

**STATE OF LOUISIANA  
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONS  
CORRECTIONS SERVICES**

**Health Care Policy  
No. HC-03**



**05 August 2011**

**CONTINUITY OF CARE**

1. **OBJECTIVE:** To ensure that continuity of health care for all offenders is provided from admission to transfer or discharge from a departmental facility, including referral to community based providers when indicated.
2. **REFERENCES:** ACA Standards 4-4347 through 4-4349, 4-4361 through 4-4365, 4-4367, 4-4414 (Adult Correctional Institutions); Department Regulation Nos. B-02-001 "Assignment and Transfer of Offenders" and B-08-013 "Offender Reentry Program;" Health Care Policy Nos. HC-06 "Medical Releases," HC-13 "Health Screens, Appraisals and Examinations," HC-14 "Medical Level of Care," HC-15 "Duty Status Classification System," HC-17 "Pharmaceuticals" and HC-33 "Offender Medical Records."
3. **APPLICABILITY:** Deputy Secretary, Chief of Operations, Department's Medical/Mental Health Director, Regional Wardens, Wardens and Director of Probation and Parole. Each Unit Head is responsible for ensuring that appropriate unit written policy and procedures are in place to comply with the provisions of this policy.
4. **POLICY:** It is the Secretary's policy to provide a treatment delivery system that provides the treating health care practitioner, regardless of location, with effective communication of necessary health information during transfer within the department or to community based providers that ensures quality patient care.

It is further the Secretary's policy to ensure safe and timely transportation of offenders, both inside and outside the facility, for health care appointments and to ensure that offenders are provided ongoing health and wellness information and that each facility has a system establishing baseline data for use in subsequent care and treatment to provide health care information for determining medical level of care, duty status classification, treatment plans and program planning.

**5. DEFINITIONS:**

- A. **Health Care Personnel:** Individuals whose primary duty is to provide health services to offenders in keeping with their respective levels of health care training or experience.

- B. **Health Care Practitioner:** Clinicians (such as physicians, dentists, psychologists, podiatrists, optometrists, nurse practitioners, physician assistants and psychiatrists) trained to diagnose and treat patients.
- C. **Health Care Professional:** Staff who perform clinical duties (such as health care practitioners, nurses, social workers and emergency medical technicians) in accordance with each health care professional's scope of training and applicable licensing, certification and regulatory requirements.

**6. PROCEDURES:**

A. Intake

- 1) Upon intake at a departmental facility, each offender shall receive an intake medical and mental health screening conducted by health care personnel. All findings shall be recorded on the RDC Initial Intake Medical Screening (Form HC-13-A). In addition, a comprehensive health appraisal shall be completed including a review of tests and identification of health care issues, unless there is documented evidence of a health appraisal within the previous 90 days. All offender health care records received from the transferring facility shall be reviewed by a health care professional.
- 2) All intra-system transfer offenders, as well as all in-transit offenders, shall receive a health care screening by health care personnel which begins upon arrival at the facility. All findings shall be recorded on the Intra-institutional Health Screening (Form HC-13-C).

B. On Site Health Care

- 1) A written individual treatment plan shall be developed for offenders requiring medical supervision, including chronic and convalescent care. This plan shall include directions to health care and other personnel regarding their roles in the care and supervision of the offender and shall be developed by the appropriate health care practitioner for each offender requiring a treatment plan.
- 2) Medical records for health care services rendered prior to an offender's incarceration shall be requested upon the determination of the attending health care practitioner. The offender shall be required to sign an Authorization to Release Medical Information (Form HC-33-A).
- 3) The conditions for periodic health examinations shall be determined by the unit's Medical Director.

C. Off Site Health Care

- 1) Offenders requiring health care beyond the resources available in the facility shall be referred to LSU-HSC, where care is available 24 hours a day, or to another Department facility with the ability to provide the required care. If the referral is to LSU-HSC, all relevant health information shall be completed and sent with the offender. If the required care can be provided within the Department, the transferring facility shall complete a Medical Record Transfer Summary (Form HC-03-A) and the offender's medical record shall accompany him to the receiving facility. Transfers within the Department require the approval of the Department's Medical/Mental Health Director or designee.
- 2) For offenders requiring health care that neither LSU-HSC nor the Department cannot provide, arrangements shall be made with local or other community resources. Each facility shall establish and maintain a list of referral sources, including emergency and routine care, which shall be reviewed and updated annually.
- 3) Health care outside of the Department and LSU-HSC shall only be allowed if that care is medically necessary to save life or limb (i.e. closest emergency room, etc.)
- 4) Examination by a private physician shall only be allowed if court ordered or required by workman's compensation. A workman's compensation visit requires the approval of the Unit Head and Health Authority.
- 5) All recommendations by non-departmental health care practitioners concerning an offender's treatment shall be reviewed by the offender's primary care provider. If the decision is made not to carry out any or all recommendations, justification shall be documented in the offender's medical record. Duty statuses or recommendations for special accommodations are not a part of the treatment plan and the primary care provider is better suited to make these decisions.

D. Transportation

- 1) The Warden, in conjunction with the Health Authority, shall ensure safe and timely transportation of offenders for medical, mental health and dental clinic appointments available both inside and outside the facility. Prioritization of medical need, urgency, i.e. ambulance versus standard transport, use of medical escort to

accompany correctional staff if indicated and transfer of medical information, etc. shall be addressed. Each facility shall provide a vehicle equipped with a wheelchair lift with proper means of securing the wheelchair and handicapped offenders during transport. All footrests on wheelchairs shall be secured in a way that prevents removal of the footrest.

E. Transfer

- 1) To initiate an intra-system transfer due to medical or mental health reasons, the Warden or designee shall submit a request to the Department's Medical/Mental Health Director along with a medical summary, reason for the request and the date the transfer is being requested. The Department's Medical/Mental Health Director shall have the authority to decide where the offender shall be housed to ensure the most efficient use of the Department's healthcare resources. The Department's Medical/Mental Health Director shall review the request and may:
  - a. Ask for more information as necessary;
  - b. Make a determination on possible placement in consultation with the Headquarters Transfer Section and upon review of the Department's Infirmity Census when indicated;
  - c. Approve the request and assign a facility placement based on the offender's healthcare needs and the efficient utilization of the Department's healthcare resources and notify the affected Wardens of his decision;
  - d. Deny the request when it is in the best interest of the offender and/or the Department and notify the Warden of his decision.
- 2) Upon transfer of an offender within the Department, a Medical Record Transfer Summary (Form HC-03-A) shall be completed and forwarded with the medical record to the receiving facility.

Information provided on the Medical Record Transfer Summary does not require a release of information.

NOTE: In complicated cases, the transferring facility shall prepare a case summary note explaining the special circumstances of the case (e.g., complicated medicine or treatment regimens, pending consultation or surgery, special duty limitation for unusual reasons,

etc.) In addition, a verbal report shall be provided to the receiving facility.

- 3) Upon transfer of an offender to a community rehabilitation center, transitional work program, local jail facility or any other jurisdiction, a Medical Record Transfer Summary (Form HC-03-A) shall be faxed and/or mailed to the appropriate facility in addition to accompanying the offender. The medical record shall be retained by the transferring facility as an active medical record in the medical section while the offender remains in the Department's custody. The confidentiality of the medical record shall be maintained at all times.

F. Medical Parole/Compassionate Release:

- 1) Should the offender be medically paroled or granted a compassionate release to a health care facility, the health care practitioner shall provide to the facility a written memorandum detailing the summary of care or the entire medical record shall be copied pursuant to applicable state and federal laws.
- 2) Should the offender be medically paroled or granted a compassionate release to an individual, a summary of care shall be provided to the individual and further instructions shall also be verbalized.
- 3) Determination of suitability for travel shall be based on medical evaluation with particular attention given to communicable disease clearance.
- 4) Written instructions regarding medication, any health interventions required in route, as well as standard or specific precautions to be taken by transportation officers shall be provided to the officers separate from the medical record.
- 5) Upon transfer or release, an adequate supply of medication as stated in Health Care Policy No. HC-17 "Pharmaceuticals" shall accompany the offender.

G. Discharge

- 1) Upon discharge from the facility, assistance shall be provided to the offender to identify treatment capabilities within his community in accordance with the procedures outlined in Department Regulation No. B-08-013 "Offender Reentry Program." In addition,

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upon the offender's written request, information concerning his health care shall be sent to the appropriate health care provider.

- 2) When released on parole, appropriate health care information shall be shared with the Probation and Parole District Office via the DPS&C Health Care Discharge Summary to P&P (Form HC-03-B.)

s/James M. Le Blanc

Secretary

Forms:	HC-13-A	RDC Initial Intake Medical Screening
	HC-13-C	Intra-institutional Health Screening
	HC-33-A	Authorization to Release Medical Information
	HC-03-A	Medical Record Transfer Summary
	HC-03-B	DPS&C Health Care Discharge Summary to P&P

This policy supersedes Health Care Policy No. HC-03 dated 01 August 2002 and Page Four dated 20 July 2006.

**DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONS  
AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

In order to release information concerning your health status to any person, we must have a signed release authorization. You may indicate below the person or persons to whom you authorize the release of this information. The first section of this form is the emergency contact name, address, telephone number and relationship of the person you want contacted should you become critically ill or seriously injured. You must also indicate whether or not you want any information regarding your HIV/AIDS status revealed. It is your responsibility to advise the Medical Department of any changes you wish to make regarding the release of medical information. This release will remain valid for the duration of your incarceration or until you advise the Medical Department in writing of a decision to withdraw this authorization.

**EMERGENCY CONTACT**

In the event that I, \_\_\_\_\_ (print name) become critically ill or seriously injured, I wish that the following person be contacted:

\_\_\_\_\_  
Name and Relationship

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip Code

\_\_\_\_\_  
Area Code/Telephone Number

I AUTHORIZE RELEASE OF HIV/AIDS INFORMATION:  Yes  No

**GENERAL CONTACT(S)**

I authorize DPS&C to release information regarding my health status to the following:

\_\_\_\_\_  
Name Relationship Area Code/Telephone

\_\_\_\_\_  
Name Relationship Area Code/Telephone

\_\_\_\_\_  
Name Relationship Area Code/Telephone

\_\_\_\_\_  
Offender's Signature and DOC Number Date

MEDICAL RECORD TRANSFER SUMMARY

FROM (Institution):

Offender's Name:

DOC #:

Age:

DOB:

Race:

Duty status upon transfer:

Diet: Regular or other copy of diet included

Allergies:

Medication: (presently taking)

Diagnosis:

Special Instructions: (BBI)

F/U Clinics or MD Appointments:

Current Tests:

PPD

(must have current ppd status)

CXR

RPR

Other: List test date and results

Medical LOC:

Mental Health LOC:

Mental Health Service Code:  ID  SH  SU  SX  DI  PM

Suicide watch history:  Yes  No

Date of last watch:

Nurse Signature

Date / Time



## DPS&C Mental Health & Medical Discharge Summary to Probation and Parole

Date:		Anticipated Discharge Date:	
From:	To:	Clinician Contact Name:	
		Clinician Contact Telephone Number:	
Offender Name:	DOC#:	DOB:	
<b>MENTAL HEALTH</b>			
Severe Mental Illness: <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Health Level of Care:		
If yes, Mental Health Diagnosis:			
If other:			
History of Suicide Watch within last 6 months:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Psychotropic medications given at discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes: Drug Name:	Dosage:	Duration:	# of Pills Given:
Prescription for Psychotropic Medication Given at Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Compliant with medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Pending Mental Health Clinic Appointments:			
Date:	Time:	Location:	
Date:	Time:	Location:	
Support Program Applied for:		If other:	
Pending Support Program Appointments:			
Date:	Time:	Location:	
Date:	Time:	Location:	
<b>MEDICAL</b>			
Medical Condition: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical Level of Care:		
If yes, Medical Diagnosis:			
Chronic Illness Medications Given at Discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes: Drug Name:	Dosage:	Duration:	# of Pills Given:
Prescription for Chronic Illness Medication Given at Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Infectious Disease Medications Given at Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Prescription for Infectious Disease Medication Given at Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Compliant with medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Pending Medical Clinic Appointments:			
Date:	Time:	Location:	
Date:	Time:	Location:	
<b>RESIDENCE PLAN</b>			
Name of Person/Facility Residing:	Address:	Phone Number:	
Additional Contact Info:			

## DPS&C Mental Health & Medical Discharge Summary to Probation and Parole

Date:		Anticipated Discharge Date:	
From:	To:	Clinician Contact Name:	
		Clinician Contact Telephone Number:	
Offender Name:	DOC#:	DOB:	
<b>MENTAL HEALTH</b>			
Severe Mental Illness: <input type="checkbox"/> Yes <input type="checkbox"/> No		Mental Health Level of Care:	
If yes, Mental Health Diagnosis:			
If other:			
History of Suicide Watch within last 6 months:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychotropic medications given at discharge?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes: Drug Name:	Dosage:	Duration:	# of Pills Given:
Prescription for Psychotropic Medication Given at Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Compliant with medications? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Pending Mental Health Clinic Appointments:			
Date:	Time:	Location:	
Date:	Time:	Location:	
Support Program Applied for:		If other:	
Pending Support Program Appointments:			
Date:	Time:	Location:	
Date:	Time:	Location:	
<b>MEDICAL</b>			
Medical Condition: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medical Level of Care:	
If yes, Medical Diagnosis:			
Chronic Illness Medications Given at Discharge?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes: Drug Name:	Dosage:	Duration:	# of Pills Given:
Prescription for Chronic Illness Medication Given at Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Infectious Disease Medications Given at Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Prescription for Infectious Disease Medication Given at Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Compliant with medications? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Pending Medical Clinic Appointments:			
Date:	Time:	Location:	
Date:	Time:	Location:	
<b>RESIDENCE PLAN</b>			
Name of Person/Facility Residing:		Address:	Phone Number:
Additional Contact Info:			

**MISCELLANEOUS**

**(COMPLETE BY CLASSIFICATION, RECORDS OFFICE, ETC.)**

Released from:

Printout of Current Medications Given to Offender:  Yes  No

List Individualized or Non-Individualized Devices/Aids Required Upon Release, if any:

If other:

Any Additional Information for Probation and Parole Staff: