	DEPARTMENT OF CORRECTIONS AND REHABILITATION CORRECTIONS ADMINISTRATION POLICY AND PROCEDURES	EFFECTIVE DATE: January 01, 2024	POLICY NO.: COR.10.E.10
		SUPERSEDES (Policy No. & Date): COR.10.1E.10 (03/09/10) and COR.10.1D.08 (07/28/09)	
	SUBJECT: DISCHARGE PLANNING		Page 1 of 6

1.0 PURPOSE

The purpose of this policy is to ensure that discharge planning is provided for incarcerated individuals with serious health needs whose release is imminent.

2.0 SCOPE

This policy and procedure shall apply to all correctional facilities and their assigned personnel.

3.0 REFERENCES, DEFINITIONS & FORMS

.1 References

a. Hawaii Revised Statutes, Section 26-14.6, Department of Public Safety; Section 353-A, Director of Corrections and Rehabilitation, Powers and Duties; and Section 334-59, Emergency examination and hospitalization.

b. Standards for Health Services in Prisons. National Commission on Correctional Health Care, (2018).

c. Standards for Health Services in Jails. National Commission on Correctional Health Care, (2018).

d. Standards for Mental Health Services in Correctional Facilities. National Commission on Correctional Health Care, (2015).

.2 Definitions

a. Discharge Planning: The process of providing a reasonable supply of current medications and/or prescriptions for short-term continuity of care upon release and arranging for necessary follow-up health services before the incarcerated individual's release to the community.

b. Reasonable Supply: A quantity of medications and/or prescriptions to allow the incarcerated individual time to arrange for follow-up in the community. The quantity of medications provided to the incarcerated individual shall not exceed thirty (30) days, except as approved by the Medical Director, Physician Manager, or Psychiatrist Manager.

.3 Forms

a. DCR 0576, Mental Health Discharge Plan.

b. DCR 0574, Authorization to Release Medical Information.

c. DCR 0577, Request for AMHD Eligibility Status.

d. DCR 0561, Eligibility Determination.

e. DCR 0579, Mental Health Status Report.

f. DCR 0588, Medications Packaged in Non-Childproof Containers

g. Patient Medical Summary (generated through EMR)

4.0 POLICY

.1 For planned discharges, health care professionals offer discharge planning to incarcerated individuals who have been identified with serious health needs and whose release is imminent.

.2 Discharge planning for incarcerated individuals with serious health needs may include the following:

a. Formal linkage between the facility and community-based health organizations.

b. A referral list of community-based health resources.

c. An incarcerated individual education session or discussions that emphasizes the importance of appropriate follow-up and aftercare.

d. Arrangement for follow-up health services before an incarcerated individual's release.

e. Timely exchange of clinically relevant health information (e.g., problem lists, medications, allergies, procedure, and test results), with community-based providers.

f. A facility process for assisting incarcerated individuals with health insurance applications prior to release.

g. A reasonable supply of currently prescribed medications and/or prescriptions, as clinically-indicated, provided to the incarcerated individual at the time of release.

.3 All aspects of discharge planning are documented in the health record.

5.0 PROCEDURES

.1 Upon identification of an incarcerated individual with serious health needs and a pending release date, health care professionals begin the process of a planned discharge. The Qualified Mental Health Professional (QMHP) initiates the Mental Health Discharge Plan [DCR 0576].

.2 Health care professionals complete the Authorization to Release Medical Information form [DCR 0574] with the incarcerated individual in order to communicate with community organizations, agencies, and/or professionals who will be involved in the discharge plan.

.3 With the incarcerated individual's written authorization to release health care information, health care staff:

a. Contacts community-based health organizations, agencies, and/or professionals to formally connect the incarcerated individual with community-based health services. The QMHP contacts the Adult Mental Health Division (AMHD) of the Department of Health to link eligible incarcerated individuals with serious mental health needs by faxing the Request for AMHD Eligibility Status form [DCR 0577] and the DOH Authorization for Use or Disclosure of Protected Health Information (PHI) form. For incarcerated individuals who are not identified AMHD consumers and currently meet AMHD eligibility criteria for mental health services, the QMHP and/or the LMHP administers and completes the Eligibility Determination form [DCR 0561].

b. Coordinates discharge planning with correctional staff, DOH, DHS, the Probation Office, the Hawaii Paroling Authority, and the community-based agency, facility, case manager, and/or provider, as applicable. Upon written request by the Hawaii Paroling Authority, the QMHP completes the Mental Health Status Report, (a.k.a., the FLO), [DCR 0579].

c. Schedules follow-up appointments with community providers prior to an incarcerated individual's release.

d. Provides continuity of care with the timely exchange of health information with community-based providers.

e. Works with community-based case managers in establishing therapeutic relationships with incarcerated individuals in preparation for release and in preparing incarcerated individuals for re-entry to the community.

f. Assists incarcerated individuals with the facility process for health insurance applications (e.g., notify facility case management or request DHS or other participating entity dispatch an insurance navigator to the facility).

.4 Health care professionals provide incarcerated individuals, who have been identified with serious health or mental health needs, with a list of community-based health resources. Health care professionals refer incarcerated individuals to specialized clinics or community-based health or mental health professionals, or arrange for direct admission to a community/psychiatric hospital, as clinically-indicated (see also HRS 334-59, Emergency Examination and Hospitalization).

.5 Prior to release from DCR custody, health care professionals provide education to incarcerated individuals with serious health or mental health needs about the importance of medication adherence, treatment needs and appropriate follow-up care.

.6 Upon release from DCR custody, health care professionals provide a copy of the Patient Medical Summary, as a written continuity of care document, to incarcerated individuals with serious health or mental health needs. The QMHP completes DCR 0576 for incarcerated individuals with serious mental health needs.

.7 At the time of release, health care professionals provide a reasonable supply of currently prescribed medications and/or prescriptions, as clinically indicated, to the incarcerated individual with serious health needs. The amount of currently prescribed medication supplied to the incarcerated individual is sufficient to carry the incarcerated individual to the first appointment with a community-based provider and not in excess of thirty (30) days, except as approved by the Medical Director, Physician Manager, or Psychiatrist Manager for the purpose of continuity of care.

a. For planned discharges, the facility shall notify the Medical Unit at least five (5) days prior to the scheduled release of an incarcerated individual to

ensure the timely delivery of prescribed medications by the pharmacy. The Clinical Services Administrator (CSA) or designee shall inform the pharmacy of the incarcerated individual's pending release to allow the prescription to be dispensed in a childproof container.

b. By the date of the incarcerated individual's scheduled release, prescribed medications shall be delivered in a sealed envelope or box to the facility staff assigned to issue property to the incarcerated individual upon release from custody. Any medication not issued to the incarcerated individual at the time of release shall be returned to the Medical Unit.

c. When the facility notifies the Medical Unit less than five (5) days prior to the scheduled release of an incarcerated individual and there is insufficient time for the pharmacy to deliver a childproof container, the incarcerated individual shall be issued the remainder of their prescribed medication in blister pack form upon release from custody. The QHCP shall educate the incarcerated individual on their responsibility to keep the medications secured and inaccessible to children. The incarcerated individual shall sign the Medications Packaged in Non-Childproof Containers form (DCR 0588).

d. When the facility notifies the Medical Unit less than five (5) days prior to the scheduled release of an incarcerated individual and there is insufficient time for the pharmacy to deliver prescribed medications, the CSA or designee shall: a) contact the pharmacy to request an emergency prescription to be dispensed at an authorized back-up pharmacy in the community for pick-up by the individual released from custody or b) issue a prescription card to the individual being released from custody to allow the released individual to obtain prescribed medications at an authorized pharmacy in the community.

.8 Upon discharge from DCR custody, all prosthesis, medical supplies or equipment owned or purchased by the incarcerated individual is given to the incarcerated individual and inventoried. Any medical supplies used by the incarcerated individual while incarcerated that cannot be used by another incarcerated individual can be released to the incarcerated individual, if it is safe to do so.

APPROVAL RECOMMENDED:

JAN 0 1 2024

Deputy Director for Corrections Date

APPROVED:

JAN 0 1 2024

DIRECTOR Date

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

MENTAL HEALTH DISCHARGE PLAN

NAME: _____ **DATE:** _____

SID: _____ **DOB:** _____ **FACILITY:** _____

CUSTODY STATUS: PTM PTF PV SM SF EXPECTED RELEASE DATE: _____

Probation/Pre-Parole Officer: _____ **Phone:** _____

COMMUNITY-BASED MENTAL HEALTH SERVICES

YES NO Is the inmate linked with the Adult Mental Health Division for mental health and case management services?

If the inmate is NOT linked for services:
Date Eligibility Determination Completed: _____
Outcome of Eligibility Determination: ☐ Eligible ☐ Not Eligible

If the inmate was previously linked for services:
Date re-linked with AMHD: _____

Case Manager: _____ **Phone:** _____
Organization/Location: _____
Date of Initial Scheduled Appointment Prior to Release: _____

Psychiatrist: _____ **Phone:** _____
Organization/Location: _____
Date of Scheduled Appointment Upon Release: _____ Time: _____

SUBSTANCE ABUSE SERVICES

YES NO Does the inmate require community aftercare services for Substance Abuse?

If YES:
Date Referral List of Community Resources provided: _____
Date AA/NA Meeting Schedule provided: _____
Date(s) Refused Services: _____

HOUSING

YES NO Does the inmate have a place to reside upon release?

☐ Own Residence
☐ Family/Friend: _____ Phone: _____
☐ Group Home: _____ Phone: _____
☐ Care Home: _____ Phone: _____
☐ Clean & Sober House: _____ Phone: _____
☐ Public Housing Agency: _____ Phone: _____
☐ Residential Treatment Program: _____ Phone: _____
Address: _____

☐ Homeless
Date notified Case Manager for Housing assistance: _____
Date(s) Refused Services: _____

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

HEALTH CARE

YES NO Does the inmate have health insurance?

- ☐ Medicare
- ☐ Medicaid
- ☐ Private Insurance: _____
- ☐ None

Date notified Facility Case Management for assistance with Health Insurance: _____
Date Application for Health Insurance submitted: _____
Date(s) Refused Services: _____

FINANCIAL SUPPORT/BENEFITS

YES NO Does the inmate have a source of financial support upon release?

If YES, specify:

- ☐ Employed (Occupation): _____
- ☐ Supplemental Security Income (SSI)
- ☐ Social Security Disability Insurance (SSDI)
- ☐ Supplemental Nutrition Assistance Program (SNAP) – Food Stamps
- ☐ Hawaii WIC Program
- ☐ Other: _____

If NO:

Date notified Facility Case Management for assistance with Financial Benefits: _____
Date Food/Clothing Community Resource List provided: _____
Date(s) Refused Services: _____

TRANSPORTATION

YES NO Does the inmate have transportation upon release?

Name of Transporter: _____ Phone: _____
Relationship/Title: _____

- ☐ Bus Pass
- ☐ Date(s) Refused Services: _____

CONTINUITY OF CARE

- ☐ Date Nursing notified to prepare Medication and Discharge Summary: _____
- ☐ Date Facility Case Manager notified to prepare Letter of Incarceration: _____
- ☐ Date(s) of Aftercare Education/Discussions: _____
- ☐ Date(s) of communication with Community-Based Provider: _____
- ☐ Unexpected Release:
  - ☐ Released from Court
  - ☐ Other: _____

_____ _____
Signature of Inmate Date

_____ _____
Signature/Title of Mental Health Staff Date

STATE OF HAWAII

DEPARTMENT OF PUBLIC SAFETY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To:_____ FROM:_____

(DR./Facility in Possession of Record) (MD/Person/Facility Making the Request)

_____ _____

(Address) (Address)

_____ _____

(City) (State) (Zip Code) (City) (State) (Zip Code)

I authorize the release of the following protected health information _____

_____ _

for the purpose of my (select one):

☐ continued health care

☐ other: _____

I understand I have the right to revoke this authorization by writing a letter to the requestor anytime prior to the actual release of information. I understand that this authorization is valid for one year from the "Date of Signature." I will not hold the person/agency in possession of my protected health information liable for the further dissemination of the information once it is released to the requestor. Treatment, payment, continued enrollment in a health plan, eligibility benefits, coercion, or remuneration are not conditions of this authorization.

_____ _____

(Print Name of Patient/Representative) (Signature of Patient/Representative

_____ _____

(Date of Birth) (Date of Signature)

My signature below indicates that I also authorize the release of the following protected health information: (Initial all that apply):

_____ Mental health/behavioral health/psychiatric care/ psychiatric treatment records

_____ Alcohol/substance abuse treatment records

_____ HIV screening and diagnostic results/treatment records

I understand the sensitive nature of the information and that if the protected health information is entered as evidence in a court case they become public record.

_____ _____

(Signature of Patient/Agent) (Signature of Witness)

_____ _____

(Date of Signature) (Date of Signature)

Original: Person or Facility in Possession of the PHI
Yellow: Medical Record
Pink: Inmate

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

REQUEST FOR AMHD ELIGIBILITY STATUS

DATE: --Select Date--

		Fax	**Phone Number**
TO:	AMHD UM ASSESSMENTS	808-453-6942	808-643-2643
FROM:	--Name-- --Title-- --Facility--	--Select Facility Fax #--	--Select Facility Phone #--

Inmate's Name:

Inmate's Date of Birth:

ADULT MENTAL HEALTH DIVISION

Is the inmate linked with the Adult Mental Health Division for mental health and case management services?

☐ **YES** ☐ **NO**

If YES, which agency is providing case management?

☐ CARE Hawaii (808) 533-3936
☐ Community Empowerment Resources (808) 942-7884
☐ Helping Hands Hawaii (808) 943-8777
☐ Hope Inc. (808) 365-5525
☐ Institute for Human Services (808) 447-2800
☐ Mental Health Kokua (All Islands)
☐ North Shore MH (808) 484-9359

Has the inmate had an eligibility determination completed in the past?

☐ **YES** ☐ **NO**

If YES, what is the Eligibility Date? _____

HEALTH INSURANCE STATUS

Does the inmate have Quest Integration or Community Care Services (CCS)?

☐ **QUEST**
☐ **CCS**
☐ **NONE**

If QUEST or CCS, which agency:

☐ AlohaCare 877-973-0712
☐ HMSA 800-440-0640
☐ Kaiser Permanente 800-651-2237
☐ 'Ohana Health Plan 888-846-4262
☐ United Healthcare Community Plan 888-980-8728
☐ Other: _____

ACTION NEEDED TO OBTAIN COMMUNITY-BASED CASE MANAGEMENT SERVICES

☐ Call AMHD for E.D. Appointment (up to 4 months prior to release)
☐ Call AMHD to get re-linked with Community-Based Case Manager
☐ Call Quest plan to get CCS Case Management
☐ Call Agency:

☐CARE Hawaii (808) 533-3936
☐Community Empowerment Resources (808) 942-7884
☐Helping Hands Hawaii (808) 943-8777
☐Hope Inc. (808) 365-5525
☐Institute for Human Services (808) 447-2800
☐Mental Health Kokua (All Islands)
☐North Shore MH (808) 484-9359
☐Queen's DTS (808) 691-4352
☐Waianae Coast Comp (808) 456-4490
☐Waikiki Mental Health (808) 922-4787
☐VA Pacific Islands (808) 832-3100
☐Other: _____

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

ELIGIBILITY DETERMINATION
[Adult Mental Health Division]

LOCUS WORKSHEET
VERSION 2010

NAME: _____ **SID:**_____ **DOB:**___/___/_____ **FACILITY:**_____

Rater Name and Title: _____ **DATE:** _____

Please check the applicable ratings within each dimension and record the score in the lower right-hand corner.
Total your score and determine the recommended level of care using either the Placement Grid or the Decision Tree.

I. Risk of Harm

- ☐ 1. Minimal Risk of Harm Criteria _____
- ☐ 2. Low Risk of Harm Criteria _____
- ☐ 3. Moderate Risk of Harm Criteria _____
- ☐ 4. Serious Risk of Harm Criteria _____
- ☐ 5. Extreme Risk of Harm Criteria _____

Score _____

II. Functional Status

- ☐ 1. Minimal Impairment Criteria _____
- ☐ 2. Mild Impairment Criteria _____
- ☐ 3. Moderate Impairment Criteria _____
- ☐ 4. Serious Impairment Criteria _____
- ☐ 5. Severe Impairment Criteria _____

Score _____

III. Co-Morbidity

- ☐ 1. No Co-Morbidity Criteria _____
- ☐ 2. Minor Co-Morbidity Criteria _____
- ☐ 3. Significant Co-Morbidity Criteria _____
- ☐ 4. Major Co-Morbidity Criteria _____
- ☐ 5. Severe Co-Morbidity Criteria _____

Score _____

IV-A. Recovery Environment - Level of Stress

- ☐ 1. Low Stress Environment Criteria _____
- ☐ 2. Mildly Stressful Environment Criteria _____
- ☐ 3. Moderately Stressful Environment Criteria _____
- ☐ 4. Highly Stressful Environment Criteria _____
- ☐ 5. Extremely Stressful Environment Criteria _____

Score _____

IV-B. Recovery Environment - Level of Support

- ☐ 1. Highly Supportive Environment Criteria _____
- ☐ 2. Supportive Environment Criteria _____
- ☐ 3. Limited Support in Environment Criteria _____
- ☐ 4. Minimal Support in Environment Criteria _____
- ☐ 5. No Support in Environment Criteria _____

Score _____

V. Treatment and Recovery History

Response to Treatment and Recovery Management:

- ☐ 1. Full Criteria _____
- ☐ 2. Significant Criteria _____
- ☐ 3. Moderate or Equivocal Criteria _____
- ☐ 4. Poor Criteria _____
- ☐ 5. Negligible Criteria _____

Score _____

VI. Engagement

- ☐ 1. Optimal Engagement Criteria _____
- ☐ 2. Positive Engagement Criteria _____
- ☐ 3. Limited Engagement Criteria _____
- ☐ 4. Minimal Engagement Criteria _____
- ☐ 5. Unengaged Criteria _____

Score _____

Composite Score

Level of Care Recommendation

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

EVALUATION REVIEW

NAME: _____ **SID:**_____ **DOB:**___/___/_____ **FACILITY:**_____

Date of Evaluation: _____

Type of Evaluation:

☐ Psychiatric Assessment

☐ Psychological Assessment

☐ Other (specify): _____

Name/Title of Evaluator: _____

Findings of Evaluation Reviewed:

Diagnosis	☐ Inmate has a qualifying diagnosis	☐ Inmate **does not** have a qualifying diagnosis
Duration	☐ Demonstrated presence of the disorder for the last 12 months, or is expected to demonstrate the disorder for the next 12 months	☐ Disorder **has not** been present in the last 12 months and is not expected to last 12 months more
Assets/Means	☐ Inmate **does not** report significant means/assets	☐ Inmate reports significant means/assets
Residency	☐ Inmate lives in Hawaii and is a citizen of or has permanent resident status in the USA	☐ Inmate **is not** a US citizen or **does not** have permanent resident status in the USA
Functional Impairment	☐ Inmate experiences significant disability from his/her mental illness	☐ Inmate **does not** experience significant disability from his/her mental illness
Eligibility Findings	☐ The inmate is eligible for AMHD services	☐ The inmate **is not** eligible for AMHD services

Diagnosis (include ICD-10 codes as applicable):

Attestation *I attest that I have personally reviewed the described information and believe that the determination accurately reflects the inmate's eligibility status.*	
LMHP Name & Credentials (Print):	
LMHP Signature/Title:	Date:

DAVID Y. IGE
GOVERNOR

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
1177 Alakea Street
Honolulu, Hawaii 96813

MAX N. OTANI
DIRECTOR

MARIA C. COOK
Deputy Director
Administration

TOMMY JOHNSON
Deputy Director
Corrections

JORDAN LOWE
Deputy Director
Law Enforcement

No. _____

May 22, 2024

TO: Hawaii Paroling Authority
1177 Alakea Street
Honolulu, Hawaii 96813

FROM: _____
---------- Title ----------
Mental Health Section
---------- Facility ----------

MENTAL HEALTH STATUS REPORT

A

Consent to Release Information Form completed?

- ☐ Yes
- ☐ No, Inmate Refused [Do Not Release Mental Health Information]

Current Diagnosis:

_____
_____
_____
_____

In the last six months, has the inmate been taking psychotropic medications as prescribed?

- ☐ Yes
- ☐ No
- ☐ Inconsistent (Inmate is NOT taking meds as prescribed)
- ☐ Uncertain
- ☐ N/A (Inmate is NOT prescribed psychotropic medication)

If yes, how long has the inmate been consistenly taking prescribed psychotropic medications?

____ months

When was the inmate's prescribed psychotropic medication last modified [specify date]?

_____

In the last year, how many Mental Health Infirmary admissions did the inmate require?

_____

When was the last time the inmate required admission to the Mental Health Infirmary?

- ☐ Never admitted to the Infirmary
- ☐ Currently housed in the Infirmary
- ☐ Last Infirmary Discharge Date: _____

Is the inmate currently housed in a designated mental health module?

- ☐ Yes
- ☐ No

If yes, which module?

- ☐ Mental Health Infirmary [Crisis Intervention Services]
- ☐ Mental Health Module with Moderate-High Therapeutic Structure
- ☐ Mental Health Module with Minimum-Moderate Therapeutic Structure
- ☐ Mental Health Module with Mixed Therapeutic Structure

If yes, approximately what percentage of psychosocial treatment activities has the inmate attended in the last six months?

_____

If no, where is the inmate presently housed?

- ☐ Structured Living Unit or Segregation/Special Holding Unit
- ☐ Medical Infirmary
- ☐ General Population

In the last six months, has the inmate been housed in a Structured Living Unit or the Special Holding Unit/Segregation?

- ☐ Yes
- ☐ No

If yes, how many days?

_____ Days

If work is available for the inmate, has the inmate been working?

- ☐ Yes
- ☐ No
- ☐ N/A

If you have any further questions/concerns, please contact the Mental Health Section at:

---------- Contact Number ----------

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

MEDICATIONS IN NON-CHILDPROOF PACKAGING

The Department of Public Safety and the contracted pharmacy strongly support and encourage the use of child resistant containers in homes with young children. You have been prescribed medications that you need to continue to take upon your release from custody. ***The medication that you are taking home is not packaged in a child resistant container.*** You must take the necessary precautions when arriving home to ***keep your medication secure and out of the reach of children.***

The nursing staff has explained it to me and I understand that the medication I am being released with and taking home is not packaged in child resistant containers. ***It is my responsibility to make sure the medications are secured and kept out of the reach of children.***

_____

(Print Patient Name)

_____ Date:_____

(Patient Signature)

_____ Date:_____

(Nurse Signature)