SUBJECT: CONTINUITY OF CARE – MEDICAL SERVICES

APPLICABILITY: Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) Continuity of Care staff, Human Service Specialists (HSS) and Special Needs Case Managers (SNCM).

PURPOSE: To provide guidelines regarding medical continuity of care services for identified clients releasing from prisons and state jails, those under community supervision (probation and/or parole), and provide technical assistance regarding those clients in a county jail.


DISCUSSION: Continuity of care (COC) is the identification of medical, psychiatric, psychological, educational, or rehabilitative service needs that allows for the development and coordination of a plan for the treatment, care and services between various agencies for clients with special needs to allow for medical services to continue in the community.

TCOOMMI provides multiple service types within the medical COC domain that provide for a coordinated approach to meet medical needs. In addition to pre- and post-release COC service coordination for conditions such as oxygen dependence, oncology treatment transition, and synchronization of other medical requirements due to a significant medical condition, placements for nursing homes, group homes and assisted living facilities are accomplished by COC staff. Medical COC staff also work closely with the Medically Recommended Intensive Supervision (MRIS) unit, as applicable, to ensure clients receive appropriate screening based on their current incarceration status.

PROCEDURES:

I. Referrals and Screening

A. Referrals for TCOOMMI medical continuity of care services come from multiple sources, both internal and external. Internal referrals may be received from medical staff on a Correctional Institutions Division (CID) unit, other Divisions, through listings generated by TDCJ -
Information Technology Division (ITD) and TDCJ Health Services Divisions contracted medical providers, or supervising parole or CSCD officers for example. External referrals may be received from sources such as family members, elected officials, social service agencies, or attorneys.

B. Upon referral or notice that a client may be in need of services, a review must be conducted for eligibility screening purposes. COC staff will review the following for additional information:
   1. TDCJ mainframe data system to determine the client’s current release eligibility status. The offender must be within 90 days of release to be eligible for medical COC services;
   2. TDCJ Electronic Medical Record (EMR) for current diagnoses, the most recent medical provider’s post release COC recommendation, and, if available, the client’s medical Individualized Treatment Plan (ITP);
   3. TCOOMMI Web Application (Web App) for medical referral(s) and status. An existing referral will contain the International Statistical Classification of Diseases and Related Health Problems diagnoses (ICD-10 code);
   4. If incarcerated, current unit job and housing assignment history may be reviewed for additional information as needed to determine eligibility; and
   5. If under Parole supervision, the client’s Offender Information Management System (OIMS) record may be reviewed.

C. Should the client’s release status, current medical provider COC recommendation and diagnoses indicate eligibility for services, COC staff will categorize those clients using the offender service type categories as identified by TDCJ – Health Services Division (Attachment A).

D. If a client is determined not eligible for COC services, notification is to be provided to the original referral source. Additionally, for those clients who have a qualifying medical issue but are not eligible due to no scheduled parole, mandatory supervision, or flat discharge date within 90 days, the case will be evaluated for referral to the Medically Recommended Intensive Supervision (MRIS) program for their review and action (refer to PGP-01.04, Medically Recommended Intensive Supervision).

II. Pre-Release Service Coordination

A. If referral and screening identify a client with a pre-release COC need, client functional limitations will determine the level of COC service needed. Those clients with medical provider identified functional limitations require additional coordination with unit medical staff, other divisions, and post release services based upon the recommendation from the client’s current medical provider.
B. For all clients, regardless of functional limitation, an e-mail notice of referral (Attachment B) will be sent to the SNCM allocated to the client’s current unit of assignment to develop the Individual Reentry Plan (IRP) addressing the treatment, care and service needs of the client regarding post release community services. Should there not be a SNCM assigned to that unit, a Web App referral will be sent to the designated HSS for the development of the plan.

C. The SNCM, or HSS as applicable, will also be responsible for assisting the client with the completion and submission of the benefits application as appropriate in accordance with PGP-02.05, Special Needs Case Management.

D. Clients without functional limitations will only need the IRP developed as they do not have restrictions associated with their diagnosis and will not need additional services to facilitate release or transport.

E. The SNCM, or HSS as applicable, will be responsible to coordinate linkage for home health care, hospice, ongoing oxygen dependence needs, dialysis, wound care or ongoing acute care for significantly/terminally ill clients.

F. On a case by case basis, an assignment will be made by the COC Supervisor to the HSS responsible for nursing home or group home placement for those clients that have this requirement authorized by the medical provider.

III. Release Preparation

A. The SNCM, or HSS as applicable, assigned to the client’s case is responsible to ensure the approved release home plan sponsor is aware of the needs and requirements associated with the client’s medical condition. By ensuring awareness, a smooth transition can be made with limited changes to the client’s home plan after release.

B. Prior to initiating contact, The SNCM, or HSS as applicable, will ensure the client has signed a release of Protected Health Information (PHI) for the listed release plan sponsor. A new PHI will be required if there is no existing PHI or the PHI on file is older than six (6) months.

C. The SNCM, or HSS as applicable, will make contact with the sponsor to ensure the release plan sponsor is aware of the client’s current medical condition, is aware of and able to meet the client’s needs, and is able to coordinate any additional services as needed.

D. For those client’s releasing to Parole supervision with no identified release plan, the SNCM, or HSS as applicable, will request a plan from the client or work with the client to develop a plan for investigation by the Parole Division. The information noted below will be entered into the OIMS Residence screen:
1. Client’s name,
2. Client’s TDCJ number,
3. Residential address,
4. Sponsor name, and
5. Phone number for contact person.

E. For those clients releasing after completion of their sentence, also known as a flat discharge, the SNCM, or HSS as applicable, will submit a residential plan containing the same information as noted in Section II. D. above via e-mail to CID - Field Services. If a SNCM or the Reentry Case Manager for that unit assisted an HSS in the release preparation, they will be copied as well.

F. Prior to the scheduled date of release, the SNCM, or HSS as applicable, will verify that medication is available so that the client will release with the required thirty (30) day supply of medication. If the medication supply will not be ready at time of release, a request will be made to have the medication sent to the client’s release plan.

G. On the scheduled date of release the SNCM, or HSS as applicable, will contact the sponsor to verify the client’s arrival. If the client is released on parole supervision, the HSS or SNCM will transfer case management to the designated field HSS for post release case management.

IV. Post Release Case Management

A. Within three (3) working days of receipt of the client’s case, the post release HSS is responsible to contact the assigned supervising officer to verify the client’s contact information, exchange information regarding the client’s home plan and conditions of release and, if applicable, provide information regarding any client service/treatment appointments.

B. The HSS is to inquire as to status of benefits and, if eligible but not applied for, provide benefit assistance by initiating appropriate applications. If already submitted, the HSS is to conduct monthly status checks of previously submitted applications until such time as a decision has been rendered. Results of status checks are to be reported to the TCOOMMI mailbox at tcoommi@tdcj.texas.gov and documented in the Web App.

C. No later than five (5) working days following release and monthly thereafter, the HSS will conduct a face-to-face contact with the client if the client resides within the travel radius established by the TCOOMMI Manager. If outside the established radius, contact with the client is to be telephonic. Monthly, the HSS is to contact the client’s supervising officer and social worker (if assigned) to discuss the case, provide/obtain updates and determine the client’s need for ongoing services and/or treatment. All contacts are to be documented in the TCOOMMI Web Application within three (3) working days.
D. Should notice be received that a client has been arrested, the HSS is to contact the custody location to verify custody status, provide the custody location the most current medical records and the HSS’s contact information. The HSS is to monitor custody status and in the event the client is to released back to community, coordinate linkage to appropriate community resources.

E. Each case will be evaluated regarding ongoing benefit assistance, human services provided, and continued case management needs at thirty (30) days and sixty (60) days after release to ensure the client still requires on-going medical COC case management services.

F. In the event a client has a need to transfer to another location, the HSS is to contact the supervising officer for status of transfer. If the supervising officer indicates that a transfer is acceptable, the HSS will contact the HSS in the destination area in order to coordinate services. Information regarding lack of services in the destination area must be reported to the supervising officer as this could impact the ability to transfer. Upon notice of approved transfer, the receiving HSS is to make contact with the client within two (2) working days.

G. Medical COC services are only authorized for a ninety (90) day period after release. Cases may be closed prior to ninety (90) days if all medical continuity of care needs are met. Inversely, cases may be authorized for services beyond the standard ninety (90) days by the TCOOMMI Manager if there are continued unmet needs that require HSS assistance. The Web App is to be updated within one (1) working day of case closure.

H. Nursing home cases are not subject to the ninety (90) day standard service period and will remain open until the client’s release from the nursing home, discharge of sentence, or death.

I. Should a client receive COC case management in excess of one (1) year (i.e. nursing home placements, extended COC services), the HSS is to conduct an electronic review of the OIMS record on a quarterly basis to evaluate the client need for ongoing services.

April Zamora, Director
TDCJ – Reentry and Integration Division
CLIENT SCREENING CATEGORIES

ELDERLY
Means an offender sixty-five (65) years of age or older.

INTELLECTUAL DISABILITY
Has the meaning assigned by Section 3, MRPA of 1977 (Article 5547-300, VTCS) and means significantly sub-average intellectual functioning existing concurrently with deficits in adaptive behavior and originating in the developmental period (until the age of 18).

LONG TERM CARE
Means a person who is deficient in the area of self-care and where there is a reasonable medical probability that the clinical condition(s) producing that inability will not change over time and requires nursing care.

MENTALLY ILL
Has the meaning assigned by Section 4, Texas Mental Health Code (Article 5547-4, VTCS) and means an illness, disease, or condition that either substantially impairs a person’s thoughts, perception of reality, emotional process, judgment, or grossly impairs a person’s behavior, as manifested by recent disturbed behavior.

ORGANIC BRAIN SYNDROME
Any of a group of acute or chronic syndromes involving temporary or permanent impairment of brain function caused by trauma, infection, toxin, tumor, or tissue sclerosis, and causing mild-to-severe impairment of memory, orientation, judgment, intellectual functions, and emotional adjustment.

PERSISTENT VEGETATIVE STATE
A condition of profound non-responsiveness in the wakeful state caused by brain damage at any level and characterized by a nonfunctioning cerebral cortex, absence of response to the external environment, akinesia, mutism, and inability to signal.

PHYSICALLY HANDICAPPED
A severe, chronic disability that is likely to continue indefinitely and results in substantial functional limitations in three or more of the following areas of major life activity: self care, self-direction, learning, receptive and expressive language, mobility, capacity for independent living, or economic self-sufficiency. These limitations are reflected in the person’s need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services of extended or lifelong duration that are individually planned and coordinated.

TERMINALLY ILL
Is a condition which is incurable and would inevitably result in death within six (6) months regardless of life sustaining treatment and requiring skilled nursing care, hospice or home health care.

Note: Definitions as reflected in Correctional Managed Health Care (CMHC) Policy A – 08.6
From: Jennifer Hanfelt
Sent: Wednesday, August 15, 2018 5:44 PM
To: Brittney Castille (Brittney.Castille@tdcj.texas.gov) <Brittney.Castille@tdcj.texas.gov>
Cc: Jacqueline Dennis (Jacqueline.Dennis@tdcj.texas.gov) <Jacqueline.Dennis@tdcj.texas.gov>
Subject: TCOOMMI Parole Release Referral – J. Offender #1234567

Offender: Offender, Joe
TDCJ #: 1234567
SID#: 07654321
Unit of Assignment: GC
Parole Vote: FI-1

Known Case Management Needs: SSA review, release plan confirmation, community medical resources

The above offender is TCOOMMI eligible for pre-release and post-release services. This offender may have already completed the beginning stages of Reentry case management; however, the offender will be wrapped into appropriate TCOOMMI program services based on individual need.

If housing assistance is needed for this offender (i.e. the offender states they have nowhere to live upon their release to community supervision), please obtain community housing needs for the offender after discussion with the unit medical provider regarding medically appropriate post-release housing needs (i.e. Nursing Home, Group Home, 24-Hour Family Care, wound care, etc.). NOTE: Offender’s often have family to return to; obtain a contact name, address and phone number, if possible. PHI must be signed by the offender prior to arranging family/friend placements or sharing of information.

If family residence is not an option and unit medical indicates the offender is unable to live without assistance post-release, an email will be sent to the appropriate TCOOMMI Pre-Release HSS for assistance with Group Home or Nursing Home with the TCOOMMI Program Supervisor II, TCOOMMI Program Supervisor, and appropriate Regional Supervisor copied.

For offenders with mental health concerns needing outpatient services, an email shall be sent to TCOOMMI Program Specialist I requesting post-release services and an appointment be set with a local LMHA. In determining mental health needs, always check EMR and MH00 for a CARE match.

For offenders diagnosed with HIV, an email shall be sent to the TCOOMMI HIV Program Supervisor, with a copy to the Regional Supervisor, requesting TCOOMMI HIV services for the offender.

Program Supervisor V – Continuity of Care
Reentry and Integration Division/TCOOMMI
Texas Department of Criminal Justice
4616 W Howard Lane, Ste. 200
Austin, Texas 78728
(512) 671-2116
Fax: (512) 671-2560

The information contained in this electronic email and any attachments is intended for the exclusive use of the addressee(s) and may contain confidential, privileged, or proprietary information. Any other interception or use of these materials is strictly prohibited. This email may not be forwarded outside the Texas Department of Criminal Justice Office of the Reentry and Integration Division without the permission of the original sender. If you have received these materials in error, please notify me immediately by telephone and destroy all electronic, paper, or other versions.