Policy # 8021  Continuity of Care and Coordination of Care

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Approved:

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POLICY:

It is the policy of the Cobb County Community Services Board and the Douglas County Community Services Board to provide coordinated care and treatment for clients from the point of initial contact through discharge in order to meet individual needs. Coordination of care involves comprehensive assessment, interdisciplinary team work, monitoring of response to care and services with appropriate adjustments and modification to treatment based on progress, careful discharge planning and linkage to appropriate external community services.

PROCEDURES:

1. Treatment planning for the client is a continuous process that begins at the point of initial contact and reflects integration of assessment data as well as participation by client and when appropriate, family members or other significant others.
2. If the data collected indicates the need for different levels of services or care, the transition to the different levels will be coordinated by designated staff with appropriate providers.
3. Internal communications are documented in the clinical record to provide appropriate information to the new level of care or service.
4. Monitoring of treatment needs based on client progress is the responsibility of the primary clinician/care coordinator or designated staff in conjunction with other members of the treatment team.
5. Access to emergency services is available 24 hours a day, 7 days a week to accommodate client needs. This access is provided by Georgia Crisis and Access Line. Each department may also have a designated on-call staff available for contact.
6. Discharge Planning is an important component of the treatment process. It is addressed at the earliest possible time in the treatment process to assure appropriate coordination of care, careful planning, transfer of necessary information, and smooth transition for the client to other services.
7. The CSB maintains agreements with hospitals and institutions which serve its clients that delineate the processes for: preadmission screening and referrals, discharge and release notification and coordination, joint discharge and community support planning, and methods for evaluating these inter-agency agreements, and special requirements for minors.
8. The CSB coordinates with hospitals and institutions for persons returning to the community. Coordination is initially done by an assigned liaison and individually followed up by the assigned case mangers/case coordinator.
9. To evaluate and improve continuity of care, the CSB conducts routine utilization management reviews on adults with mental health and substance abuse needs from the agency admitted to hospitals, indigent care inpatient beds and the Stabilization Unit. Continuity of care activities for inpatient children and adolescents and clients with developmental disabilities are performed by identified staff in the respective departments.

10. All clients discharged from hospitals and institutions are given an after care appointment within 5 days of discharge or earlier depending on clinical need.

11. Each client within the agency is assigned to a program and/or staff member.

12. Transition of records is done in a timely manner and in accordance with confidentiality regulations, policies and procedures. For transitions/referrals within the CSB, the transitioning staff makes contact with the new services site (clinician or site supervisor) to discuss the transition and sends all necessary paperwork to Medical Records at the earliest possible time to ensure appropriate care. Status update forms are completed by the transitioning staff.

13. Interdisciplinary treatment team planning conferences and interagency planning conferences are an integral component of care for some clients and held as need dictates.

14. Upon discharge a continuum of care plan is developed with the client, and when appropriate, family members, to include appropriate community supports and services.

15. The continuum of care plan should be signed by the client and documented in the clinical record.