POLICY MANUAL

Subject: Youth Program 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: 03/10 CBates, 02/11 PC, 04/12 PC DP, 03/13 PC, 2/14 RDP

Revision Dates: 12/08 PC/CM, 07/10 PC, 03/15 RDP

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 at Cumberland Heights 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 drug 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 the Electronic Medical Record (EMR)
3. The Case Manager or Primary Counselor, consulting with the Referent within the first two days of treatment and determine the frequency and the kind of contact desired by the referent, will formulate a preliminary continuing care plan consisting of options to explore within the first 10 days.
4. The Case Manager or Primary Counselor will encourage parents to begin to set up the necessary appointments. If the parents have not made appointments, these are to be secured by the primary counselor during the meeting with the parents in family week. 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 Continuing Care plan of the EMR.

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.

5. The Continuing Care 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 Discharge Plan in the EMR.
6. 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 Discharge Plan in the EMR.
7. The Primary Care Counselor works cooperatively with both the patient and family as appropriate, as well as with other referral sources as needed.
8. A re-entry contract is negotiated between patient and family. This document specifies household rules, chores, and recovery participation.