Referral Procedures: Deschutes County Health Services Nurse Home Visiting & Oregon Mothers Care

## Oregon Mothers Care

Referral at clinic

1. OMC staff will accept referrals from providers in clinic to follow-up or contact clients.
2. OMC staff will contact the referred client to provide information on available programs and offer enrollment in services. OMC Coordinator will provide a client assessment to identify need.
3. Client will be scheduled/ referred for WIC, Oregon Mothers Care, Maternal Mental Health, NHV (sent to Suzie), and other services as appropriate
	1. Until collaborative documentation is available, OMC staff will also document in TWIST & WTY as appropriate
	2. The OMC Coordinator will document the referral in WTY, and send a screenshot to the referral coordinator with the referral outcome if known. In the email, the OMC coordinator will specify if this is a first birth, the provider who saw the client, the client’s location, and high risk score (See Appendix A for directions).

OCHIN Referral

1. OMC staff will check the OCHIN referral queue daily for referrals sent from Suzie/ referral coordinator to OMC
2. OMC staff will contact the referred client to provide information on available programs and offer enrollment in services. OMC Coordinator will provide a client assessment to identify need
3. Client will be scheduled/ referred to WIC, Maternal Mental Health, NHV (PN in OCHIN), and other services as appropriate
	1. Until collaborative documentation is available, OMC staff will also document in TWIST & WTY as appropriate.
	2. If client accepts referral to NHV, OMC Coordinator will add client to the NHV referral queue (PN in OCHIN). OMC Coordinator will contact the referring provider to communicate the referral outcome.
4. If the client refuses or cannot be contacted, the OMC Coordinator will document this and close the referral in OCHIN. OMC Coordinator will contact referring provider to communicate the referral outcome to referring provider.
5. If client is a prior or current Healthy Families of the High Desert (HFHD) participant, OMC Coordinator will send a message to the NHV Supervisor to determine if HFHD is appropriate.

## Referral Coordinator (Suzie)

1. The referral coordinator will receive all internal & external referrals via the Internal Referral Form, JHIE, OCHIN, Fax, email, and other means.
2. The referral will be documented in the OCHIN module for data tracking. If necessary, an OCHIN mini-registration will be completed to add the client to OCHIN.
	1. Staff entering referrals should cross-reference the current database for duplicates and infant referral born to mother’s previously referred.
	2. The method of receiving the referral will be noted (JHIE, Internal referral process, fax, etc)
3. If the client is pregnant, the referral will be assigned to the OMC queue in OCHIN (New Prenatal Screening).
4. If the client is referred to NHV, the referral will be assigned to the NHV queue in OCHIN (Care Coordination).

## NHV Nurses

1. Nurses will check the OCHIN referral queue, and accept referrals to their caseload by assigning the client to their queue in OCHIN. This is done daily.
2. If client is a prior or current Healthy Families of the High Desert (HFHD) participant, OMC Coordinator will send an OCHIN in basket message to the NHV Supervisor to determine if HFHD is appropriate.
3. Nurses will contact client to schedule the appointment and document in OCHIN
	1. The nurse assigned the referral will attempt to call within 3 business days of receiving the referral
	2. The nurse will attempt to contact the referred client at least 2-3 times over four weeks to offer Home Visiting services.
	3. After four weeks with no contact, a letter will be sent to the client, if deemed appropriate by the nurse or the referral can be closed if no letter is sent. If there is still no contact two weeks after sending the letter, the referral will be closed.
4. If the client refuses or cannot be contacted, the nurse will document this and close the referral in OCHIN. The nurse will use the OCHIN letter template to fax referral outcome to referring provider.
5. If the client accepts, the nurse will document this in OCHIN, the OCHIN calendar, & outlook calendar. After the first visit, the nurse will use the OCHIN letter template to fax referral outcome to referring provider

## NHV Supervisor

1. The NHV Supervisor will check the referral module to see if there are referrals that have not been assigned to a staff member within 3 business days.
	1. If referrals have not been assigned to a nurse in OCHIN or contacted by an OMC Coordinator, the supervisor will contact nurses to assign the referral. If no nurse can accept the referral, the client will be referred to Health Families of the High Desert (HFHD) via fax as deemed appropriate.
2. The NHV Supervisor will check the referral module daily to assign MOSAIC referrals to OMC or NHV. This is done daily.
3. The nurse home visiting supervisor will also close the loop on all internal referrals submitted using the internal referral form. This is done weekly
4. The nurse home visiting supervisor will triage prior or current Healthy Family referrals to determine if NHV will accept the client and respond appropriately. If referred to healthy families, the NHV Supervisor will use the OCHIN letter template to fax the referral outcome to referring provider. This is done daily.
5. If the supervisor is out of the office for more than one day, another nurse will monitor referrals. The NHV Supervisor or Program Manager will assign the nurse.

*Appendix B*

Defining High Risk

Score each below category with a 1 if the client discloses the Risk to you.

1. Mental Diagnosis including Substance use/abuse
2. Medical Diagnosis especially those that effect the pregnancy
3. Pregnant Teen
4. Homeless living in a tent, car, RV without water hook ups etc.
5. Referred by a Medical Provider, Therapist, any DHS staff, and other counties
6. IPV current or previous
7. Identified on High Risk OB list

Assign the client a number 0-7 based on score