Rancho Los Amigos National Rehabilitation Center
OUTPATIENT SERVICES: MOBILE CLINIC POLICY AND PROCEDURE

SUBJECT:	**Mobile Clinic Behavioral Health Team Roles and Responsibilities**	**Policy No.:**	**99**
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PURPOSE:

This document is intended to describe the roles, duties, and responsibilities of the members of the Behavioral health team for the mobile clinic. The Behavioral health team is an integral part of the Mobile Clinic team. This document serves to help facilitate effective utilization of team members so that the mobile clinic team can provide the quality care and services in the most effective manner

Policy:

Mobile Clinic Team Members' Roles and Responsibilities- Behavioral Health team

The behavioral Health team is a multidisciplinary team that will provide behavioral health care to people experiencing homelessness in the unsheltered setting. Direct patient care will be provided in a mobile clinic, encampments and on the streets. The behavioral health unit of the street medicine will include two clinical supervisors, Senior clinical social workers, substance abuse counselors, community health workers, medical case workers. The patients that will be served include clients with complex medical mental health conditions and those with high risk with complex behavioral health issues.

The roles and responsibilities of BH staff for the mobile clinics will continue to evolve as we improve individual and population-level care in the field setting. It is the intent to clearly define the roles and responsibilities of our BH Care team members conducting this work as well as train and support them to provide the highest quality population and care management services possible.

Examples of duties are described, and expectations are documented in order to provide role clarity and guidance to facilitate care coordination and quality of care to our clients. It is not the intent of this document to take the place of an individual's duty statement; rather, it will serve as a reference that can be used to modify existing duty statements.

I. Clinical Social Work Supervisor I

A. Role The mobile clinic Clinical Social Work Supervisor I will be part of the behavioral health unit including the Psychiatrist, clinical social workers, Community Health workers, and Substance abuse counselors. The Clinical Social Work Supervisor I, in partnership with the SW chief, plans, directs, assigns and evaluates the work of professional social work and support staff including Community Health Workers, Medical Caseworkers and Substance Use Counselors. Confers with the Mobile Clinic team leadership to plan new programs and coordinate the Behavioral Health Service Delivery to mobile clinic patients and clients.

B. Responsibilities include but not limited to:

- Provide supervision and oversight for (2) Mobile Clinics teams for HFH

- Direct Report/Supervision will include Clinical and Administrative oversight for following staff on mobile teams:
- Sr. Clinical SW
- Substance Abuse Counselor
- Community Health Workers
- Supervision to include job assignment, performance management /evaluation and training of staff.
- Assist with the identification of training needs and the development HFH BH team
- Ensures appropriate training and competent service delivery related to Substance Use intervention and treatment, Mental Health Service delivery models, and addressing Social Determinants of Health (food insecurity, housing, etc.)
- Assist with the identification of training needs and the development HFH BH team
- Reviews and revises departmental policies interprets Federal, State, County and departmental policies and regulations for social work to department staff.
- Plans and maintains orientation and in-service training/staff development programs.
- Will provide oversight to ensure there is optimal care coordination and continuity of care for the SPA's covered by the mobile teams, including:
- Coordination, facilitation & participation of SPA multidisciplinary Mobile Clinic Care Meetings
- Work with staff to promote care integration with outreach to workforce and other treatment teams

II. Senior Clinical Social Worker (Sr. CSW)

A. Role

The mobile clinic Sr Clinical Social worker will be part of the behavioral health unit including the social work Supervisor, psychiatrist, community health worker, and Substance abuse counselors. Under the direction of Mobile clinic social work Supervisor, the senior clinical social worker will provide behavioral health services and case management services to patients of the mobile clinic teams.
The Senior Clinical Social Worker serves as team lead, coordinating social work services including consultation for Medical Case Workers, Community Health Workers, Substance Use Disorder Counselors, and other team members, for delivery of services related to mental health and social services linkages, community resources, and any presenting psychosocial issue.

B. Responsibilities include but are not limited to:

- Assesses and treats the complicated psychosocial problems of homeless individuals including but not limited to medical condition and/or functional status, untreated or under- treated mental health or substance abuse condition, economic instability, legal problems, and inadequate social supports, housing and transportation.

- Engages in case management services with members of the mobile clinic team to meet the agreed upon treatment goals.

- Assists in increasing housing placement, retention, and maintain supportive relationships with the homeless individual during critical care.
- Conducts comprehensive psychosocial assessments of people experiencing homelessness and develops treatment plans that are sensitive to the patient's diverse needs and abilities.
- Use of Behavioral Health Techniques including, but not limited to, motivational interviewing, cognitive behavioral therapy, relapse prevention therapy, psychotherapeutic and/or systems interventions, and trauma-informed care, delivered in an individual and/or group setting.
- Provides individual, group, and family psychotherapy and advanced level case management interventions, including but not limited to: participating in treatment groups that support health promotion such as medication assisted treatment, group visits using motivational interviewing and a trauma informed approach.
- Conducts in-services, workshops, and groups with the substance use population
- Completes PHQ-2 and PHQ-9 when indicated for screening and treating depression
- Documents written psychosocial evaluation and identified problems, treatment process and clinical outcome in electronic medical record
- Participates in clinic huddles and team conference
- Provides clinical consultation to the multidisciplinary teams on complex social work diagnosis and treatment problems, with the support of the psychiatrist as needed
- Identifies, evaluates and reports suspected dependent adult, elder, child and domestic violence/intimate partner abuse
- Assume instructor responsibilities for graduate social work students.
- Participate in staff peer review activities.
- Serve as acting social work supervisor during staff shortages when requested.
- Demonstrate advanced knowledge and skill in a social work treatment modality or area of practice.

Administrative

- Participates in team huddles, case conferences, and multidisciplinary team meetings as needed.
- Participates in performance/quality improvement (PI/QI) activities and contributes to policy development as needed.
- Shares knowledge and effective practices with other Care Team members.

III. Community Health Worker (CHW

A. Role

The mobile clinic community health worker will be part of the behavioral health unit including the social work Supervisor, psychiatrist, clinical social workers and Substance abuse counselors. CHWs work closely with the medical and social service team within the PCMH to provide "wrap around" services to our most vulnerable, complex patients and provide them with health promotion and harm reduction services. These patients

typically have chronic medical conditions, behavioral health issues, and social struggles such as homelessness, addiction, social isolation, illiteracy, and poverty. CHWs team are delegated tasks by the Sr CSW. They provide key interventions that include health coaching, disease self-management support, accompaniment to appointments, and transitions of care support after hospitalizations to prevent readmissions. They also provide linkages to community-based resources and provide support and encouragement to help patients achieve health, improve their health care utilization patterns, and improve their overall wellbeing and function in society.

B. Responsibilities include but are not limited to:

- Establishes a trusting, open relationship with complex patients receiving health care within the outpatient setting
- Conducts a baseline needs assessment and works with the patient/family and mobile team to create a comprehensive care plan
- Using MI, CHW motivates and activates the patient to set and achieve personal goals
- Provides health education and counseling around disease management, medication adherence, mental health, addiction, and self-care
- Enhances patient's health literacy and ability to self-manage / cope with physical disease, addiction, or mental illness
- Assists patient/family with navigating the medical, social service, and behavioral health systems
- Accompanies patients to key medical, behavioral health, and social services appointments and ensure that patients understand and follow through with recommendations made by service providers
- Assists the patient/family around "transitions of care" as patient transfers from one care setting to another and promotes greater use of outpatient resources
- Advocates for patient within clinic and community-based settings to help patient achieve health and life goals
- Completes all required documentation in the electronic medical record related to the services they provide to patients/families.
- Participates in program evaluation and quality improvement projects
- Helps design / implement group sessions for patients on disease self-management or stress management

Administrative

- Participates in team huddles, case conferences, and multidisciplinary team meetings as needed.
- Participates in performance/quality improvement (PI/QI) activities.
- Shares knowledge and effective practices with other Care Team members.

IV. Substance Use Disorder Counselor (SUD-C)

A. Role

The mobile clinic substance abuse counselor will be part of the behavioral health unit including the social work Supervisor, psychiatrist, clinical social workers and community health workers. The substance abuse counselor in collaboration with the street medicine medical provider and psychiatrist will provide medication assisted treatment to patients with opioid use disorder in collaboration with the substance abuse counselor. The substance abuse counselor will refer patients in need of behavioral counselling to the clinical social worker to maximize patient outcomes in those enrolled in the MAT program. Therapy will be individual as well as in group in collaboration with the clinical social worker. The substance abuse counselor will collaborate with the community health worker and other team members to ensure access to substance abuse treatment medications and their safe storage in the community.

B. Responsibilities include but not limited to

- Interviews clients and collect information and health history to evaluate and implement treatment plans.
- Provide counselling to patients with substance abuse disorder and leads/participates in substance abuse groups.
- Refer to higher level of care such as inpatient residential facility and work with MCW for placement arrangements as necessary.
- Participates with multi-disciplinary team in developing and implementing substance abuse treatment/therapy.
- Monitors and documents client's progress with substance abuse. Informs clients on preventative care methods, education regarding relapses, available community resources and coping skills.
- Provide intake for MAT patients, complete ASSIST and TNQ tools upon admission to program, and monitor progress with program participants through all phases of treatment
- Provide MAT groups for program participants as needed
- Provide Harm reduction education and harm reduction kit to patients as needed
- Provide follow up to clients to assist with maintenance of client progress and assessment for additional resources.
- Performs in-person visits on the streets and telephone calls in order to follow up with clients.
- Attends trainings and other opportunities to enhanced professional skills in order to address the specific needs regarding substance abuse with PEH
- Provides Educational In-Services to Treatment team related to substance use disorder.
- Conducts in-services, workshops, and groups with the substance use population, including running MAT groups for program participants
- Participates in clinic discussions, team meetings, case conferences/rounds and provides relevant information to interdisciplinary staff to improve coordination of care.

V. Medical Case Worker (MCW)

A. Role

The Medical Case Worker helps provide tangible support with needs to address social determinants of health such as housing, food security, and transportation. Assists with coordination of transition services to optimize patient in the community which may include home health, durable medical equipment, higher level of care, and linkage to a variety of community-based services/programs

B. Responsibilities include but not limited to:

- Identifies and provides referrals for appropriate community resources based on assessments/screening results from other BH team member (SBDOH).
- Problem solves and coordinates patients' transition of care needs to the community, addressing social determinants of health such as linkage to food, housing, and transportation resources
- Identifies and reports suspected dependent adult, elder, child and partner/intimate partner violence
- Makes referrals to social welfare programs and community resources beneficial to the patient
- Documents social history and identified problems problem-solving process and outcomes in electronic medical record
- Coordinates with external and internal agencies (e.g., DHS Managed Care Services, L.A. Care, and Health Net) to provide services or equipment (e.g., durable medical equipment, transportation, home health services, dialysis and self-administered medications) as ordered by the medical provider and according to approved workflows. Completes Prior Authorization forms as needed. Consults with provider or Care Manager when clinical questions arise.
- Assist with arrangements for patients needing placement to higher level of care, including but not limited to placement needs for residential treatment program, methadone treatment program, and/or psychiatric placements or referrals
- Collaborates with external / internal customers as needed to ensure that patient care needs are met.
- Participates in clinic discussion, team conferences and provides relevant information to interdisciplinary team
- Participates in team huddles, case conferences, and multidisciplinary team meetings as needed.
- Participates in performance/quality improvement (PI/QI) activities.
- Shares knowledge and effective practices with other Care Team members.