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

SUBJECT:	**Behavioral Health Team:**	**Policy No.:**	**103**
		Supersedes:	**NEW**
	Care Coordination and Case Conferencing	**Revision Date:**	**January 26, 2022**
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PURPOSE

To ensure that all Housing for Health (HFH)- Rancho Los Amigos National Rehabilitation Center (RLANRC) mobile clinic behavioral health (BH) staff have a process to provide continuous and seamless coordination of services that will assist patients in accessing needed services from existing and potential providers. BH staff working with patients will serve as the bridge between multiple organizations, advocate on behalf of clients and evaluate services being provided.

Policy:

The HFH-RLANRC Mobile Clinic Team members will promote coordination of care and facilitate effective communication and strong collaboration between other street-based teams, Department of Mental Health (DMH), Department of Public Social Services (DPSS), and other providers servicing the People Experiencing Homelessness (PEH) population.

Procedure:

1. The BH team shall promote collaboration among colleagues and the care team to enhance service delivery and facilitate patient goal attainment
2. Coordination of care with the referring outreach team/treatment team is essential to promote continuity of care

3. In order to support the patient in achieving care plan goals, the care team make referrals to and or collaborate with other agencies and/or community-based organizations including but are not limited to:
    a) Other Street Based Teams serving PEH
    b) Department of Social Services (DPSS).
    c) Department of Mental Health (DMH) providers.
    d) Social Security Administration.
    e) Behavioral health treatment providers.
    f) Social support groups.
    g) Housing for Health for interim housing services; and other housing or tenancy support service providers for permanent supportive housing (i.e., Coordinated Entry System (CES)
    h) Other community-based resources.

4. The BH team member Senior Clinical Social Worker (Sr CSW), Substance Use Disorder (SUD) counselor, or Community Health Worker (CHW) shall conduct review of chart and other data systems for history and past services and connections.

5. Upon receiving referrals, prior to each initial assessment, and/or follow up, designated clinical staff shall complete a full chart review including but not limited to:

    a) Gather information or perspective from referring party (outreach teams, treatment team, family, etc.) regarding presenting problem, triggering events and functioning.
    b) Review Patient medical records from all available sources such as ORCHID, IBHIS, CHIP, CHAMP, HMIS, etc...
    c) Document record review in ORCHID with summarization of pertinent findings.
    d) Review/confirm past and current services and connections directly with patients when completing the full assessment and developing the care plan
    e) Offer and facilitate PHI Confidentiality Release forms to patient upon intake to ensure shared communication regarding key supports and treatment teams.

6. Sharing of pertinent information contributes to effective care coordination of patient's health and psychosocial needs. BH team members are expected to share information with the rest of the Care Team to facilitate their understanding of overall needs of the patient and individualized treatment of each patient.

    a) The BH team will engage in Case Conferences with other mobile clinic teams members (i.e., daily, or weekly huddles with mobile clinic teams) in order to continue to promote and facilitate care coordination within the teams, report patients progress of care plan goals, and discuss any identified challenges and barriers.
    b) Once case conference concludes, charting in patient's electronic health record (Orchid) including updates to care plan, should be completed within 24 hours.

7. With patient's consent, the BH Team will communicate, collaborate, and coordinate with outside community outreach programs and other community support systems. This includes but not limited to probation officers, other street-based teams, other community social workers/case managers etc.

    a) The BH team member shall participate in a regularly scheduled (biweekly or monthly) care coordination meeting (1 hour) with regionally designated per Hub or Zone of other street-based teams and community organizations
    b) Designated mobile clinic BH member (social work supervisor or Sr. Clinical Social worker) shall serve as moderator and lead on the meetings.
    c) The agenda for the Community Care coordination meeting shall include:
        - Review of high-risk clients as identified by high-risk criteria conducted by Mobile Clinic/SM teams
        - Clinic teams shall submit to the moderator/lead the list of high risk / high priority patients identified a day prior to the meeting.

- Discuss hand offs, updates on patients, confirmation of street medicine assignments, linkages made, and any follow up needed.
- Evaluate effectiveness of plan and interventions and challenges of Discussion of what is successful, challenges and barriers identified, and input from teams on problem solving strategies should occur in this meeting.

d) Once care coordination meeting concludes, the designated BH member and /or meeting facilitator should relay any pertinent updates to BH team member directly managing the case and report any follow-ups or updates.
e) BH team member should document in electronic health record (Orchid) within 24 hours with any updates to care plan.