Purpose:
To delineate a criteria and procedure for client discharge so as to ensure continuity of care.

Scope:
For all clinicians providing direct services.

Procedure:
1. Goals for treatment will be determined upon initiation of treatment, on the Individualized Action Plan, with discharge goals and criteria identified.

2. The client will be considered for discharge in accordance with his/her successful completion or progress towards the goals as determined by the client and clinician.

3. Subsequent recommendations for follow-up care or other types of services will be discussed and will be coordinated with the client prior to discharge.

4. Any referrals to other health providers and/or community resources will include all referral source information, including contact names, locations, and telephone numbers.

5. A client has the right to terminate treatment at any time despite the opinion or recommendations of the clinician.
   - If a client does not attend therapy sessions as indicated by two consecutive “no shows,” he/she will be contacted by letter inviting the client to return to therapy stating the date by which this contact needs to be made before the case is closed.
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- When a clinician terminates with the agency, each client is provided with three documented choices on continuation of care: if the client’s goals have been met, the case may be discharged; if further treatment is needed, the client will be transferred to another clinician within the agency; if the clinician continues employment outside of the agency, the client may choose to continue treatment with that clinician.

6. The client can be discharged from services if the client poses a serious danger to either himself/herself or to the clinic staff and is unable or unwilling to participate in establishing goals and engaging in therapy to address the behavior. This could include bringing weapons or drugs on site or displaying violent, acutely suicidal, or homicidal behavior. Emergency procedures will be followed on a case-by-case basis. An earnest attempt will be made to work with the client before a decision to terminate the case is made.

7. If the case is closed due to failure to respond and the client has run out of prescribed medications, the Clinic Director or designee will contact the prescribing professional to determine if there are any risks in discontinuing the prescribed medication and the results will be noted in the clinical record. If necessary, the client will be provided with a maximum two-week supply of prescribed medications to allow for coverage until medication management services may be established by the client elsewhere. For any case being closed due to non-response by the client, the Clinic Director will review the chart for completeness and then sign off to discharge the case. Termination of care will end the responsibility of BAMSI Outpatient Services. It will then be the responsibility of the client to find another resource to continue his/her care. BAMSI Outpatient Services will work with the client to help facilitate this transfer of care, where indicated.

Termination of a Case:

1. When a decision has been made to terminate services at the clinic, either by the client or the clinician, the clinician will complete a Discharge Summary within thirty (30) days of discharge. See attached instructions and blank Discharge Summary/Plan.

Discharge Summary and Final Diagnosis, DSM IV (Axis I-V): Information for the Discharge Summary may be gathered from the person served; the family, when applicable;
COUNSELING AND COMMUNITY RESOURCES
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a legally authorized representative, where appropriate; and the referral source or other community service, when permitted. The Discharge Summary will include:

- Why the client was entered into the system – a brief statement of chief complaints and history
- Description of problem areas, strengths and needs, abilities, and preferences addressed by the provider
- Description of pertinent positive findings – gains during treatment, client’s strengths and needs, abilities, and preferences
- Description of the methodology used for treatment – include client’s response, complications, and consultations, if any
- The client’s condition on discharge in regard to problem resolution
- The final diagnosis code indicated by DSM IV number and nomenclature
- Instructions suggested for continuing care – other therapeutic measures, referrals/appointments; discharge to other health providers; suggestions for appropriate schedule for follow-up contact
- Service Provider, Title, Date: Signature, degree, and title of provider reporting on this form, signature and degree of Clinic Director, and date the form was completed/signed must be indicated

For clients attending four (4) sessions or less, a Summary of Contacts will be used rather than a Discharge Summary.

2. Information regarding options available if symptoms recur or additional services are needed will be provided to the client as part of the discharge process.

Discharge Planning:

1. If the discharge plan indicates the need for additional services, personnel are identified who will be responsible for follow-up to maintain continuity and coordination of needed services.
2. When an unplanned discharge occurs, personnel will be identified who will follow-up to
determine, with the person served, whether further services are needed or to refer to needed
services, when possible.

3. When a person is discharged for aggressive/assaultive behavior, follow-up will occur to
ensure linkage to appropriate care within seventy-two hours of discharge.

4. All completed Discharge Summaries will be reviewed and signed off by the Clinic Director
in order to close the case.