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		HEALTH CARE SERVICES DIRECTIVE - ADULT Manual of Policies and Procedures		

Title POST-RELEASE CONTINUUM OF CARE
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Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other Reference:
IC 8-2-5 IC 31-33-5-1	01-02-101 01-04-101 01-07-101	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) describes the transitional healthcare services, of the Transitional Healthcare Liaisons (THL) in order to increase opportunities for a successful transition into the community.

II. GUIDELINES:

Transitional Healthcare Liaisons (THL) will work within the continuum of care directly with the Health Services vendor and Transitional Healthcare Facilitators, the Department's Transitional Healthcare Division, Parole District Supervisors, Parole Agents, and local community providers.

- This HCSD assists with the facilitation of programs, provides guidelines regarding application and services necessary for returning citizens' successful reintegration into society.
- This HCSD assumes the collaborative teamwork effort of all staff within the Health Services Vendor, Transitional Healthcare Facilitators, the Health Services Division, and Parole Services

III. DEFINITIONS:

- A. **ACTIVE CASE LOAD:** Returning citizen non-compliant or needs more intensive follow-up by Transitional Healthcare Liaison and services.

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- B. **COMPLIANT CASE LOAD:** Returning citizen who is compliant with all recommendations of community providers and Parole requirements.
- C. **COMMUNITY REFERRAL:** Written recommendation to a community provider to address, and attend to, a specific area of concern related to the physical, mental, or transitional needs of the returning citizen.
- D. **COMPLIANCE:** The act of complying and following all recommendations of community service providers in correlation with referrals made by Transitional Healthcare Liaisons.
- E. **CRISIS:** An unstable and dangerous mental health state that could negatively affect an individual or the community.
- F. **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 incarcerated individual must serve; 3) credit time which the incarcerated individual has earned prior to sentencing; and, 4) the maximum amount of credit time which the incarcerated individual would earn if the individual remained in the current credit class during the period of confinement.
- G. **EMERGENT REFERRAL:** A referral that must be performed without delay to address a community safety concern or to avoid permanent physical or mental health issues. This referral shall be completed to the THL via telephone.
- H. **HEALTHY INDIANA PLAN (HIP):** HIP is a health insurance program for qualified adults.
- I. **INITIAL CASELOAD:** Returning citizens referred for Transitional Healthcare Liaison services after triage is complete.
- J. **LGBT:** An acronym that stands for lesbian, gay, bisexual, and transgender person.
- K. **TRADITIONAL REFERRAL:** A referral that can be performed within the next business day of services that will not disrupt community safety or the functions of physical or mental health.

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- L. OFFENDER CASE MANAGEMENT SYSTEM (OCMS): The electronic database used by Unit Team to record, store, and review incarcerated individuals' data including case plans and progress reports.
- M. REFERRAL: A documented written or verbal request for further action or review.
- N. RETURNING CITIZEN (RC): An individual serving a sentence inside a correctional facility who has or will be released from a correctional facility. Each returning citizen is considered unique with individualized barriers and needs for assistance before, immediately, and during the reintegration process.
- O. SPECIAL NEEDS INDIVIDUAL : A returning citizen who has been determined to require special attention due to a complex physical or behavioral health condition that requires a continuum of care upon release.
- P. TRANSITIONAL HEALTHCARE FACILITATOR: A member of the Health Services vendor that collaborates with physical health, addiction recovery services, behavioralhealth, family members, supervising agencies, and various community resources inorder address healthcare needs of RCs.
- Q. TRANSITIONAL HEALTHCARE LIAISON: A member of the Health Services vendor's staff that assesses parolee needs and develops, along with advocating for individual treatment plans, community resources and support services.
- R. TRANSITIONAL HEALTHCARE DEPARTMENT (THD): A subdivision within the Health Services Division of the Department specializing in coordination and continuum of health care when incarcerated individual enters and is released from the Department.
- S. TRIAGE: Assessing what appropriate referrals that are needed for an RC.
- T. URINE DRUG SCREEN (UDS): A test that analyzes urine for the presence of certain illegal drugs and prescription medications.

IV. PROCEDURES:

THL shall be assigned by Parole District or specialized care determined by the Health Services vendor's Regional Director of Transitional Healthcare. All performance measurements and production outcomes of the THL are under the direct guidance and supervision of the Health Services vendor's Regional Director of Transitional

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Healthcare and Health Services Division Transitional Healthcare Department. The THL shall be responsible for meeting the following the outlined performance measures:

A. Caseload Management:

The THL shall be responsible for maintaining an updated caseload roster using the designated Department's caseload monitoring system.

The caseload monitoring system shall be housed at a location assigned by the Executive Director of Transitional Healthcare. Each THL is required to use the same caseload monitoring system and they are not authorized to change the formatting of the system.

The caseload roster shall be updated within one business day of referral action. Each RC's needs shall be documented as an individual referral. At no time shall referrals be added together if individual needs are being addressed.

THL shall be responsible for ensuring that RC's information is updated and accurate

The THL shall complete 4 (four) hours of community engagement each month and report the hours to the Health Services vendor's Regional Director of Transitional Healthcare. Community engagement is defined as an entity that can or currently provides services to RCs. This is to ensure that THL make a continued effort in maintaining relationships and positive rapport by engaging with community providers of services.

B. THL Referral Process

Referrals to the THL, regardless of referral source, will be added to the Transitional Healthcare Liaison tracker and referred appropriately to services.

Referrals from Transitional Healthcare Facilitators shall be in accordance with HCSD 5.01A, "Transitional Health Care Pre-Release Continuum of Care."

The following shall be reviewed for referrals received in accordance with HCSD 5.01A:

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1. Ensure RC was released with all prescribed medications in accordance with HCSD 2.15, "Medication Management."
 - a. THL shall contact the Transitional Healthcare by close of business day of notification if medications were not received.
 - b. THL shall contact the Transitional Healthcare Department with questions regarding the status of the RC's health care coverage in accordance with HCSD 5.02A, "Healthcare Application Process."
 - c. THL shall follow up the status of Medicaid application completed while the RC was incarcerated within one week of release.
 - d. THL shall contact the Transitional Healthcare Department regarding any issues with activating health care coverage. A referral to a Community Navigator may be required.
 - e. Any additional food assistance, disability benefits, or childcare assistance applications shall be followed-up as needed within one week of release.
 - f. The THL shall be responsible for triaging referral to a "Traditional" or "Emergent" referral.

2. Traditional Referrals

Any returning citizens with the known following concerns:

- a. Domestic violence situation
- b. Recent death in the family
- c. Loss of employment
- d. Noticeable or verbalized presence of life stressors
- e. Possess protected health concerns
- f. In active crisis mode
- g. Any areas in which the returning citizen is at-risk for reoffending
- h. Testing positive for a prescription medication without a prescription
- i. Known behavioral health code of B or C at time of release
- j. If a returning citizen is pregnant or becomes pregnant
- k. Known self-report of a history of any mental illness
- l. Known report of substance use history
- m. F behavioral health code

3. Emergent Referrals

- a. Known behavioral health code D, E, or F at time of release;
- b. Known physical health code of B or F at time of release;

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- c. Any disability code other than A
- d. Positive UDS for any illegal substances;
- e. Physical Health needs requiring life determinant medication or skilled care;
- f. Behavioral health needs that require immediate intervention;
- g. Classified as special needs SNI per HCSD 5.01A

C. Assessment and Triage for Services:

Once a referral is received, the THL shall assess all below concerns and identify a Triage for Services to ensure appropriate community referrals are completed. Interaction shall be documented in OCMS. The THL shall follow all laws and regulations in accordance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, which can be found online.

A triage shall, at a minimum, include the following:

1. Whether the RC is appropriate for inpatient or outpatient treatment.
2. Whether the RC needs detoxification services for substance abuse.
3. Transportation and/or housing barriers
4. Access to a birth certificate, State identification, and Social Security card.
5. Resources available to assist with goals.
6. Specific barriers identified in the RC's life.
7. Any ongoing legal issues
8. Any financial problems
9. Driver's license status.
10. Status of health care coverage.
11. Status and/or applicability of SSI/Disability
12. Family or personal relationship issues
13. Any other applicable barriers identified during the interview
14. Whether an RC self-identifies as a part of the LGBT population.

Once triage for services is completed, returning citizen shall be placed on THL caseload as INITIAL, ACTIVE, or COMPLIANT.

1. INITIAL Case Load Assignment:

If a returning citizen has been referred to a THL for services, they shall be placed on a THL Initial Referral Case Load. The THL shall connect with the returning citizen weekly for a minimum of 30 days from time of release or initiated referral. After thirty days, THL shall review the returning citizen's participation to determine what caseload is appropriate for returning citizen

2. ACTIVE Case Load Assignment:

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Any emergent referral shall be placed on the “ACTIVE Case Load.”

Special Need Individuals shall be placed under ACTIVE case load for 90 days with required weekly contact with RC. After 90 days, the THL shall review the RC’s participation in services to determine placement on ACTIVE or COMPLIANT case load.

If RC is not compliant with services or referral, RC shall remain on ACTIVE caseload for an additional 60 days with a minimum of four contacts. The RC shall remain on the ACTIVE caseload until compliance is met.

3. COMPLIANT Case Load Assignment:

- a. If a special population individual is compliant with services and referral, RC shall be moved to COMPLIANT caseload for an additional 60 days with a minimum of two contacts.
- b. If RC continues to be compliant with community referrals after 60 days, the THL shall discharge returning citizen from COMPLIANT caseload.
- c. If an RC has been compliant with a traditional referral for 30 days and has been successfully clinically discharged from all programming, and verification of that successful discharge is in writing from the service provider, they may be removed from the THL program.
- d. Successful discharges shall be documented in OCMS within 3 business days of occurrence.

B. Community Service Referrals

Once the RC has been triaged and placed on appropriate case load, THL shall complete necessary community service referrals applicable to the RC’s assessment and need.

Community service referrals shall correlate with the RC’s location, physical health, mental health, addiction recovery, and circumstantial need.

All referrals to community agencies shall include the most up-to-date information and include:

1. Current place of residency;
2. Current telephone number of releasing citizen;

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3. Specific information regarding need for referral;
4. If substance abuse related, known substance used and last time of use;
5. If for mental health services, known specific mental health symptoms; and,
6. Required documents as defined in section F.

C. Documents for THL Services

The THL shall obtain the necessary documentation as below to facilitate care coordination with community partners. THL shall coordinate signatures if face to face interaction cannot be arranged. THL shall explain each form's purpose and the importance prior to obtaining the RC's signature.

1. State Form 46729, "Authorization to Release/Request Information;"
2. State Form 55940, "Referral-FSSA Recovery Works."

D. Communication and Documentation

Should the THL receive information that an RC is not in compliance with recommended treatment, the THL shall notify the Supervising Parole Agent via email of the non-compliance within one business day and document any information that was communicated regarding the RC in OCMS, following all laws and regulations in accordance with Health Insurance Portability and Accountability Act of 1996, Public Law 104-191

Documentation in OCMS shall be completed within three business days of occurrence following all laws and regulations in accordance with Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

The following events shall be documented in OCMS:

- a. When a referral has been received;
- b. Date of Triage assessment;
- c. Completion of Triage assessment including transitional plan, submission of community service referrals, acknowledgement from RC of assessment results, and date for next follow-up;
- d. Submission of community service referrals;
- e. Monthly status of compliance with community service referrals; and,
- f. Any additional information that will enhance communication regarding the process of the RC.

All assigned goals assigned to the RCs assigned shall be completed on the SMART

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Goal template. Completion of the SMART Goal Template(Attachment) shall be monitored by the assigned THL.

E. Refusal Process

Should an RC be deemed appropriate for a referral to mental health or substance abuse treatment, they are required to adhere to the THL recommendation. Should the RC choose to refuse services, the THL shall utilize motivational interviewing techniques with a minimum of three attempted engagements. An RC can retrack a refusal at any opportunity during Parole supervision. All attempted engagements shall be documented in OCMS.

If an RC is determined as not compliant with mental health or substance abuse treatment recommendations, the THL shall inform the Supervising Parole Agent of the non-compliance for further review. Documentation shall occur in OCMS within 24 hours of occurrence following all laws and regulations in accordance with Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

F. THL Reporting Requirements for Crisis or Public Safety Concern

Should the THL feel that a true emergency exists, such as the RC is having suicidal or homicidal thoughts, and the need for law enforcement and/or medical attention is needed, they shall call 9-1-1 immediately and contact the Parole District Supervisor, Director of Parole Services, and Executive Director of Transitional Healthcare when time permits. Mandatory reporting as defined in Indiana Code 31-33-5-1 shall be followed.

G. Privacy and Security

The THL shall follow all laws and regulations in accordance to Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. The THL shall protect an RC's protected health information in verbal communication.

A hard copy file shall be created for each referred RC. The hard copy shall include all referral documents, a copy of the individual's next steps plan, and any follow-up information from providers. Hard copy files shall be kept in a locked cabinet. The hard copy file shall be in compliance with and Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

In the event hard copies are not able to be obtained, THL shall notify the Health Services Vendor's Regional Director of Transitional Healthcare for further instruction.

H. THL Conduct and Expectations for Leave of Absence:

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All THL Staff are to comply with Policy and Administrative Procedure 04-03-103, "Information and Standards of Conduct for Departmental Staff."

The THL should report any leave of absence to the Health Services vendor's Regional Director of Transitional Healthcare by email. All leaves of absence shall be documented on the THL's outlook calendar. The THL outlook calendar shall be shared with the Health Services vendor's Regional Director of Transitional Healthcare.

I. Questions or Conflicts with THL

When questions or conflicts develop, personnel are advised to obtain consultation with the Health Services vendor's Regional Director of Transitional Healthcare and the Executive Director of Transitional Healthcare.

III. APPLICABILITY:

This HCSD is applicable to all Health Services staff, Parole Services staff, Transitional Healthcare Facilitators, and Transitional Healthcare Liaisons.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date