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

SUBJECT: **Documentation Process and Procedures**

Policy No.: 102
Supersedes: New
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PURPOSE:

To define the documentation process and procedures that the Mobile Clinic Behavioral Health Team will be completing based on their assessments.

DEFINITION(S):

The Mobile Clinic Behavioral Health Team includes a Senior Clinical Social Worker (SCSW), Medical Case Worker (MCW), Community Health Worker (CHW) and a Substance Use Disorder (SUD) Counselor.

POLICY:

The Mobile Clinic Behavioral Health Team conducts needs assessment of patient(s) and families facing a crisis resulting from mental, emotional, social, and economic stressors. The staff is knowledgeable of the patient(s) Stages of Development and are sensitive to their unique needs presented during their developmental stages. The Behavioral Health Team provides assistance to the interdisciplinary staff in understanding and meeting the psychosocial needs of patients. Documentation of clinical assessments and services provided will be charted in the patient's electronic health record (Orchid). Documentation should be clear, concise, and legible to communicate social work intervention to physicians, nurses, and other team members involved in the patient's care.

The Behavioral Health team should respond to referral within same day of receipt of referral, if possible. Depending on the volume of referrals, the BH staff would prioritize based on clinical judgment and/or prioritization guidelines (protocol attached).
The goal would be to prioritize based on risk to be seen at this encampment visit, follow up at next visit, and/or ability to follow up via phone or other means, if not in person.

I. Senior Clinical Social Worker

Initial Psychosocial Assessment

A. Time Standard:
The Senior Clinical Social Worker should respond to and assess a referral within the same day received, if possible. The CSW would prioritize based on own clinical judgment and/or prioritization guidelines. Once assessment is complete, charting in patient's electronic health record (Orchid) should be within 24 hours.

B. Format:
The Senior Clinical Social Worker will complete the Psychosocial Assessment directly in the patient's electronic health record (Orchid) under Adhoc Form. Charting should contain relevant information regarding patient's presenting problem, living situation, support system, family dynamics, assessment of patient's coping and adjustment to current medical condition, as well as any risk factors including substance abuse, mental health history and/or any abuse concerns.

C. Outcomes:
Document Interventions, treatment goals, improved symptoms and overall functioning, plan and disposition. Document linkage to services to include agency name and contact information.

D. Late Entry:
Documentation for a previous time must be titled "Late entry for (date)."

II. Medical Case Worker, SUD counselor, and Community Health Worker

A. Time Standard:
The Medical Case Worker, Community Health Worker, and SUD Counselor should respond to and assess a referral within the same day received, if possible. The BH staff should prioritize based on prioritization guidelines and/or consultation with the Sr. CSW. Once assessment is complete, charting in patient's electronic health record (Orchid) should be within 24hours.

B. Format:
The Medical Case Worker, SUD, Community Health Worker will chart in the patient's electronic health record (Orchid) under the Discharge Planning Adhoc Form. The SUD Counselor will document under Substance Abuse Counselor Progress Note and complete the Substance Use Disorder Screening tool in Adhoc. Charting should contain summary statements of interventions provided and goals achieved to the identified problems. It should include resources, referrals provided, patient's support system, current living situation, pertinent patient contact information and any abuse concerns.

C. Outcomes:
Document Interventions, treatment goals, improved symptoms and overall functioning, plan and disposition. Document linkage to services to include agency name and contact information.

D. Late Entry:
Documentation for a previous time must be titled "Late entry for (date)."

III. Psychosocial Re-assessment: Senior Clinical Social Worker, Community Health Worker, Medical Case Worker, and SUD counselor

A. Time Standard:

The Sr. CSW, CHW, MCW, or SUD should respond to and assess a referral within the same day received, if possible. The BH staff would prioritize based on clinical judgment (Sr. CSW) or prioritization guidelines. Once assessment is complete, charting in patient's electronic health record (Orchid) should be within 24 hours.

B. Re-Assessments:
Should be charted under the Psychosocial Assessment Adhoc Form.

C. The need for Re-Assessments:
Will be determined in relation to the patient's diagnosis, treatment setting, home environment, change in patient's support system and/or economic status, change in patient psychosocial, emotional, mental, physical status, the patient's motivation for treatment (including capacity for change) and the patient's response to any previous treatment. Any member of the health care team may request a reassessment by the Behavioral Health Team at any time. The Senior Clinical Social Worker can also determine based on the above-mentioned factors when and/if a Psychosocial Re-assessment is warranted. It is important to note that reassessment is an integral part of the basic day-to-day, session-to-session social work practice that is continuous and seamless. This process is based on clinical judgment.

D. Outcomes:
Document Interventions, treatment goals, improved symptoms and overall functioning and disposition. Document linkage to services to include agency name and contact information.

E. Late Entry:
Documentation for a previous time must be titled "Late entry for (date)."

IV. Medical Case Worker, SUD counselor, and Community Health Worker

A. Time Standard:
The Medical Case Worker, Community Health Worker, and SUD Counselor should respond to and assess a referral within the same day received, if possible. The BH staff should prioritize based on prioritization guidelines and/or consultation with the Sr. CSW. Once assessment is complete, charting in patient's electronic health record (Orchid) should be within 24hours.

B. Format:
The Medical Case Worker, SUD, Community Health Worker will chart in the patient's electronic health record (Orchid) under the Discharge Planning Adhoc Form. Charting should contain summary statements of interventions provided and goals achieved to the identified problems. It should include resources, referrals provided, patient's support system, current living situation, pertinent patient contact information and any abuse concerns.

C. Outcomes:
Document Interventions, treatment goals, improved symptoms and overall functioning, plan and disposition. Document linkage to services to include agency name and contact information.

D. Late Entry:
Documentation for a previous time must be titled “Late entry for (date).”

V. Progress Note:

A. Assigned Staff: Clinical Social Worker, Medical Case Worker, Community Health Worker and SUD counselor.

B. Time Standard: Once patient follow-up is complete, documentation in patient’s electronic chart (Orchid) should be within 24 hours.

C. Format:
A social work progress note is used only when an Initial Psychosocial Assessment cannot be completed during the required timeframe due to inability to contact patient, patient’s inability to provide needed psychosocial information and patient provides verbal and/or written consent to speak to collateral contacts if patient is cognitively able to do so.
Should be used for ongoing documentation of patient follow-up once the initial Psychosocial/Discharge Plan has been completed and charted.
Should be used for transitions of care and/or termination of services.

D. Outcomes:
Document Interventions, treatment goals, improved symptoms and overall functioning and disposition. Document linkage to services to include agency name and contact information.

E. Late Entry:
Documentation for a previous time period must be titled “Late entry for (date).”

VI. How to document Case Conferencing

A. Assigned Staff: Clinical Social Worker, Medical Case Worker, Community Health Worker and Substance Abuse Counselor

B. Time Standard:
Once case conference concludes, charting in patient’s electronic health record (Orchid) should be within 24 hours.

C. Format:
1. Social Work Progress Note Adhoc Form
2. Document all participating members that can include the patient, patient’s support system and the interdisciplinary treatment team.
3. As a key member of the interdisciplinary treatment team, the social work team actively contributes to all parts of the team conference. Charting should demonstrate continuity of care and include interdisciplinary collaboration to address barriers to care. It should contain interventions and should not contain a restatement of medical information.

VII. Addendums to Documentation:

A. Documentation (Psychosocial Assessments/Discharge Planning/Progress Notes/ Substance Abuse Counselor Progress Note and Substance Use Disorder Screening tool) are not to be modified if an error is made in the patient electronic record, a dated Addendum should be added to the record explaining the error.
B. Modifications can only be made to "Modify" incorrect dates entered in an Adhoc Document and when information is entered into a patient's chart erroneously.

VIII. Documentation for lost to follow up:

A. Documentation should be completed for all outreach attempts after receiving initial referral and for ongoing attempts.

B. If there is no answer or BH team cannot reach or find patient, then documentation should be completed that reflect the outreach within 24 hours of the outreach.

C. After at least three attempts to reach the patient unsuccessfully over a 1-month period, the BH team member can consider closing out the referral after consultation with the Sr. CSW and the referring party.

NOTE: When crisis intervention(s) are provided such as suicide intervention, abuse reporting, etc. documentation is completed immediately following the intervention directly into the patient's electronic health record (Orchid). For abuse reporting cases, it is important to include case tracking number to allow cross covering Behavioral Health Team the ability to follow-up on cases if needed (see Child Abuse Reporting Policy and Elder Abuse Reporting Policy.)
Use the Elder Abuse Screening and/or Child Abuse Reporting Forms located under AdHoc.

IX. General Considerations:

A. Legal Consideration: Assure departmental and state mandates are met when assessing and charting all abuse/neglect situation (see Child Abuse Reporting Policy, Elder Abuse Reporting Policy).
*Complete Child Abuse Reporting
B. Chart Advance Directives
C. Chart Behavioral Health Team request to Psychiatry consults.

References:

DHS Policy 390.1 "Medical Records Documentation"
Rancho Administrative Policy A326 "Medical Records Documentation Standards"