

 HEALTH CARE SERVICES DIRECTIVE – ADULT Manual of Policies and Procedures	State of Indiana Indiana Department of Correction	Effective Date	Page 1 of	Number
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Title TRANSITIONAL HEALTH CARE PRE-RELEASE CONTINUUM OF CARE
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Legal References (includes but is not limited to) IC 11-8-5-2	Related Policies/Procedures (includes but is not limited to) 01-02-101 01-04-101 01-04-105	Other Reference: National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) outlines the process for identifying and coordinating a continuum of care for patients identified as having a special need.

II. DEFINITIONS:

For the purpose of this policy and administrative procedure, the following definitions are presented:

- A. **ACTIVITIES OF DAILY LIVING (ADL):** The basic tasks that must be accomplished every day for an individual to thrive. Examples include bathing, dressing, grooming, and toileting.
- B. **BUREAU OF DEVELOPMENTAL DISABILITIES SERVICES (BDDS):** Services for individuals with developmental disabilities that enable them to live as independently as possible in their communities.
- C. **CASE MANAGEMENT STAFF:** A member of Unit Team who acts as the initial point of contact in the housing unit for day-to-day issues, coordinates case management matters, facilitates access to programs and services, works with incarcerated individuals to create case plans, and assists in preparing the individual for the release and the Re-Entry process.
- D. **CHIEF MEDICAL OFFICER (CMO):** An Executive leadership position within the Department designated as head of the Health Services Division, who serves to advise and lead a team of health experts on matters of public health importance.

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- E. COMMUNITY TRANSITION PROGRAM COORDINATOR: Community Corrections Division staff located in Central Office, responsible for managing the Statewide program and collaborating with county supervising agencies for program delivery.
- F. CRISIS: An unstable and dangerous mental health state that could negatively affect an individual or the community.
- G. DELTA: The single source system of record for incarcerated individuals' data.
- H. DIRECTOR OF OPERATIONAL SUPPORT SERVICES: Leadership position within the Operations Division that supervises movement, transportation, and facility populations.
- I. DIVISION OF DATA SCIENCE AND ANALYTICS: The Division of Data Science and Analytics is responsible for data stewardship and the preservation of Department's data assets. The Division has primary responsibility for Department reporting and analyses of Department data and information collected from the Department's operational systems of record.
- J. EARLIEST POSSIBLE RELEASE DATE (EPRD): The date on which an incarcerated individual would be entitled to discharge or release, taking into consideration: 1) the term of the sentence; 2) the term of any other concurrent or consecutive sentence which the individual must serve; 3) credit time which the individual has earned prior to sentencing; and, 4) the maximum amount of credit time which the individual would earn if the individual remained in the current credit class during the period of confinement.
- K. EPIDEMIOLOGIST: A person who studies or is an expert in the branch of medicine which deals with the incidence, distribution, and possible control of diseases.
- L. EXECUTIVE DIRECTOR OF TRANSITIONAL HEALTHCARE: An executive leadership member that oversees and supervises Transitional Healthcare within the Health Services Division .
- M. FAMILY AND SOCIAL SERVICES ADMINISTRATION (FSSA): FSSA is a health care and social service funding agency of the State of Indiana that oversees five (5) care divisions that administer services to Indiana residents.

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- N. HEALTH SERVICES ADMINSTRATOR (HSA): An employee selected by the Health Services vendor that is responsible for planning, directing, and coordinating health care services in a Department facility.
- O. HIV CARE COORDINATION RELEASE OF INFORMATION: A Non-Medical Case Management Release of Information document that authorizes coordination of Case Management services with the Indiana Department of Health relevant to the care of a person living with human immunodeficiency virus who is due to be released from a Department facility.
- P. H&P: shorthand for history and physical, the initial clinical evaluation and examination of the patient.
- Q. IMMEDIATE RELEASE: A court order notification requiring the release of an incarcerated individual immediately upon a completed release review and issuance of a Release Authorization.
- R. INDIANA DEPARTMENT OF HEALTH (IDOH): The public health funded agency of the State of Indiana that promotes quality of life by providing health resources for Indiana residents.
- S. INTELLECTUAL DISABILITY: Disability originating before the age of 18 (eighteen) characterized by significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behavior, which covers a range of everyday social and practical skills.
- T. LEVEL OF CARE: the intensity or effort required to diagnose, treat, preserve, or maintain an individual's emotional or physical health.
- U. LONG TERM CARE: Level of care that provides a variety of services designed to meet a person's health and personal care needs.
- V. MEDICAL ISOLATION: Confining a confirmed or suspected case (ideally to a single cell with solid walls and a solid door that closes), to prevent contact with others and to reduce the risk of transmission.-
- W. MANAGED CARE ENTITY (MCE): An entity that provides health care plans and services through health insurance.
- X. MEDICAL QUARANTINE: Confining individuals who have had close contact with a positive case to determine whether they develop symptoms of the disease.

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- Y. OFFENDER TRANSPORT ORDER (State Form 23605): The document authorizing the transportation of an incarcerated individual from one facility to another facility or agency, authorizing the gate to be released for the transportation and/or serves as a receipt for an incarcerated individual being received or transferred between facilities or agencies.
- Z. PUBLIC HEALTH CRISIS: An urgent situation in which the health status of an area within the territory is adversely affected including localized outbreaks of an infectious disease or a potential outbreak of an infectious disease that has a reasonable possibility of occurring and that poses a significant threat to a community or region in the territory.
- AA. PANDEMIC: A disease outbreak that spreads across countries or continents occurring over a wide geographic area and affecting an exceptionally high proportion of the population.
- BB. PRIOR AUTHORIZATION: A utilization management process used to determine if a health care entity will cover a prescribed procedure, service, or medication.
- CC. REGIONAL DIRECTOR OF TRANSITIONAL HEALTHCARE: A leadership position selected by the Health Services vendor to oversee and direct Transitional Healthcare Liaisons and Transitional Healthcare Facilitators and special needs referrals Statewide.
- EE. SPECIAL NEEDS DASHBOARD: A database that is managed by Transitional Healthcare that houses information on releasing incarcerated individuals which includes the: EPRD, health classification, location, and potential county of release.
- FF. SPECIAL NEEDS INDIVIDUAL (SNI): An individual who has been determined to require special attention or possess a physical health or behavioral health condition that requires a continuum of care upon release.
- GG. SUPERVISOR OF CLASSIFICATION: The facility employee who renders the final decision on all classification activities at the facility.
- HH. TRANSITIONAL HEALTHCARE FACILITATOR: An employee of the Health Services vendor that collaborates with Health Services, Addiction Recovery Services, Behavioral Health, family members, supervising agencies, and various community resources in order to address healthcare needs of releasing individuals.

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- II. TRANSITIONAL HEALTHCARE MANAGER (THM): An employee of Transitional Healthcare Division that supervises the Transitional Healthcare Specialists and the activation of health coverage for releasing individuals.
 - JJ. TRANSITIONAL HEALTHCARE LIAISON: An employee of the Health Services vendor who assesses parolee needs and develops, along with advocating for, individual treatment plans, community resources and support services.
 - KK. TRANSITIONAL HEALTHCARE: A team within the Health Services Division specializing in coordination and continuum of health care when an incarcerated individual enters and is released from the Department, including the processing of health care applications, and communicating with FSSA in matters related to State of Indiana benefits .
 - LL. TRANSITIONAL HEALTHCARE SPECIALIST (THS): An employee of Transitional Healthcare team that reviews health care coverage for releasing individuals and assists in continuum of care planning post release.
 - MM. TEMPORARY LEAVE: A period of time in which an incarcerated individual is authorized by the Warden to leave the facility, either escorted by staff or unescorted, including temporary passes issued by a Work Release facility.
 - NN. UNIT TEAM MANAGER: The administrator and supervisor of a unit who supervises the Casework Manager and Correctional Caseworker.
 - OO. 24 HOUR SKILLED NURSING: Care that requires around the clock services to complete activities of daily living.
- IV. COMMUNICATION AND FACILITY INVOLVMENT:

Communication is necessary and required for the success of the Transitional Healthcare Team. The Transitional Healthcare Facilitator (THF) shall host or attend a scheduled meeting monthly to review upcoming special need releases with Case Management, Operations, Classification, and Health Services staff. In addition, there should be consistent collaboration with Re-Entry and Case Management staff at each facility on a regular basis. If a meeting cannot be accommodated, the facilitator shall inform the facility HSA, the Health Services vendor's Regional Director of Transitional Healthcare, and Transitional Healthcare Manager via email with justification and resolution. The THF shall acquire an up-to-date Unit Team directory for their sites(s) and distribute the 180-day special needs report to Unit Team on a monthly basis. The THF shall collaborate with each facility's

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designated Re-Entry Coordinator to present information at each START class regarding the following:

- General overview of their duties and responsibilities
- Available referrals for releasing citizens that meet special needs criteria
- Medicaid Key Terms
- Care coordination with MCEs
- Continuum of care post-release, including resources for each type of supervision (e.g., Parole, Probation, Community Corrections, CTP, and discharge).

V. ONE HUNDRED AND EIGHTY (180) DAYS FROM Earliest Possible Release Date (ERPD):

A. Identification:

The Division of Data Science and Analytics shall provide IDOC Transitional Healthcare and the THFs a monthly dashboard of incarcerated individuals releasing within 180 days. This database will include the incarcerated individual's name, DOC number, age, received date, facility, classification designation, comprehensive medical codes, county of release, restrictive housing status, and available good time credit.

The THF shall review the dashboard to triage incarcerated individuals by release date, most severe physical health codes, behavioral health codes, and disability codes. Patients classified with a physical health code of B or C shall be triaged as potential long-term care or skilled nursing placement and shall adhere to the HCSD.

The THF shall notify the Transitional Healthcare Manager (or designee) for individuals with a behavioral health code E or physical health code B or C no later than 120 days prior to release or as soon as these codes are identified on the special needs dashboard to begin the Medicaid review process.

When a skilled nursing or state hospitalization candidate has been identified, Case Management should make every effort to locate alternate placement. Shelter placement shall only be entered as an alternate placement option once all other options have been exhausted.

At the time of CTP eligibility, the CTP Coordinator shall contact the Department's Transitional Healthcare Specialist (THS) regarding any incarcerated individual with a B, C, F, I physical health code, B, C, D disability code, or a C, D, E, or F Behavioral Health Code, to determine capability of participating in CTP. The

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Department's Transitional Healthcare designee shall communicate the need for care coordination within five (5) business days of CTP notification.

Case Management staff shall communicate pending CPCT time cuts for special needs releases and anticipated effect on EPRD to the assigned THF. In the event of an immediate release Case Management staff, Classification Supervisor, and on-site Health Services vendor staff shall determine if the incarcerated individual requires special needs release planning. This may include, but is not limited to skilled nursing care, durable health equipment, or infectious disease care coordination. If a special needs coordination is indicated, the HSA or designee shall communicate with the THF regarding what referrals are necessary for appropriate care coordination. If the assigned Case Management staff becomes aware of an immediate release that meets the special needs definition, they shall contact the THF immediately providing information regarding, placement information, and transition planning concerns.

B. Notification

The THF shall triage their special needs dashboard. They shall contact the HSA or designee to provide clarification and communication of the patient's diagnosis, physical or behavioral health needs, level of care including ambulation issues, wound care, and any issues related to activities of daily living. Information shall be submitted to the THF within ten (10) business days of initial notification. If a facility does not have an assigned THF, the Contracted Medical Vendor Regional Director of Transitional Healthcare (or designee) will work directly with the HSA as needed.

The HSA (or designee) shall ensure that the medical release template is documented in EMR and updated for release planning purposes. The HSA or designee shall ensure all required documentation is current including but not limited to diagnoses match the problem list, detailed H&P if required, detailed description of assistance needed, and any durable medical equipment required for release. HSA shall adhere to HCSD 2.20A, "Communications Regarding Special Needs Patients," and HCSD 2.03A, "Continuity of Care."

After physical and behavioral health information has been received from the site HSA, the THF shall import data into the special needs tracker and document all interactions and referrals in EMR within five (5) business days after those interactions and referrals.

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The THF shall review documentation provided by the HSA or designee and generate an appropriate behavioral health and physical health referral for any diagnosis that will require an insurance prior authorization within ten (10) business days of notification. The patient's needs may also be determined during a face-to-face discussion where the following information is covered:

- Patient's self-report of well-being/illness
- Patient's requested health services
- Where the patient will reside after release
- Are there any identified Addiction Recovery needs?
- Will the patient require SNAP benefits after release?
- Confirmation of date of release (parole, probation, or discharge)

Patients who have been identified with a diagnosis of an intellectual disability shall be triaged as a Bureau of Developmental Disabilities (BDDS) patient. BDDS referral shall be forwarded to the Health Services vendor's Regional Director of Transitional Healthcare or designee for notification for necessary assessments.

The Health Services Associate Director of Transitional Healthcare (or designee) shall coordinate with the on-site behavioral and physical health staff to determine if additional testing is needed.

The site Psychologist shall ensure any additional testing or assessments are scheduled within seven (7) days of request. Once the application is submitted to the physician for confirmation of diagnosis, the Health Services vendor's Associate Director of Transitional Healthcare or designee shall submit the assessment and testing information to the BDDS local office within thirty (30) days of identification.

C. Refusal Process

Should the special needs individual choose to refuse services, the THF shall use motivational interviewing techniques with a minimum of three (3) attempted engagements. A special needs individual may retract a refusal at any opportunity during release planning. All attempted engagements shall be documented in DELTA and the EMR. If the special needs individual refuses after all three (3) attempted engagements, the THF shall have the individual complete State Form 9262, "Refusal and Release from Responsibility for Medical, Surgical, Psychiatric, and Other Treatment," and upload to the EMR within five (5) business days.

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VI. NINETY (90) DAYS FROM EPRD:

The THF shall contact the HSA to review the special needs dashboard for any change in the patient's behavioral health or physical health status. The HSA or designee shall review the EMR to ensure the problem list is accurate and matches all diagnoses included on the medical release template. The HSA shall submit information within five (5) business days of notification if additional changes occur. The THF shall update special needs dashboard within five (5) business days of receiving information.

The Health Services vendor's Regional Director of Transitional Healthcare or designee shall ensure documentation of a continuum of care plan is updated on the special needs dashboard and information is triaged appropriately, within 10 business days of the HSA's notification of changes. This information shall be available to the Department's Transitional Healthcare and the Transitional Healthcare Liaisons for monitoring of healthcare coverage status and timeliness of community referrals. Referrals and educational material related to the continuum of care plan shall be provided to the patient via release portfolio.

The Transitional Healthcare Facilitator shall notify the Health Services vendor's Associate Director of Transitional Healthcare or designee to schedule services for all psychotropic injection participants, patients requiring advanced level of care assessments, and BDDS applicants regardless of supervision type. A continuum of care action plan shall be documented in the EMR within five (5) business days of notification.

Transitional Healthcare Facilitator shall provide site Addiction Recovery Services (ARS) Director, or designee, with an upcoming release list of patients with "F" Behavioral Health codes. The ARS Director shall assess, determine, and communicate level of need and treatment recommendations.

The DON/designee shall provide oversight to ensure that all diagnoses are correctly documented in the EMR including the current problem list. All EMR documentation shall adhere to HCSDs 2.04A, "Physical Health Status Classification Assignments," 2.05A, "Disability," and 2.06A, "Behavioral Health."

VII. SIXTY (60) DAYS FROM EPRD:

The Transitional Healthcare Facilitator shall contact the assigned Case Management staff along with Unit Team Manager if placement has not been established or if placement options cannot meet the patient's level of need.

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The Transitional Healthcare Facilitator shall review any pending prior authorization referrals to ensure that all required paperwork is completed. The Transitional Healthcare Facilitator shall contact the assigned Case Management staff as needed to ensure that vital documents have been applied for and received on behalf of the patient.

The Health Services vendor Associate Director of Transitional Healthcare shall facilitate monthly meetings with facility Case Management staff, Re-Entry monitors, IDOC Transitional Healthcare, and Transitional Healthcare Liaisons to discuss special needs individuals who: release from a mental health facility, receive psychotropic injections, require durable medical equipment, under review for skilled nursing placement, were referred by Parole Board, and/or receive dialysis services.

The Department's Transitional Healthcare Specialist shall adhere to HCSD 5.02A, "Healthcare Application Process," when applying for health care coverage for releasing patients. If the patient qualifies for additional State or federal benefits, the Transitional Healthcare Specialist shall make every attempt to apply for qualified benefits.

The HSA and site Transitional Healthcare Facilitator shall adhere to HCSD 3.03A, "Human Immunodeficiency Virus," and 3.04A, "HCV Management," in regard to infectious disease release planning.

If the patient's Managed Care Entity (MCE) is known, the Transitional Healthcare Facilitator or designee shall review the health record for a completed State Form 46729, "Authorization to Release / Request Information," to contact the MCE or community providers for continuum of care planning. If a completed State Form 46729 is not found, the patient will be requested to complete the form.

VIII. THIRTY (30) DAYS FROM EPRD:

Patients with a Hepatitis C diagnosis that have successfully completed treatment shall receive educational information about community resources from the Transitional Healthcare Facilitator.

All incarcerated individuals shall receive educational information regarding infectious disease control in their release portfolio.

HSA shall ensure that the EMR release planning template notes the date of any physical health or behavioral health injections and shall provide the prescriptions to the Transitional Healthcare Facilitator or designee within three (3) business days of the EPRD. The HSA shall provide documentation that the prescription was forwarded to Case Management staff for inclusion in the Release Portfolio in the EMR by close of business.

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Any patients identified as special needs releasing to Parole supervision shall be referred to the assigned Transitional Healthcare Liaison no later than thirty (30) days from EPRD or within one (1) business day of EPRD change under thirty (30) days. The Transitional Healthcare Facilitator shall provide information, not limited to patient's physical and behavioral health codes, IDOC number, and any information regarding actions taken by the Transitional Healthcare Facilitator.

A. Transportation

The Supervisor of Classification or designee shall be notified by the HSA or designee if the patient will be released with medication. A transport order shall be completed for all releasing medications.

If a patient is not released with their prescribed medication, the HSA shall ship, overnight, or the most expedited manner for the patient to receive, the medication(s) by close of business the day of the notification, as required in HCSD 2.15A, "Medication Management," and document the action taken in EMR within one (1) business day of action. The Transitional Healthcare Manager, Health Services vendor's Regional Manager, and Health Services vendor's Director of Nursing shall be notified of any case in which an incarcerated individual was released without prescribed medication or durable medical equipment.

If releasing patient is identified by medical or behavioral health staff as being in a crisis upon discharge, they must notify the Executive Director of Transitional Healthcare (or designee) in order to contact the Director of Operational Support Services to request consideration for a single transport rather than combined transport. Quick collaboration with the Health Services vendor's Regional Director of Transitional Healthcare will be necessary to determine if the patient needs to be sent to a crisis center, hospital emergency room, or other alternative placement than what was previously determined. The patient shall be transported by IDOC Custody staff. If patient refuses entrance into a crisis center or hospital emergency department, the transporting officer shall contact the Warden immediately for instructions. Unless directed by the Chief Medical Officer, at no time shall the transporting officer leave a patient in crisis unattended.

If the patient requires a special transport vehicle such as an ambulance, the HSA shall communicate with the Director of Operational Support Services and adhere to Policy and Administrative Procedure 02-03-110, "Adult Offender Transportation," regarding specialized transportation needs.

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Any scheduled specialized transportation shall be documented in the EMR by close of business day.

In the event that a patient needs released outside of the scheduled release date or time, the Executive Director of Transitional Healthcare shall contact the Executive Director of Classification for approval and assist in completing necessary paperwork.

B. Classification:

The Supervisor of Classification or designee shall contact assigned Case Management staff if placement is not confirmed within one week of EPRD.

The IDOC Transitional Healthcare Specialist shall contact the patient's assigned MCE, if known, to confirm release date, release address, and healthcare concerns. If the patient is on probation or community supervision, the IDOC Transitional Healthcare Specialist or designee shall attempt to convey release needs to supervising agency.

IX. CONTINUUM OF CARE POST RELEASE:

In the event of a declared public health crisis, release procedures relevant to the Department's Transitional Healthcare shall be established by the Chief Medical Officer.

XII. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file
Adrienne Bedford, MD
Chief Medical Officer

3/13/2025
Date