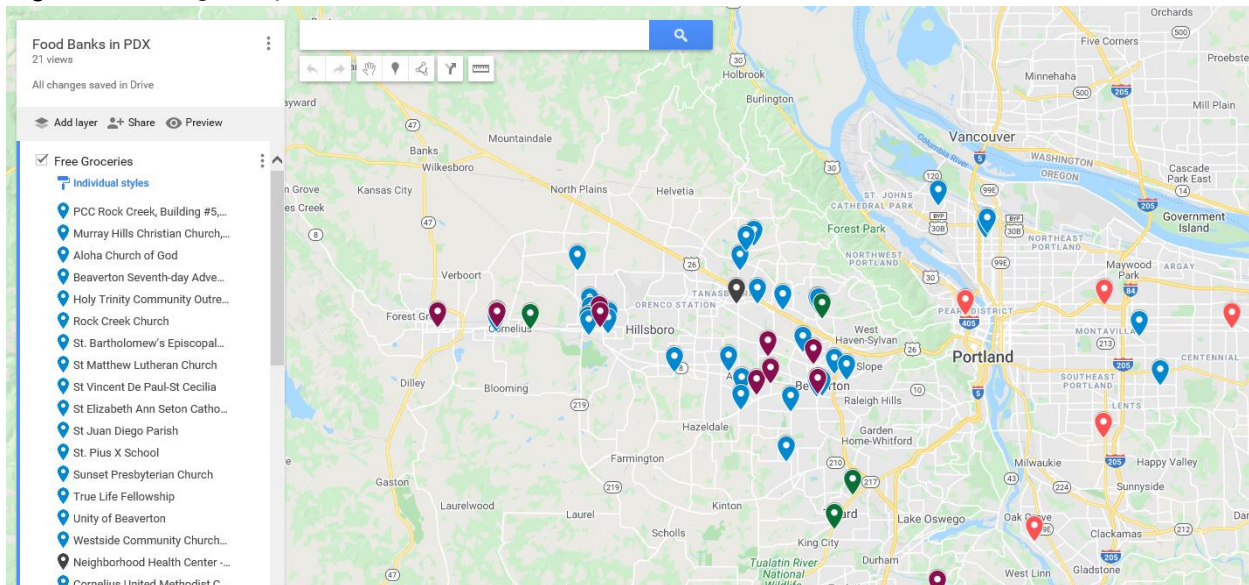
We recommend that you make a clear list of all your internal and external resources available to families to share with your team. You can see our example of our list in Appendix N1. We recommend sharing this list with all pertinent staff and assigning a staff member (ideally the P-5 Coordinator, an occupational therapist, a behavioral health specialist, a social worker or a community resource specialist) to continue to update this list every few months. See Appendix O for workflows to support screening and responding to your patients' social needs.

Additionally, we created print material tools to match common issues where connecting a family to concrete resources was indicated:

- Food insecurity
- Housing insecurity
- Smoking

One example of this is our “Food Insecurity” handout which is included in Appendix F. An additional example of this is a partnership we have with the Oregon Food Bank. They have a wonderfully thorough handout of all local food bank options organized first by geographic location, then broken down further by what is offered (a food box, a “grocery store” experience, or a hot meal) with dates/times, addresses, phone numbers and details on who qualifies for these services. We were able to use this tool to support our parents. We took this a step further by entering each of these locations into a Google map, which allowed providers to show families on the computer, in visits, exactly where a facility was located and find food banks closest to the patient’s home or work.

Figure 18: Google Maps Tool for Food Banks



Because it is not feasible for all providers to know of all resources and to know how to respond to and coach families on a wide variety of social issues that may arise, we recommend training staff on identifying needs and connecting patients with the occupational therapist for additional

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support to address the needs. See Appendix O for workflows and Appendix F for parent resources.

14. Risk Stratified Care Pathways

- Bring suggested P-5 PATH Risk Informed Care Pathways to a team meeting for **input and site-specific modifications**.
- Tailor the proposed care pathways** to fit your program and organizational needs.
- Provide **staff training** on Risk Informed Care Pathways.
- Perform **audits** to determine successful completion of your care pathways.

Once a risk level has been assigned to a patient, the next step is to use that risk level to inform next care steps. This tool is meant to assign an overarching risk level and subsequent overarching next steps in *wellness* care. This tool is not meant to replace existing tools, which categorize and assign a risk level for highly specific illnesses or issues. It is also not meant to guide return to care or medical management for specific illnesses or issues. For example, if a PCP is using a tool to categorize an infant's risk of negative sequelae and need for intervention given their bilirubin levels and medical history, and the outcome suggestions immediate follow up, this would supersede the risk level assigned by the P-5 PATH Risk Stratification tool assignment and care pathway suggestion. Or if a dentist has identified a tooth abscess that needs immediate attention, this would, again, supersede the care pathway recommendations given by using the P-5 PATH Risk Stratification tool.

The premise of the P-5 PATH Risk Stratification tool and the Risk Stratified care pathways we created is to identify infants and children who are at higher risk than same age peers for developing an illness, experiencing an accident, or failing to live up to their individual potential due to presence of specific risk factors. Therefore, our recommended Risk Informed Care Pathways were developed to provide one or more of three foundational care elements:

1. More support within WCC and dental visits to maximize child and parent participation and build lasting health relationships.
2. More thorough and frequent assessment of health by our interdisciplinary team.
3. Supportive interventions into primary care, dental visits, and follow up visits aimed at reducing risk.

MAXIMIZING CHILD AND PARENT PARTICIPATION & DEVELOPING RELATIONSHIPS

This first care element is founded on the idea that establishing and engaging regularly and positively in care within your Health Home is beneficial to a patient's overall wellness. We believe that when safety, inclusiveness, and participation are prioritized from the start of care, parents will be more engaged, children will be more compliant, and the care team will accomplish more at each visit. Child compliance is particularly essential to dental visits, where we need a child to hold things within the mouth, open the mouth, and sit relatively still for extended periods of time. While small children can be forced into compliance, we believe that the more sustainable and respectful approach involves gaining trust and teaching the child to develop active participation. We believe our trauma informed approach is an essential step to building an activated patient who engages in regular preventative care, well beyond their childhood.

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THOROUGH & FREQUENT ASSESSMENT OF HEALTH BY INTERDISCIPLINARY TEAM

This second care element is founded on the idea that for certain patients, standard WCC and Well Dental check-ins are spread too far apart and allow for disease and risk to grow substantially between visits. Using this foundational belief, we encouraged our care team to recommend patients in high moderate and high-risk groups to return to care at shorter intervals. Each of these touchpoints allows our team to complete brief assessments of health and risk in a variety of areas to determine areas where the care plan needs to change or where additional intervention or referral may be warranted to keep our patients and families healthy. Because we know that our health team can only accomplish so much at each visit, more frequent follow ups also ensure that our providers can accomplish all that they feel is needed in the care of the patient. This helps our providers feel more effective, which is one step in reducing burn-out and improving provider satisfaction.

INTERVENTIONS DURING & OUTSIDE OF WCC AND DENTAL VISITS

Targeted interventions are the third care element of our risk informed care pathways. These interventions are carefully scaffolded to provide population level education and support to maximal number of patients, through more individualized and intensive intervention, as needed to meet the needs of our patients. As noted previously, much of this intervention is centered around building wellness habits and skills, though we were also able to include some focused intervention to treat certain health issues, such as poor growth, developmental delay, and torticollis for example.

Our interventions were not meant to replace referrals to specialists when indicated. For example, if a child's developmental delay was moderate or severe, we referred that child to Early Intervention services, including Speech and Language Pathology, Occupational Therapy, and Physical Therapy. Our intervention services are designed to bridge the child between the time concerns were identified and the start of outpatient services, which is often spans one or more months of waiting. Our intervention services are also designed for those patients who do not qualify for specialist or outpatient developmental services. Because our patient population is at high risk for mild to moderate delays, behavioral issues, and health concerns while also being more likely to not have the financial means to access supportive services and specialists when not covered by their insurance, our interventions were also meant to be a safety net for these patients. As such, all interventions centered around parent training and coaching to build parent capacity to support the child in the home environment.


UNIDENTIFIED RISK

Because risk level is not established until the end of the initial visit or possibly after the second or third visit if there are more pressing issues to be addressed in those initial visits, we default to using a proactive approach to providing support until we know where a child's risk score falls. This included integrating the occupational therapist into establishing visits whenever possible to help with risk stratification and establishment of a relationship early between the occupational

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therapist and the family. See Chapter 11: Logistics- Time, Space, and Tools for OT for further details on ways identifying key visits for evaluation and OT interventions.

 Until the occupational therapist can join the visit and/or the child’s risk score is assigned, we use “standard” care, which is the same care we have always provided for all children in dental and medical visits at NHC. However, as our program has progressed, we find that all staff members are gradually “upskilled” by our interdisciplinary and collaborative efforts. This means that our “standard care” has improved in quality and comprehensiveness. One example of this is the upskilling of our Dental Assistants, who have developed excellent skills in adapting the environment to support young children and engaging parents through use of a coaching approach.

RISK-BASED CARE PATHWAYS

Table 6: Risk-based Care Pathways

Follow up frequency	Follow up type	Outreach	Education format	Extra support
LOW RISK				
Standard recall-every 6 months for dental and on the AAP recommended WCC schedule	N/A, unless the family requests additional follow up or support	Only if an appointment is missed or patient becomes overdue for care	Verbal and standard print in AVS	Goal setting at end of each visit.
LOW MODERTE RISK				
1-2 additional touch points in addition to standard recall-every 6 months for dental and on the AAP recommended WCC schedule for medical	Phone visits, unless the family requests individual follow up. Group classes will also be offered if there is an identified need	Call 1-3 months post clinic visit by OT or P-5 PATH Coordinator to check progress towards goals and follow up on needs	Verbal and print AVS, with key points highlighted. Additional handouts provided on targeted topics at end of visit with pictures and less text	Goal setting at end of each visit. Verbal reminders to sign up for MyChart
HIGH MODERATE RISK				
1-4 additional touch points in addition to standard recall-every 6 months for dental and on the AAP recommended WCC schedule for medical	Group classes and 1-2 one-on-one follow up visits if specific needs are identified. Otherwise, 1-2 phone check-ins with occupational therapist	Call 1-3 months post visit by OT or P-5 PATH Coordinator to check progress towards goals. Coordinator will call family 1 month before child is due for dental or medical visits	Tailored handouts using strong visual supports. Demonstration of skill and/or parent practice in visit when possible	Goal setting at end of each visit + identification of smallest “first step” and potential barriers to improvement. Support setting up MyChart, & reminders about community events

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HIGH RISK				
Weekly to monthly follow up depending on the needs	In-office one-on-one follow up with occupational therapist if possible, or phone follow ups if needed (due to transportation barriers)	Consistent outreach if patient misses appointments and to schedule upcoming wellness visits	One-on-one with occupational therapist, aimed at demonstration then practice of skill. All content provided in tailored handouts with several of visual supports	Support setting up MyChart, reminders about community events, OT support in visits to practice skills and problem solve barriers to health in the family's daily life

15. Community Partnerships

- Identify key stakeholders** in your community who provide services that benefit your clients or who serve clients who would benefit from P-5 PATH.
- Narrow your list** based on the capacity of your organization and team to the most promising partnerships.
- Identify systems** (internal and external) which may support ease of referral and/or flow of information.
- Determine outcomes** which indicate successful partnerships for your organization and the community partner.
- Set up monthly or quarterly meetings** with these partners to assess progress and improve upon current systems.

Because health extends well beyond the walls of the clinic and there are programs and services which we do not offer within our Health Home at NHC, P-5 PATH embraced community partnerships. We began by identifying key stakeholders who provided services and supports which matched the needs we were seeing in our patients as well as community partners who might service clients who could benefit from our holistic and supportive approach to pediatric care.

Our most commonly used community partners included:

- Women, Infants, and Children (WIC)
- Early Intervention
- Head Start
- Home visitation programs (Nurse Family Partnership, CACOON, Babies First, Healthy Families)
- Food Banks (The Oregon Food Bank)

Forming and maintaining community partnerships can be time consuming work, so we encouraged you to narrow down your list to those partners who are most likely to benefit your clients or narrow the scope of your partnership work to accomplish specific collaborations. We will share a few examples of the ways the P-5 PATH team deepened and expanded our community partnerships with key stakeholders to support our clients.

WIC

Most of our patient population qualifies for services through WIC and connecting our families to WIC is a priority for our team. We met with key players at our local WIC branch on three occasions over the course of our pilot project. Our first meeting was to identify areas of improved collaboration and to inform them of P-5 PATH at NHC. We arranged at that meeting to provide an in-service at a WIC staff meeting to explain P-5 PATH and to further discuss areas of improved collaboration. We identified two-way communication as the main area to support improved partnership and met a third time several months later to brainstorm solutions to improve two-way communication. At that meeting, it was identified that an opt-out universal ROI to be used at time of registration could be a solution. The P-5 PATH team developed this ROI,

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approved its use through the appropriate internal channels, and released it for use for our 0-5-year-old patients. You can see an example of this in Appendix D.

THE OREGON FOOD BANK

Food insecurity was a commonly reported social issue amongst our patient population. We identified three areas of need which became our target for collaboration:

1. Making a more comprehensive and useful tool for staff and patients to access free food through our local food banks.
2. Hosting group classes that centered around practice choosing and preparing healthy, low sugar snack options for young children.
3. Providing our food boxes at medical and dental visits for our highest risk patients who may not have access to local food banks.

We quickly accomplished our first goal with one on-site meeting with staff at the Oregon Food Bank. They were able to share work they were already doing, which included four handouts of all local food bank options organized first by geographic location, then broken down further by what is offered (a food box, a “grocery store” experience, or a hot meal) with dates/times, addresses, phone numbers, and details on who qualifies for these services. As mentioned in Chapter 13: Risk Stratification, we took this a step further by creating a Google map, which allowed providers to show families exactly where a facility was located, and find food banks closest to the patient’s home, work, child’s school, or our clinic depending on the patient’s preferences.

PROVIDENCE WOMAN’S CLINIC (PWC)

At the time of launching P-5 PATH, we were approached by the Obstetric and Midwifery Unit at our local hospital with a request for enhanced partnership. As they implemented new screening tools and identified a large percentage of their population who did not have a Health Home for consistent dental or primary care, this group was looking for Health Homes which accepted CAWEM Prenatal (Oregon’s emergency benefits package, which covers all pregnant and uninsured women) in order to help their patient establish with a PCP and dentist. This allowed us to screen and support pregnant mothers with improving wellness before the infant was born and build relationships and trust with our Health Home team.

To facilitate referrals, we created a tailored and streamlined referral form which was also a FAX cover sheet, which allowed providers at PWC to easily refer patients to our clinic. The P-5 PATH coordinator participates in weekly phone calls with the Patient Navigator at PWC to report back on patients who we were not able to get ahold of or who missed an appointment with our dental or medical team to support engagement. Using this weekly communication between the P-5 PATH coordinator and the PWC Patient Navigator, we additionally created a workflow to share and collaborate on patients’ self-management health goals. See Appendix P for more details on this workflow.

16. Personnel Specific Sections

This chapter is designed so that individual staff may select the specific section that pertains to the job requirements, role, and expectations for their role within P-5 PATH. While reading this full toolkit is ideal for administrative staff and key team members, such as the occupational therapist, the physician, and the dentist, we understand that this is impractical for all staff and so these sections will be a starting point for most clinical staff members. As we mentioned in Chapter 3: Defining Your Program, you may not have each of these roles in your iteration of P-5 PATH. If this is the case, we encourage your administrative team to look through the job requirements, roles, and expectations for each staff position that you will not be using in order to reassign these duties amongst existing staff.

This section will provide additional information and role clarification for the following staff:

- a. P-5 PATH Coordinator
- b. Occupational Therapist
- c. Dentist
- d. Dental Assistant
- e. Dental Hygienist
- f. Pediatrician
- g. Family Medicine Physician
- h. Medical Assistant
- i. Front Desk

- Distribute all sections** to the appropriate staff member.
- If your organization will not be filling/utilizing all roles, **distribute job duties among existing staff positions** and **determine any duties that may not be feasible** given staffing limitations.
- Use at least one **clinical team meeting** to talk through roles and assure all staff are familiar with the expectations of their role and any new duties.

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a. P-5 PATH COORDINATOR

The role of the coordinator is primarily panel management and outreach. However, the P-5 PATH Coordinator is a role best filled by an individual who enjoys connecting with people, thinking creatively and holistically, and who can keep information organized. The coordinator interacts with all team members, follows up on team member requests and needs, and is a thread that keeps the team connected. Primary duties include phone outreach, reading and responding to emails or chart messages, keeping the schedule organized and updated, chart combing, tracking patient needs, and keeping printed resources and files organized.

Key job requirements which work best for this program.

- Certified Medical Assistant
- Bilingual (Spanish speaker)
- Basic or higher proficiency in Excel

Key attributes which we encourage in the ideal candidate include:

- Some familiarity with your organization's EHR (or similar EHR)
- Organized
- Strong phone skills
- Strong interpersonal communication skills

The P-5 PATH Coordinator engages in daily, weekly, monthly, and on-going duties. We break down the role in this way to help understand the work. We recommend you look through Appendices P and Q to familiarize yourself with the weekly and monthly work tasks and as well specific workflows for key coordinator duties. Additionally, we recommend you familiarize yourself with key coordinator tools found in Appendix P, which include scripts for use in the EHR, and sample community resource handouts.

DAILY TASKS

- First thing in the morning: comb the schedule for the day to make sure that all 0-5-year-old and pregnant patients are appropriately scheduled with updated appointment messages and notes. This means that the OT is added to the patient appointment for all WCC visits *20 minutes after the MD is scheduled* and the paperwork is added to the appointment message for front desk staff and the OT is added to all Well Dental visits *at the same time as the dental visit*. This also includes making sure the dental insurance is added to the appointment notes so that the team knows this patient should be offered a dental appointment if appropriate.
- 8:00am-8:15: attend clinic-wide huddles in conference room.

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- Morning: Comb the P-5 PATH Epic inbox for new messages from providers and for appointment notices, which alert you that a patient appointment for a P-5 PATH patient was made, cancelled, no showed, or rescheduled.

- Before end of day: Check the referral inbox at front desk and collect any new referrals from community partner.

- Before end of day: Complete reminder calls for patients scheduled the following day to remind of their appointment and double check interpreter and transportation needs.

WEEKLY TASKS

- Every Monday 7:00-7:15, comb dental and pediatric schedules and note patient appointment dates/times and risk score if documented.

- Every Monday 7:15-7:30am: attend P-5 PATH team huddle to discuss patients who will be seen by team that week. Report on risk scores if known.

- Completed outreach calls to all newly assigned 0-5-year-old medical and dental patients. Be sure to offer a coordinated WCC and dental visit if the patient qualifies to see both departments. Document each call and the outcome using dot phrase for outreach calls.

- Complete outreach calls to all unengaged 0-5-year-old patients and send follow up letters as appropriate. Document each call and the outcome using dot phrase for outreach calls.

- Comb P-5 PATH Patient Roster for all needs/tasks that are due.

- Outreach and connect with any patients who had follow up needs identified on the P-5 PATH Patient Roster. Document each call and the outcome using dot phrase for outreach calls.

- Update P-5 PATH Patient Roster with new patient seen the following week.

- Update P-5 PATH Patient Roster with updated patient and visit information based on any new patient encounters which occurred the previous week or based on messages from other team members.

- Follow up with patients who no showed or cancelled appointments the previous week to check barriers to care and to reschedule.


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- Check in with community partners by phone, email, or in person depending on needs to update them on outcomes of visits as needed (if release of information is signed) and to learn about upcoming community events which may benefit our patients.
- Update community events calendar and/or post flyers/handouts if appropriate on health promoting, free community events for young children and families.

MONTHLY TASKS

- 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 CareOregon 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 be posted or given to families.
- Clear out old events/resources that are no longer applicable or are outdated.

 Our coordinator works a four-ten schedule (four days a week, ten hours per day) with Fridays off, so reminder calls for patients seen on Mondays go out on Thursday evenings.

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b. OCCUPATIONAL THERAPIST

The occupational therapist is a central role to P-5 PATH. The role requires the occupational therapist to do many of the standard tasks that would be familiar to any occupational therapist, including using the occupational profile; completing screenings and assessment; making intervention plans, recommendations and referrals; and complete one-on-one and group interventions. The occupational therapist will track patient outcomes, complete re-evaluations, update plan of care as needed, document on all work completed, and follow up with the other team members to assure that interdisciplinary and holistic care is provided to the patient.

P-5 PATH care is primarily pediatric care and as such, the occupational therapist should have experience in working with pediatric patients. Because primary care encompasses many issues and is a front line of defense in care, the occupational therapist should be skilled in triage and in research appraisal in order to know how to look up current literature on a wide variety of topics to plan care accordingly. Additionally, primary care centers on wellness, so the occupational therapist must be familiar with typical development and strategies to support child and family wellness. Last, because P-5 PATH emphasizes holistic health, the occupational therapist must be familiar with how to assess and address the occupations of feeding, eating, and mealtime, which includes expertise in oral structures, oral motor skills and coordination, and oral sensory processing as related to eating a wide variety of healthy foods.

Key job requirements which work best for this program:

- Licensed Occupational Therapist within your state
- Pediatric experience
- At least basic experience with supporting the occupations of feeding, eating, and mealtime

Key attributes which we encourage in the ideal candidate include:

- Some familiarity with your organization's EHR (or similar EHR)
- Background in addressing mental and physical health needs
- Strong inter-personal communication skills
- Familiarity with transdisciplinary model of change, motivational interviewing, and parent coaching

It is important for the occupation therapist to remember that P-5 PATH is provision of occupational science informed changes at the systems level to support population health, while also providing direct OT screening, evaluation, and intervention within primary care visits, dental visits, and within the clinic as a Health Home. At the direct intervention level, it is essential that the occupational therapist determine a cut-off between what services can and will be provided within visits at the Health Home and which services fall under the realm of outpatient OT practice, Early Intervention, or another discipline.

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DIFFERENTIATING BETWEEN P-5 PATH AND OUTPATIENT OT SERVICES

While there is not a single answer to this question, we settled on the following criteria for when a patient would be seen within NHC by the occupational therapist vs when a patient would be referred outside the Health Home to outpatient OT services, EI, or other follow up.

The patient will be referred out for outpatient OT, EI, and/or other follow up:

- If the patient will likely qualify through insurance for more intensive outpatient services or EI services, we refer for these.
- If a patient has needs that fall outside the scope of expertise of the occupational therapist or move beyond what the occupational therapist can offer within the Health Home, the patient is referred to the appropriate discipline for evaluation and services.

The patient will be seen by the occupational therapist at NCH:

- If a family is uninsured and cannot afford additional support services out of pocket, the occupational therapist at NHC will provide services and support to the extent we are able to help the patient.
- If the parents require support with the steps needed to access outside services (searching for possible facilities, calling to schedule visits, completing screening/intake paperwork, etc.) the occupational therapist at NHC will work with the family to accomplish these steps until the family is able to establish care at the outside facility.
- If the patient has a significant need and will qualify for outpatient OT, PT, or SLP services but due to waitlists, will not be seen for several months, the occupational therapist at NHC will work with the patient and family on developing and using a home program to bridge the gap until outpatient services are initiated.

Our goal is to evaluate patient needs on a case-by-case basis in order to meet the needs of the patient. We want our patients to be as healthy as possible and to receive the level of support that is needed to accomplish this. We also recognize the limitations of our healthcare system to fund preventive services and interventions for children with more mild health needs so P-5 PATH seeks to be a safety net, ready to support our patients when connecting to more intensive and appropriate services is not feasible.

The occupational therapist duties and job role can be broken down in a variety of ways and we have decided to organize this section based on what the occupational therapist can or may do generally to support the team and our patients from a population level, in a dental visit, a WCC visit, in our dental group visits, and in an individual OT follow up session.

OT AND POPULATION HEALTH

At the systems level, it is important for the occupational therapist to spend time working with front desk staff, administration, office management, and others to identify areas where environmental redesign or workflow changes may support improved participation and engagement in the occupation of health management. While a thorough occupational profile and task analysis can identify strengths and barriers to participation for an individual, these tools may also support identification of ways to improve system's level care within your organization.

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Some examples of this type of work which the occupational therapist identified and addressed at NHC include:

- Adding child-specific seating, toys, and books to our waiting rooms to increase child organization and comfort.
- Modifying our existing registration and intake paperwork to be child-specific to capture health risk information that may be missed using adult paperwork.
- Creation of well visit questionnaire packets to be used in WCC and Well Dental visits to screen all children for common and deleterious health experiences including ACEs, caries, parental depression, and social needs.
- Creating or identifying tools which provide information for families about community resources and making these available for all families in medical and dental suites.
- Implementation of risk screening and stratification within each wellness visit.
- Staff trainings to change culture to think about the barriers that this patient or family is experiencing and how we can support them in moving past the barriers.
- Staff training to change culture from whether the patient is healthy today, to how likely the healthy patient is to develop illness or complications over time?
- Providing dental supplies to all 0-5-year-olds seen for WCC.
- Creation of, or modification to existing print resources to include more visual supports.
- OT/Patient Activation wellness curriculum included in WCC and Well Dental visits.

WHAT DOES OT ADDRESS IN PRIMARY AND DENTAL CARE SETTINGS

Table 7: OT Scope of practice in primary care setting

Parent		Child	
Client specific factors	Overarching areas of occupation	Client specific factors	Overarching areas of occupation
Maternal mental health	IADL of health management and healthcare engagement	Child development	ADL of play
Attachment	IADL of parenting/child rearing- including supporting development, and health promoting daily discrete tasks of parenting, feeding, bathing, diapering, potty-training, sleep, getting in and out of the home, trimming nails, etc.	Child physical skills	ADL of eating
Maternal functional cognition	IADL of health management for child	Child mental health	ADL of oral care
Maternal-child Co-regulation and sensory processing	IADL of home management	Child social-emotional skills	ADL of sleeping
Maternal physical strength, ROM, and pain	ADL of sleep	Child functional cognition	ADL of toileting
	ADL of feeding		Occupation of participation in school
	Occupation of social participation		

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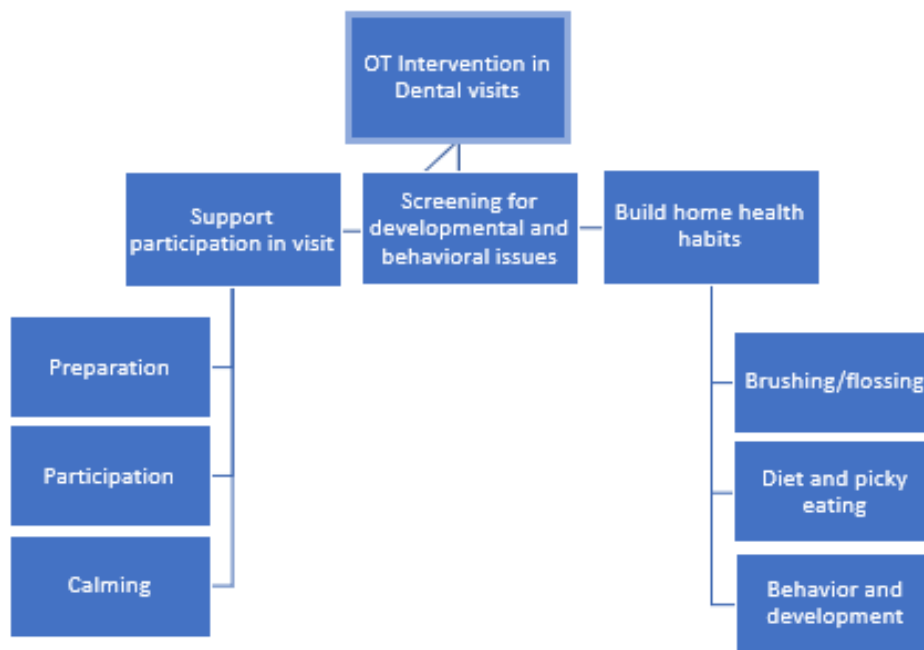
OT AND DENTAL VISITS

Because P-5 PATH prioritizes the development of healthy habits and routines over time for our youngest patients, the role of OT within dental visits is, first and foremost, supporting the child, family, and dental team with keeping the child comfortable, organized, and engaged at a developmentally appropriate level to assure that the child and family have a positive experience, while maximizing the effectiveness of the dental staff in completing care steps within the visit.

The secondary priorities are supporting the team with screening the child for developmental and/or behavioral concerns which may have been missed in primary care and which may require further evaluation or intervention, and lastly supporting the team and family with building home health habits which will support dental and overall health outcomes.

OT intervention in the dental setting can be conceptualized through the following graphic.

Figure 19: OT Intervention Areas in Dental Visits



The occupational therapist uses the following theory, models, and frames of reference as the theoretical basis to guide interventions:

- Attachment
- Developmental
- Sensory integration
- Cognitive behavioral
- Person, environment, and occupation-performance

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Participation in Visit

OT interventions to support infant and child participation and comfort in dental visits focuses on three areas:

Figure 20: OT Intervention to Support Participation in Dental Visit



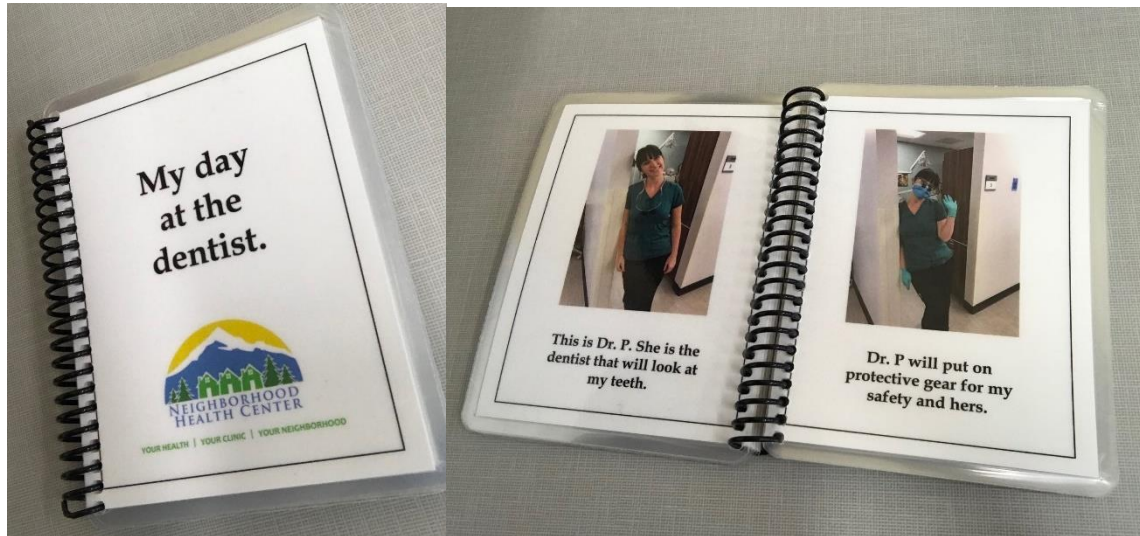
What this looks like in the visits:

1. **PREPARATION:** Preparing the child's and parent's nervous systems to be calm and open to participation before the visit by engaging the relational system to support child and parent co-regulation and calming sensory systems to increase organization:
 - a. OT meets the family in the waiting room, introduces herself, OT, and what to expect in the visit. OT physically gets down at child's level and briefly engages in therapeutic play to quickly but effectively build relationship. OT uses clinical reasoning to determine next step intervention, which might include:
 - i. Calming an energetic child: expending energy through physical play which engages the proprioceptive system to help calm and transition into soothing, organizing movement, song, and deep breaths.
 - ii. Alerting or engaging a hesitant child: Modeling safety through deep breaths, slow and predictable movements, and visual tools to explain what can be expected.
 - b. OT supports the parent with feeling calm and organized as this will support co-regulation for the child. OT may verbally explain what to expect for the family or if needed, use tools, such as a social narrative picture book which shows each step of the visit using pictures taken in our clinic of our staff.

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Figure 21: “My Day at the Dentist” Story to Support Participation (See Appendix R)



2. **COMFORTABLE PARTICIPATION:** OT uses sensory regulation, attachment, and cognitive behavioral strategies at a developmentally appropriate level to achieve child organization, improve focus, and increase participation. This is modeled for staff as well, including:
 - a. Environmental modification: modifying the environment before visit or in the moment by letting in natural light, closing doors to reduce extraneous sounds, turning on music, or reducing lights.
 - b. Cognitive behavioral and language-based supports: Modeling for staff on use of language to support engagement:
 - i. Using declarative language instead of questions for young children (i.e. “Sit in the chair” instead of “Are you ready to sit in the chair?”).
 - ii. Using simplified language with very young children or when a child is becoming triggered (i.e. “Open mouth” instead of, “Hi buddy, open your mouth for me please”).
 - iii. Use of choices when appropriate to empower and help but always in a way where either choice works to accomplish your goals. (i.e. “Do you want to climb into the chair by yourself or do you need help?” “Should I put the bib on you or can you lift it over your head by yourself?” “Should I start with your front teeth or your back teeth?”).
 - iv. Actively discussing and practicing self-advocacy and coping strategies. For example: “you can hold your hand up when you need a break.” “You can take a deep breath and hold mom’s hand when you feel nervous.”
 - v. Setting a goal to get through a certain number of care steps before taking a break.
 - c. Visuals: OT may use pop up picture books of animals opening their mouth to help a child understand that we need him/her to open her mouth.
 - d. Sensory fidgets and distractions: OT brings in and offers small fidget items to keep hands busy and help young children wait while seated in the dental suite.

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Coaching from OT is often necessary, so these items do not become a bigger distraction than a support.

- e. Calming sensory tools: using weighted devices and seating which supports movement (Move 'n Sit disk) and engages the core musculature.
 - f. Movement: OT suggests alternate positioning, such as the use of standing, kneeling, or a wiggle seat positioner to support young children with engaging in services when sitting still for long stretches is challenging.
3. **CALMING/COPING ONCE UPSET**: helping a triggered child to calm back down and continue with care by:
- a. Pacing & Movement: Encouraging staff to give breaks frequently for young children to walk around or sit with the parent and trying again once the child calms.
 - b. Visual supports: Providing and using a visual timer during visits.
 - c. Relational co-regulation: OT may use caregiver or self as a source of comfort and soothing by:
 - i. Asking the parent to hold the child in their lap.
 - ii. Telling the parent and child that it is time for a hug break.
 - iii. Asking the parent to hold the child's hand or keep the parent's hand on the child's leg.
 - iv. Have the parent read a story or sing a song to the child while the dental team works.
 - v. Modeling taking deep breaths, relaxing shoulders, and smiling to re-engage the parasympathetic nervous system and asking the parent to do the same.
 - d. Grounding to soothe the nervous system: providing novel sensory tools and toys to narrow the child's attention to their hands and the moment to soothe the child's anxiety, then explaining what is needed next and encouraging the child to continue with treatment.

Screening Needs and Providing Support for Health Habits

In addition to supporting patients and families with engagement in the dental visit, the role of the OT is to support parent and child development of home habits and routines which are foundational to long term oral health. Our dentist, dental assistants, and hygienists work diligently to care for our patient's oral health, educate families on why oral health matters, provide strategies to protect teeth at home and coach families to set goals to build home care habits. This work lays an excellent foundation for knowledge and skill development. Often, we see that even more practice and problem solving is needed to ensure these recommendations are integrated into the patient's life. The OT is well suited to supporting and building upon the excellent work being done by the dental team. While dental visits are obviously designed to support dental health and wellness, the occupational therapist is able to support the team and family with recognizing the ways that many daily occupations impact dental health (such as eating, watching television, sleep, even outdoor play) and otherwise tie this into overall health.

Additionally, the occupational therapist's expertise in child development and behavior position the occupational therapist to support the goals of the entire team by screening for

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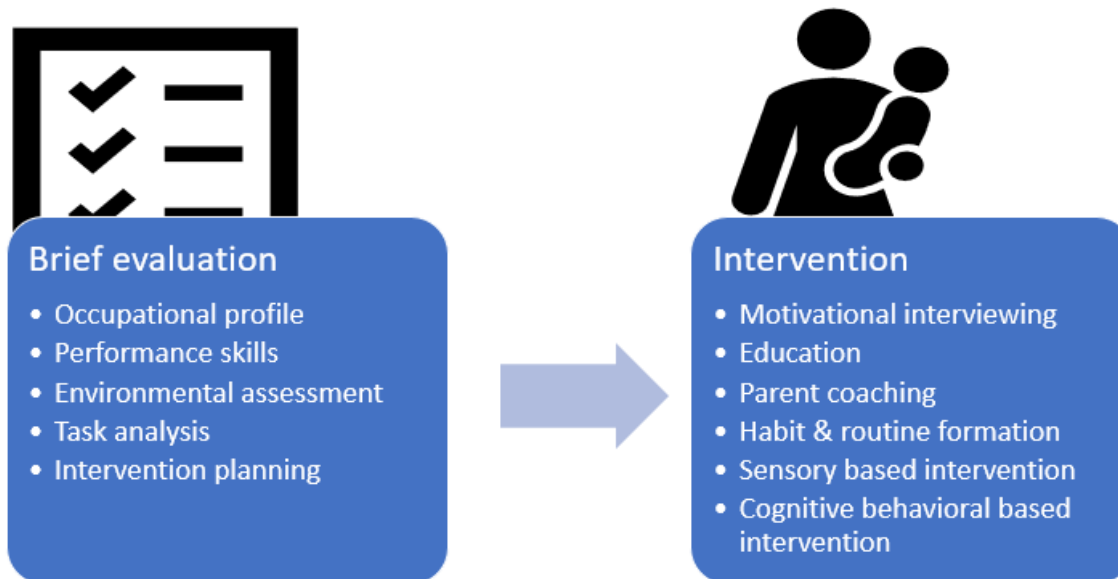
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developmental delay and behavioral concerns which may have been missed in Well Child Care visits and which may require further assessment and intervention.

What this looks like during visit: The dental team or occupational therapist identifies through screening paperwork and discussion an area of need or concern that may be negatively impacting the child's health. The occupational therapist follows two key steps to provide care.

See Appendix S for detailed workflows on identification of need and how to respond and connect families with OT in dental visits.

Figure 22: Key steps to OT intervention to support home health habits within the health visit



Step 1: If there is time, the occupational therapist completes a brief assessment during the dental visit:

- Occupational profile- This is a brief screen of what current participation in the occupation of looks like for this patient, what the family's performance patterns include, and what has been tried in the past to improve participation.
- Assessment of the child's performance skills- If needed the occupational therapist specifically assesses the child's skills in the following areas:
 - Oral sensory motor
 - Gross and fine motor
 - Communication
 - Cognition
 - Social-emotional skills
- Assessment of the parent's performance skills- If needed the occupational therapist assesses the parent's skills (strength, flexibility, coordination, self-control, organization, coping, etc.).
- Environmental assessment- The occupational therapist asks about supports and barriers within the family's home or daily routines which can be capitalized on, added, or removed to support behavior change.

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- Task analysis - If needed, the occupational therapist uses this skill to determine which elements of the occupation are going well and which need support.
- Intervention plan- Based on identified areas of strength and deficit as well as function and dysfunction, the occupational therapist creates an intervention plan.

Step 2: The occupational therapist determines next steps, which may include one or more of the following possibilities:

- Brief intervention provided within the visit
- Follow up intervention needed via phone
- Follow up intervention needed one-on-one in clinic
- Follow up intervention needed in group setting

Some examples of what brief intervention techniques look like:

- Motivational interviewing and use of the transtheoretical model of change- discussion with use of visuals and handouts when needed.
- Education if needed around a specific topic.
- Parent coaching model- plan, act, assess performance, determine what will be done differently next time.
- Modeling of skills- therapist models skills which the parent or the child may need to develop.
- Habit & routine formation principles- this may include discussion and support with implementation of steps to form an action into a habit, such as creating visual prompt for the parent to place in environment, writing down implementation intentions or possible habit stacks, supported searching for technology-based tools for tracking and reminders. May also include calendar planning and balance wheel work.
- Sensory based intervention- use of weighted tools to provide calming support for the child while child, parent, and therapist explore new foods and textures.
- Cognitive-behavioral based intervention- use of graded desensitization, exploration of thought patterns or fears/anxieties preventing participation.

EXAMPLES- Occupational therapist identifies through screening paperwork and discussion that one or more of the following areas may be negatively impacting the child's health.

Picky Eating or Family Eating Habits:

Step 1: The occupational therapist completes a brief assessment:

- Occupational profile- discussion around what mealtime currently looks like for this child, what times throughout the day the child eats, who feeds the child, and how the child typically responds, along with anything this family has tried in the past to solve the problem.
- Assessment of the child's performance skills- specifically assess the child's oral sensory-motor, gross, and fine motor skills.
- Assessment of the parent's performance skills- specifically assess parent's skills with identification of health meal options and meal planning, as well as use of coping strategies and self- regulation to remain calm when child is triggered. Determine

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parent's cognitive capacity to problem solve solutions when the child does not eat or to recall the solutions you discuss, practice, and recommend to address the picky eating.

- Environmental assessment- Discussion around where the family eats, what the seating position/device looks like, whether they eat as a family, whether there are distractions in the eating environment.
- Task analysis - let the parent feed the child and the child accept and eat or refuse the food. Watch for where participation breaks down and how parent responds.

Step 2: Intervention will address one or more of these areas:

- Create and help family use daily mealtime schedules to foster healthy hunger.
- Support caregiver knowledge and skill of meal planning and preparation which includes identifying healthy vs less healthy food options, creating meals around these foods, creating and using shopping lists.
- Manage negative mealtime behaviors from the child in a developmentally supportive way that honors boundaries.
- Use activity and exercises to improve the child's oral motor patterns for chewing or drinking.
- Model and practice supportive strategies used during the activity for a child with anxiety tasting and eating new foods.
- Use exposure and boundary setting to increase variety in a child's diet.

Brushing Teeth:

Step 1: The occupational therapist completes a brief assessment:

- Occupational profile-discussion around what current oral hygiene looks like for this child and parent, how often the parents are brushing the child's teeth, what the barriers are to brushing, and what the family has tried in the past to solve the problem.
- Assessment of the child's performance skills- specifically occupational therapist assesses the child's oral sensory-motor responses to tolerate the brush in the mouth in all quadrants, the fine motor skill to manipulate the brush, and cognition to recall and independently complete the steps to oral care.
- Assessment of the parent's performance skills- determine if the parent is using strategies that might not be effective and also note whether the parent has the physical capacity to help the child hold the toothbrush and brush, the cognitive capacity to problem solve and be flexible in the moment, and/or the social-emotional capacity to remain regulated and connected with the child to support child engagement when the child refuses or cries.
- Environmental assessment- Where is the brush stored, can the child reach it independently, is it visible to cue the child and parent to participate in brushing, does the family need new brushes or paste?
- Task analysis- Watch the child brush his/her own teeth and observe the parent attempting to brush the child's teeth. Not positioning, regulation strategies used, social interaction, and behavior management strategies used. Watch for where participation breaks down and how parent and child respond.

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Step 2: Intervention will address one or more of these areas:

- Increase visibility of brush/paste and help parent connect this habit to a more established current habit.
- Change around time of day for participation to improve follow through.
- Increase child's oral sensory tolerance to brush in mouth.
- Improve child's understanding of steps of brushing and that the task has a beginning and an end through use of visual prompts (visual routine).
- Use backwards chaining techniques to build child skill and participation.
- Identify child interests and motivations to increase tolerance and buy-in from child.

Bedtime Routines & Sleep:

Step 1: The occupational therapist completes a brief assessment:

- Occupational profile-discussion around what current sleep routines and patterns looks like for this child and parent, how consistent the parents are with bedtime routines, what the barriers are to a consistent bedtime schedule and routine use, what night time wake issues are occurring, and what the family has tried in the past to solve the problem.
- Assessment of the child's performance skills- specifically occupational therapist assesses the child's oral sensory-motor responses to tolerate the brush in the mouth in all quadrants, the fine motor skill to manipulate the brush, and cognition to recall and independently complete the steps to oral care.
- Assessment of the parent's performance skills- determine if the parent is using a bedtime routine currently or not, and specifically focus on whether or not the parent has the cognitive capacity to recall a routine without visual supports and to problem solve in the moment if the child resists bedtime, as well as the social-emotional capacity to remain regulated and connected with the child to support child engagement when the child refuses or cries.
- Environmental assessment- Where is the brush stored, can the child reach it independently, is it visible to cue the child and parent to participate in brushing, does the family need new brushes or paste?
- Task analysis- Watch the child brush his/her own teeth and observe the parent attempting to brush the child's teeth. Note positioning, regulation strategies used, quality of social interaction, and behavior management strategies used. Determine where participation breaks down and how parent and child respond once this occurs.

Step 2: Intervention will address one or more of these areas:

- Increase visibility of brush/paste and help the parent connect this habit to a more established current habit.
- Change around time of day for participation to improve follow through (for example, if participation in the morning routine is challenging, determine if brushing can occur at daycare or school).
- Increase the child's oral sensory tolerance to the toothbrush in the mouth through graded desensitization strategies.
- Improve the child's understanding of the steps of brushing and of the idea that the task has a beginning and an end through use of visual prompts (visual to do list using

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objects, photographs, drawings, or words depending on the child's level of comprehension).

- Use backwards chaining techniques to build child skill and participation.
- Identify child interests and motivations to increase tolerance and buy-in from child.

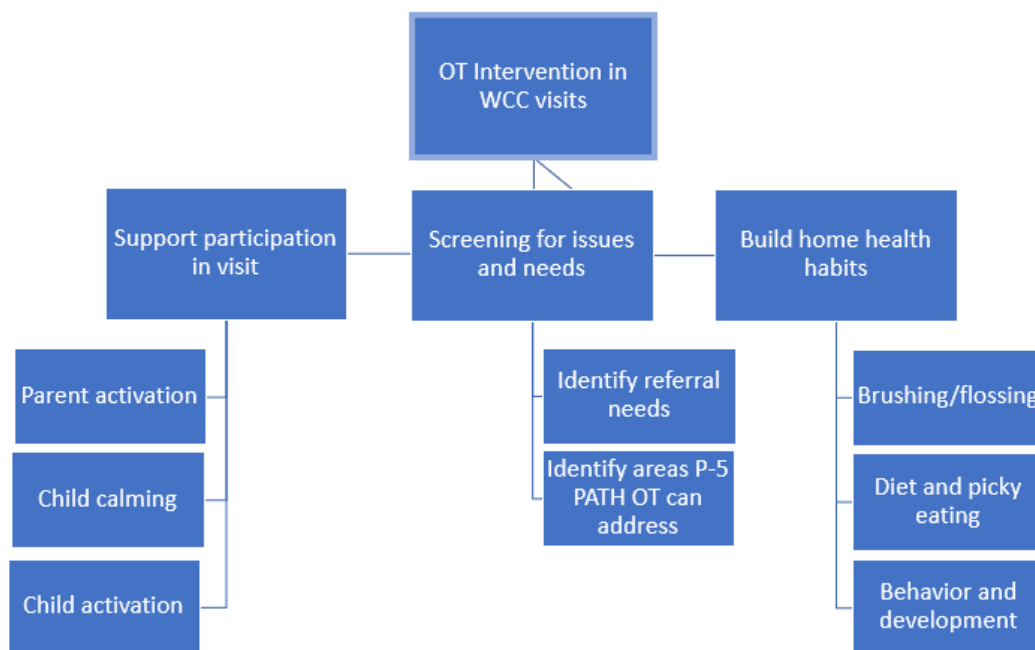
OT AND WELL CHILD CARE VISITS

The role of OT within WCC visits is multi-faceted and include:

- Screening
- Assessing readiness for change
- Assessing barriers to health and participation in health promoting daily activities
- Providing health coaching
- Practicing and supporting skills needed for participation in health promoting daily activities
- Supporting the team with making recommendations for the patient

OT intervention in the medical setting can be conceptualized through the following graphic.

Figure 23: OT Intervention Areas in WCC Visits



You will notice that the occupational therapist role in WCC is similar to the role in dental visits in that there are 3 main areas of intervention: participation, screening, and home health habits. However, there are a few key distinctions in the details of what the occupational therapist will do in WCC visits in each of the main areas.

The occupational therapist uses the following theory, models, and frames of reference as the theoretical basis to guide interventions:

- Attachment

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
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- Developmental
- Sensory integration
- Cognitive behavioral
- Person, environment, and occupation-performance
- Neurodevelopmental Treatment

Participation in Visit

WCC visits for infants and very young children are often more about discussion with the parent than about engaging with the child. Because of this, the occupational therapist's role with supporting participation focuses on *parent* participation and the concept of *patient activation*. Patient activation describes how confident and competent a person is with managing their own health. This concept is supported by a tool, the Patient Activation Measure (PAM) which measures patient activation in a standardized manner and assigns a score as well as a risk level. The scores range from 0-100 and levels range from 1-4 with low scores and levels indicating low activation and high scores and levels indicating high activation. Research looking at patient activation measured using the PAM has found that higher levels of activation is associated with improved health outcomes, improved health care engagement, and reduced cost of care (Hibbard & Greene, 2013).

Parent Activation: We used the *Parent Patient Activation Measure (PPAM)* as one metric to track the success of our program and to guide OT intervention.

	Families complete this screening tool as part of intake paperwork and the occupational therapist scores it.
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The occupational therapist supports parents who score as having low activation with developing activation over time through education, modeling, and discussion within WCC visits. At the very lowest level of activation (level one), the occupational therapist can support the parents with generally understanding their own role in WCC visits and at home with keeping their child healthy. This is done through a mix of discuss, use of handouts, and activities. Patients at a level two, tend to know that they should take a role in visits and in managing their child's health at home, but often need coaching and support with understanding where to start and how to make changes. The occupational therapist focuses on motivational interviewing and parent coaching with an emphasis on active participation in interventions which support the changes that the parent identifies as a priority. An example of this: the occupational therapist completes a balance wheel with the parent to identify daily routines which support health or lack of routine which is increasing the child's stress or difficulty with participation in certain occupations, such as mealtime or bedtime.

Child Activation: As the child gets older, as early as 4 and 5 years, the occupational therapist can also support the child with becoming more engaged in the medical visit through questions and activities which are directed to the child rather than the parent. This shift allows the child to begin to develop an activated role in the visit and in their own health while the parent is still a key component in the visit to provide support. Starting this transition early, however, may help

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make a smoother shift between the parent having full control of the child’s health information in WCC and the child taking the lead role as he or she approaches teenage years.

Child Calming: The last role of the occupational therapist in WCC under the main area of “participation” is support for the child to feel safe and remain organized throughout the visit. This work will use a mix of relationship, age appropriate developmental tools (often toys) brought into the visit, and sensory regulation strategies to help the child develop the foundational belief that he or she is safe within the visit and wants to return for ongoing engagement. Your medical team will be well versed in these strategies already most likely and the occupational therapist is there to add to the child-directed care already in place and to identify and provide additional support for children who might be particularly sensitive and have already established the notion that doctor visits are scary.

Screening for Issues and Needs

While the occupational therapist will engage in some level of screening health risk and needs in dental visits, this will be emphasized in WCC visits. WCC is specifically designed to keep children healthy in all areas and make sure that development is on track. The occupational therapist can be a key member of the team because our expertise in child development, behaviors, and participation in daily occupations. Many physicians appreciate support with identifying children who should be referred out for tailored care.

Referrals & follow up: As the occupational therapist completes screening in WCC, you may identify 3 situations.

- **Group 1:** Children with no addition needs outside of care as usual
- **Group 2:** Children with specific short term needs the occupational therapist can help with
- **Group 3:** Children who have more substantial or specialized needs

When determining which patients to follow up with and where the role of the occupational therapist ends the first two groups are straight forward:

- **Group 1:** the primary care occupational therapist will not follow up
- **Group 2:** the primary care occupational therapist will complete phone or in-office follow up with 1-4 visits to help empower parents to manage the issue and if issue progresses or does not improve, the occupational therapist can let the medical team know this patient will need a referral to additional support services.
- **Group 3:** we recommend using the following chart to determine if the child should be seen by the OT in primary care or not.

Table 8: Determining the need for primary care OT follow up

Ask these questions	If YES	If NO
Will this child qualify (insurance will pay for) community supports, including EI, outpatient OT, PT, SLP services, mental health services, etc.?	Refer out. No need for OT services in primary care.	See for OT in primary care for 1-10 sessions to build parent capacity to manage this issue at home independently or to help the family connect to more sustainable services.

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Will this service have a substantial waitlist, where there will be more than a month or two before services begin?	See for OT in primary care for 1-4 sessions to help family build capacity to begin managing this issue at home while waiting for more intensive support services to begin.	Refer out. No need for OT services in primary care.
Does this family need more support in order to access the community support services that this child qualifies for?	See for OT in primary care for 1-4 sessions to help this family connect in a meaningful way to the appropriate services.	Refer out. No need for OT services in primary care.

Providing Support for Health Habits

In addition to supporting patients and families with activation and supporting the team with screening, the role of the OT is to support parent and child development of home habits and routines which are foundational to long-term health. The medical team works diligently to identify areas of need and to make sure our patients are healthy and on track for future health. Often, we see that practice and problem solving is needed to ensure these recommendations are integrated into the patient’s life. The OT is well suited to supporting and building upon the excellent work being done by the medical team. The occupational therapist can support the family with recognizing the ways that many daily occupations impact health and with taking active steps to make changes which are situated in the family’s daily routine in a way to assure they become habits.

Which areas of health

There are many areas of health and wellness that can be addressed by the occupational therapist, though the key element to focus on are:

- Areas of occupation that:
 - Impact the child’s health
 - Impact the parent’s capacity to care for the child and subsequently puts the child’s health at risk

Table 9: Sample areas of occupation addressed in WCC visits

Feeding/eating	Breast/bottle feeding Transition to solids Picky eating Mealtime battles/issues
Sleep concerns	Daytime naps Nighttime sleep Sleep hygiene
Play and Leisure	Screen time Outdoor play Physical play

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Activities of daily living	Oral care Bathing Dressing Grooming
Parenting	Daily routine and habit formation Maternal mental health Parenting confidence and satisfaction

- Performance skills- Motor skills, attention, knowledge, communication skills
 - Development
 - Communication
 - Social skills
 - Gross/fine motor skills
 - Cognition
 - Behavior concerns
 - Resilience
- Performance patterns- Habits, schedules, routines, roles
- Environmental contexts- Home or school environment, social or cultural environment
 - Stress & trauma
 - Social needs
 - Food & housing insecurity
 - Smoking in home
- Activity demands- Sequencing and required actions
- Client factors- Body systems, structures, or functions

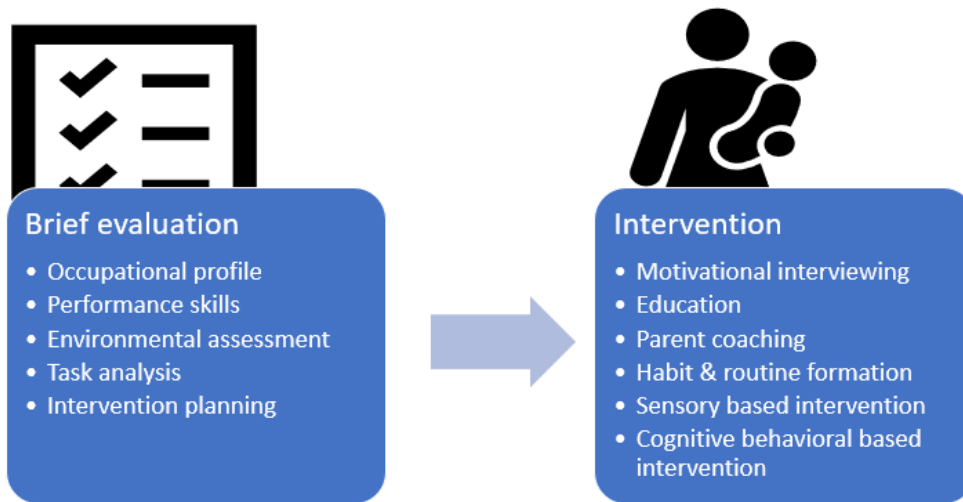
What this looks like during visit: The medical team or the occupational therapist identifies through screening paperwork and discussion an area of need or concern that may be negatively impacting the child’s health. The occupational therapist follows the same two key steps to provide care as was described above under the previous section on OT in dental visits. It is included again here with the only difference being the inclusion of neurodevelopmental interventions to support developmental skill acquisition.

See Appendix S for detailed workflows on identification of need and how to respond and connect families with OT in WCC visits.

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Figure 24: Key steps to OT intervention to support home health habits within the health visit



Step 1: If there is time, the occupational therapist completes a brief assessment during the medical visit:

- Occupational profile- This is a brief screen of what current participation in the occupation of looks like for this patient, what the family's performance patterns include, and what has been tried in the past to improve participation.
- Assessment of the child's performance skills- If needed the occupational therapist specifically assesses the child's skills in the following areas:
 - Gross and fine motor
 - Communication
 - Cognition
 - Social-emotional skills
- Assessment of the parent's performance skills- If needed the occupational therapist assesses the parent's skills (strength, flexibility, coordination, self-control, organization, coping, etc.).
- Environmental assessment- The occupational therapist asks about supports and barriers within the family's home or daily routines which can be capitalized on, added, or removed to support behavior change.
- Task analysis - If needed, the occupational therapist uses this skill to determine which elements of the occupation are going well and which need support.
- Intervention plan- Based on identified areas of strength and deficit as well as function and dysfunction, the occupational therapist creates an intervention plan.

Step 2: The occupational therapist determines next steps, which may include one or more of the following possibilities:

- Brief intervention provided within the visit
- Follow up intervention needed via phone
- Follow up intervention needed one-on-one in clinic
- Follow up intervention needed in group setting

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Some examples of what brief intervention techniques look like:

- Motivational interviewing and use of the transtheoretical model of change- discussion with use of visuals and handouts when needed.
- Education if needed around a specific topic.
- Parent coaching model- plan, act, assess performance, determine what will be done differently next time.
- Modeling of skills- therapist models skills which the parent or the child may need to develop.
- Habit & routine formation principles- this may include discussion and support with implementation of steps to form an action into a habit, such as creating visual prompt for the parent to place in environment, writing down implementation intentions or possible habit stacks, supported searching for technology-based tools for tracking and reminders. May also include calendar planning and balance wheel work.
- Sensory based intervention- use of weighted tools to provide calming support for the child while child, parent, and therapist explore new foods and textures.
- Cognitive-behavioral based intervention- use of graded desensitization, exploration of thought patterns or fears/anxieties preventing participation.
- Neurodevelopmental interventions- use of developmentally tailored handling techniques, facilitation, and targeted activity participation to support the maturation of gross motor, fine motor, communication, problem solving, and social-emotional skills.

EXAMPLES- The examples noted in the previous section on OT in dental visits will also apply to WCC. One additional example will be included here in order to give examples of use of neurodevelopmental interventions in the WCC setting.

Occupational therapist identifies through screening paperwork and discussion that one or more of the following areas may be negatively impacting the child's health.

Child has delayed gross motor development:

Step 1: The occupational therapist completes a brief assessment:

- Occupational profile- discussion around what the daily routine currently looks like for this child, how often the infant/child is physically active and whether or not the parent engages in physical play with their son/daughter, as well as anything this family has tried in the past to solve the problem.
- Assessment of the child's performance skills- specifically assess the child's gross motor skills and note differing responses with specific amounts of support or input to determine what is needed to allow this child to be successful.
- Assessment of the parent's performance skills- specifically assess whether the parent has the physical strength and dexterity to play actively with the infant or child on the floor or outside. Assess whether the parent has the cognitive ability to recall a routine and new ways to support their child with movement. Look at whether the parent has the emotional health to bond and play with their child as well or if the parent may be needing support with their own mental health before supporting the child with developing new skills.

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- Environmental assessment- Discussion around what the home environment looks like and what opportunities there are within the home for gross motor play (including toys or supplies that might be used to encourage gross motor movements in the child). Also ask about the community environment including access to parks and outdoor spaces that are safe.
- Task analysis - let the parent play on the floor with the infant/child and observe how they play. Watch for how parent responds and offers support to the infant/child.

Step 2: Intervention will address one or more of these areas:

- Create and help family use daily schedules to foster multiple opportunities for gross motor play in a variety of settings (indoor and outdoor) and to reduce use of screens or sedentary activities.
- Support caregiver knowledge and skill of games and activities which can be used with their child to encourage specific gross motor movements. Help parent use these games to capture the child's attention and promote engagement.
- Manage negative child behaviors in a developmentally supportive way that honors boundaries and teach parents to do the same.
- Model and practice supportive positioning and handling used during play to elicit certain movements and skills.

Last, another role of the occupational therapist is to identify needs that extend beyond an individual patient to multiple patients, which might be best addressed through group follow up using curriculum. In this context, we encourage you to consider classes which involve the parent and child working together, rather than having the parent engage separately. We currently use a group model to support building oral health habits in your children. Some additional examples of topics which we are considering:

- Supporting development from 6-12 months
- Supporting development from 15-24 months
- Postpartum depression play and bonding
- Managing challenging behaviors
- Planning and cooking healthy meals
- Using mindfulness with kids
- Managing picky eating
- Managing sleep issues
- Reducing sugar intake
- Increasing physical play in young children

Phone appointments and group visits will be discussed in Chapter 17: Visit Specific Sections.

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c. DENTIST

The role of the dentist within P-5 PATH is to lead dental visits and the dental care team towards preventative care that emphasizes building a parent's capacity to keep their child's teeth healthy between dental visits. This concept is not new but can be overlooked or overpowered by the common approach that suggests the dentist's job is to keep the child's teeth healthy. This is true, of course, but the biggest element of keeping a child's teeth healthy is to empower the person caring for the child (and the child's teeth) 365 days of the year during the 1-2 days per year where you are able to see and work directly on the health of the child's teeth.

While education and teaching of care techniques falls in large part under the role of the dental assistant and hygienist (and occupational therapist within P-5 PATH) we encourage our dentist to take a proactive role with creating and guiding the care plan with clear instructions for the parent and the team for how much support is needed and in which areas in order to get the parent's knowledge, skill, and confidence to a proficient level so that the child's teeth remain as healthy as possible between visits. When this collaborative effort between the dentist, dental team, and the parent is at its best, the parent feels highly confident in caring for the child's teeth between visits and looks forward to dental visits for confirmation that the child's teeth are as healthy as possible—knowing we can't prevent 100% of accidents or illness.

The main areas of practice that might be new for the dentist beginning P-5 PATH are:

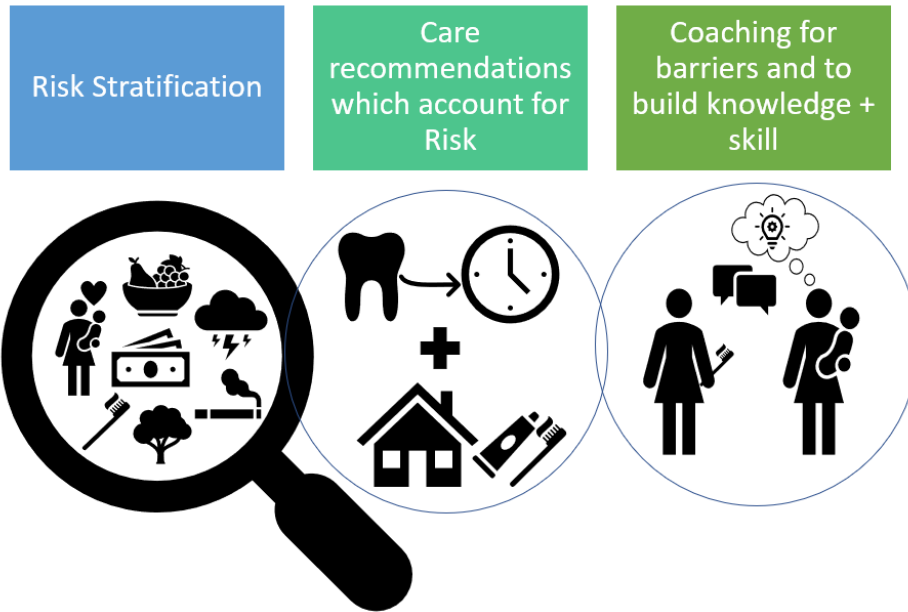
- Self-management goal setting
- Speaking to risk over time, not only current state of health
- Wrapping oral health into the idea of whole body health
- Using motivational interviewing principles to frame all patient/parent interactions
- Engaging parents in discussions about barriers to oral care home habits rather than educating on importance
- Prescribing more frequent follow up with the dental team or occupational therapist when coaching work is needed
- Collaborating with the medical team to address whole body health goals and redirect patients to care who are over-due for care steps

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What this looks like in practice:

Figure 25: Dental care in P-5 PATH



Dental visits follow the same basic format as was previously being used prior to launch of P-5 PATH. The DA collects the patient from the waiting room, takes a height/weight, walks the child to the dental suite and sits the child in the dental chair with bib and eye protection. The DA completes the Caries Risk Assessment and intake questions with the parent, then completes x-rays if the child is able to participate, toothbrushing, and flossing. The DA sets a self-management goal with the patient, then the dentist is called and joins the visit to do an oral exam and fluoride varnish with parent education.

Risk Stratification:

The dentist looks over intake paperwork which offers a glimpse of the patient's risk for caries, oral health self-management skills, social health, and daily routines. The dentist uses this information to inform the clinical picture and make recommendations for the patient. The dentist must use her clinical expertise to combine the information from the intake paperwork and exam to discern whether this parent-patient dyad needs more support to develop self-management of the child's oral health. One indicator is high caries risk, though this is not the only factor that indicates a family needs more support from the dental team. Social stress and unhealthy daily habits, poor previous follow through, low health literacy, and high medical needs all round out the clinical picture to show us that a family may benefit from a more supportive and intensive care plan.

If more information is needed to create a clear clinical picture the dentist will engage the parent in discussion. The dentist can use this opportunity to discuss the self-management goal and engage the parent in a brief discussion about what the dentist sees as current risks and what the parent's priorities are for addressing today. If the patient has a previous self-management goal set in a medical visit, the dentist should acknowledge this, congratulate the parent for working on the child's physical health and ask how progress is going towards that goal. A brief


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acknowledgement of family goals set in the medical setting reminds a family that they are part of a health home and that oral and physical health are connected.

Risk Informed Care Recommendations:

Next the dentist will set a clear care plan for the patient. We found that without clear recommendations, patients tend to decline further novel supports such as the dental group or intervention from the occupational therapist. However, when the dentist helps to identify specific needs and lets the family know that certain care steps are recommend, such as following up with the dental group or with an OT visit, the family is more likely to engage with further care steps.

 Here is an example of what setting a clear plan with a parent might sound like: “So we identified that brushing twice per day with a toothpaste with fluoride and making changes to Sarah’s diet is an important part of keeping her teeth health between dental visits. It sounds like you want to focus on brushing twice daily, is that right?” [Parent: “Yes”] “Great, then I recommend we come up with a plan for this with our occupational therapist.”

Coaching for Barriers and to Build Knowledge and Skill:

We recommend motivational interviewing training for dental staff to support this work. The important elements to remember are:

- Asking permission before offering advice
- Asking what the parent/patient already knows before offering more knowledge
- Asking the patient what their priorities are

Example of what this dialogue sounds like:

DENTIST: Would it be ok if we discuss what I found today during your son’s exam?

PARENT: Sure.

DENTIST: I see from the exam that you are working hard at keeping those front teeth healthy.

PARENT: Thanks, I’m trying.

DENTIST: This matters to you, I can see that. I’d like to discuss those back teeth, especially the ones on the bottom. Tell me what you’re doing now to keep those teeth healthy?

PARENT: Oh yeah, he hates to brush the back teeth. I do it, but he fights me. I try to get it over with as quickly as possible.

DENTIST: So those back ones are a real challenge for you guys.

PARENT: Yes! I really am doing my best but it’s hard. Is there a cavity back there?

DENTIST: You’re putting in some effort there and you’re not sure it’s enough.

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PARENT: Well we set that goal to brush 2 times a day but it's going to be tough.

DENTIST: You're committed to really working on this even though it's going to take some hard work. I don't see a cavity yet, but I can see that if we don't get on this now, we might see one by next visit.

PARENT: Oh. I am committed because I don't want him to be put to sleep like his brother.

DENTIST: Well we're also committed to supporting you with this. Can I share my recommendations for next steps and you can let me know where you want to start?

PARENT: Sure.

DENTIST: You can help keep those teeth healthy and I recommend two important steps. 1. brushing twice a day with some extra attention to those back teeth, 2. adding a few healthy snacks to your usual list of snacks for your son which protect his teeth. Which one do you think is a top priority for you?

PARENT: I think I'd like to work on the brushing but it's hard! He really fights me on it.

DENTIST: That does sound like a challenge. Can I tell you about a resource other patients have found helpful?

PARENT: Sure.

DENTIST: We have an occupational therapist here who specializes in kiddos. She can help you make the brushing more enjoyable for your son and help you make a game plan that will fit your life and your needs. Does that sound ok to you?

PARENT: I am pretty busy, but I might be able to squeeze in a visit.

DENTIST: This is a priority for you and you're willing to find the time in your busy schedule. You can schedule at the front desk on your way out or I can see if she is available right now. Which do you prefer?

PARENT: I'll schedule to come back next week.

DENTIST: Great. I would also like to see your son back in 6 months to re-check and see how your son's teeth are looking. Six months is a long time though and what you do at home between now and then matters. This is why that visit with the occupational therapist is so important.

PARENT: Ok I'll make that appointment.

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You can see from this dialogue that the dentist is prioritizing making a clear recommendation and care plan for this patient which takes the patient's risk into consideration and is acknowledging that the parent is an expert in her son's care. The approach empowers the parent to choose her top priority and to engage actively in the process of caring for her son's teeth. This interaction drives home the message that the parent and child's daily habits make the difference in keeping her son's teeth healthy.

When there are no specific issues to address and no need for additional care follow-up, the dentist can use this opportunity to check on other health behaviors which tie into oral health but also speak to whole body health, such as noting if the patient is behind on vaccinations and recommending that the parent schedule to bring those up to date, or eliciting from the parent more information about screen time habits and outdoor play opportunities to highlight that a healthy body and a healthy mouth work together.

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d. DENTAL ASSISTANT

The dental assistant plays a key role in P-5 PATH work during dental visits. The main differences in care provided by the DA using this model is the completion of a standardized Caries Risk Assessment, the opportunity to set a self-management health goal with the parent, and support to the dental team with getting an after-visit summary (AVS) completed and printed for the patient.

Dental visits follow the same basic format as was previously being used prior to launch of P-5 PATH. The DA collects the patient from the waiting room, takes a height/weight, walks the child to the dental suite and sits the child in the dental chair with bib and eye protection. The DA completes the Caries Risk Assessment and intake questions with the parent, then completes x-rays if the child is able to participate, along with toothbrushing and flossing. The DA sets a self-management goal with the patient, then the dentist is called and joins the visit.

Caries Risk Assessment:

There are many tools which can be used to collect information about the patient's Caries Risk and we use a version created by the Oregon Oral Health Coalition for children 6 and under. This assessment tool combines information about lifestyle factors with a visual assessment to determine if a child is at low or high risk for caries.

Our DAs administer this assessment verbally and then use the responses to guide coaching and goal setting. Our dental team is trained in Motivational Interviewing, which acknowledges that parents are experts in their children and often have more knowledge on health than we may realize, allowing us to ask key questions that speak to barriers and motivation to make changes. Key phrases and questions that are often used by our DA include:

“Tell me more about that.”

“What are you doing currently at home to manage this?”

“Tell me more about why you want to make that change.”

Self-Management Goals:

Another important job of the DA is helping the family to set a self-management goal for their child to work on changing health behaviors. The CRA is used to support goal setting, but because these goals are shared between the medical and dental team, the goal does not have to be specific to oral health and caries risk. What is most important is that the goal is meaningful to the family. We have worked with our DAs to help them understand that we are coaching our parents to set a goal that is relevant and motivating to their family, instead of choosing a goal for them.

The scripting we have come up with to support this work is as follows:

“This might seem a bit different, but we ask all our families to think up and set 1 health goal for their child. This is a goal that you can work on at home, which will help you keep your child's teeth as healthy as possible between now and your next visit. Is there anything we've discussed

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today that you'd like to work on at home?" If the parent is unable to think of anything, the DA can offer some ideas that the parent can consider, but ideally, we want the parent to come up with the goal on their own. If further support and prompting is needed, we do have a sample goal sheet which the DA can use. This prompt sheet is shared between our medical and dental clinics with certain goals that relate more to oral health and others which speak more to physical health, to allow the family to see that dental health and medical health both fit together under the umbrella of "health."

Figure 26: Sample self-management goal prompt sheet.



After-Visit Summary & Next Steps:

Last, the role of the DA in P-5 PATH well dental visits is to support the dentist with adding the goal, the recommendations for care, and the recommendations for follow up to the EHR under the appropriate headings in order to populate the AVS. Once this information is entered in the

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appropriate sections of the EHR, it will populate the patient's AVS and the DA can print the document and give to the family to wrap up the visit.

When possible, the DA can also scan the medical record to determine care gaps and overdue health steps. The DA acts as a reminder touchpoint, letting the family know that the child is overdue for vaccinations, a WCC visit, developmental screen, and/or other follow up visits with the medical team. Once identified, the DA can either tell the family to stop at the front desk on the way out to schedule a medical visit to close care loops or can message the P-5 PATH Coordinator making sure that outreach is completed for this family.

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e. DENTAL HYGIENIST

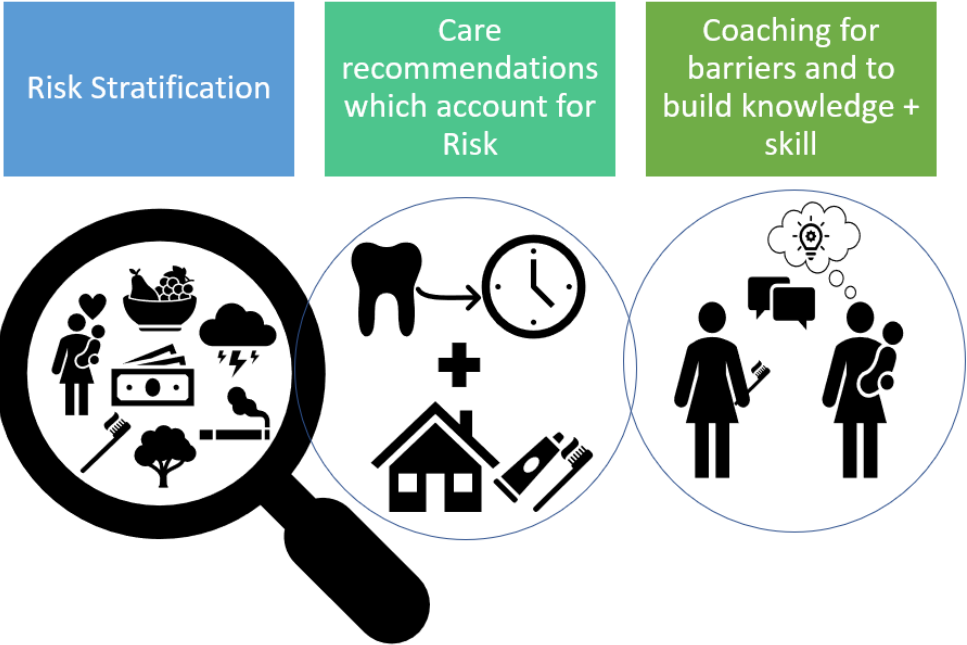
The dental hygienist plays a pivotal role in integration efforts within P-5 PATH. In dental visits, the hygienist supports the dental team’s work to provide risk informed care to keep our youngest children healthy, with strong emphasis placed on building parent capacity to manage health at home through daily health promoting habits. In medical visits, the DH provides direct care within WCC visits- screening, assessing, and offering intervention. The DH also leads group intervention efforts with the occupational therapist in order to support parents with the development of skills to manage the child’s oral health.

Similar to the role of the dentist, the main areas of practice that might be new for the dental hygienist beginning P-5 PATH are:

- Self-management goal setting
- Speaking to risk over time, not only current state of health
- Wrapping oral health into the idea of whole-body health
- Using motivational interviewing principles to frame all patient/parent interactions
- Engaging parents in discussions about barriers to oral care home habits rather than educating on importance
- Prescribing more frequent follow up with the dental team or occupational therapist when coaching work is needed
- Collaborating with the medical team to address whole body health goals and redirect patients to care who are over-due for care steps

What this looks like in practice in a dental visit:

Figure 27: Dental care in P-5 PATH



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Dental visits follow the same basic format as was previously being used prior to launch of P-5 PATH. The DH collects the patient from the waiting room, takes a height/weight, walks the child to the dental suite and sits the child in the dental chair with bib and eye protection. The DH completes the Caries Risk Assessment and intake questions with the parent, then completes x-rays if the child is able to participate, toothbrushing, flossing and polishing. The DH sets a self-management goal with the patient, then the dentist is called and joins the visit to do an oral exam and fluoride varnish with the DH and dentists both supporting parent education.

Risk Stratification:

The DH should look over intake paperwork as soon as a patient enters the suite because the paperwork offers a glimpse of the patient's risk for caries, oral health self-management skills, social health, and daily routines. The DH uses this information to inform the clinical picture and make recommendations for the patient. The DH must use clinical expertise to combine the information from the intake paperwork and exam to discern whether this parent-patient dyad needs more support to develop self-management of the child's oral health. One indicator is high caries risk, though this is not the only factor that indicates a family needs more support from the dental team. Social stress and unhealthy daily habits, poor previous follow through, low health literacy, and high medical needs all round out the clinical picture to show us that a family may benefit from a more supportive and intensive care plan.

If more information is needed to create a clear clinical picture the DH will engage the parent in discussion. The DH can use this opportunity to discuss the self-management goal and engage the parent in a brief discussion about what the dentist sees as current risks and what the parent's priorities are for addressing today. If the patient has a previous self-management goal set in a medical visit the DH should acknowledge this, congratulate the parent for working on the child's physical health and ask how progress is going towards that goal. A brief acknowledgement of family goals set in the medical setting reminds a family that they are part of a health home and that oral and physical health are connected.

Risk Informed Care Recommendations:

Next the DH will set a clear care plan for the patient. We found that without clear recommendations, patients tend to decline further novel supports such as the dental group or intervention from the occupational therapist. However, when the DH helps to identify specific needs and lets the family know that certain care steps are recommend, such as following up with the dental group or with an OT visit, the family is more likely to engage with further care steps.



Here is an example of what setting a clear plan with a parent might sound like: "So we identified that brushing twice per day with a toothpaste with fluoride and making changes to Sarah's diet is an important part of keeping her teeth health between dental visits. It sounds like you want to focus on brushing twice daily, is that right?" [Parent: "Yes"] "Great, then I recommend we work on your brushing technique together right now and then you have one visit with the occupational therapist to come up with a plan for making this a habit so you don't even need to think about it, you just do it."

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Coaching for Barriers and to Build Knowledge and Skill:

We recommend motivational interviewing training for dental staff to support this work. The important elements to remember are:

- Asking permission before offering advice
- Asking what the parent/patient already knows before offering more knowledge
- Asking the patient what their priorities are

Example of what this dialogue sounds like:

DH: Would it be ok if we discuss what I found today during your son's exam?

PARENT: Sure.

DH: I see from the exam that you are working hard at keeping those front teeth healthy.

PARENT: Thanks, I'm trying.

DH: This matters to you, I can see that. I'd like to discuss those back teeth especially the ones on the bottom. Tell me what you're doing now to keep those teeth healthy?

PARENT: Oh yeah, he hates to brush the back teeth. I do it, but he fights me. I try to get it over with as quickly as possible.

DH: So those back ones are a real challenge for you guys.

PARENT: Yes! I really am doing my best but it's hard. Is there a cavity back there?

DH: You're putting in some effort there and you're not sure it's enough.

PARENT: Well we set that goal to brush 2 times a day but it's going to be tough.

DH: You're committed to really working on this even though it's going to take some hard work. The dentist can talk a bit more about that tooth and whether there is a cavity, but I want to talk about what we can do to keep all your son's teeth healthy between this visit and the next visit.

PARENT: Oh. I am committed because I don't want him to be put to sleep like his brother.

DH: Well we're also committed to supporting you with this. Can I share my recommendations for next steps and you can let me know where you want to start?

PARENT: Sure.

DH: You can help keep those teeth healthy and I recommend two important steps. 1. brushing twice a day with some extra attention to those back teeth, 2. adding a few healthy snacks to your usual list of snacks for your son which protect his teeth. Which one do you think is a top priority for you?

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PARENT: I think I'd like to work on the brushing but it's hard! He really fights me on it.

DH: That does sound like a challenge. Can I tell you about a resource other patients have found helpful?

PARENT: Sure.

DH: We have an occupational therapist here who specializes in kiddos. She can help you make the brushing more enjoyable for your son and help you make a game plan that will fit your life and your needs. Does that sound ok to you?

PARENT: I am pretty busy but I might be able to squeeze in a visit.

DH: This is a priority for you and you're willing to find the time in your busy schedule. You can schedule at the front desk on your way out or I can see if she is available right now. Which do you prefer?

PARENT: I'll schedule to come back next week.

DH: Great. I would also like to see your son back in 6 months to re-check and see how your son's teeth are looking. 6 months is a long time though and what you do at home between now and then matters. This is why that visit with the occupational therapist is so important.

PARENT: Ok I'll make that appointment.

You can see from this dialogue that the DH has prioritized making a clear recommendation and care plan for this patient which takes the patient's risk into consideration and is acknowledging that the parent's priorities. The approach empowers the parent to engage actively in the process of caring for her son's teeth. This interaction drives home the message that the parent and child's daily habits make the difference in keeping her son's teeth healthy.

When there are no specific issues to address and no need for additional care follow-up, the DH can use this opportunity to check on other health behaviors which tie into oral health but also speak to whole body health, such as noting if the patient is behind on vaccinations and recommending that the parent schedule to bring those up to date, or eliciting from the parent more information about screen time habits and outdoor play opportunities to highlight that a healthy body and a healthy mouth work together.

What this looks like in practice in a medical visit:


One unique integration effort within P-5 PATH is the integration of the DH into WCC visits. The goal of this integration effort was to maximize the number of children seen for direct dental screening and intervention while making it as easy as possible for families to combine care for their child into one visit.


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Our hygienist is available one afternoon per week in WCC visits. In order to maximize her time and help establish the role we set the following parameters:

1. The hygienist will see any children 0-17 in for a WCC visit, regardless of insurance status or establishment of a dental home outside of NHC, unless the family declines the dental services.
2. If the family identifies that the child needs a cleaning or has a specific dental need, the patient can be scheduled with our DH to leave primary care and complete a full dental visit either just before or just after their WCC visit.


 The P-5 PATH Coordinator completes outreach to all families scheduled for a WCC visit on the afternoon the DH is in primary care and offers a dental screening with the DH. The coordinator also adds to the appointment note which dental insurance the child has, so that we can advise families if they can be seen for a comprehensive exam by our dental team or if not, so that we can help them navigate to a dental home aligned with their insurance.

 We found that completing the WCC visit, a dental screening, and meeting with the occupational therapist was too time consuming and overwhelming for some children and families. We adjusted our care on those days to have the occupational therapist not join the visit, unless there was a specific need and the family requested time with the occupational therapist. This helped reduce visit lengths.

See Chapter 12: Logistics: Time, Space, and Tools for Dental Hygienist in Primary Care for additional information.

What this looks like in group dental visits:

An important care offering is the group dental class for children who screen high for caries risk and overall health risk. These groups are co-led by the dental hygienist and the occupational therapist. The curriculum emphasizes the development of care skills for the parent and child. Our goal is to discuss then practice a few key skills that our families commonly struggle with. The focal topics are preparing and serving healthy snacks and brushing skills. Serving healthy snacks encompasses reading food labels, knowing which foods are healthy choices, serving them in a developmentally appropriate way, and encouraging kids to eat the healthy choice. Brushing skills involve positioning the infant or child, encouraging compliance and participation, making sure you are able to brush all quadrants of the mouth, and then implementing personal strategies to make brushing twice daily a part of the daily routine. See Appendix T for details on class tools, activities, timelines, etc.

 We split our groups up into 0-3 years and 4-5 years to make sure the content was developmentally appropriate for all attendants. We encourage siblings to attend. Groups are held once a month and all children seen in our dental department who were considered high caries risk, high overall risk, or who had active caries are referred for this group.

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At this time, we have not determined a method of billing for these groups and they are considered value added to the clinic and to the care of our patients.

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f. PEDIATRICIAN

The physician plays a central role in setting the interdisciplinary and collaborative tone for P-5 PATH care. Most families are familiar with the idea of Well Child Care and expect to check in with their baby’s doctor several times over the first few years of life. Because of this, the pediatrician and family medicine physician serve as a gateway into P-5 PATH care which connects the family to several other services and disciplines. The physician provides the “warm handoff” needed to help the family build trust and rapport with the rest of the team. The benefit to the physician is support to extend the care provided in order to accomplish more and to achieve whole body wellness for their patients. The benefit to the patient is also an extension of care, with more touch points, increase opportunities for both education and skill practice in order to support wellness behaviors that matter in infancy and childhood, such as attachment, breastfeeding, frequent loving communication and playing, tummy time, outdoor time, healthy diet, etc.

Figure 28: Physician role in P-5 PATH



Beyond setting the tone for wellness and connecting the patient and family to the right services early (i.e. dental, occupational therapy and other specific resources depending on the case) the physician’s role is to screen for risk, work with the family to create a patient specific care plan that accounts for this risk, and set a clear action plan for next care steps to follow between Well Child visits. This will include connection to the occupational therapist if needed for specific support or additional screening, connection to dental once the baby has a first tooth erupted, and recommendations for more frequent returning to primary care for weight checks or other needs with the physician or with the nurse team.

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Changes to the physician standard practice workflows include:

- Huddling with the P-5 PATH team, including the dental team, the occupational therapist, and the coordinator once per week for 10-15 minutes.
- Huddling with the occupational therapist in the morning before patient care begins to discuss the WCC visits or follow ups scheduled that day.
- Collecting and looking over the intake paperwork to determine needs, red flags, or areas of concern to be addressed.
- Using motivational interviewing strategies to support parent education and discussions.
- Emphasizing risk, rather than current state of health to guide the care plan.

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g. FAMILY MEDICINE PHYSICIAN

The family medicine physician will serve a similar role to the pediatrician for WCC, but also has the added role of primary care services for pregnant mothers. Because NHC does not provide prenatal services, these visits were specifically for pregnant women who needed to establish care with a primary care provider to establish their health home for health needs outside of pregnancy. This population was identified through a community partnership with a local prenatal clinic and birth hospital, whose staff identified that several of their patients were utilizing prenatal care visits instead of primary care visits to discuss health needs outside of the pregnancy, which their team was not equipped to manage. With this population identified, our P-5 PATH team recognized the opportunity for partnership and to introduce P-5 PATH care prenatally to build trust and healthy habits for the baby and the family from the earliest point of care possible.

Primary Care for pregnant women:

Each woman was seen by our family medicine physician for an establishing visit which was completed in the same manner as any other new patient visit. The only changes to the visit flow was a warm handoff to the occupational therapist at the end of the visit (for introduction to P-5 PATH, the services that are offered, a wellness screen focused on infant and family health, and a referral to dental services. If the occupational therapist was not available for an establishing visit with the pregnant woman, the family medicine physician was expected to provide mom a handout about P-5 PATH and, if specific needs were identified, to recommend to the mother that an appointment be made with the occupational therapist to discuss that need.

Primary care for infants and children:

The physician plays a central role in setting the interdisciplinary and collaborative tone for P-5 PATH care. Most families are familiar with the idea of Well Child Care and expect to check in with their baby's doctor several times over the first few years of life. Because of this, the pediatrician and family medicine physician serve as a gateway into P-5 PATH care which connects the family to several other services and disciplines. The physician provides the "warm handoff" needed to help the family build trust and rapport with the rest of the team. The benefit to the physician is support to extend the care provided in order to accomplish more and to achieve whole body wellness for their patients. The benefit to the patient is also an extension of care, with more touch points, increase opportunities for both education and skill practice in order to support wellness behaviors that matter in infancy and childhood, such as attachment, breastfeeding, frequent loving communication and playing, tummy time, outdoor time, healthy diet, etc.

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Figure 29: Physician role in P-5 PATH



Beyond setting the tone for wellness and connecting the patient and family to the right services early (i.e. dental, occupational therapy and other specific resources depending on the case) the physician's role is to screen for risk, work with the family to create a patient specific care plan that accounts for this risk, and set a clear action plan for next care steps to follow between Well Child visits. This will include connection to the occupational therapist if needed for specific support or additional screening, connection to dental once the baby has a first tooth erupted, and recommendations for more frequent returning to primary care for weight checks or other needs with the physician or with the nurse team. The workflow for physician, MA, and occupational therapist within WCC visits can be found in Appendix U.

Changes to the physician standard practice workflows include:

- Huddling with the P-5 PATH team, including the dental team, the occupational therapist, and the coordinator once per week for 10-15 minutes.
- Huddling with the occupational therapist in the morning before patient care begins to discuss the WCC visits or follow ups scheduled that day.
- Collecting and looking over the intake paperwork to determine needs, red flags, or areas of concern to be addressed.
- Using motivational interviewing strategies to support parent education and discussions.
- Emphasizing risk, rather than current state of health to guide the care plan.

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h. MEDICAL ASSISTANT

The medical assistant role within P-5 PATH is essential to directing the flow of a WCC and primary care visit. These visits have a few moving parts that make them unique compared with other primary care visits, including the team-based nature of care with the physician and the occupational therapist or at times the physician and the dental hygienist both involved with the visit.

The medical assistant will complete the following care steps beyond what is standard care practices:

- Assure that the patient has received the appropriate paperwork while they are being roomed and enter screening tool results into the appropriate EHR section.
- Let the physician and the occupational therapist know if red flags are identified in the paperwork responses or in discussion with the family.
- Schedule follow up appointments for the patient if follow up is recommended within the next 3 months.

The MA is well situated to help the patient and family feel comfortable and know what to expect. We have also found that the MA is often the first to identify a red flag and can pass that information on to the rest of the team. The workflow for these care steps can be found in Appendix U.

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i. FRONT DESK

For front desk personnel we recommend that key staff members familiarize themselves with the P-5 PATH paperwork (see Chapter 9: Key Tools and Chapter 10: Staff Training for details on the paperwork).

The intake paperwork and questionnaires:

- Integrated, pediatric specific registration paperwork (see Appendix D)
- A set of age-specific intake paperwork for use in WCC visits (see Appendix K)
- A single 0-5-year-old intake paperwork for use in Well Dental visits (see Appendix K)

Figure 30: Front desk filing cabinet with P-5 Paperwork



Identifying patients who need this paperwork and then appropriately disseminating it is the key role of the front desk within P-5 PATH. This essential step allows the rest of the P-5 PATH team to complete the appropriate care steps to risk stratify the patient and determine areas of need. Front desk staff should know the valuable role they play in providing high quality, preventative care to the clinic's youngest and most vulnerable patients.

As an overview, the occupational therapist or coordinator will add a note to each appointment to indicate to the front desk staff which paperwork packet should be given out to the patient.

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Figure 31: Adding a “message” to patient appointments in Epic

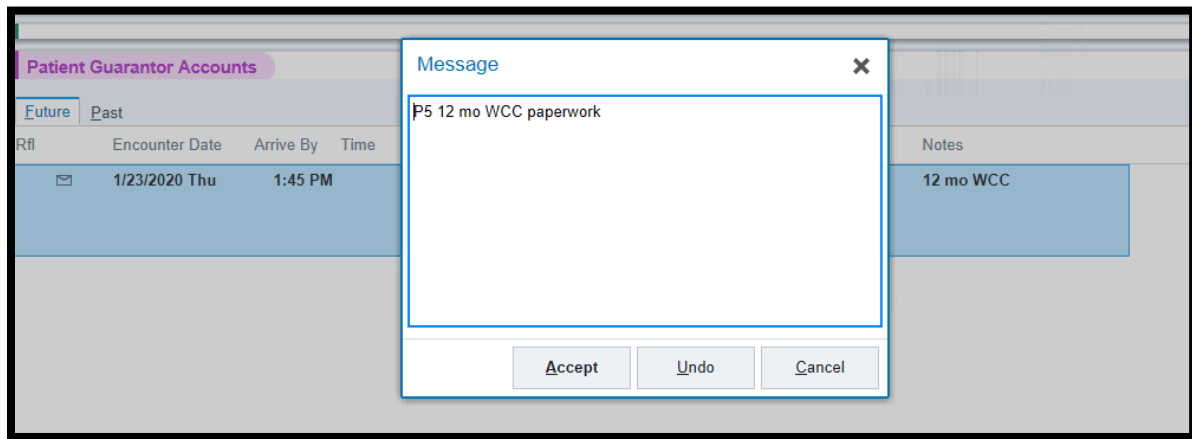


Figure 32: Back office view of appointment messages in Epic

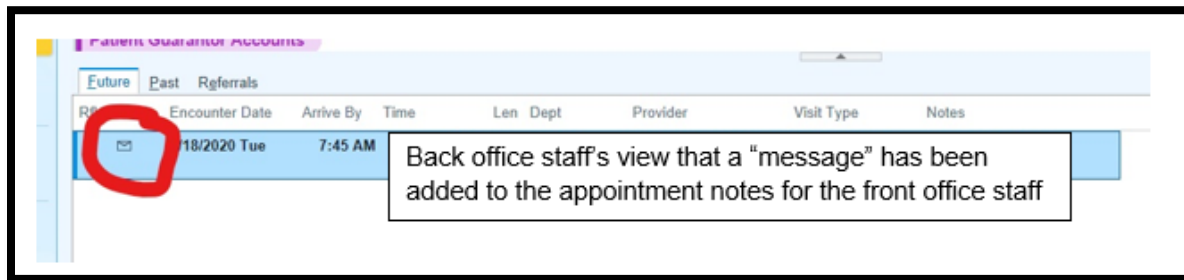
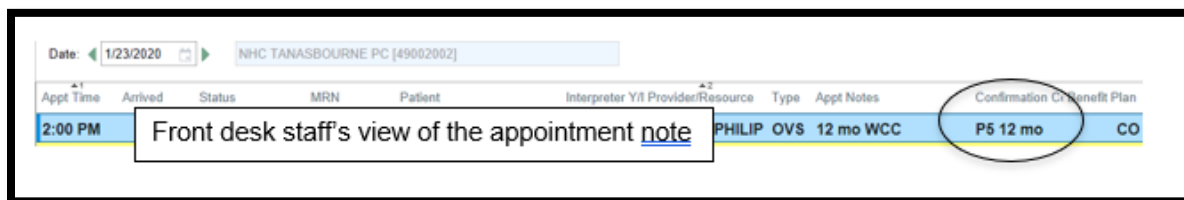


Figure 33: Front office staff view of appointment messages in Epic



Training:

It is important that the administrative team identify a front desk lead at the launch of P-5 PATH in order to help tailor front desk workflows to your clinic, such as who will print P-5 PATH paperwork, where this paperwork (files and hard copies) will be stored, and who will be responsible for training new staff or answering questions from staff as they familiarize themselves with the program and with workflows. See Chapter 10: Staff Training for further detail on this.

17. Visit Specific Sections

This chapter is designed so that clinical staff may select the specific section that pertains to the type of visit that they will be a part of and see how all team members fit together in this visit to provide coordinated care within P-5 PATH. We encourage the occupational therapist to read each section as this role will be included in all visit types. For the remaining team members, we encourage you to read through the sections that speak to the specific type of visit where you will be a participant. As we mentioned in Chapter 3: Defining Your Program, you may not have each of these visit types in your iteration of P-5 PATH. If this is the case, you can skip over the visits types that your team will not use.

This section will provide additional information and role clarification for the following visits:

- a. Well Dental visits
- b. Well Child Care visits
- c. Phone Occupational Therapy visits
- d. Individual Clinic-Based Occupational Therapy visits
- e. Group Dental Education visits
- f. Sick visits (in dental and primary care)
- g. Pregnant Woman Primary Care visit

- Distribute all sections** to the appropriate staff members who will participate in that visit type.
- Use at least one **clinical team meeting** to talk through roles within each visit type and assure all staff are familiar with the expectations of their role and the workflows within that visit type.
- Consider a trial run** for each visit type with a mock patient to practice in real time what the workflow will look and feel like.
- Determine **communication methods** between pertinent staff members to communicate when running late or if there is an unexpected change that will need to happen in the expected workflow.

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a. WELL DENTAL VISITS

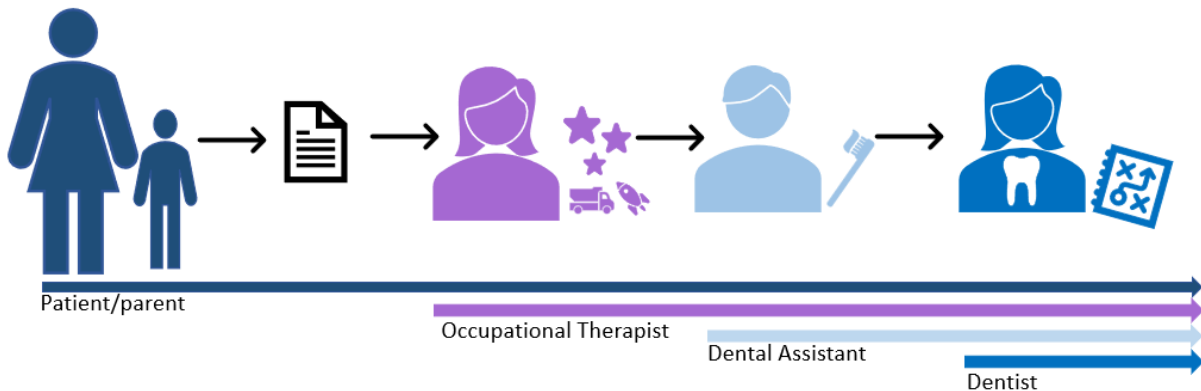
The flow and detail of a Well Dental visit can be found in this section. Well Dental visits are dental visits which are focused on screening needs, assessing the health of the mouth in the context of the rest of the body, and providing interventions which support wellness. These visits do not include dental visits where fillings or other restorative work is provided.

The primary difference to our P-5 PATH Well Dental visits compared with standard care is:

- The inclusion of pediatric screening tools in the intake paperwork to screen not just for need but also for parent capacity.
- A standardized caries risk assessment tool in all visits.
- The inclusion of the occupational therapist within the visit to support screening, participation, and interventions which either build parent capacity or which support child engagement.
- The use of goal setting with families.
- The use of coaching for activation and Motivational Interviewing.
- The use of a dental specific pediatric behavior and participation tool called the Modified Frankl Assessment to quantify engagement in the dental visit (See Appendix M, sections 2 and 3).
- The emphasis on risk informed care plans with allow for further support for patients in need.

These care steps impact the traditional flow of our Well Dental visits and necessitate both training and updating of workflows based on staff feedback. See Figures 34 and 35 for further details on flow of a patient through Well Dental visits involving the front desk, the occupational therapist, the DA, and the dentist.

Figure 34: P-5 PATH well dental visit flow




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Figure 35: Dental visit flow



For specific job roles within the Well Dental visit, look for the job title under Chapter 16: Personnel Specific Sections.

 One idea that our team is considering is the role of the P-5 PATH Coordinator in identifying medical care gaps (upcoming, missed, or overdue WCC visits, vaccinations, developmental screens, or follow up care) and then adding this information to dental visit appointment notes to support the front desk and dental team with addressing this need. Our occupational therapist and dental team have discussed supporting the medical team with connecting our patients back for care in medical as needed, but a workflow has not yet been developed around this work.

Well Dental Care Paperwork

All new patients who are seen at NHC will be asked to complete new patient intake paperwork, which includes a Registration, Health History, HIPAA form, Income Verification form, and a

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Release of Information form (you can find examples of our Pediatric Registration and Health History form in Appendix D.) One important step of medical and dental care within P-5 PATH was integrated intake paperwork. This paperwork is completed only once by the family with certain elements updated annually. The front desk must check to be sure this paperwork is entered in the EHR (for example at the time of a previous medical appointment) and if not, must administer the paperwork for new patients seen for a Well Dental visit. At all Well Dental visits, (bi-annually) the parents must also complete a short P-5 PATH visit questionnaire (see Appendix K for this questionnaire), which asks about home health habits and includes questions about SDOH needs. Paperwork is collected and entered into the EHR by the DA. The questionnaire is then given to the dentist and/or the occupational therapist to look over and determine the intervention and care plan advised based on responses. The DA is also able to use the intake paperwork to help set an actionable goal with the family, using baseline numbers of how often per week families are engaging in certain care behaviors to set an attainable goal for improvement. Once the paperwork is entered, the occupational therapist collects it (or it is placed in the occupational therapist’s in-basket in the office for later collection).

Figure 36: P-5 PATH Well Dental visit questionnaire

Do you feel your child is more sensitive to brushing teeth or eating certain textures than other kids?	No	Yes
Do you (parent) feel anxious or scared at the dentist?	No	Yes
Do you think your child feels anxious or scared at the dentist?	No	Yes
Does your child see a doctor for Well Child Care visits?	Yes	No
If yes, at NHC or another medical office? (Please circle):	NHC medical office	Other medical office
Is your child up to date on his/her vaccinations?	Yes	No

In the past week, how many days did (circle one number per question)

1. You or a family member serve your child fruit or vegetables at <i>most</i> meals/snacks?	1	2	3	4	5	6	7
2. You or a family member serve your child a sugary beverage?	1	2	3	4	5	6	7
3. You eat at least 1 meal together with your child as a family?	1	2	3	4	5	6	7
4. You or other family members read to your child?	1	2	3	4	5	6	7
5. Your child play outside for more than 30 minutes?	1	2	3	4	5	6	7
6. Your child spend more than 2 hours looking at screens (TV, phone, tablet)?	1	2	3	4	5	6	7

Please answer a few more questions about how you and your family are doing by circling “Yes” or “No”

Does anyone smoke in the home?	No	Yes
Would you like information today about WIC or options for free groceries and meals in your area?	No	Yes

Caries Risk Assessment

To standardize our assessment of caries risk between our medical and dental departments for young children, we use the Caries Risk Assessment tool created by Oregon Oral Health Coalition for children 6 and under. This assessment tool combines information about lifestyle factors with a visual assessment to determine if a child is at low or high risk for caries. Children who score 2 or more are considered at high risk.

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Figure 37: Caries Risk Assessment tool

Have you or any of your family members had a new cavity in the last 12 months?	Yes or not sure	No
What foods or drinks does your child frequently snack on between meals? (Check all that apply)		
<input type="checkbox"/> Crackers or cookies	<input type="checkbox"/> Milk, juice, soda, or sports drinks	<input type="checkbox"/> Fresh fruit or vegetables
<input type="checkbox"/> Cheese or yogurt	<input type="checkbox"/> Seeds or nuts	<input type="checkbox"/> Fruit snacks, fruit leathers, or fruit roll ups
<input type="checkbox"/> Other:	<input type="checkbox"/> My child does not usually snack between meals	
Do you give your child a fluoride supplement OR is there fluoride in your drinking water?	Yes	No or Not sure
Do you use fluoride toothpaste to brush your child's teeth at least twice daily? (Only circle "yes" if you brush your child's teeth twice a day AND use a fluoride toothpaste both times)	Yes	No or Not sure
Does your child get a fluoride varnish on his/her teeth 2 times a year at dentist or doctor visits?	Yes	No or Not sure
Does your child have a dentist where they go for regular dental checkups? (Please circle "No" if your child has never been to a dentist or only gone when you had a concern)	Yes	No or Not sure
Does your family receive any support through OHP, WIC or Head Start?	Yes	No
Does your child have any special healthcare needs OR has anyone ever told you your child was developmentally delayed?	Yes	No
Has your child had a cavity before?	Yes or Not sure	No

OFFICE USE ONLY				
<input type="checkbox"/> Visual assessment	<input type="checkbox"/> Plaque	<input type="checkbox"/> White spot lesions	<input type="checkbox"/> Decay	<input type="checkbox"/> Other _____

Our DAs administer this assessment verbally and then use the responses to guide coaching and goal setting. Our dental team is trained in Motivational Interviewing, which acknowledges that parents are experts in their children and often have more knowledge on health than we may realize and allows us to ask key questions that speak to barriers and motivation to make changes. Key phrases and questions that are often used by our DA include:

“Tell me more about that.”

“What are you doing currently at home to manage this?”

“Tell me more about why you want to make that change.”

We chose this tool in part because it was already available within our EHR system (Epic/Wisdom) as a flowsheet for easy entry and tracking which make it ideal for this pilot project. It is also brief. This tool was administered in Well Dental visits by the DA near the beginning of the visit, once the patient was seated in the dental chair. The tool can be

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administered out loud, or it can be printed for the parent to complete as part of the intake paperwork.

◆--● We use a printed version in medical visits while the dental team prefers to verbally ask
↓
●--■ the questions directly to the parent at the start of the visit. The responses are entered into the EHR by the DA immediately.

One purpose of the CRA is to support risk stratifying our patients. We use this tool as one marker that indicates that the child would fall into a higher category of risk, so it is important that it is completed at every visit.

Shared Self-management Goal

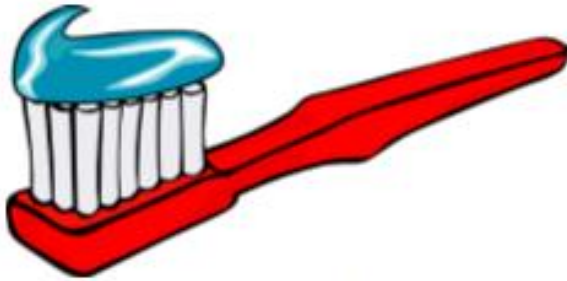
One feature of P-5 PATH that speaks to parent activation is self-management goal setting. These are goals which the parent sets which are meaningful to the family and can be accomplished at home. Goals should be actionable and attainable. We want staff to understand that we are coaching our parents to set a goal that is meaningful to their family and that we are not choosing a goal for the family. We call these goals “shared self-management goals” because they are shared between the family, the medical team, and the dental team. Because these goals can be set in either the medical or dental setting, we encourage staff to call it a health goal and focus on any area which supports the child’s health.

The scripting we have come up with to support this work is as follows:

“This might seem a bit different, but we ask all our families to think up and set 1 health goal for their child. This is a goal that you can work on at home, which will help you keep your child’s teeth as healthy as possible between now and your next visit. Is there anything we’ve discussed today that you’d like to work on at home?” If the parent is unable to think of anything, the DA can offer some ideas that the parent can consider, but ideally, we want the parent to come up with the goal on their own. If further support and prompting is needed, we do have a sample goal sheet which the DA can use. This prompt sheet is shared between our medical and dental clinics with certain goals that relate more to oral health and others which speak more to physical health, to allow the family to see that dental health and medical health both fit together under the umbrella of “health.”

Figure 38: Sample self-management goal prompt sheet.

Self-Management Goal



Brush 2x per day with fluoride toothpaste



Play outside more



More Family meals



Drink less juice

Modified Frankl Tool

We modified an existing dental pediatric behavior scale called the Frankl Behavioral Rating Scale to help support the P-5 PATH work. The Frankl Scale is a 4-point scale used to classify a child's behavior within the dental visit. We modified this tool by splitting the scale into two parts—a behavior section and a participation section. The tool still scores on a 4-point scale but is better able to show us changes in participation and behaviors. The DA uses the Modified Frankl Scale at the end of the visit to score a child's ability to participate and to remain calm throughout the visit and to document this in the EHR in a standardized way that allows us to track

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improvements over time. You can view this tool and a cheat sheet that can be given to Dental team members in Appendix M, sections 2 and 3.

Figure 39: Modified Frankl Behavior & Participation Assessment (Scoring cheat sheet)

Modified Frankl Behavior & Participation Assessment (Scoring cheat sheet)

Score A	Behavior How the Child Presents	Score B	Participation How Tx Went/Ability to get visit elements completed
1	Definitely negative. Forceful crying, yelling, fearful, combative, any other signs of extreme negativism.	1	Not able to participate, Completed 0-10% (1/10) of the visit elements
2	Negative. Uncooperative with fussing but able to be soothed, sullen, withdrawn, clinging to parent.	2	Participated a little, completed 11-50% (2-5/10) of the visit elements
3	Positive. Cautious but willing. Uncooperative at times but no crying or yelling.	3	Mostly participated, completed 51-99% (6-9) of the visit elements
4	Definitely positive. Good rapport with the dentist, interested, laughing, smiling, happy, engaged.	4	Full participation, completed 100% (10/10) of the visit elements

Behavior- Score based on **WORST/MOST NEGATIVE** behavior observed even if brief

Participation- Score based on % of visit elements **ACTUALLY COMPLETED** (# completed / 10 possible elements), even if the kiddo was “too young” to do that step.

10 steps to a dental visit for a child:

- | | |
|---|--|
| <ol style="list-style-type: none"> 1. Weight, Height, and walks to suite 2. Sits in chair, puts on bib and glasses 3. Opens mouth and does visual exam- dental assistant 4. X-rays 5. Cleaning- brushing | <ol style="list-style-type: none"> 6. Cleaning- flossing 7. Cleaning- Polishing 8. Opens mouth and does visual exam- dentist 9. Explorer 10. Fluoride varnish |
|---|--|

Total Score: “A.B” (i.e. “2.4”)

Comments: observations or important notes

Case Studies

We are including two case examples to highlight how we use this tool in practice.

Case example 1- The patient is a 2-year-old girl, seen for her first dental visit. The patient is hesitant but completes weight/height, walks to the dental suite, sits in dental chair and accepts the bib and glasses. She opens her mouth to accept the visual exam with DA and accepts brushing, but begins crying and refuses to open her mouth for flossing with the DA. When the dentist arrives, the patient begins crying again and refuses to participate. With positioning support from mom holding the patient’s arms, the dentist completes a visual exam and places fluoride varnish on the child’s teeth while she screams.

Score =1.3, documented “MFS= 1.3”

Reasoning- The child forcefully cried during the dental intervention, which immediately puts their behavior score at a 1. The dental team was still able to complete 6/10 elements of the visit (some with active child participation and some with refusal behaviors using supportive positioning). Even though the child was held by her mother and cried during the exam and fluoride varnish application, the dentist was able to complete that care step and so it would be counted towards the participation score.

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Case example 2- A 3-year-old boy is hesitant but completes weight/height and walks to the dental suite. He refuses (no yelling or fussing) to sit in the dental chair, but sits on mom's lap. The bib and glasses not used, and he allows the DA to examine and brush his teeth but not to floss his teeth (he turns his head but does not yell or fuss). X-rays and polishing are not attempted due to his refusal w flossing. When the dentist arrives, the boy opens his mouth for the exam and tolerates fluoride varnish placement before the visit ends.

Score= 3.2, documented "MFS= 3.2"

Reasoning- The child was uncooperative for flossing but remained calm- he never cried or fussed- thus he scored a 3 for behavior. He only participated in 5/10 (50%) of the elements of the visit, so he would be scored a 2 for participation.

It is important to notice that a dental practitioner may prioritize participation over behavior (i.e. letting the child cry in a knee-to-knee exam in order to complete the exam and place fluoride varnish) or the practitioner may prioritize a positive experience and behavior at the expense of participation (not offering the bib or skipping the flossing to maintain an overall positive experience. In this way, you may end up with a patient that scores high on behavior and low on participation or vice versa. You can also have a patient that scores low on both areas or high on both areas. The tool is meant to help our team track both participation and behavior over time.

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b. WELL CHILD CARE VISITS

The flow and detail of a Well Child Care visit can be found in this section. We will not go over every care step traditionally found in a WCC visit but will focus instead on the ways our program differs than the traditional WCC visit.

We incorporated several changes to the care that was provided in WCC visits. These changes included:

- **Dental integration** through large and small efforts. This includes the integration of the hygienist in WCC visits but also encompasses our efforts to better screen oral health and caries risk, to connect families early and often to our dental team, to provide oral hygiene supplies to our families, to support and coach our families on strategies to self-manage the child's oral health.
- **Risk stratification** system with risk informed care pathways.
- **Direct intervention** by the occupational therapist in WCC visits to target areas of risk and need identified by the parent or physician for the child or parent.

DENTAL INTEGRATION INTO WCC

We took a multi-pronged approach to the integration of dental health into our WCC visits. The first was to improve our processes for completing brief oral health assessments with application of fluoride varnish and health coaching around oral health within WCC visits. Prior to the launch of P-5 PATH, the Tanasbourne clinic was at a 5% application rate for fluoride varnish in WCC for our patients 6 months to 6-years-old. This was a care step frequently forgotten amongst the many other important care steps. By improving our workflows, we were able to improve this to 33% within a year. Additionally though diligent efforts to connect our patients to our dental department, we were able to increase our shared patients (0-5 year-olds who were seen by both our medical and dental departments) by 65% from 2017-2018 compared with 2019-2020 (P-5 PATH was launched in September 2018). These efforts reflect a mix of more attention from all medical staff to oral health needs of our patients.

Dental Care Coordination

Outside of WCC visits, the P-5 PATH Coordinator leads this initiative by combing charts and making notes in all WCC appointments indicating if the patient is eligible to be seen by our dental team. Within WCC, the physician and the occupational therapist work together to make sure that the oral exam is completed, dental health has been discussed with the patient and the patient has been referred to their dental home.

Caries Risk Assessment

Specifically, the occupational therapist is the one to go over the caries risk assessment (see Figure 40) with the family and coach for behavior change around home habits that support oral health. The tool used is the Caries Risk Assessment created by Oregon Oral Health Coalition, for children 6 and under. This assessment tool combines information about lifestyle factors with

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a visual assessment to determine if a child is at low or high risk for caries. Children who score 2 or more are considered at high risk.

Figure 40: Caries Risk Assessment Tool

Have you or any of your family members had a new cavity in the last 12 months?	Yes or not sure	No
What foods or drinks does your child frequently snack on between meals? (Check all that apply)		
<input type="checkbox"/> Crackers or cookies	<input type="checkbox"/> Milk, juice, soda, or sports drinks	<input type="checkbox"/> Fresh fruit or vegetables
<input type="checkbox"/> Cheese or yogurt	<input type="checkbox"/> Seeds or nuts	<input type="checkbox"/> Fruit snacks, fruit leathers, or fruit roll ups
<input type="checkbox"/> Other:	<input type="checkbox"/> My child does not usually snack between meals	
Do you give your child a fluoride supplement OR is there fluoride in your drinking water?	Yes	No or Not sure
Do you use fluoride toothpaste to brush your child's teeth at least twice daily? (Only circle "yes" if you brush your child's teeth twice a day AND use a fluoride toothpaste both times)	Yes	No or Not sure
Does your child get a fluoride varnish on his/her teeth 2 times a year at dentist or doctor visits?	Yes	No or Not sure
Does your child have a dentist where they go for regular dental checkups? (Please circle "No" if your child has never been to a dentist or only gone when you had a concern)	Yes	No or Not sure
Does your family receive any support through OHP, WIC or Head Start?	Yes	No
Does your child have any special healthcare needs OR has anyone ever told you your child was developmentally delayed?	Yes	No
Has your child had a cavity before?	Yes or Not sure	No
OFFICE USE ONLY <input type="checkbox"/> Visual assessment <input type="checkbox"/> Plaque <input type="checkbox"/> White spot lesions <input type="checkbox"/> Decay <input type="checkbox"/> Other _____		

Fluoride Varnish Application

The occupational therapist is also the one to apply the fluoride varnish at the end of the visit, which is one less care step for the MA or the doctor to manage. When the occupational therapist is not present for the visit, the doctor is the one to apply the fluoride varnish.

Oral Hygiene Supplies Distributed

For every patient 9 months and older, the occupational therapist distributes toothbrushes and tooth paste during the WCC visit as part of the discussion around oral health and home care habits. If the patient is younger than 9 months but has teeth present, the occupational therapist will provide a finger toothbrush to the family to encourage brushing routines. At times, these brushes are used immediately, in the visit as part of skill building, especially if the parent mentions that the child has not had their teeth brushed yet today or if the parent admits that the child is highly resistant to brushing. The toothbrush is used as part of a therapeutic intervention

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to help the parent understand ways to encourage improved participation from the child in oral hygiene.

Dental Hygienist Integrated into WCC

One of the innovative ways we took this integration a step further was to include our dental hygienist into WCC visits once per week for an afternoon (1pm-5pm). The goal of this integration effort was to maximize the number of children seen for direct dental screening and intervention while making it as easy as possible for families to combine care for their child into one visit.

Our hygienist is available one afternoon per week in WCC visits. In order to maximize her time and help establish the role we set the following parameters:

1. The hygienist will see any children 0-17 in for a WCC visit, regardless of insurance status or establishment of a dental home outside of NHC, unless the family declines the dental services.
2. If the family identifies that the child needs a cleaning or has a specific dental need, the patient can be scheduled with our DH to leave primary care and complete a full dental visit either just before or just after their WCC visit.

The P-5 PATH Coordinator completes outreach to all families scheduled for a WCC visit on the afternoon the DH is in primary care and offers a dental screening with the DH. The coordinator also adds to the appointment note which dental insurance the child has, so that we can advise families if they can be seen for a comprehensive exam by our dental team or if not, so that we can help them navigate to a dental home aligned with their insurance.

We found that completing the WCC visit, a dental screening, and meeting with the occupational therapist was too time consuming and overwhelming for some children and families. We adjusted our care on those days to have the occupational therapist not join the visit, unless there was a specific need and the family requested time with the occupational therapist. This helped reduce visit lengths.

See Chapter 12: Logistics: Time, Space, and Tools for dental hygienist in primary care as well as Chapter 16: Personnel Specific Sections (the section titles Dental Hygienist) for additional details on workflow and what this looks like in practice. Also see Appendix J for additional details on this work.



The P-5 PATH Coordinator completes outreach to all families scheduled for a WCC visit on the afternoon the DH is in primary care and offers a dental screening with the DH. The coordinator also adds to the appointment note which dental insurance the child has, so that we can advise families if they can be seen for a comprehensive exam by our dental team or if not, so that we can help them navigate to a dental home aligned with their insurance..



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join the visit, unless there was a specific need and the family requested time with the occupational therapist. This helped reduce visit lengths.

RISK STRATIFICATION

One way we emphasize upstream preventative efforts is through identification of risk factors which put a child at increased likelihood of developing illness or experiencing poor health outcomes over time. Our risk stratification tool and care pathways are fully described within Chapter 13: Risk Stratification and Chapter 14: Risk Stratified Care Pathways.

The risk stratification is a team effort, led by the occupational therapist and the physician and supported by the intake questionnaires and screening tools as well as through parent discussion. The occupational therapist is the one to document the risk stratification score within the OT visit note and the P-5 PATH Coordinator adds this information to the Patient Roster. Once a risk level is established, the occupational therapist and the physician can work together to determine the specific follow up plan the patient and family need, which includes calls, in-office follow up with the occupational therapist and in-office follow up with the doctor.

Figure 41: P-5 PATH Pediatric Risk Stratification Tool

	CHILD	MATERNAL	FAMILIAL
<p>MILD RISK FACTORS</p> <p>(Add all risk factors from each box in this row)</p>	<p>Growth concerns</p> <p>Developmental delay (at risks or mild)</p> <p>Behavioral concerns</p> <p>Feeding issues/Picky eater</p> <p>Sleep concerns</p> <p>Dental issues/caries</p> <p>Child ACEs score 1-2</p> <p>Undervaccinated child</p> <p>Medical complexity (mild)</p>	<p>Mental illness (controlled)</p> <p>Learning disorder</p> <p>Low education level</p> <p>Low health literacy</p> <p>Parental language barriers</p> <p>Developmental disability</p> <p>"Harsh" parenting style</p> <p>H/o substance abuse (in remission)</p> <p>Parental ACEs score 1-3</p>	<p>Tense partner relationship</p> <p>Stress in home</p> <p>Lives below poverty level</p> <p>Incarcerated parent</p> <p>Smoking in the home</p> <p>Single parent household</p> <p>Multiple missed appointments</p>
<p>SEVERE RISK FACTORS</p> <p>(Add all risk factors from each box in this row)</p>	<p>High medical complexity</p> <p>Prenatal drug/alcohol exposure</p> <p>Developmental delay (mod or severe)</p> <p>Hx physical, emotional, or sexual abuse</p> <p>History of neglect</p> <p>In foster care</p> <p>Child ACEs score 3 or more</p> <p>Frankl behavior or participation score 1-2</p>	<p>Teenage</p> <p>Low PPAM score</p> <p>Parental ACEs score 4 or more</p> <p>Disability or chronic illnesses</p> <p>Mental illness (uncontrolled)</p> <p>H/o substance abuse (active)</p>	<p>DHS involvement</p> <p>Domestic violence</p> <p>Food insecurity</p> <p>Housing instability</p> <p>Death of a parent</p>
<p>Level 1- Low Risk Care Pathway</p> <p>0-2 "mild" risk factors AND 0 "severe" risk factors</p>	<p>Level 2- Low/Mod Risk Care Pathway</p> <p>3-4 "mild" risk factors AND 0 "severe" risk factors</p>	<p>Level 3- High/Mod Risk Care Pathway</p> <p>5-7 "mild" risk factors OR 1 "severe" risk factors</p>	<p>Level 4- High Risk Care Pathway</p> <p>5-7 "mild" + 1 "severe" risk factor OR 8 or more "mild" risk factors OR 2 or more "severe" risk factors</p>

Our Pediatric Risk Stratification tool focuses on “mild risk factors” and “severe risk factors” that a child, parent and family may experience. The “mild risk factors” are issues which are not profoundly detrimental to a developing brain, but which tend to negatively impact a child’s health if left unaddressed over time. The “severe risk factors” are experiences and issues which we

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know to have a more substantial impact on a child’s current and long-term health and/or which cause significant barriers to the parent’s ability to connect with and care for the child. Our tool hypothesizes that several “mild risk factors” can add up to a high degree of risk for illness and dysfunction in the same way that experiencing even a few of the “severe risk factors” can impact a child’s wellness.

In addition to responding to family needs in the moment (connecting the family to concrete resources) we use the results of our risk assessment to guide the patient’s care pathways which provide one or more of three foundational care elements:

1. More support within WCC and dental visits to maximize child and parent participation and build lasting health relationships.
2. More thorough and frequent assessment of health by our interdisciplinary team.
3. Supportive interventions into primary care, dental visits, and follow up visits aimed at reducing risk.

What this looks like within a WCC visit:

One role of the occupational therapist is to help support the team with identifying families who need more support within the visit to be activated—or to get the most out of a wellness check in. The occupational therapist can help the team determine when extra visual supports are needed, when the family needs information repeated or explained differently, and when the family needs support to advocate for themselves. The occupational therapist can help reiterate recommendations from the physician and can use a teach-back method to assure that the family understands how to complete actions recommended by the physician.

For children that need more frequent assessment of health, we strive to bring these families back at a frequency that allows the family to practice skills on their own but with check-ins and support from the occupational therapist and if needed the physician to assure the child does not get lost to care. More frequent assessment and check-ins can also help us connect families with outside resources that are meaningful and necessary within an appropriate timeframe. For example, a child who is experiencing mild developmental delay may not qualify yet for EI services and putting in the referral too soon may interfere with later access to services should they become necessary. However, several months to a year may pass between visits and a small delay can grow into a large delay during that time period. This can mean that by the time child gets into services he or she may have a more severe delay that could have been prevented with a timelier introduction to support services. Bringing families back at a more frequent rate allow for improved monitoring of these situations which allows the care team to make more informed decisions.

Supportive interventions within primary care can be OT services provided to a child or family during the WCC visit or may be a follow up visit with the occupational therapist outside of WCC to provide further evaluation and intervention to support health. See the section later in this chapter titled: d. Individual Clinic-Based Occupational Therapy Visits for details on what these services look like outside of WCC visits.

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DIRECT OT INTERVENTION

One novel element of P-5 PATH is the modified behavioral health approach using an occupational therapist embedded into WCC and Well Dental visits to support wellness. Our vision is that occupational therapy services are wellness-focused and available for all children and families, not only for those with an identified need.

Within our WCC visit, the standard flow is the MA rooms the patient and hands off care to the physician and occupational therapist. The physician enters the room, goes over age-specific topics and areas of need identified by the intake paperwork, then completes the physical. Additional anticipatory guidance and care planning is provided by the physician then care is handed off to the occupational therapist for screening and intervention. When seeing clients within a WCC visit the occupational therapist focuses on:

1. Screening to determine risk level and follow up needs.
2. Providing brief follow up interventions in the visit.
3. Making and sharing with the family a clear care plan with next steps.

Which areas of health

OT intervention responding to specific needs identified by the parent or physician often focus on one or more of the following areas:

- Areas of occupation that:
 - Impact the child's health
 - Impact the parent's capacity to care for the child and subsequently puts the child's health at risk

Table 10: Sample areas of occupation addressed in WCC visits

Feeding/eating	Breast/bottle feeding Transition to solids Picky eating Mealtime battles/issues
Sleep concerns	Daytime naps Nighttime sleep Sleep hygiene
Play and Leisure	Screen time Outdoor play Physical play
Activities of daily living	Oral care Bathing Dressing Grooming
Parenting	Daily routine and habit formation Maternal mental health Parenting confidence and satisfaction

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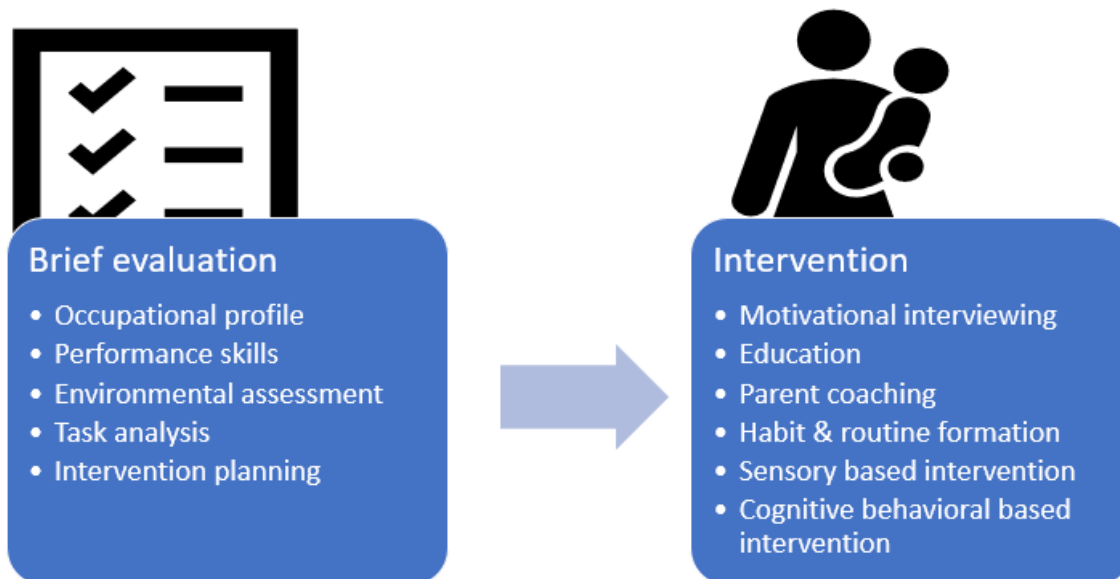
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- Performance skills- Motor skills, attention, knowledge, communication skills
 - Development
 - Communication
 - Social skills
 - Gross/fine motor skills
 - Cognition
 - Behavior concerns
 - Resilience
- Performance patterns- Habits, schedules, routines, roles
- Environmental contexts- Home or school environment, social or cultural environment
 - Stress & trauma
 - Social needs
 - Food & housing insecurity
 - Smoking in home
- Activity demands- Sequencing and required actions
- Client factors- Body systems, structures, or functions

Brief Follow up Intervention- What this looks like during visit: The medical team or the occupational therapist identifies through screening paperwork and discussion an area of need or concern that may be negatively impacting the child's health. The occupational therapist follows the same two key steps to provide care as described above under the previous section on OT in dental visits. It is included again here with the only difference being the inclusion of neurodevelopmental interventions to support developmental skill acquisition.

See Appendix S for detailed workflows on identification of need and how to respond and connect families with OT in WCC visits.

Figure 42: Key steps to OT intervention to support home health habits within the health visit



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Step 1: If there is time, the occupational therapist completes a brief assessment during the medical visit:

- Occupational profile- This is a brief screen of what current participation in the occupation of looks like for this patient, what the family's performance patterns include, and what has been tried in the past to improve participation.
- Assessment of the child's performance skills- If needed the occupational therapist specifically assesses the child's skills in the following areas:
 - Gross and fine motor
 - Communication
 - Cognition
 - Social-emotional skills
- Assessment of the parent's performance skills- If needed the occupational therapist assesses the parent's skills (strength, flexibility, coordination, self-control, organization, coping, etc.).
- Environmental assessment- The occupational therapist asks about supports and barriers within the family's home or daily routines which can be capitalized on, added, or removed to support behavior change.
- Task analysis - If needed, the occupational therapist uses this skill to determine which elements of the occupation are going well and which need support.
- Intervention plan- Based on identified areas of strength and deficit as well as function and dysfunction, the occupational therapist creates an intervention plan.

Step 2: The occupational therapist determines next steps, which may include one or more of the following possibilities:

- Brief intervention provided within the visit
- Follow up intervention needed via phone
- Follow up intervention needed one-on-one in clinic
- Follow up intervention needed in group setting

Some examples of what brief intervention techniques look like:

- Motivational interviewing and use of the transtheoretical model of change- discussion with use of visuals and handouts when needed.
- Education if needed around a specific topic.
- Parent coaching model- Plan, act, assess performance, determine what will be done differently next time.
- Modeling of skills- Therapist models skills which the parent or the child may need to develop.
- Habit & routine formation principles- this may include discussion and support with implementation of steps to form an action into a habit, such as creating visual prompt for the parent to place in environment, writing down implementation intentions or possible habit stacks, supported searching for technology-based tools for tracking and reminders. May also include calendar planning and balance wheel work.
- Sensory based intervention- use of weighted tools to provide calming support for the child while child, parent, and therapist explore new foods and textures.

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- Cognitive-behavioral based intervention- use of graded desensitization, exploration of thought patterns or fears/anxieties preventing participation.
- Neurodevelopmental interventions- use of developmentally tailored handling techniques, facilitation, and targeted activity participation to support the maturation of gross motor, fine motor, communication, problem solving, and social-emotional skills.

EXAMPLES- The examples noted in the previous section on OT in dental visits will also apply to WCC. One additional example will be included here in order to give examples of use of neurodevelopmental interventions in the WCC setting.

Occupational therapist identifies through screening paperwork and discussion that one or more of the following areas may be negatively impacting the child's health.

Child has delayed gross motor development:

Step 1: The occupational therapist completes a brief assessment:

- Occupational profile- discussion around what the daily routine currently looks like for this child, how often the infant/child is physically active and whether or not the parent engages in physical play with their son/daughter, as well as anything this family has tried in the past to solve the problem.
- Assessment of the child's performance skills- specifically assess the child's gross motor skills and note differing responses with specific amounts of support or input to determine what is needed to allow this child to be successful.
- Assessment of the parent's performance skills- specifically assess whether the parent has the physical strength and dexterity to play actively with the infant or child on the floor or outside. Assess whether the parent has the cognitive ability to recall a routine and new ways to support their child with movement. Look at whether the parent has the emotional health to bond and play with their child as well or if the parent may be needing support with their own mental health before supporting the child with developing new skills.
- Environmental assessment- Discussion around what the home environment looks like and what opportunities there are within the home for gross motor play (including toys or supplies that might be used to encourage gross motor movements in the child). Also ask about the community environment including access to parks and outdoor spaces that are safe.
- Task analysis - let the parent play on the floor with the infant/child and observe how they play. Watch for how parent responds and offers support to the infant/child.

Step 2: Intervention will address one or more of these areas:

- Create and help family use daily schedules to foster multiple opportunities for gross motor play in a variety of settings (indoor and outdoor) and to reduce use of screens or sedentary activities.
- Support caregiver knowledge and skill of games and activities which can be used with their child to encourage specific gross motor movements. Help parent use these games to capture the child's attention and promote engagement.

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- Manage negative child behaviors in a developmentally supportive way that honors boundaries and teach parents to do the same.
- Model and practice supportive positioning and handling used during play to elicit certain movements and skills.

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c. PHONE OCCUPATIONAL THERAPY VISITS

Occupational therapy follow up visits are an important part of P-5 PATH care. These are opportunities to connect with a family more frequently, to make sure that recommendations and care plans created in a WCC or Well Dental visit were understood and being used by the family and to dive deeper on a topic in order to further assess or provide intervention for an issue which may be too detailed to cover during a WCC or Well Dental visits.

Based on our risk stratification system not all families need or would benefit from individual follow by our care team. Some families do need additional support, but do not seem to need intensive intervention. Still others would benefit from more intensive follow up with our care team, but due to schedule barriers and transportation issues, the families do not schedule follow ups or do not follow through on scheduled appointments. In these instances, phone follow up visits with the occupational therapist are recommended.

When do we use these visits:

We use a brief phone follow up session after a WCC or Well Dental visit to reach out to families to help them understand that we care for them and the health of their child is important to us. We use these phone sessions at times to check on progress towards goals and care plans or to check to make sure a parent is progressing as expected. If progress is not following the expected path, these phone sessions can be an opportunity for the occupational therapist to problem solve issues and barriers which the family may be facing, which could be fixed with a small change.

Timing:

The timing of the occupational therapy phone follow up visit is individual to the patient and may be a few days after the WCC or Well Dental visit if a time-sensitive issue is being discussed or may be several months later, to check in with the family to make sure all is well between in-office WCC and Well Dental visits. The call itself can last 5-20 minutes and the occupational therapist can benefit from setting this expectation at the start of the phone call by letting the parent know 20 minutes has been scheduled for the call. If needed you can always schedule another follow up call before wrapping up the current call. If the call will occur within a few days of the WCC or Well Dental Visit, the occupational therapist may consider scheduling a specific time of day with the parent when the call will occur. If the call is several months after the WCC or Well Dental visit, we recommend starting the call by confirming that the family has the time to talk on the phone at that particular moment for 5-20 minutes.

Format:

While the format of the OT phone follow ups can vary, the general structure is for the occupational therapist to confirm that the parent is the person on the line, then remind the parent why the occupational therapist is calling, and last double check with the parent that the time is appropriate for him/her for a 5-20 minute phone conversation. Once this groundwork has

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been laid, the call can continue, and the phone session would mirror an in-person parent coaching session. Motivational interviewing and eliciting for what the parent knows, what the parent has already tried, and what the parent wants/values can be effective tools for OT phone follow up sessions.

Documentation:

These phone sessions should be documented in the patient's chart as would an in-person OT session. These sessions are a part of the care plan and are opportunities to move the care plan forward. It is important for documentation should reflect this. We currently do not have a billing mechanism for these sessions, and they are considered value added to the clinic and to the care of our patients.

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d. INDIVIDUAL CLINIC-BASED OCCUPATIONAL THERAPY VISITS

Just like the phone OT sessions, individual clinic-based OT sessions are opportunities to bring a patient and family back to the clinic for more support. These visits can focus on making sure that recommendations and care plans created in a WCC or Well Dental visit were understood and being used by the family, or allow a deeper dive to further assess or provide intervention for an issue which may be too detailed to fully cover during a WCC or Well Dental visits.

WCC and Well Dental visits are an ideal vehicle for wellness and problem-based intervention because parents generally expect their infant or child to attend these visits on a consistent schedule and there is generally good parent buy-in that these are an important care step throughout childhood. Occupational therapy services for a healthy and typically developing child are much less common and unexpected. When we launched P-5 PATH, we found a notable degree of hesitancy from families around the idea of scheduling and attending one-on-one sessions with the occupational therapist to address risk areas and/or areas of potential need. While we were careful to describe the program as a wellness and prevention focused endeavor, families expressed concern that things were not “that bad” when it was suggested by a PCP that they return to the clinic to work with the occupational therapist. Over time, however, we have leveraged relationship building within WCC and Well Dental visits in order to help parents find value in spending their time returning to care to meet with the occupational therapist. This has also taken consistent effort to change parent’s perception of what is expected from their WCC and Well Dental visits as well as what a pediatric occupational therapist might provide for the child, the parent, or the family. When trust is built and value is demonstrated over time, we have experienced significant improvements in parent “buy-in” for these services, evidenced by increased scheduling and completion of follow up visits.

Scheduling:

These visits are often scheduled by the occupational therapist or the MA prior to the end of the WCC appt. If these visits do not get scheduled before the family leaves the clinic, our P-5 PATH Coordinator reaches out to the family to schedule the follow up visit on a date and time that works for both the occupational therapist and the family.

Timing:

These visits are scheduled for 20-minute increments, though if it is a first visit, this is considered an evaluation and it is scheduled for 60 minutes (across three 20-minute appointment slots). If needed for follow up beyond the initial evaluation appointment, 40-60 minute appointment can be booked (across two or three 20-minute appointment slots) to assure that the occupational therapist has enough time to build rapport with and meet the needs of the patient and family. The occupational therapist should be prudent with time management and this is best accomplished by setting an expectation at the start of each visit for how long the visit will last. If 20 minutes have been scheduled for the follow up, letting the family know that you have 20 minutes and leading by asking them to help you prioritize the top 2-3 topics of concern can help

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keep you on time for your other appointments. We also recommend that you assure families that you will get to all their topics of concern over time, even if it takes several visits.

Coordinated care:

When possible, we recommend paying attention to already scheduled care visits and helping families schedule return OT visits for dates/times when they will already be in clinic. This is a thoughtful way to respect and maximize parent’s time.

Areas of intervention:

Similar to what was described in the previous section on OT phone visits, individual clinic-based OT visits may cover one or more of the following areas:

Table 11: Sample areas of occupation addressed in WCC visits

Feeding/eating	Breast/bottle feeding Transition to solids Picky eating Mealtime battles/issues
Sleep concerns	Daytime naps Nighttime sleep Sleep hygiene
Play and Leisure	Screen time Outdoor play Physical play
Activities of daily living	Oral care Bathing Dressing Grooming
Parenting	Daily routine and habit formation Maternal mental health Parenting confidence and satisfaction

- Performance skills- Motor skills, attention, knowledge, communication skills
 - Development
 - Communication
 - Social skills
 - Gross/fine motor skills
 - Cognition
 - Behavior concerns
 - Resilience
- Performance patterns- Habits, schedules, routines, roles
- Environmental contexts- Home or school environment, social or cultural environment
 - Stress & trauma
 - Social needs
 - Food & housing insecurity

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- Smoking in home
 - Activity demands- Sequencing and required actions
 - Client factors- Body systems, structures, or functions

Evaluation

When seeing a client for a one-on-one OT session outside of a WCC visit or a Well Dental visit, the occupational therapist completes a more thorough evaluation than is feasible during a WCC or Well Dental visit. The evaluation tools used will depend on the needs of the parent and child, though common issues we've seen and the tools our occupational therapist uses to evaluate needs are found in Table 12.

Table 12: Common parent/child needs and assessment tools used

Common Areas of need/concern	Assessment tool
Developmental delay	Developmental Assessment of the Young Child, 2 nd Edition (DAYC-2)
Sensory processing needs	Sensory Profile 2, parent questionnaire (Long and short version depending on case)
Disrupted daily occupations (feeding, sleep, toileting)	Canadian Occupational Performance Measure (COPM) Occupational participation with clinical observation
Behaviors Behavior management	COPM ACEs screen (Center for Youth Wellness Pediatric ACEs and Related Life Events Tool) Sensory profile 2, short form Clinical observation
Parental mental health	Edinburgh Postnatal Depression screen PHQ-9

These assessment tools are either available commercially for sale or are open source and freely available for use from the internet and can be located using a search engine to search the name of the tool. Results from the assessment tools will be added to the occupational profile in order to determine client needs, areas of dysfunction, underlying impairments, and to create a care plan with parent identified goals. The OT evaluation write up template is included in Appendix J.

OT Intervention

Intervention activities will vary depending on the needs of the patient and family and covering all possible interventions is not feasible for this toolkit. A licensed occupational therapist will have the knowledge and training to care plan and create interventions suited to each client's needs. Because the age range is somewhat broad (0-5 and pregnant mothers) we recommend looking for a clinician with at least 1-2 years of practice working with infants, children, and families. This will assure that the clinician has a strong foundational knowledge of how to support pediatric and family needs. The therapist does not need to be an expert clinician. He or she is expected to know where to look to find evidenced theory to support a wide variety of patient needs.

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As a rule of thumb interventions should emphasize skill practice through hands on activity whenever possible. For example, teaching a parent to mix formula verbally is a reasonable start to an intervention session but the intervention should also include a hands-on, teach back component to allow the family to practice the skill and build independence. Similarly while teaching a family the importance of routine is an excellent first step in an intervention targeting modification of daily habits, a strong intervention would move on to creating a written or visual schedule of the family’s daily routines with the parent and possibly with the child if he or she is old enough to participate through task grading (drawing, pointing to pictures, gluing pictures, etc.) so that the family has the opportunity to practice the skill of examining and building a schedule which can then be used in the home to support on-going work.

Table 13: Examples of activity-based interventions for pediatric primary care services

Feeding issues	Looking online or through a newspaper to identify healthy vs processed food options Reading food labels to identify foods with a higher calorie or nutrition content Snack preparation Coaching the family while engaged in a snack, mealtime, or bottle/breast feeding Creating a mealtime schedule or a mealtime routine visual with the family
Toothbrushing issues	Creating a brushing routine with the parent that fits into the daily routine Identifying opportunities for “stacking” habits to improve recall of a new habit Practicing positioning the child for successful brushing Teaching and practicing songs and games to improve child participation Engaging in play where the child can play with a toothbrush and brush parent’s teeth, their own teeth, or toys for motor skill practice and to reduce resistance to brushing Teaching parent brushing techniques which reduce aversive responses from child and help to desensitize the mouth
Sleep issues	Creating a sleep schedule or bedtime routine visual with the family Practicing component parts, such as reading a book with the child to help the parent understand how to respond if the child does not engage, or singing songs or using infant massage techniques that the parent will use at home as part of the bedtime routine

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Developmental delay	<p>Modeling play with the child Coaching the family while engaged in child-led play to support moving play forward, facilitating specific skills, or to grow connection between parent and child</p> <p>Creation of simple busy play kits with the parent using inexpensive materials which can be taken home</p> <p>Creating a daily play routine with the family that includes active play, outdoor play, imaginative play, and seated/tabletop play</p>
Building activation	<p>Creating with the parent a “To do” list of steps needed to complete a referral or enroll the child in a program</p> <p>Helping the parent with understanding where to look and how to get help to complete doctor or dentist recommended care steps</p> <p>Role playing phone calls or conversations with intake personnel or providers</p> <p>Walking the parent and child through the dental or medical space prior to a visit with the provider to build familiarity and confidence</p>

Follow up


As noted previously, OT intervention in a primary care setting is meant to be short term. If a parent or child needs significant support over a longer stretch, we strongly recommend that the appropriate referrals be made to outpatient services, community-based programs or classes, and/or other support services. While the specific number of follow up sessions completed prior to considering a referral to more robust support is open for interpretation by your site, your client needs, and by the availability of resources in your community, we recommend that more than 3-4 follow up sessions in a month may be a good cut off point. Many families will need ongoing check in on a monthly basis but would not qualify for more intensive support services and so they would continue to be seen by the occupational therapist until goals are met or until a point where the needs have escalated and the client would qualify for other services. It will take some hunting and gathering to identify services that are available in your area for your patient population. A few ideas of services to look for:

- Mental health services (screening, assessment, counseling) for child, parent, and/or family
- Parent Child Interaction Therapy (PCIT)
- Dietician services
- Outpatient OT/Physical Therapy/Speech Therapy services
- Parenting classes
- Parent groups
- Food bank
- Autism programs

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e. GROUP DENTAL EDUCATION VISIT

The group dental class is an exciting P-5 PATH offering aimed at building home oral health management for 0-5-year-olds seen in our dental clinic. The groups are held monthly with one group class for 0-3-year-olds and a separate group class immediately following for 4 and 5-year-olds. The class is co-led by the occupational therapist and the dental hygienist. The content and activities were selected to allow parent and child practice of skills specific to caring for young teeth. The class is meant to engage both parents and children in the learning process.


 We call our group “Healthy Smiles” and we run it monthly from 3-4pm and 4-5pm. Siblings are invited as are additional caregivers if the family requests this. Snacks are provided as are oral hygiene supplies at the end of the group.


Goals:


- Improved parent-child collaboration with oral hygiene
- Increased awareness of the need to brush 2 x/day
- Increased awareness of the issue with sugary foods and frequent snacking/grazing
- Increased independence with reading food labels to identify sugar and nutrition content
- Improved ability to compare snack options and identify the healthiest options
- Improved rates of follow up with preventative dental services
- Reduced caries risk over time and at future visits

Class Outline & Activities:

The class consists of around 4-7 activities of short duration to keep young children engaged. Please see Appendix T for the class outline with activity descriptions.

 The occupational therapist, coordinator, or dental hygienist pick up snacks in the morning or at lunch time on the day of the class. We provide healthy snack options, such as a fruit and vegetable plate, cheese and hummus dips, and whole grain crackers.

 30 minutes prior to the start of the group the occupational therapist, the dental hygienist, and the coordinator set up the space (a conference room) by moving tables and chairs out of the way, adding blankets and toys to the floor, and setting up snacks and supplies. The front desk checks in the families and they wait in the waiting room until the class begins. When class begins, the hygienist and occupational therapist gather the families, walk them to the conference room and give everyone a few minutes to get settled in a circle on the floor. Once families are settled, the leaders lay ground rules, including reminding everyone that the group is confidential and meant to be supportive and fun. We remind families that the kids are always welcome to keep playing with toys if they are not able to participate in the activities or if their attention span is brief.

 At the culmination of the group, we recommend having the coordinator help schedule families for any follow up visit needs, as the front desk can become congested and overwhelmed with attempting to help many families exiting at the same time.

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f. SICK VISITS (IN DENTAL AND PRIMARY CARE)


P-5 PATH care, particularly OT screening and intervention as well as dental hygiene services are meant to occur during WCC and Well Dental visits or as follow up to these visit types. However, while “sick visits” are not the primary target of P-5 PATH services and intervention, there are times when the occupational therapist may join the dental or medical team to support care during these visits. The following list is not exhaustive but covers several common situations where OT support and intervention can be beneficial during a “sick visit”:

- When a family has no showed or missed WCC or Well Dental visits and is not reachable by phone the occupational therapist, coordinator, or dental hygienist may consider joining a sick visit to check in with the family, build rapport, attempt to determine needs and reengage the family.

- When a child needs support participating in the sick visit, such as sitting still for a dental filling or tolerating an injection the team may request therapeutic support from the occupational therapist. In these instances, the occupational therapist can support the child, parent, and team from a developmental and sensory processing lens to make the visit run more smoothly for all.

- When a dentist or physician recognizes that the parent might not have the ability to complete follow up recommendations without additional support and could benefit from work to grow their activation and health management skills OT intervention may be appropriate. For example, when a parent needs practice to appropriately use tools such as a thermometer to track fever or syringe to draw up medicine prescribed by the doctor or to calm a sick child to administer a medication OT services are appropriate within the sick visit to build parent capacity and support the care plan.

 In the instances described above, the physician or dentist is generally the one responsible to identify the need and contact the hygienist, coordinator, or therapist.

 We also recommend that the coordinator pay special attention to both well and sick visits for siblings, as these can also be opportunities to connect with a parent and remind of a missed care step.

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g. PREGNANT WOMAN PRIMARY CARE VISIT

NHC is a primary care clinic and does not provide Obstetric or Prenatal services. However, we do have woman who receive primary care services at NHC who are pregnant and receiving pregnancy related services elsewhere. We also have an informal partnership with a local clinic providing prenatal services who identified that 50% of their pregnant mothers do not have an established primary care home or PCP- NHC is a potential site for referral depending on the patient's residence location and preference. Many of these women are newly insured under an emergency coverage arm of the Oregon Health Plan, which provides them a medical benefits package with prenatal Medicaid services while they are pregnant and postpartum. Because of this, often these women do not have a history of engagement in a health home and this is an opportunity to get general health needs met and build a relationship with a PCP at NHC who will continue to see this patient as a self-pay patient under our sliding fee scale even if she loses her insurance coverage shortly after the baby is born.

When a pregnant woman is establishing care at NHC, she is scheduled with a family medicine PCP and with the occupational therapist. The visit is scheduled for 20 minutes with the PCP and 20 minutes with the therapist immediately following the visit with the PCP.

In these visits the front desk provides the patient with intake paperwork that included a PHQ-9 to screen for depression. The MA rooms the patient according to standard practice, enters the results for the PHQ-9 into the patient's chart, and then hands off the patient to the family medicine physician and occupational therapist.



On particularly busy days, the occupational therapist may go into the visit at the same time as the family medicine doctor to meet the pregnant woman, introduce the program and screen for areas of need.

Occupational therapy

The physician will complete a typical intake visit for this patient and then provide a warm handoff to the occupational therapist. If a need has been identified, the occupational therapist can address it. Examples of topics and areas that the occupational therapist may address:

- Back, shoulder, arm, or wrist pain
- Sleep issues
- Diet and food issues
- Exercise needs, including fitting this into the daily routine and choosing appropriate exercises
- Parenting fears and preparation
- Accessing dental services
- Social needs

If no areas of need are identified, the occupational therapist will introduce P-5 PATH and describe the program, letting mom know about our pediatric services and the availability of OT services within WCC visits.

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Dental hygiene

If the pregnant patient identifies a dental need and the DH is available, the doctor or occupational therapist can also do a warm handoff to the DH for an assessment. An example of this can be found in the following case study.

Case study:

A 35-week pregnant patient was referred to our program to establish a medical home and PCP. The mother was seen by the physician and found to have no specific health needs. The physician completed a warm handoff to the occupational therapist who introduced P-5 PATH and mentioned among other things that one of our goals is to connect families to dental care. Mom reported that she had not yet been to the dentist during this pregnancy and she was currently experiencing tooth pain. Because this visit happened to fall on Monday afternoon, which is a day that the DH is available to see children in WCC visits, the occupational therapist was able to complete a warm handoff to the DH. The DH identified that the mother had a tooth abscess and was able to walk her across the hallway for immediate intervention and connection to the dentist. Antibiotics were prescribed and a follow up visit was made in 2 weeks.

The mother no showed her follow up dental appointment because she was in the hospital delivering her baby. The mother and baby returned to see the medical team for the infant's 3-5-day WCC check and the DH, who was not available, asked that we remind the mother about her dental needs and help her reschedule her missed appointment. The occupational therapist was able to support mom and baby with breastfeeding during the WCC visit and schedule the mother for a follow up visit with the hygienist a few weeks later. Mom was able to return for her dental cleaning and further intervention with the DH, notably before her emergency health insurance coverage expired, which happens ~2 months after giving birth.

18. Lessons Learned & Future Opportunities

- Consider our key lessons and areas of focus for future opportunity.
- Determine applicability to your organization.

This chapter covers our key lessons learned from conception through implementation of P-5 PATH. We will focus on areas of success, challenges, and opportunities for the future.

AREAS OF SUCCESS

Collaboration & Integration: P-5 PATH was a massive undertaking, requiring our administrative and clinical team to overhaul most of the systems currently in place supporting dental, medical, and behavioral health for our youngest patients. This program required interdisciplinary buy-in across our clinic. One of our biggest successes is the substantial improvement in collaboration between departments and staff. We have progressed from a co-located medical, dental, and behavioral health clinic to one with emerging integrated care with full body wellness for our young patients at the very core of this improvement. Oral health is now an expected part of all WCC visits and is discussed often by more than one medical team member during a patient visit. This is evidenced by our success with increasing fluoride varnish application rates within WCC visits from 5% to 33%. Social-emotional and physical health are likewise acknowledged and addressed in dental visits compared with prior to program launch, evidenced by our integration of a patient driven self-management goal collaboratively managed and shared between our medical and dental teams for 68% of our patients seen by both our medical and dental teams.

Opportunities for future: Our medical and dental teams are interested in launching a monthly pediatric team huddle to discuss all high and moderate high risk patients to track needs and move care forward as a care team.

Social needs: Another area of success is the integration of social risk screening and our risk stratification system within primary and dental care. This was a huge undertaking to both create and then launch a cohesive screening tool and workflow within WCC and dental visits. One element of success is in the number of patients who have now been screened for social risk that would have very likely gone unidentified previously. Out of the 300 patients seen over the past year and a half in primary care and dental visits by the P-5 PATH team, 58% have been screened for social risk/needs.

Opportunities: We have the ability now to determine how many families report needs and then begin tracking the number of families who were directly connected to a resource to support identified needs.

Robust care: P-5 PATH is demonstrating one model of robust, integrated, collaborative, and holistic care. We have found that the population served by NHC Tanasbourne is one with high health complexity. About a quarter (26%) of our patients have been identified as high risk or

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moderate high risk based on our risk stratification tool and screening efforts. These families often screen positive for social needs and risk as well as either developmental, behavioral, or occupational deficits. Many of these patients and families do not qualify for more intensive outpatient programs and services while others are not accessing these even if they do qualify. Meeting families where they are, building relationship, and then supporting them to meet their goals in a meaningful way has been a huge success of P-5 PATH care, which is built on bringing OT and dental hygiene services directly to our families. As families come to expect these services and this type of care, we find that we are slowly changing the culture around what can and should be done by a health home and by parents to help a child reach their fullest potential.

Opportunities: We see the potential to expand this care from 0-5 to all our pediatric patients. Risk and needs do abate over time with support but often families may hit new bumps or roadblocks which require new or a continuation of previous support. Additionally, many of our teenage patients have substantial and complex health needs which we believe will be well served by our P-5 PATH team and workflows.

Building capacity: We are particularly proud of the success we have had with not just educating families but also practicing skills and growing parent and child capacity for success with habits and behaviors we know effect health over the long term. Teaching families through hands-on practice significantly increases their chance of success with using new skills and behaviors in their daily lives.

Opportunities: We are interested in growing our group-based learning with our families to continue to practice skills while also making social connections. We are particularly interested in collaborating with our local food bank to provide both resources and cooking support for families which engages the child as well as the parent.

CHALLENGES

Group WCC Visits: At the start of this program, our team had plans for initiation of group WCC visits at 9 and 15 months. These ages were selected for a few key reasons:

- If a baby is on track with vaccinations, these are visits where vaccinations do not need to be administered.
- These age WCC visits tend to include a significant portion of developmental guidance which falls under the expertise of a pediatric occupational therapist.
- 9 and 15 months are ages where a baby is likely to have teeth newly erupted but frequently unlikely to be engaged in preventative dental services, which our team felt made these ages ideal for direct oral health screening and education with our dental hygienist.

We created both curriculum and workflows for these visits (see Appendix V and W respectively) and four dates were selected to trial these visits, with two dates selected for the 9-month group visit and two dates set for the 15-month group visit. Our coordinator completed outreach to identified patients due for 9 and 15-month WCC visits around the target dates, describing the flow and goals of a group visit, offering either an individual visit or a group visit to each family

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and scheduling patients. Depending on the date, each group visit was scheduled with between 3-5 patients, however due to patient no shows, we were unable to complete any group visits. Due to the challenges with scheduling enough patients for each group visit, the idea was tabled. However, based on what we learned from the experience, our team decided to trial monthly group dental classes instead, which we found to be better attended and more successful overall.

Staffing: There have been many challenges over the past two years surrounding the launch and implementation of P-5 PATH. The primary challenge is staffing. We have experienced setbacks and slowed progress each time a staff member leaves the organization and new staff is onboarded. Because these workflows were different than previously used and were also different from workflows used with adult patients, the learning curve is sharp, and it takes significant collaboration and focus to keep this work going. One missed step by a staff member can impact the workflow of the next, which makes it essential that staff are well trained and have a high level of buy-in regarding their role. We found this particularly true with front desk staffing, as the visit workflows depend on the front desk initiating our P-5 PATH visit by giving the appropriate paperwork and checking the patient in correctly and in a timely manner.

Sustainability: As our grant comes to an end, assuring that this work is sustainable and continues is paramount. While this work fits well under local and national wellness efforts aimed at preventative care supported by an alternative payment system free of a traditional fee-for-service model, the reality is that this system is still being developed and needs are significant, especially within the adult population. Children are an upstream effort with slow and delayed payoffs, which means that shifting resources from high needs adults with current and active needs towards children with potential needs is a tough sell even if the pay-off is substantial down the road in cost savings. Proving this model will take a lot longer than two years, which makes it challenging to keep efforts going while we wait for proof of concept.

Collaboration & Integration: While one of our biggest successes is the tremendous growth in our team and organization's interdisciplinary and inter-departmental collaboration, the work continues to open our eyes to the incredible complexity of fully integrating all our workflows and systems. The effort required through conceptualization, workflow creation, training, and implementing this work is enormous and the more we accomplish the easier it is to see that there is so much more ahead. Still, with our successes behind us it is also easier to see the benefits to patients, staff, and our healthcare system of the work we are doing which motivates us to continue working towards that ultimate goal of fully integrated, collaborative, interdisciplinary care.

LESSONS LEARNED

Staff training and retention is an essential piece of this work because robust care is made up of too many care steps for any one or two people to accomplish independently. This work takes a team of people working together, understanding their roles, supporting each other, and lifting each other up in order to make P-5 PATH work.

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Interdisciplinary, collaborative care takes imagination and flexibility. This work is not taking the same care and doing it better. It is re-imagining what care can be and how a patient might be a part of that. Re-working care in a deep and meaningful way takes courage and persistence, especially when the team and our efforts slide back into familiar patterns or hit barriers that were not seen when working under the old model. During times when progress feels slow and the work feels heavy, remembering the ideal state and leaning on the strength of the team has been essential.

Our patients are worth all the effort required to change care systems. Seeing this work improve the lives of our patients and families firsthand is inspiring. Seeing an infant or small child make progress or witnessing the pride of a parent who is working so hard and succeeding at helping her child is evidence of success and of the value of our program. Sharing those success stories liberally with the team and with the organization can help keep morale high and reflect back all that the team has accomplished.

19. Version History

V1: 3/4/2020, by Kary Rappaport, MS, OTR/L, Jonathan Hall, DMD, Alynn Vienot, EPDH, MPH
V2: 10/19/2020 by Kary Rappaport, MS, OTR/L, Jonathan Hall, DMD, Alynn Vienot, EPDH,
MPH

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Formatting and content support provided by Elissa S. Lee, OTS.

Project management support provided by Alexis Vannerson, BSN, RN and Jenna Wilson Crain, ND, MSN, MAAT.

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21. Appendix

- A. Master Checklist of Chapter Objectives
- B. Key Questions to Assess Organizational and Clinical Readiness for P-5 PATH
- C. Leadership Team Meeting Agenda Template and Example
- D. Integrated Pediatric Intake Paperwork
- E. Integrated Front Desk Registration, Intake Paperwork Storage and Usage Workflow
- F. Sample P-5 PATH Patient Education Handouts
- G. Sample presentation- “What is P-5 PATH”
- H. 1- What is Occupational Therapy Signage
- H. 2- OT Minute signage
- I. Sample presentation- “Intro to Occupational Therapy”
- J. Documentation template for OT in well dental visits and Documentation template for OT in WCC visit (*multiple*)
- K. P-5 PATH Intake Forms by Age and Visit Type (*multiple*)
- L. Sample presentation- “Patient Activation, Occupational Science, and Trauma Informed Care”
- M. 1- Risk Stratification Criteria P-5
- M. 2- Modified Frankl Behavioral Rating Scale
- M. 3- Modified Frankl Behavior Scoring Cheat Sheet
- M. 4- Diagnosis Codes MILD and SEVERE Risk Factors
- N. 1- Sample Pediatric and Family Community Resources Handout
- N. 2- Sample presentation- Introduction to Social Determinants of Health: Screening and Responding to Needs
- O. Sample workflow- SDOH Screening in Well Visits
- P. Coordinator Duties- Weekly, Monthly and Sample Scripts
- Q. Coordinator Workflows
- R. OT Tools for Dental Visits- Social Narrative Picture Book
- S. OT in Dental and Medical Visit Workflows
- T. Dental Group Visit 1-3 years Class Outline
- U. P-5 Path_WCC_Workflows
- V. Group WCC 9&15 Month Visit Curriculum
- W. WCC Group Visits_Workflow
- X. ICAR_Modified_Final

22. Glossary

Electronic Health Record (EHR): a systematized collection of patient and population electronically-stored health information in a digital format. NHC uses Epic and Wisdom.

Federally Qualified Health Center (FQHC): a community-based health care provider that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients (Health Resources & Services Administration, HRSA).

Health Homes help to coordinate care for people with Medicaid who have chronic conditions, operating under the “whole-person” philosophy. Providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person. They operate under the Affordable Care Act of 2010, Section 2703 (Social Security Act, Section 1945) (Medicaid.gov)

Occupational Therapy (OT): a healthcare profession that provides a form of therapy for that encourages rehabilitation, habilitation, and wellness/prevention for people of all abilities to increase function and performance in meaningful daily life activities.

Patient activation: Patient activation describes how confident and competent a person is with managing their own health.

Patient activation Measure (PAM): A tool which measures patient activation in a standardized manner and assigns a score as well as a risk level. The scores range from 0-100 and levels range from 1-4 with low scores and levels indicating low activation and high scores and levels indicating high activation. Research looking at patient activation measured using the PAM has found that higher levels of activation is associated with improved health outcomes, improved health care engagement, and reduced cost of care (Hibbard & Greene, 2013).

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APPENDIX A. Master Checklist of Chapter Objectives.

1. Background and Program Overview	<ul style="list-style-type: none">• Learn about the background of P-5 PATH for pediatric primary care and dental care in a Health Home.• Determine appropriateness of P-5 PATH for your organization and clinic.
2. Legend & Abbreviations	<ul style="list-style-type: none">• Understand key symbols and common abbreviations which will be used throughout this tool kit.
3. Defining Your Program & Outcomes	<ul style="list-style-type: none">• Determine your organizational and clinical limitations.• Identify which components of P-5 PATH will be implemented in your clinic and which sections of this manual you may be able to skip.
4. Organizational and Clinic Readiness	<ul style="list-style-type: none">• Assess organizational readiness for P-5 PATH implementation using Key Questions to Assess Organizational Readiness.• Define key organizational players and the functions they serve.• Decide on meeting logistics for steering committee.<ul style="list-style-type: none">○ Attendance○ Facilitation & agenda setting○ Meeting frequency, time, and space○ Meeting communications methods• Identify location and space for P-5 PATH program.• Assess clinic's readiness for P-5 PATH implementation using Key Questions to Assess Clinic Readiness.
5. Clinical Systems Integration & Logistics	<ul style="list-style-type: none">• Assess meeting structure for P-5 PATH clinical team and determine areas of possibility for integration efforts.• Assess the feasibility of physical space sharing between medical and dental teams for P-5 PATH clinical team and determine areas of possibility for integration efforts.• Assess readiness to move towards integrated registration and intake paperwork for medical and dental visits.

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	<ul style="list-style-type: none"> • Determine staff capacity to learn and implement new workflows around intake, insurance verification, and scheduling of medical and dental patients.
<p>6. Determining & tracking Clinical Outcomes</p>	<ul style="list-style-type: none"> • Collect and examine clinic level data surrounding current functioning. • Identify clinical priorities and outcomes which will guide your program towards an envisioned future state. • Set measurable and achievable outcomes based on your clinic’s baseline functioning and desired state.
<p>7. Personnel Overview</p>	<ul style="list-style-type: none"> • Define key clinical players and the functions they serve. • Discuss roles and expectations individually and as a team. • Ensure appropriate credentials and system access.
<p>8. Interprofessional Roles & Collaboration</p>	<ul style="list-style-type: none"> • Gather your interdisciplinary clinical team to introduce and discuss P-5 PATH. • Introduce occupational therapy to the clinic. • Find reminder touchpoints for providers. • Identify methods of communication with staff. • Troubleshoot role clarification. • Set a plan for ongoing training and feedback regarding barriers and successes.
<p>9. Key Tools</p>	<ul style="list-style-type: none"> • Understand the difference between the 3 types of P-5 PATH paperwork to be integrated into Primary and Dental care for all 0-5-year-olds. • Familiarize staff with each type of paperwork and when to use. • Complete staff training on use of these tools.
<p>10. Staff Training</p>	<ul style="list-style-type: none"> • Determine your model for training non-clinical staff (identifying a champion vs training of all staff). • Determine training schedule for non-clinical staff on each vital topic and obtain approval to complete trainings. • Determine who will lead trainings for clinical and non-clinical staff. • Determine the appropriate pathway for scheduling and completing staff trainings for clinical staff. • Determine the appropriate pathway for scheduling and completing staff trainings for non-clinical staff.

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	<ul style="list-style-type: none">• Set intermittent opportunities for re-train sessions on a quarterly to annual basis.• Set a plan for ways to gather feedback regarding barriers and successes which indicate the need for updates or additional training.
11. Logistics – Time, Space, & Tools for OT	<ul style="list-style-type: none">• Set guidelines around which medical and dental visits the occupational therapist will be involved in on an automatic basis.• Decide on time functions of OT follow up treatment - duration, frequency, & number of sessions.• Find space for OT treatment to take place.• Obtain materials needed for OT sessions.• Create a plan (and template) for OT documentation.• Decide on treatment model for OT follow up with guidelines for who qualifies for which type of follow up intervention.
12. Logistics- Time, Space, & Tools for Dental Hygienist in Primary Care	<ul style="list-style-type: none">• Set guidelines around which medical visits the hygienist will be involved in.• Decide on an ongoing date/time for hygienist to join Well Child visits.• Make sure that the hygienist schedule is blocked in an ongoing manner for these visits.• Confirm outreach and scheduling protocol to fill primary care Well Child visits with patients who need dental care and have an insurance your dental clinic can accept on the days/times when hygienist is available.• Find space for hygienist assessment and treatment to take place.• Gather supplies and tools needed for hygienist’s work in primary care.• Create a plan (and template) for hygienist documentation.
13. Risk Stratification	<ul style="list-style-type: none">• Familiarize your team with the P-5 PATH risk stratification tool and how to score.• Determine who will be responsible for scoring and assigning a risk level to your patients.

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	<ul style="list-style-type: none">• Determine where to document this information within the EHR.
14. Risk Stratified Care Pathways	<ul style="list-style-type: none">• Bring suggested P-5 PATH Risk Informed Care Pathways to a team meeting for input and site-specific modifications.• Tailor the proposed care pathways to fit your program and organizational needs.• Provide staff training on Risk Informed Care Pathways.• Perform audits to determine successful completion of your care pathways.
15. Community Partnerships	<ul style="list-style-type: none">• Identify key stakeholders in your community who provide services that benefit your clients or who serve clients who would benefit from P-5 PATH.• Narrow your list based on the capacity of your organization and team to the most promising partnerships.• Identify systems (internal and external) which may support ease of referral and/or flow of information.• Determine outcomes which indicate successful partnerships for your organization and the community partner.• Set up monthly or quarterly meetings with these partners to assess progress and improve upon current systems.
16. Personnel Specific Sections	<ul style="list-style-type: none">• Distribute all sections to the appropriate staff member.• If your organization will not be filling/utilizing all roles, distribute job duties among existing staff positions and determine any duties that may not be feasible given staffing limitations.• Use at least one clinical team meeting to talk through roles and assure all staff are familiar with the expectations of their role and any new duties.
17. Visit Specific Sections	<ul style="list-style-type: none">• Distribute all sections to the appropriate staff members who will participate in that visit type.• Use at least one clinical team meeting to talk through roles within each visit type and assure all staff are familiar with the

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	<p>expectations of their role and the workflows within that visit type.</p> <ul style="list-style-type: none">• Consider a trial run for each visit type with a mock patient to practice in real time what the workflow will look and feel like.• Determine communication methods between pertinent staff members to communicate when running late or if there is an unexpected change that will need to happen in the expected workflow.
18. Lessons Learned & Future Opportunities	<ul style="list-style-type: none">• Consider our key lessons and areas of focus for future opportunity.• Determine applicability to your organization.
19. Version History	
20. Acknowledgments	
21. Appendix	
22. Glossary	
23. References	