MONTANA DEPARTMENT OF CORRECTIONS

MONTANA STATE PRISON
HEALTH SERVICES OPERATIONAL PROCEDURE

Procedure No.: MSP HS E-10.0	Subject: **DISCHARGE PLANNING**	
Revised: NCCHC Standard P-E-10, 2018, HS D-02.6 Discharge Medications, DOC 4.6.7 Medical Parole		Page 1 of 3 and 5 attachments
Effective Date: November 1, 2010		Revised: October 1, 2020
Signature / Title: /s/ Cindy Hiner / /Medical Bureau Chief		
Signature / Title: /s/ Paul Rees M.D. / Medical Director		

I. PURPOSE

To offer discharge planning to inmates with serious health needs upon notification of their imminent release (discharge, probation parole, etc.).

II. DEFINITIONS

Discharge planning – the process of providing sufficient medications and arranging for necessary follow-up health services before the inmate's release to the community.

Health care staff – includes qualified health care professionals and non-licensed health care staff (e.g., medical records staff, health care aides) responsible for offender health care administration and treatment.

III. PROCEDURES

A. General requirements

1. Health Care Staff will initiate a discharge plan for an inmate with medical, dental or mental health conditions when notified of the inmate's anticipated release. If adequate notification is not provided, health care staff still have the responsibility to ensure that continuity of care is extended into the community for that inmate.

2. The designated Clinical/Mental Health Services Discharge Planner, in consultation with a Qualified Healthcare Professional, will review current Medial Points assigned to each offender who is either paroling or discharging their sentence.
   a. Inmates who have been assigned 40 or more Medical Classification Points or a Mental Health Code of 3-4 will receive a discharge plan that will include as needed: referral to a community agency, supervised aftercare plan/housing or a community clinician; an exchange of clinically relevant information with the community resource, assistance in application for SSDI, SSI and Medicaid insurance benefits if necessary, a Clinical Services Discharge Summary, a 30-day supply of medications (HS D-02.6), medical equipment defined by condition, and a 30-day supply of medical supplies, as appropriate.
   b. Inmates who have been assigned 20-30 Medical Classification Points or a Mental Health Classification Code of 2 will receive a discharge plan that will include as needed: referral to a community agency or clinician, as appropriate, and an exchange of clinically relevant information with that resource, assistance in application for SSDI,SSI and Medicaid insurance benefits, a Clinical Services Discharge Summary, and a 30-day supply of medications.
   c. Inmates who have been assigned no more than 0-10 Medical Classification Points or a Mental Health Code of 0-1 will receive a discharge planning packet that will include as needed: a list of community agencies or clinicians, a discharge summary, a 30-day supply of medications,

and instructions for access of health records.

d. All medications will be provided in a child-proof container.
e. If an inmate is released without essential prescribed medication, the medication will be mailed to the inmate at the address given to the pharmacy. Inmate addresses can be found on the discharge paperwork from the MSP IPPO office.
f. The unit case manager, IPPO staff, and the designated Clinical/Mental Health Services Discharge Planner are available as a resource for assistance with discharge planning.
g. All discharging inmates will be given a written document that details contact information for the MSP Records Department and the process for accessing their health records after discharge into the community.

3. Prior to release, the designated Clinical/Mental Health Services Discharge Planner will provide inmates with discharge health care instructions.
   a. Inmates who have been assigned 40-50 Medical Classification Points or a Mental Health Code of 3-4 will be scheduled by the Clinical/Mental Health Services Discharge Planner to discuss verbal and written discharge instructions.
      1) Discussion with the inmate will emphasize the importance of appropriate follow-up care and the recommendation for community follow-up care, as needed.
      2) When an inmate is being released with a reportable disease or other serious medical need the designated Clinical/Mental Health Services Discharge Planner will refer the inmate to the Montana Department of Public Health and Human Services, as required by public health laws, or specialized clinics and community health providers. An exchange of clinically relevant information will be communicated to the community provider or DPHHS via fax or electronic transferring of records at the time the appointment or referral is made.
      3) When appointments with community providers are made prior to discharge; the inmate will be provided with written instructions for the appointment/s including; date, time, name of provider, and address of provider with telephone contact number will be given to the inmate as part of the discharge plan.
      4) The designated Clinical/Mental Health Services Discharge Planner will confirm all scheduled community appointments prior to the discharge date and give the community provider any known contact information for the discharging inmates. i.e. known discharge address or telephone number.
      5) The designated Clinical/Mental Health Services Discharge Planner will assure that the community provider has all necessary and relevant medical information.
   b. The designated Clinical/Mental Health Services Discharge Planner will provide written discharge instructions to inmates with less than 40 Medical Classification Points or a Mental Health Code of 2 or less.
   c. Discharging inmates will receive a 30-day supply of current medications and information concerning access of health records.
4. All aspects of the medical discharge process will be maintained in the Inmate's health record.
5. An inmate may refuse any part of the discharge plan. A refusal of treatment form will be signed by the inmate and witnessed by an MSP staff member. It will include detailed specifics of the refusal. Refusals will be in accordance to with *DOC 4.5.32, Right to Refuse Medical Treatment*.

IV. CLOSING

Questions concerning this operational procedure will be directed to the Clinical Services Manager

V. ATTACHMENTS

MSP Clinical Services Discharge Summary form	attachment A
Health Information Request to Release Records (Release of Information)	attachment B
Clinical Services Discharge Form	attachment C
Mental Health Codes	attachment D
Medical Classification/Points	attachment E

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MSP Clinical Services Discharge Summary
NEED FOR FOLLOW-UP CARE

Name of Inmate: _____

It has been explained to me that I have _____

_____

_____
(Name of Condition)

which requires medical follow-up with a health care provider. I understand that the recommended follow up includes:

1.

2.

3.

I understand that I am responsible for seeking health care 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 medication. I understand that I am financially responsible for the health care services that I seek.

SIGNED:_____DATE:_____

Printed Name:_____

Witness:_____
(DOC Health Care Provider)

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Health Information Request to Release Records

Patient Name: _____

DOC ID/AO Number: _____

Date of Birth: _____

Social Security Number: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. All health care information in your possession, whether generated by you or by any other source, may be released to me or to _____ [name person] for:

_____

_____

[purpose of the disclosure].

3. Covering the period(s) of healthcare:

From (date) _____ to (date) _____

From (date) _____ to (date) _____

4. Information to be disclosed:

☐ Discharge Summary	Progress Notes	☐ Operative Notes
☐ History & Physical	☐ Laboratory Tests	☐ Pathology Report
☐ Consultation Reports	☐ Emergency Room Report	☐ X-ray/imaging Reports
☐ Immunization Record	☐ Complete Health Record	
☐	☐	

Other (please specify) _____

5. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV)or Hepatitis A, B or C. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

6. The revocation is effective from the time it is communicated to the health care provider, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization is valid for up to 30 months from the date of execution below. If no expiration is specified this authorization will automatically expire six (6) months from the date of signing. This authorization does not permit the release of health care information relating to health care that the patient receives more than 6 months from the date of execution below. Mont. Code Ann. §50-16-527.

7. The Montana Department of Corrections, Montana State Prison, its health care providers, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information pursuant to the Uniform Health Care Information Act, Mont. Code Ann. §50-16-501 through §50-16-553 or the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d..

8. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____/_____/_____

Signature of patient or patient's representative — Date

_____

Relationship to the patient

_____ _____/_____/_____

Witness — Date

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Montana State Prison
Clinical Services Discharge Form

NAME:_____ DOC ID#_____
Last First

DATE OF DISCHARGE:_____ DATE FORM INITIATED:_____

MEDICAL RECORD ACCESS LETTER GIVEN: YES/NO MEDICAL RECORDS STAFF INITIALS:_____

MEDICATION BOTTLES/BLISTER PACKS ISSUED: YES/NO PHARMACY STAFF INITIALS:_____

WRITTEN PRESCRIPTION WRITTEN (AS NEEDED): YES/NO DISCHARGE PLANNER INITIALS:_____

DATE TO TRANSPORTATION:_____ PHARMACY STAFF INITIALS: _____

MEDICAL PACKET RECEIVED: YES/NO
TRANSPORTATION STAFF INITIALS:_____ PHARMACY STAFF INITIALS: _____

MEDICATIONS RECEIVED: YES/NO
TRANSPORTATION STAFF INITIALS: _____

DISCHARGE SUPPLIES: ☐ **wheelchair** ☐ **diabetic supplies** ☐ **walker** ☐ **none**

☐ **other medical supplies:** (list)_____

_____

INMATE SIGNATURE:_____DATE:_____

(By signing above, you verify that you have received your medical packet and all of your medications as indicated by stickers below)

WERE MEDICATIONS MAILED TO DISCHARGE ADDRESS: YES/NO STAFF INITIALS: _____

PLACE MEDICATION STICKERS IN THIS AREA

Please route COPY of completed form to Discharge Planner
Please route ORIGINAL completed form promptly to medical records

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Mental Health Codes

Code	Diagnosis?	How are they currently doing?		How are they managing symptoms?
0	N	No evidence of MH needs	----	----------
1	Y	Has history of MH issues OR has current MH symptoms but is stable	OR	High Degree of symptom management
2	Y	Mild impairment/needs	OR	Properly managing significant symptoms
3	Y	Moderate impairment/experiencing significant symptom severity/needs	OR	Typically, cannot function in the general population for extended periods of time and requires on-going mental health monitoring
4	Y	Acute symptoms severity/needs	___	May be danger to self/others or may be substantially unable to care for self

Modifier	Meaning	Examples
C	Cognitive Impairment	Dementia, FASD, Developmental Disorders
P	Psychotic Disorder	Not oriented to reality, hallucinations, delusions (Many times comes with an "S" criteria as well)
M	Mood Disorder	Depression, Bipolar
A	Anxiety Disorder	PTSD, Anxiety, Acute Stress Disorder
PD	Personality Disorder	Antisocial, Borderline, Narcissistic, Histrionic (May not be picked up on initial assessment)

*Primary issue/diagnosis/concern = which modifier to use

Temporary (T) = Want to staff more or get more records but have a very strong inclination of some kind of specific disorder. May need further evaluation.

Acute Symptoms = Highly impact ability to function on a daily level. (Example: Hearing voices)

S: Meets Serious Mentally Ill (SMI) criteria (Page 1)

N: Does not meet SMI criteria

Qualified Mental Health Provider: _____ Date/Time: _____

Assigned MH Code: _____ Entered into OMIS? Y / N

Attachment: C

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Medical Classification/Points

50 points - MSP placement or facility approved by DOC Medical Director

Inmate has:

1. disabling physical condition requiring periodic infirmary care
2. elderly or one or more unstable chronic illness
3. unstable chronic disease requiring physician services every 2 to 4 weeks
4. requires significant nursing resources
5. pending surgery or current intensive medical management (Cancer, HIV or HEP C treatments)

40 points - MSP or CCC/Shelby placement is acceptable

Inmate has:

1. orthopedic problems that may require frequent intervention/physical therapy
2. chronic disease and/or condition requiring on-going services or frequent monitoring

30 points - MSP, CCC/Shelby, or Great Falls Regional Prison

Inmate has:

1. stable chronic medical conditions or requiring minimal monitoring

20 points - MSP, CCC/Shelby, Great Falls Regional, or Dawson County Correctional Facility

Inmate has:

1. orthopedic or gastric problems which may require meds or braces but not physical therapy or Surgery

10 points - MSP, CCC/Shelby, Great Falls Regional, Dawson County Correctional Facility

Inmate has:

1. good health or minor health related problems

** Dawson County cannot accept insulin dependent diabetics*