Liberty Community Services, Inc.

mHEALTH

Transition and Discharge Planning

Policy Statement: The mHEALTH Network Navigator and Peer Navigator services are intended to be transitional. These interventions focus on assisting the people served to secure housing and long term support services to remain housed. The intervention will be in place for a maximum of 16 months thus it is imperative to begin the process of transition upon admission in the following way:

Procedures

1. Intake – the Network Navigator is responsible for conducting a housing assessment during the admissions process. The housing assessment includes the identification of all current providers. Furthermore, the assessment process aids the Network Navigator in the identification of long term services for which the person served may be eligible.
2. Referral- the Network Navigator and/or Peer Navigator will make referrals to housing, services and/or programs for which the person served is eligible.
3. Collaboration – the Network Navigator and/or Peer Navigator will secure the necessary authorizations to:
    a. Establish strategies for communication and service planning.
    b. Identify the roles and responsibilities for each provider.
    c. Share/receive information.
4. Transition – should be reviewed no later than the 12th month of providing services, the Network Navigator and other involved providers will transition responsibility for services that will assist the person served in remaining housed. These include but are not limited to: benefit redetermination applications, energy assistance applications, regular face-to-face contacts, etc. The Network Navigator/Peer Navigators will work collaboratively for an agreed upon period of time (1 -2 months) during the transition phase. Responsibility will be transferred to providers and person served will be discharged from services of the Network Navigator/Peer Navigator.
    a. Criteria for Transition
        i. Person served has been housed at least 90 days.
        ii. Person served has paid his/her portion of rent for 3 consecutive months.
        iii. Person served demonstrates engagement with clinical care. This means:
            1. Generally keeps medical/clinical appointments
            2. Generally adheres to medications and treatment plans
            3. Has some insight into recovery and is taking steps (at his/her own pace)
        iv. Person served is managing budget
            1. Has money management or payee in place if necessary
            2. Uses appropriate community resources for basic needs
            3. Is not in crisis every month due to spending habits
        v. Person served is engaged in meaningful activity of some type:
            1. Employment or employment program
            2. Education or training
            3. Spirituality
            4. Fellowship meetings
            5. Volunteerism

5. Discharge – A discharge summary will be prepared collaboratively with the person served and providers that identifies the responsibilities of the person served and the providers.
6. Follow-up – The Network Navigator/Peer Navigator will make at least monthly contact with the person served and key providers for 90 days post discharge. The purpose of follow-up is to ascertain the effectiveness of the transition plan to keep services and housing stable.

This publication is part of a series of manuals that describe models of care that are included in the HRSA SPNS Initiative Building a Medical Home for HIV Homeless Populations. Learn more at http://cahpp.org/project/medheart/models-of-care