

## **Title: Corrections Discharge Planning**

**Date: February 2007**

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**Policy:** A component of effective health care treatment planning is development of long-range goals inclusive of discharge planning. As inmates near release, the Discharge Planner will assure that inmates are involved in planning for continuity of care into their particular community setting.

**Procedure:**

- A. The Corrections Discharge Planning Process includes the following components:
1. All inmates will receive an Individual Needs Assessment at booking to include the person's medical, employment, housing, and family or support network.
  2. As appropriate, and as time allows, Discharge Planners will coordinate Pre-Release Skill Training to overcome needs or problems identified for the individual including topics such as goal setting, control of one's emotions, pre-employment skills, money management, and educational attainment.
  3. As appropriate, and as time allows, Discharge Planners will coordinate Pre-Release Qualification for Benefits possessed at the time of entrance to care or for which the person qualifies, to include restoration of civil rights, identification and supporting documentation, and mainstream human services programs such as food stamps, SSI, Medicaid, and welfare cash assistance.
  4. A written Discharge Plan will be developed and reviewed with the individual prior to the scheduled release date.
  5. Each plan will iterate appropriate referrals to community based providers for post-release services to assure the individual has appointments or action plan to obtain and continue follow up services, treatment, and care without interruption.
  6. At Discharge, provision of essential resources to include such items as medications, medical supplies, clothing, transportation or other basic resources needed and in quantity to enable the individual to transition back to the community are provided.

7. At Discharge, a notice to the planned housing provider will be sent to confirm that the person to be released is expected to arrive and occupy the available housing.
  8. The Discharge Planner will provide post-release monitoring and evaluation to track whether the individual was able to transition into the community, remain self-sufficient, and avoid becoming homeless.
  9. Composition of the discharge planning team is flexible and may include: the individual, family members, community case manager, institutional representative, community resource specialist, mental health and substance abuse specialists, housing specialist, entitlement/income specialist, criminal justice system representative, health care system representative, pay-or representative, policy maker, advocate, peer supporter.
  10. The designated team leader (community case manager) is responsible for following up with the individual to ensure the implementation of the discharge plan, including ongoing assessment, identification of team members, and coordination.
  11. Team members will utilize a well-designed information system to link the community and institution that track procedures, feature safeguards and consent agreements.
- B. A discharge plan will be developed for inmates with significant health care, mental health or housing problems that will require complex or coordinated community health care that the patient cannot arrange for themselves and supervision in the community. The Discharge Planner is available as a resource for assistance with discharge planning.

The discharge plan will include as needed:

Place of residence upon Discharge. Does the individual have access to stable housing options upon release so as to avoid homelessness? Where no stable housing is identified or available other than to emergency shelters, assure referral to the local homeless coalition for assistance in sheltering the person.

Transportation Need. Does the individual need transportation assistance to their place of residence upon discharge back to the community?

Aftercare Referrals. What follow up care or services does the individual need after release, and to what agencies or providers has the individual been referred for services?

Resources Provided at Discharge. What medications, medical supplies, clothing, transportation, or other basic resource needs, will the individual be provided at the time of discharge?

Eligibility for and enrollment for Benefits upon Discharge. What programs of assistance does the individual need upon release, has the individual's eligibility been determined for services, and has the individual been approved for receipt of the benefits prior to discharge?

Employment. Does the individual have a job placement secured upon release, or, if not, what referrals or assistance have been arranged for the individual on discharge?

Identification and Documentation. Has the individual been provided with personal identification paperwork, and copies of back-up documentation to support such identification, such as birth records, Social Security Number, and copies of back-up documentation to support such identification, such as birth records, SSN, and resident status?

Risk Assessment for Homelessness. Given the availability of stable housing, employment, and the need for after care treatment or services, is the individual at-risk of becoming homeless upon discharge? What efforts should be made to link the individual to the community's homeless services network?

Support Network. Does the individual have family, friends or other support entities to assist him/her in transitioning back into the community? Have these support persons or entities been participating in creating the discharge plan?

Post Release/Discharge Actions. Will there be follow up contact or services provided to the person after discharge to help adjust their plan as needed? Does the agency evaluate the effectiveness of the discharge plan on the individual's success in transitioning back into the community?

- C. Discharge orders will be written by the Discharge Planner or assigned practitioner for patients who are being released and require prescription medication for the continuing treatment of chronic illness. Inmates will receive up to a 30-day supply of

medication when adequate notification of pending release has been received by the Pharmacy. Adequate notification is at least five (5) working days. If the assigned practitioner has not written discharge medication order(s), a discharge supply may be dispensed per an existing valid order.

- D. Patients who are being released and are receiving medication(s) for an acute illness may take their medication cards to complete the course of therapy consistent with accepted medical practice.
- E. Should an inmate have an acute health care need present at discharge, health care staff will assure that the appropriate level of care is available to the inmate at release, inclusive of the need for hospitalization.
- F. Prior to release, the inmate will meet with discharge staff and be provided with verbal and written discharge care instructions. The importance of proper follow-up aftercare will be stressed. A copy of the discharge planning documents will be kept in the health care record. See attached documents.
- G. Time Frames for Discharge Planning. Discharge planning begins upon entrance to the facility, beginning with a needs assessment. The individual Discharge Plan will be prepared and presented to the individual at least \_\_\_ days prior to the planned release date or exit. NOTE: Number of days to be set based on population being discharged. Post-release monitoring and evaluation shall be completed at a minimum of 30 days following release, and at 6 months following the date of release.

Effective Date: \_\_\_\_\_

TO: (INSTITUTION NAME)

FROM: \_\_\_\_\_(Name of Inmate)

SUBJECT: NEED FOR ONGOING/FOLLOW-UP

It has been explained to me that I have \_\_\_\_\_

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(Name of Condition)

which requires medical follow-up. I understand that the recommended follow-up includes:

- 1.
- 2.
- 3.

I assure Institution Name Services that I will be responsible for seeking services in the community. I understand that before the supply of medication provided by the Department of Corrections is depleted, I must see a community practitioner for renewal of the medicine. I understand that I am financially responsible for the health care services I seek.

I am aware that with a signed release of information, copies of pertinent medical records will be mailed free of charge to my new health care practitioner.

I have been given a copy of this memo so that I may refer to it and follow through with the recommended care.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

Please Print  
Name: \_\_\_\_\_

Witness: \_\_\_\_\_  
Department of Corrections Health Care Provider

Witness: \_\_\_\_\_

Dear

This letter is to notify you that you have a health/mental health care condition that warrants further medical follow-up.

You were scheduled for a follow-up appointment for \_\_\_\_\_ however you were released from (Institution Name) prior to this appointment. You should contact your private physician for follow-up care as soon as possible.

In order to have your medical records sent to your physician, you must sign a release of information at your physician's office. No medical records can be released until we receive this form.

Please remember you are financially responsible for this appointment.  
If you have any questions, you may phone the (Institution Name) Clinic at (Phone Number).

Sincerely,

Discharge Planner