



State of Indiana  
Indiana Department of Correction

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4.01A

## **HEALTH CARE SERVICES DIRECTIVE -ADULT Manual of Policies and Procedures**

Title

### **ADDICTION RECOVERY SERVICES**

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References:
IC 11-8-2-5(a)(8) IC 11-10-3-4(a)(1) IC 35-50-6-3.3	01-02-101 01-04-101 01-02-106 01-07-101 01-02-107 03-02-104 01-03-103	National Correctional Healthcare Standards

#### **I. PURPOSE:**

Adult patients with substance use treatment needs shall have access to comprehensive addiction recovery treatment services. This Health Care Services Directive (HCSO) provides an overview of the way addiction recovery services shall be provided in Indiana Department of Correction (IDOC or "the Department") adult facilities.

#### **II. POLICY STATEMENT:**

The Department recognizes that a significant portion of the patients committed to the Department have been involved in some form of problematic substance use. In order to address this problem, the Department has established coordinated addiction recovery services (ARS) that provide education, treatment, and support programming for patients within the Department's facilities.

#### **III. DEFINITIONS:**

For purposes of this Health Care Services Directive the following definitions are presented:

- A. **ADDICTION RECOVERY SERVICES (ARS):** The entire continuum of services and programming offered at Department facilities for the treatment of problematic substance use.

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- B. ADDICTION RECOVERY SERVICES FACILITY DIRECTOR (ARS FD): The ARS staff at each location responsible for coordinating and providing addiction recovery services at their location. This individual may or may not supervise other ARS staff.
- C. ARS STAFF: The employee(s) at each location responsible for direct delivery of Addiction Recovery services. Staff must have an Addiction Consultant in Training (ACIT) credential at minimum, with eligibility to obtain the CADAC I certification or higher within eighteen (18) months of the date of hire. Credentials such as Licensed Addiction Counselor (LAC), Licensed Clinical Addiction Counselor (LCAC), and Licensed Clinical Social Worker (LCSW) may also qualify as Addiction Recovery Staff.
- D. CASE PLAN CREDIT TIME (CPCT): CPCT is an earned credit time cut structure that is driven by the needs indicated in the IRAS and incentivized through the individual case plan to provide each individual the opportunity to earn the maximum credit time as allowed by law.
- E. COMPREHENSIVE SUBSTANCE USE ASSESSMENT (CSUA): The formal assessment process used with newly referred patients to establish eligibility for participation in ARS and determine the appropriate Level of Care.
- F. CO-OCCURRING DISORDERS: A condition in which a patient has at least one diagnosable mental illness along with one or more substance use disorders.
- G. DIRECTOR OF ADDICTION RECOVERY SERVICES (D/ARS): The Central Office employee responsible for the oversight, coordination, and direction of the ARS program within the Department.
- H. EARLIEST PROJECTED RELEASE DATE (EPRD): The date on which a patient would be entitled to discharge or release from a Department facility.
- I. ELECTRONIC MEDICAL RECORD (EMR): The secure electronic system used to record all health care information for a patient, including ARS treatment records.
- J. IDOC RECORDS MANAGEMENT SYSTEM (IRIS): The Web-based program that facilitates the digital capture and storage of document images along with associated indexing data.
- K. INDIVIDUALIZED TREATMENT PLAN (ITP): The document that specifies a patient's personal Addiction Recovery needs, goals, and measurable objectives that will be addressed, and interventions that will be implemented, during their participation in ARS.

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- L. LEVEL OF CARE (LOC): The clinically indicated intensity and frequency of services that the patient needs to meet their individualized treatment goals. There are three (3) active levels of care in the Recovery While Incarcerated (RWI) treatment program to which a patient can be assigned: 1) Residential Level of Care (RES); 2) Intensive Outpatient (IOP); and 3) Outpatient Level of Care (OP).
- M. MEDICATION ASSISTED TREATMENT (MAT): The use of FDA-approved medications that may be used in combination with counseling and behavioral interventions for the treatment of substance use disorders.
- N. MONTHLY SERVICE REPORT: The monthly report sent to the D/ARS providing information regarding ARS staffing, treatment changes, and census and outcomes data.
- O. MULTIDISCIPLINARY TEAM (MDT): A treatment team comprised of individuals from different disciplines that contribute a broad range of perspective and treatment modalities in the management of patients' needs.
- P. OFFENDER CASE MANAGEMENT SYSTEM (OCMS): The electronic database used by Unit Team staff to record, store, and review patient data, including Case Plan and Progress Reports.
- Q. OFFENDER CASE MANAGEMENT SYSTEM NOTE: A documentation entry that includes information necessary for the continuity of patient care management throughout the Department which does not include information that is protected by the Health Insurance Portability and Accountability Act (HIPAA) confidentiality guidelines and 42 CFR.
- R. PATIENT: Any incarcerated individual receiving Health Services.
- S. PROGRAM MANAGEMENT REFERRAL SYSTEM (PMRS): The electronic referral system housed within OCMS that tracks patient Program/Course participation.
- T. PROTECTED HEALTH INFORMATION (PHI): Individually identifiable information including demographic information that relates to past, present, or future physical or mental health conditions of, or provision of health care to, an individual.
- U. PURPOSEFUL INCARCERATION (PI): An initiative by which a sentencing authority (a judge or the Indiana Parole Board) agrees to consider a modification to the patient's sentence pending completion of a Department-recognized ARS program.

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- V. RECOVERY ORIENTED COMMUNITY (ROC): A dedicated housing unit set aside for participants in the Recovery While Incarcerated program designed to facilitate mutual support for patients during their recovery. All patients in Residential Level of Care will be required to live in a ROC while those in other levels of care may not.
- W. RECOVERY WHILE INCARCERATED (RWI): The Department's comprehensive addiction recovery treatment program.
- X. REGIONAL DIRECTOR OF ADDICTION RECOVERY SERVICES: The contracted employee responsible for collaborating with the Director of Addiction Recovery Services for the purpose of providing oversight, coordination, and direction of all Addiction Recovery Services within the Department.
- Y. REGRESSION: A clinical treatment decision to require a patient to repeat or complete a more intensive Level of Care based on current clinical needs being exhibited.
- Z. SUBSTANCE ABUSE MANAGEMENT SYSTEM (SAMS): The computerized system that provides for program and system administration for patients participating in ARS.
- AA. SUPPORT GROUPS: Programs including Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Celebrate Recovery, and other groups designed to assist patients in maintaining recovery from substance use. These groups can be conducted by volunteers, peer recovery coaches, or patient-led self-help groups.

#### IV. TREATMENT STANDARDS:

- A. The overall operation of the Department's addiction recovery services (ARS) treatment, known as Recovery While Incarcerated (RWI), shall be in accordance with Policy and Administrative Procedure 01-02-106, "Addiction Recovery Services."
- B. The Department's ARS shall include assessment, treatment (including medication assisted treatment [MAT]), and referral for post-release recovery support for patients with substance use disorder(s). Continuity of care must be provided from admission to discharge from the Department, including referrals to appropriate community-based providers, in collaboration with Transitional Health Care staff.
- C. All ARS, including assessment, and treatment, shall be conducted by ARS staff within the scope of their professional credential(s), competency, and training.

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- D. All treatment interventions provided by ARS staff shall conform to accepted national professional standards, utilize standardized curricula approved by the Department, and be delivered in accordance with an Individualized Treatment Plan (ITP).
- E. Regardless of housing assignment, patients must have access to ARS assessment and treatment. ARS must be provided in a manner in which affords the patient confidentiality and provides physical protection for the staff.
- F. Each facility shall identify an ARS Facility Director (ARS FD) who functions as the coordinator for the ARS provided within the facility.
  - 1. The ARS FD shall collaborate with the Health Services Administrator (HSA), Warden, and other facility staff to ensure the facility's ARS program is properly managed and appropriate for patients who require addiction treatment.
  - 2. The Regional Director of Addiction Recovery and Regional Director of Mental Health shall identify an ARS FD and Psychologist from another facility who shall provide leadership and direction as necessary at facilities without an ARS FD or Psychologist on site.
- G. ARS is a voluntary treatment program, and a patient always has the right to refuse to participate without punishment or reprisal (unless under a court order for involuntary treatment for substance use).
  - 1. If the patient refuses the recommended Level of Care, they will be offered other engagement opportunities such as attending support groups (AA, NA, Celebrate Recovery), completing the Foundation Curriculum, utilizing recovery coach services, and all Tablet-Based Resources. These resources will not be a part of a treatment plan or time-cut eligible programming but instead allow the patient to stay engaged and encourage future participation in the recommended Level of Care.
  - 2. Every attempt must be made by the person receiving the refusal to obtain the patient's signature on State Form 9262, "Refusal and Release From Responsibility for Medical, Surgical, Psychiatric and Other Treatment."

V. RWI PROGRAM COMPONENTS AND DESCRIPTION:

- A. Independent Study
  - 1. The Foundations Curriculum consists of independent study by the patient of the Department-approved substance use education, resources, and information manual.

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The Foundations Curriculum is multifunctional in that it may be used for those who refuse to complete the recommended Level of Care, those who do not wish to participate in any organized ARS treatment programming, those seeking educational resources without the need for addiction treatment, or those who are restricted from participating in a group setting at that time due to administrative/housing restrictions (e.g., patients in restrictive status housing).

2. Facilities shall keep a sufficient stock of Foundations Curriculum at the facility to provide to patients and are responsible for re-ordering the material when inventory runs low.

#### B. Active Treatment / Level of Care (LOC)

There are three (3) Levels of Care in RWI in which the treatment modality consists of group sessions led by ARS staff and peers. Individual sessions should only be conducted for Individualized Treatment Plan (ITP) review or as clinically indicated.

1. Residential Level of Care (RES): the most intense Level of Care reserved for patients who need stabilized. Patients in RES will receive twenty plus (20+) hours of group treatment each week spread over five (5) or more days. This Level of Care will require a patient to live among their peers in a Recovery Oriented Community (ROC). RES Level of Care may not participate in other programs or be employed for the duration of time in RES.
2. Intensive Outpatient (IOP): The next level of services offered in the continuum for patients who are stable or have successfully completed the RES Level of Care if that was the initial treatment recommendation. Patients in IOP will receive a minimum six (6) hours of group treatment each week spread over two (2) or more days. This Level of Care is not required to live in the ROC but may if it is available and appropriate. IOP Level of Care is encouraged to participate in other programs concurrently and/or maintain employment.
3. Outpatient Level of Care (OP): Patients in OP shall receive a minimum of one hour of group treatment per week. This Level of Care is not required to live in the ROC but may if it is available and appropriate. OP Level of Care is encouraged to participate in other programs concurrently and/or maintain employment.

#### C. Aftercare

Enrollment in Aftercare is reserved for patients needing or desiring ongoing relapse prevention support without the structured services provided in RWI. Patients may enroll

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in Aftercare after successfully completing OP or may directly enroll in Aftercare with approval of the ARS Facility Director (ARS FD).

#### VI. COLLABORATION WITH OTHER FACILITY DIVISIONS:

- A. Collaboration and exchange of information across treatment and facility operational divisions is essential to providing quality care within a correctional environment. Every facility shall create and maintain a Multidisciplinary Team (MDT) in order to review conduct, safety/security concerns, Case Management needs, physical health needs, and mental health needs of patients participating in ARS. The facility MDT shall include representatives from each clinical, operational, and administrative division within the facility.

The facility MDT shall meet at a regular frequency determined appropriate by the facility, but no less than once per month, to discuss and make decisions regarding:

1. Circumstances (other than clinical assessment) that may affect patient's appropriateness for admission into ARS; and,
  2. Removing a patient from ARS for behavior such as treatment non-engagement, repeated minor conduct violations, or a pattern of violation of ARS rules and expectations.
- B. The management and treatment of mental health and psychiatric disorders is the responsibility of the contracted medical provider's Behavioral Health Services Division and is supervised by the contracted Regional Director of Behavioral Health Services. When mental illness symptoms are recognized or suspected, ARS staff must ensure the patient is referred for mental health services in accordance with current behavioral health procedures and referral guidelines. ARS and Behavioral Health staff are required to hold, at minimum, a monthly staffing of patients with co-occurring behavioral health and substance use disorders. These meetings shall be documented and kept on file with the site Health Services Administrator (HSA) for auditing purposes.
  - C. The management of acute intoxication and withdrawal is primarily the responsibility of Health Services personnel in accordance with HCSD 2.32A, "Intoxication and Withdrawal." However, consultation with ARS staff may be needed to manage acute intoxication and withdrawal, and ARS staff shall collaborate as needed with facility Health Services personnel. Patients treated by Health Services personnel for acute intoxication or withdrawal shall be referred for substance abuse assessment by the Health Services staff who place them on intoxication/detoxification hold.

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- D. Patients newly diagnosed with Hepatitis C (that is, the diagnosis was made after the patient was committed to the Department) or being treated for Hepatitis C shall be referred for substance abuse assessment by Health Services staff.
- E. ARS staff shall collaborate as needed with facility Unit Team staff for the purpose of identifying treatment goals to be documented on the Clinical Review Form for patients who are participating in the Case Plan Credit Time process and who have been identified as needing addiction treatment. A copy of the Clinical Review Form with identified goals shall be shared with the patient's Unit Team staff to coordinate treatment plan and case plan goals. Annual reviews, or reviews at the completion of addiction recovery treatment, documenting the patient's progress in addiction recovery treatment shall be completed on the Clinical Review Form and shared with the patient's Unit Team staff for consideration in their Case Plan Credit Time review.

#### VII. REFERRING A PATIENT FOR ARS:

- A. In routine cases, a patient begins the assessment and enrollment process for ARS via a "Refer to Substance Abuse Assessment" assignment entered in the Program Management Referral System (PMRS). However, a referral in PMRS is not required for an assessment to be initiated in urgent cases (for example, a patient who has recently overdosed or referred by Health Services).
- B. Only Case Management staff can enter a "Refer to Substance Abuse Assessment" assignment in PMRS. This assignment must be entered in PMRS in the following circumstances:
  - 1. When the "ARS Screening Note" or "Initial Assessment Note" in the Offender Case Management System (OCMS) states that a referral to ARS is indicated;
  - 2. When a patient is written up on any conduct charge related to illegal substances;
  - 3. When a patient has a positive urine drug screen (UDS) or fails to comply with a UDS request;
  - 4. When a referral is requested by ARS staff, other facility staff, or Central Office staff; and,
  - 5. Per the patient's request.
- C. The **ONLY** substance use option to which a patient should be referred in PMRS is "Refer to Substance Abuse Assessment."



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- D. Once the “Refer to Substance Abuse Assessment” assignment is entered in PMRS, Case Management’s responsibility has ended. ARS staff are tasked with managing the patient’s addiction treatment program assignments going forward. Case Management staff should not close or otherwise modify any ARS-related assignment in PMRS unless specifically requested to do so by the ARS FD. Unit Team staff will be a point of contact for ARS staff completing Clinical Review Forms for patients who are participating in the Case Plan Credit Time structure. Copies of Clinical Review Forms with newly identified goals at Intake and at each review, and reviews completed annually, or at the conclusion of a patient’s addiction treatment shall be shared with the patient’s Unit Team.

#### VIII. DETERMINING CLINICAL ELIGIBILITY:

- A. Establishing clinical eligibility for ARS most often begins when a patient is referred for “Substance Abuse Assessment” in PMRS. However, the clinical assessment of a patient demonstrating an urgent need for ARS intervention must not be delayed while awaiting a formal referral in PMRS. In these cases, ARS staff shall initiate the clinical assessment as soon as possible, and follow up with Case Management staff to have the formal referral entered in PMRS.
- B. Facility ARS staff shall schedule a Comprehensive Substance Use Assessment (CSUA) with all patients referred.
1. The CSUA shall take place within twenty (20) business days from the date the referral was entered into PRMS.
  2. The CSUA consists of five (5) mandatory components:
    - a. Patient Packet Review to gather pertinent information related to the patient’s biopsychosocial history, substance use history and patterns, criminal charges, and prior participation in treatment for addiction. Particular attention should be given to the patient’s pre-sentencing investigation (PSI), the mental health and nursing Intake, and the Classification Intake Summary. The packet review should include a review of the IDOC Records Management System (IRIS), patient’s hard copy, and review of the Electronic Medical Record (EMR).
    - b. A comprehensive face-to-face clinical interview with the patient, to include administration of the Department-approved behavioral health assessment tool.

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- c. Safety and Security Review to determine if there are recent conduct violations or historical involvement with trafficking, gang affiliation, or other undocumented activities that would disqualify the patient from participating in group treatment or the ROC.
  - d. Urine Drug Screen per Health Services vendor policy and procedures.
  - e. Treatment Level of Care Recommendation. Using information gathered from the CSUA and MDT, appropriately trained ARS staff shall determine the appropriate RWI Level of Care for the patient. Whenever possible or necessary, ARS staff completing the CSUA should consult with other ARS staff and/or the ARS FD regarding the appropriate treatment Level of Care for a patient.
3. ARS staff must document the completion of the CSUA in both OCMS and the EMR. The content of the documentation in each system differs, based on the information needs of the targeted reader and the requirement to safeguard protected health information (PHI). Sample language for the OCMS note and a template for the EMR entry are provided by the Department's contracted medical services provider.

**IX. PROGRAM MANAGEMENT REFERRAL SYSTEM (PMRS) USE BY ARS STAFF:**

- A. ARS staff are responsible for managing a patient's referral for "Substance Abuse Assessment" and for entry and management of all subsequent addiction recovery-related assignments in PMRS.
  1. It is essential that the information entered in PMRS be correct and timely to accurately convey a patient's current participation status in addiction treatment.
  2. When ending a patient's ARS-related assignment, staff must be mindful that the completion type may have different meanings depending on the patient's assignment.
- B. ARS staff shall refer to the "PMRS Use by ARS Staff" document for specific instructions on accessing the functions in OCMS.

**X. SUBSTANCE ABUSE MANAGEMENT SYSTEM (SAMS):**

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- A. The Substance Abuse Management System (SAMS) shall only be used for administrative management of patients participating in RWI. No clinical documentation shall be entered in SAMS.
- B. Administration tasks executed in SAMS include patient Level of Care assignments (including start and end dates for each level and completion code), ARS staff member caseload assignment, and time cut request submissions for those that opt-out of the Case Plan Credit Time (CPCT).
- C. ARS staff should refer to the “SAMS Counselor Manual” for specific instructions on accessing the functions in SAMS.

#### **XI. ADMISSION PRIORITY AND PROCESS:**

##### **A. Admission Priority Management**

Admission priority is, by necessity, a fluid situation that requires constant monitoring due to the various criteria that must be considered when determining who will next be admitted. The following guidelines will help inform admission priority but should not be considered a substitute for clinical judgment.

1. First priority regarding access to treatment will always consider clinical need above all other policies/guidelines. If the clinical presentation is severe and urgent enough (e.g., recent overdose) that immediate access to treatment is warranted, the decision to bypass the waiting list and admit a patient at the next opening, must be determined by a facility MDT meeting or by the ARS FD.
2. Admission to the program is at the discretion of the ARS FD based upon the following circumstances:
  - a. A patient who transferred into the facility while in active treatment; and,
  - b. A patient who is no more than twelve (12) months from their EPRD.
3. The remaining enrollments of patients who do not meet the previous criteria will be admitted based upon the date that their referral was entered into PMRS. PI patients will not be given special priority for enrollment; however, the ARS FD should attempt to enroll PI patients within a reasonable amount of time to allow completion of their treatment and notice provided to their sentencing judge.

##### **B. Enrollment Procedure and Requirements**

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1. After completion of the CSUA and decision about Level of Care, an individualized orientation session shall be held within twenty (20) business days of the CSUA. During this orientation session, the following activities must occur:
  - a. Review the results of the CSUA;
  - b. Create an initial Individualized Treatment Plan (ITP) that is comprehensive of goals for each Level of Care needed;
  - c. Completion and signing of State Form 46494, “Informed Consent,” and State Form 46490, “Notice of Confidentiality Guidelines;”
  - d. Signing the RWI Participation Consent; and,
  - e. Signing the contracted medical provider’s UDS Consent Form.

Patients who refuse to sign any of the required forms or otherwise participate in any component of the individual orientation session should not be admitted to treatment, and their refusal communicated to Unit Team.
2. Patients who had a waitlist date entered prior to treatment shall have another Safety and Security Review prior to enrollment in a ROC Level of Care to ensure they have not incurred any disqualifying conduct or Intelligence and Investigations involvement since their initial assessment.
3. Documentation requirements and PMRS management
  - a. ARS staff shall enter a Start Date for the patients who have a referral with a waitlist date program assignment in PMRS.
  - b. A brief note is entered in OCMS stating that the patient has begun RWI programming.
  - c. An Admission/Orientation Note is entered in the EMR using the contractor-provided template.
4. In the event that the patient was enrolled in “Foundations” and decided to enroll in treatment upon completion, or are now administratively able to participate in treatment, they shall have another Safety and Security Review prior to enrollment.

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- a. ARS staff shall enter an End Date for the patient's "Foundations" assignment in PMRS using the completion type "Transferred to Program". ARS staff shall enter an "Active" program referral assignment in PMRS and enter the Start Date;
- b. A brief note is entered in OCMS stating the patient has begun RWI programming; and,
- c. An Admission/Orientation Note is entered in the Electronic Medical Record (EMR) using the contractor-provided template.

## **XII. CASELOAD ASSIGNMENT AND MANAGEMENT:**

- A. The ARS FD is responsible for assigning newly admitted patients to a primary ARS staff member. With limited exceptions, the expectation is that the patient will remain on that staff member's caseload throughout their participation in each Level of Care in RWI, to maximize continuity of care and ability of staff to recognize and facilitate change as the patient progresses.
- B. The ARS FD is responsible for evaluating and approving any reassignment of a patient to another ARS staff's caseload. This should only be done in rare circumstances, such as when issues of countertransference arise, or when the safety of a staff member becomes jeopardized.

## **XIII. RECOVERY ORIENTED COMMUNITY (ROC) MANAGEMENT:**

- A. The occupancy mix of the Recovery Oriented Community is designed to be fluid, in order to meet the needs of the RWI program at each facility. There is no minimum, maximum, fixed number, or ratio of ROC beds that must be filled by patients in each Level of Care.
- B. Priority assignment of ROC beds shall be for patients in Residential Level of Care, with any remaining beds assigned to patients in the IOP or OP Level of Care. A limited number of ROC beds may be assigned to RWI graduates serving as mentors or Peer Recovery Coaches.
- C. Safety and Security Considerations
  1. Patients who represent an immediate or significant threat to the health and safety of themselves, other patients, ARS staff, or other facility staff should be removed from the ROC immediately.

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2. Patients who do not represent an immediate health or safety risk but may be engaged in other dangerous or prohibited behavior should be staffed by the MDT at the earliest opportunity, and the MDT shall determine future participation. These behaviors include active substance use, possession of illegal substances, STG activity, inappropriate sexual contact, and other behaviors that are significantly disruptive to the ROC or potentially interfere with other patients' treatment.
3. Removal from the ROC for safety and security reasons does not automatically constitute removal from RWI program but will require MDT discussion and decision about the appropriateness of continued participation in another level of RWI.

#### XIV. INDIVIDUALIZED TREATMENT PLAN (ITP):

The Individualized Treatment Plan (ITP) is an essential piece of clinical documentation, forming the foundation of a patient's participation in RWI. It documents the patient's strengths, resources, and protective factors as well as problem areas, treatment needs, and measurable objectives which will help the patient reach their identified goals. Goals and objectives on the ITP must be relevant to the individual and be sensitive to and respectful of cultural differences and values.

##### A. ITP Development Requirements

1. The ITP shall, by definition, be specific to each patient.
2. Because the creation and management of the ITP is a collaborative process between the patient and their treatment team, the development, review, and update of the ITP must only be conducted during an in-person individual session with the patient. A patient shall be provided a copy of their ITP upon request at any time and at no charge.

##### B. Initial ITP Development and Review/Update Timeframes

1. A patient's initial ITP shall be developed at the individual orientation session and entered in the EMR within five (5) business days of the orientation.
2. The ITP shall be reviewed a minimum every thirty (30) calendar days while in Residential Treatment and every ninety (90) calendar days while in IOP or OP Level of Care. The ITP shall be updated as necessary. The ITP for patients in After Care are required to be reviewed/updated annually. These treatment plan reviews should include a clinical note summarizing treatment goals completed, setbacks, and success during that review period.

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3. Other circumstances for which an ITP review/update is required include:
  - a. When a patient successfully completes a Level of Care;
  - b. When a patient is regressed in treatment or moved to a more intensive Level of Care; and,
  - c. When new treatment needs, goals, and/or measurable objectives are identified.
4. All ITPs (initial and review) shall be entered into the EMR using the contractor-provided template.
5. An ITP is not required for a patient enrolled in “Foundations”; however, staff shall review those enrolled every six (6) months to determine if “Foundations” referral can be closed in PMRS.

**XV. PROGRESSION COMPLETION SUMMARY AND TREATMENT SUMMARY:**

**A Completion Summary**

1. A Completion Summary is entered in the EMR, using the contractor-provided template, when a patient completes a Level of Care. In the case of a patient’s successful completion of Outpatient Treatment, the Treatment Summary (see Section B below) takes the place of the Completion Summary.
2. The Completion Summary’s purpose is to document the staff member’s clinical determination that the patient met the required competencies for a given Level of Care and summarizes the patient’s participation in treatment activities and provides a subjective observation of the patient’s behavior. The Completion Summary must also include specific measurable evidence that the patient met their identified treatment goals and objectives established for that Level of Care and the ITP must be reviewed and updated.

**B. Treatment Summary**

1. A Treatment Summary is completed when a patient’s participation in RWI ends, whether through successful completion, voluntary or involuntary termination, release from Department custody, or transfer to another facility.

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2. The Treatment Summary is an essential piece of clinical documentation, which serves as the record of a patient's entire participation in RWI and is sometimes made available to persons outside of the Department as a verification and clinical summary of a patient's involvement in addiction treatment. It must effectively communicate to the reader (who is often not a behavioral health professional) the growth and successes attained by the patient, ongoing concerns, and areas for continued clinical attention, and prognosis and recommendations for further addiction recovery treatment.
3. The Treatment Summary must contain information about a patient's overall participation and growth during their entire enrollment in RWI. It must document specific evidence that the patient met or did not meet the most significant identified treatment goals and objectives established on the ITP.
4. The primary ARS staff who provided treatment to the patient shall complete the Treatment Summary in cases where that is possible. If the primary ARS is unable to complete the Treatment Summary, it shall be completed by the ARS FD. The Treatment Summary is entered in the EMR using the contractor-provided template.
5. When a paper copy of the Treatment Summary is produced, it shall be signed and dated by the ARS staff that completed the summary, or the ARS FD if that staff member is unavailable.

**B. Case Plan Credit Time**

Patients who are participants in the Case Plan Credit Time process shall have a review of treatment goals identified on the Clinical Review Form reviewed annually; when a patient is removed from RWI treatment prior to completion; or when a patient successfully completes RWI treatment. The patient's progress or lack thereof should be documented on the Clinical Review Form and the form shall be sent or scanned to the participant's Unit Team staff.

**XVI. CLINICAL DOCUMENTATION DESCRIPTION AND REQUIREMENTS:**

Accurate and timely clinical documentation is an essential part of the delivery of quality clinical services. Clinical documentation shall include a patient's participation in treatment from referral through the end of their participation in services. It shall identify the patient's needs, treatment involvement, outcomes of treatment, and post-treatment recovery plans and prognosis. In addition, information contained in the clinical documentation for a patient participating in RWI becomes part of that patient's Department record, and is used by other health services providers, other



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Department divisions, the court system, and other entities to make health care and custody decisions.

A. Treatment Notes (EMR)

1. Treatment Notes document a clinical intervention or activity that takes place with a patient. Treatment Notes are entered into the EMR only, since they contain protected health information (PHI) which is subject to protections under the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR.
2. Treatment Notes must be entered within five (5) business days of the date the activity occurred, or in the case of Weekly Progress Notes, within five (5) business days of the end of the seven- (7-)day period covered by the note.
3. Treatment Note types and descriptions
  - a. CSUA Note – entered when a CSUA is completed with a patient and the orientation session has been concluded.
  - b. Weekly Progress Note – entered for every patient enrolled in Residential and Intensive Outpatient treatment, summarizing their participation in all treatment interventions during a 7-day calendar period. A Weekly Progress Note is required even if a patient does not participate in any treatment activities during the 7-day period, so any gaps in treatment are appropriately documented and the reason made clear to a reviewer.
  - c. Treatment Plan Review – entered following an individual session with the patient. It shall determine if they completed the current LOC and can be progressed, or document the reason(s) why the patient should remain in the current LOC.

B Administrative Notes (EMR)

Administrative Notes are entered as needed to document activities other than treatment sessions or interventions that are relevant to the patient's participation in RWI, such as:

1. Communication with outside offices or agencies pertaining to the patient's participation in ARS (e.g., phone calls and/or letters to a court or the Indiana Parole Board).
2. Outcome from a facility MDT meeting.

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3. Temporary interruptions in treatment, such as the patient being out to court, extended facility lockdown, long-term medical treatment for the patient, etc.

C. OCMS Notes

1. In addition to entering clinical documentation in the EMR, ARS staff are also responsible for entering various non-treatment administrative documentation into OCMS. These OCMS Notes are vital for communicating information necessary for the continuity of patient holistic case management to Department staff who are not treatment providers.
2. OCMS Notes must be entered within five (5) business days of the date the activity occurred. Since OCMS Notes are intended for use by Department staff, contractors, and other persons who are not health care or treatment providers, they must not contain PHI or information that is protected by HIPAA and 42 CFR.
3. OCMS Note types and description
  - c. Initial Assessment Note – states the CSUA was completed and provides information about the disposition and/or recommendations for RWI. In the event this was completed before a referral was placed by Case Management staff, this will give the direction for them to enter a referral for assessment as well.
  - d. Enrollment Note – provides the date a patient was admitted into RWI and whether the patient is able to participate in another time cut-eligible program or employment.
  - e. Refusal Note – states a patient refused to participate in any component of RWI.
  - f. Discharge Simple Note – states the date patient was discharged from RWI.

XVII. ADMINISTRATIVE REPORTING:

A quantitative Monthly Service Report shall be submitted via email no later than the tenth (10<sup>th</sup>) of each month to the contracted Regional Director of Addiction Recovery Services and the Department's Director of ARS. All clinical and administrative documentation must be completed prior to submission of the Monthly Service Report. The Monthly Service Report shall be

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completed using the ARS contractor-developed (-or provided) templated approved by Director of ARS.

#### XVIII. DRUG AND ALCOHOL TESTING/ILLCIT SUBSTANCE POSSESSION:

- A. The RWI program shall include drug and alcohol testing as an integral part of patient accountability. Routine drug and alcohol testing shall be conducted in accordance with the contracted medical vendor's policy and procedures.
- B. A positive test for drugs or alcohol, admission of use, or a conduct charge related substances shall not automatically cause a patient to be dismissed from ARS. Substance-related incidents involving ARS participants shall be reviewed by the facility MDT to determine the appropriate response and intervention. Immediate termination from the program, removal from the ROC, clinical regression to an earlier Level of Care, or other sanctions shall all be considered within the scope of response.

#### XIX. REMOVAL OF PATIENTS FROM RWI:

Terminating a patient from RWI is almost always a last resort, especially when there is no serious conduct violation or other obvious justification for removing the patient. There are significant clinical and administrative ramifications to consider before deciding to terminate a patient from addiction treatment. For this reason, it is strongly recommended that all applicable clinical interventions be attempted first, including, but not limited to extra assignments, treatment plan revision, referral to additional services such as Behavioral Health, and regression in treatment level. Clinical interventions to address problematic behavior must be documented thoroughly, as well as the patient's response to those interventions. This provides valuable information for the MDT to consider when deciding whether to terminate a patient.

- A. In many cases, a conduct report is not generated as a result of a patient's actions. Other times, the conduct report is rescinded, dismissed, or overturned at appeal. Therefore, a patient may be removed and terminated from treatment after a facility MDT consensus decision or after consultation with the Director of ARS or higher-ranked employee.
- B. No matter the reason for termination the RWI termination form must be signed by the facility RWI/ARS Director and maintained on file by the Addiction Recovery Department and documentation for the reason placed in EMR.
- C. If the patient is removed from RWI, they will continue to be offered other engagement opportunities such as attending support groups (AA, NA, Celebrate Recovery), completing the Foundation Curriculum, utilizing recovery coach services, and all Tablet-Based Resources.

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XX. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities housing adult patients.

signature on file

\_\_\_\_\_  
Kristen Dauss, MD  
Chief Medical Officer

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Date