POLICY MANUAL

Subject: Outpatient Programs Continuing Care Plan **Effective Date**: 10/13/03

Initiated By: Cinde Stewart Freeman
Chief Quality Officer

Approved By: James B. Moore
Chief Executive Officer

Review Dates:

Revision Dates: 12/08 LH

POLICY:
In order to provide the most effective continuum of care transition for the patient, planning for discharge and continuing care begins at the time of admission. This process is the responsibility of the multi-disciplinary team as outlined below.

PROCEDURE:

1. At the time of the Initial Assessment, the Admissions counselor will gather information regarding the following factors
    a. Co-occurring medical and/or psychiatric disorders that may require additional care/services after treatment is completed;
    b. Current healthcare providers, including physicians, psychiatrists, psychologists, counselors, etc. and contact information if available (as well as the appropriate releases of information)
    c. Current living environment, including any potential relapse factors such as use in the home, domestic violence, etc.

2. This information will be communicated to the counseling staff by the Admissions counselor as part of the initial report on the patient via EMR.
3. As part of the treatment planning process, the Primary Counselor and the patient, consulting with the Referral Relations Liaison as necessary, will formulate a preliminary continuing care plan consisting of options to explore. This will be done within four sessions and documented in the progress notes by the Primary Counselor. The plan is also documented in the Referral Tracking log.
4. The OP counselor will schedule an appointment to meet with the patient within the first four sessions of treatment or sooner if necessary and notify the patient of the time of that appointment.
5. The Primary Counselor will then meet with the patient to begin to set up the necessary appointments. This may include appointment dates/times for

individual, group, or family counseling, as well as for extended treatment, halfway house placement, etc. This will be documented in the progress note, as well as the Referral Tracking log.

Note: If a patient refuses a particular recommendation, the refusal and the reasons surrounding it are documented in the progress notes, as well as the alternative referrals that are made.

6. The CC Plan will continue to be revised and updated as needed throughout the remainder of treatment. Relevant information is documented in the progress notes and in the Referral Tracking log.
7. The Primary Counselor will meet with the patient to finalize the continuing care plan and specific referral arrangements. This will be documented in the progress notes and the Referral Tracking log.
8. The Primary Care Counselor and the Referral Relations Liaison work cooperatively with both the patient and family as appropriate, as well as with other referral sources as needed.