

Transitional Planning Standards

Transitional planning is a multi-step service that helps to ensure a continuum of services for HIV-infected pre-release incarcerated individuals who have disclosed their HIV status within the correctional facility. Transitional planning addresses care, prevention and support services needs of incarcerated individuals to ensure a coordinated transition from incarceration to community. Appropriate referral agency listings and linkage agreements must be maintained and updated annually. It facilitates access to interventions that will address the prevention needs of persons who are HIV-infected. Post-release follow-up is required to determine health and human service outcomes and, if necessary, reconnect to care and prevention services. Forms used for Transitional Planning can be found in Appendix A thru E.

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Standard	Criteria	Guidance
<p>1. Transitional Planner Qualifications Qualifications for transitional planners should be determined by the hiring contractor according to pre-determined guidelines as set forth in the agency's policy and procedure manual.</p>	<p>Transitional planning takes place in a complex environment. Staff involved in transitional planning must be able to navigate institutional, inter-organizational, interdisciplinary and interpersonal issues. Coordination with key community providers and Department of Correctional Services (DOCS) personnel (e.g., nurse administrator, parole officer) responsible for discharge planning is required. Cultures, missions, objectives and legal mandates of organizations differ, as do the issues faced by incarcerated individuals.</p> <p>Contractors must ensure that transitional planners are qualified and appropriately trained. Training must include basic knowledge of HIV/AIDS, HIV confidentiality, fundamentals of case management, entitlements, community resources, referrals, DOCS protocols (e.g. gate clearance, volunteer training etc.), county jail protocols, and any other issues specific to the needs of the client being released.</p> <p>Transitional planners must be knowledgeable about the processes for completing applications for entitlements such as:</p> <ul style="list-style-type: none"> • Uninsured Care Program (AIDS Drug Assistance Program - ADAP) • Medicaid • Social Security Income (SSI) • Social Security Disability Income (SSDI) • Food Stamps • New York City HIV/AIDS Services Administration (HASA) 	<p><u>Purpose/Rationale</u> Releasees/parolees living with HIV/AIDS require continuity of care and services upon their return to the community. It is, therefore, important for transitional planners to be qualified, trained and aware of the challenges and ways to overcome barriers to service delivery.</p> <p><u>Best Practice</u> Hiring of transitional planners should include consideration of any or all of the following:</p> <ul style="list-style-type: none"> • Education and/or work history in health and human services, including social work. • Utilization of a peer approach by seeking to hire representatives of the target population e.g. formerly incarcerated, persons living with HIV/AIDS, and/or individuals in substance use recovery, who have successfully navigated social service systems. <p><u>Exceptions</u> Contractors are encouraged to hire formally incarcerated individuals, however NYS correctional facility policies must be considered prior to hiring as they may create a barrier for access to clients.</p>

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<p>2. Intake/Assessment Intake/assessment is the collection of personal data on the HIV positive incarcerated individual, which enables the coordination of care and services upon release to the community. Intake/assessment should begin three (3) to six (6) months prior to release.</p>	<p>The intake/assessment is the collection of personal data regarding the pre-release incarcerated individuals, including family history, medical and psycho-social needs, benefit eligibility and substance use history, utilizing the Transitional Planning Intake/Assessment form (Appendix C) developed by the AIDS Institute Criminal Justice Initiative.</p> <p><u>Minimum information to be collected:</u></p> <ul style="list-style-type: none"> • Client demographics • Signed “HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV-Related Information” (DOH-2557) for appropriate contacts (see Appendix A) • Signed standardized “Consent for Participation in Transitional Planning Services” form (see Appendix C) • Confirmed HIV status • HIV risk behavior(s) – Risk Assessment form • Basic HIV/harm reduction education needs • Recent hospitalizations/medical treatment history/medical needs • Substance use and history of treatment • Mental health history/counseling needs • Housing/family/support needs • Escort/Transportation needs upon release • History of previous services prior to current incarceration • Benefits/documentation/referrals needed prior to release (e.g., Medicaid) • Legal Assistance: Legal assistance is limited and only related to accessing and maintaining services in support of the transitional plan (e.g., request from incarcerated individuals for transitional planner to write a letter to the court attesting to their medical needs, or to a legal organization for pro bono assistance related to permanency planning). Requests for legal services related to criminal charges should be referred to legal counsel. • <u>For state correctional facilities:</u> Parole status/information (e.g., in-facility parole officer, board date, release date) • <u>For county jail facilities:</u> obtain release date, if known <p>The intake/assessment must be signed and dated by the client, transitional planner and supervisor. Information gathering for intake/assessment continues through the development of the transitional plan.</p>	<p><u>Purpose/Rationale</u> The purpose of the intake/assessment is to identify the needs and determine the necessary information and activities required to enable acquisition of HIV-related services upon release to the community.</p> <p><u>Best Practice</u> A client-centered interview that includes active listening will enhance the building of rapport with the incarcerated individual. Rapport will assist in obtaining personal data necessary for the development of the transitional plan.</p> <p>An early assessment of incarcerated individual’s readiness for community reentry provides an opportunity to offer interventions prior to release and timely information for benefits acquisition.</p> <p>Agency should have a Client Grievance Policy in their Policies and Procedures Manual.</p> <p><u>Exceptions</u> It may not be feasible to conduct intake/assessment three (3) to six (6) months prior to release. In county jails, this may be due to the short period of time for detention or sentence. In state correctional facilities and county jails, there may be a late identification of an incarcerated individual in need of services or an unanticipated early release.</p>

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<p>3. Development of Client-Specific Transitional Plan The plan should be appropriate to the incarcerated individual’s identified needs utilizing information gathered from the intake/assessment to ensure continuity of care for HIV positive incarcerated individuals upon release. The plan should be negotiated with the incarcerated individual and the process well documented.</p>	<p>The transitional planner and incarcerated individual must work together with in-facility staff responsible for transitional/discharge planning:</p> <ul style="list-style-type: none"> • <u>Medical Staff</u> - to ensure optimal service provision and obtaining medical summaries • <u>In-Facility Parole Officer</u> - to ensure coordination (for state correctional facilities when appropriate) • <u>Other Staff</u> - to ensure completion of forms and securing ADAP card <p>Results of coordination must be documented in the client file to assure that responsibilities are clearly understood and there is no duplication of services. If there was no opportunity to coordinate responsibilities, the transitional planner must also document that outcome in the client file.</p> <p>Referrals and services to be provided upon release must be customized based on the intake/assessment and the desire for services expressed by the incarcerated individual :</p> <ul style="list-style-type: none"> • Entitlements needed • Acquisition or verification of documentation needed to qualify for services • Referral(s) to services within the incarcerated individual ’s home community • Two week follow-up to verify services were obtained upon release (see Standard #5) <p>The transitional planner must assist the incarcerated individual with obtaining <u>at least</u> the following documents and entitlements for their release packet and document the process in the progress notes, confirming those documents obtained:</p> <ul style="list-style-type: none"> • Comprehensive Medical Summary (CMS form)/M11Q • ADAP Card and/or submitted ADAP Application • Personal identification (e.g. Birth Certificate, Social Security Card, NYS ID) <p>The transitional planner, as appropriate, must assist the incarcerated individual with obtaining the following services and referrals for their release packet:</p> <ul style="list-style-type: none"> • Medical appointment scheduled with primary or HIV physician • Referrals for secure housing (in coordination with Parole Officer, if client will be released on Parole) • Community ReEntry coordination for inmates being released to NYC including: Escort/Transportation to housing and scheduled appointments e.g. Community Action of Staten Island (CHASI) • Medicaid application completed and appointment made with Local Department of Social Services (LDSS) • SSI benefit application completed, when eligible (e.g., client requires immediate release to a hospice or skilled nursing facility) • Income support and housing applications for county social service or New York City HIV/AIDS Services Administration (HASA) 	<p><u>Purpose/Rationale</u> The development of the client specific transitional plan prepares the incarcerated individual for community reentry. This preparation requires an assessment of the incarcerated individual’s readiness to meet the challenges of community reentry. The development of the plan includes the initiation of the process to acquire documents needed to access benefits/entitlements in the community.</p> <p><u>Best Practice</u> The transitional plan is client-specific and corresponds to the intake and assessment of the incarcerated individual’s needs. If the incarcerated individual will be paroled, there is evidence that the plan was approved by the in-facility parole officer. Development of the plan must be timely and address immediate, concrete needs. Ample time and multiple meetings between the incarcerated individual and transitional planner can be crucial for making arrangements for housing, treatment adherence and continuity of medical care.</p> <p><u>Exceptions</u> Time and resource constraints may not allow obtaining certain documents and entitlements for the release packet. Any such constraints should be documented in the client file.</p> <p>All clients returning to NYC should be offered CHASI’s Community Service Coordination upon release.</p>

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<p>4. Transitional Plan Every incarcerated individual receiving transitional planning must be provided with a written plan upon release.</p>	<p>Transitional planning forms developed by the AIDS Institute’s Criminal Justice Initiative should be used during transitional planning (Appendix C). The transitional plan should contain the following:</p> <ul style="list-style-type: none"> • Comprehensive Medical Summary(CMS form)/M11Q • Documentation citing coordination with facility medical staff regarding HIV medications (30-day supply), prescription (30-day supply) and other required medications • Personal Identification • Housing arrangement - approved by NYS Division of Parole (DOP) if appropriate • Substance abuse treatment placement - approved by DOP, if appropriate • Address and phone number of Local Department of Social Services (LDSS) • Referral or appointment for case management services • Appointment(s) for medical care • ADAP card (or ADAP application in process with card to be sent to parole officer or case management referral agency counselor) • Pharmacy referral for ADAP-enrolled pharmacies in the service area of client’s residence • Transitional Planning agency address, phone number and contact person to address incarcerated individual’s questions immediately after release • Basic HIV information, hotline and key phone numbers to supportive services in the community where the incarcerated individual is returning. • <u>For parolees from state correctional facilities:</u> If possible, field parole officer’s name, phone number, date of first visit and location • <u>For probationers from county jail facilities:</u> If possible, probation officer information <p>The transitional plan must be reviewed, signed and dated by the incarcerated individual, transitional planner and supervisor. A copy of the finalized Plan must be provided to client upon release and must be documented in AIRS and/or in the progress notes. NOTE: If plan is not provided to client upon release see Exceptions in the right column.</p>	<p><u>Purpose/Rationale</u> The transitional plan ensures a coordinated transition from incarceration to community. The plan facilitates access to interventions that will address the needs of the incarcerated individual to maintain optimal health and well-being, and to diminish the risk of HIV transmission to others.</p> <p>The transitional plan provides the client with information related to appointments for primary care, HIV prevention and risk reduction services, supportive services and community-based case management.</p> <p><u>Best Practice</u> Supervisory review of the transitional plan should occur prior to it being given to the client to ensure quality service delivery, confirm entitlements have been obtained and that referrals are in place. Enhancements to the transitional plan include:</p> <ul style="list-style-type: none"> • arrangement for escort and transportation • linkage to faith community contact <p><u>Exceptions</u> If the transitional plan is not provided to the incarcerated individual upon release, the transitional plan MUST be forwarded to the formerly incarcerated client or field parole officer or an identified appropriate contact. The reason and to whom the plan was forwarded MUST be documented in the progress notes.</p> <p>Parole or probation officer information may not be available; if so, this must be documented in the client file.</p>

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<p>5. Release to Community Two-week post-release follow-up is required to confirm that the releasee was connected to care and services.</p>	<p>There must be a documented procedure in place for two-week post-release follow-up to confirm that the releasee is connected to care/services, and if not, to identify why and attempt to return the individual to care/services. Two-week follow-up must include determination of whether the releasee received housing placement and kept his/her first appointment for medical care and case management services. The two-week follow-up must also include determination of whether the client had stable housing (i.e., known address(es) for two weeks following the date of release).</p> <p>Also at two weeks post-release, the transitional planner must confirm that an ADAP Card was issued to the client before release, or that the client was enrolled in the Uninsured Care Program (ADAP) before or after release. If the releasee was not enrolled into the Uninsured Care Program (ADAP), the transitional planner, at a minimum, should provide the releasee with the Uninsured Care Program (ADAP) phone number (1-800-542-2437) and encourage enrollment.</p> <p>If the paroled releasee is lost to care, the transitional planner must attempt to contact the field parole officer to conduct the two-week post-release follow-up. All outcomes of the transitional planner's inquiries to providers must be documented in the transitional plan progress notes.</p>	<p><u>Purpose/Rationale</u> Transitional Planners <u>must</u> confirm linkage to care and services for incarcerated individuals after release. Post-release follow-up is <u>required</u> to determine health and social service outcomes and, if necessary, attempt a re-connection to care and prevention services. Connections made and kept by clients within two weeks of release enhance the likelihood of successful community reentry.</p> <p><u>Exceptions</u> A two-week post-release follow-up may not be possible due to: - Refusal of the releasee to continue to participate in transitional planning - Re-arrest of the releasee</p> <p>Reasons for inability to follow-up must be documented in the releasee's client file.</p>

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<p>6. Case Closure After the two-week post-release follow-up is completed, the final outcome of the releasee's community reentry must be documented in the client file.</p>	<p>The case closure form must be completed by the transitional planner and includes reasons for case closure (e.g., services completed, refusal of releasee to participate, re-incarceration, death). The case closure form must be signed and dated by the transitional planner and supervisor.</p>	<p><u>Purpose/Rationale</u> Case closure documents the conclusion of the transitional planning process and records the significant outcomes of the releasee encounters.</p> <p><u>Best Practice</u> Documentation should be clear, concise, accurate and timely.</p> <p><u>Exceptions</u> None</p>

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<p>7. Evaluation/ Quality Assurance Evaluation and quality assurance protocols must be defined within the program policy and procedures manual and include its frequency and staff responsibilities.</p>	<p>Evaluation of transitional planning services may include, but not be limited to, the following and be conducted by:</p> <p>Transitional Planner</p> <ul style="list-style-type: none"> • Distribution and retrieval of a written client satisfaction survey <u>prior to release</u> and, if possible, post-release <p>Supervisor/Program Manager</p> <ul style="list-style-type: none"> • Assessment of the quality of referrals, the appropriateness of the referral agency(s) and the associated service outcomes upon community re-entry e.g. schedule visits to shelters and service providers; observations of transportation services • Documentation of client file review to ensure all appropriate information has been provided in a timely manner and all transitional plans are appropriate • Documentation of annual review and updates of referral resources and linkage agreements • Assessment of services to ensure compliance with Article 27-F, HIV Confidentiality Law (DOH-2557 Appendix A completed for all referral agencies.) • Completion of a supervisory review, including staff performance evaluations, in accordance with the agency's policy and procedures manual 	<p><u>Purpose/Rationale</u> The intent of evaluation and quality assurance is to continually assess that releasee needs are being met. It is a process of monitoring consumer services to identify opportunities to improve the quality of service provision.</p> <p>The design of an effective quality assurance program includes multiple opportunities to continuously integrate the findings of evaluation into the program.</p> <p><u>Best Practice</u> An evaluation and quality assurance program should include oversight by experts in the field. This may be accomplished through establishing a relationship with an academic institution.</p> <p><u>Exceptions</u> None.</p>

Appendix A:

*“HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV-Related Information”
DOH-2557 (8/05)*

Appendix B:

“Transitional Planning Forms”

1. “Transitional Planning Intake/Assessment/Action”
2. “Transitional Plan”
3. “Program Notes”
4. “Follow-up Post Release & Case Closure”

Appendix C:

“AIRS Data Collection Forms”

1. “AIRS Short Intake”
2. “Prison Project Service Encounter”

Glossary

Comprehensive Medical Summary (CMS) - The CMS is a NYS Department of Correctional Services (NYSDOCS) form that provides the incarcerated individual's known medical history including diagnosis of HIV infection, treatment and care. Upon discharge, this form is required in order to process social service entitlements and determine housing eligibility.

M11Q: The M11Q is a NYC Department of Social Services, HIV/AIDS Service Administration (HASA) form that provides an individual's known medical history including diagnosis of HIV infection, treatment and care. Upon discharge, this form is required in order to process social service entitlements and determine housing eligibility. HASA will accept NYSDOCS' CMS to determine client eligibility.

New York State Division of Parole (DOP) - The DOP is the government organization responsible for promoting public safety by preparing incarcerated individuals in state correctional facilities for community release and supervising parolees (an incarcerated individual released prior to completion of sentence) through the successful completion of their sentence. <https://www.parole.state.ny.us/>

New York City HIV/AIDS Service Administration (HASA) - HASA provides essential services and benefits to individuals and families with AIDS and advanced HIV illness. These services are intended to assist clients in managing their illness, live their lives with the fullest independence and facilitate the acquisition of entitlements. www.nyc.gov/html/hra/html/directory/hasa.shtml

Supplemental Security Income (SSI) - Funded by the federal government, the Supplemental Security Income (SSI) program makes cash assistance payments to aged, blind and disabled people (including children under age 18) who have limited income and resources. www.ssa.gov/ssi/

Social Security Disability Insurance (SSDI) - SSDI provides benefits to disabled or blind individuals who are "insured" by workers contributions to the Social Security trust fund. These contributions are the Federal Insurance Contributions Act (FICA) social security tax paid on their earnings or earnings of their spouses or parents. www.ssa.gov/pgm/links_disability.htm or www.ssa.gov/disability/

HIV Uninsured Care Programs (ADAP, ADAP Plus and HIV Home Care) - Established by the New York State Department of Health's AIDS Institute for New York State residents with HIV infection who are uninsured or under insured, the AIDS Drug Assistance Program (ADAP), ADAP Plus and HIV Home Care provide free medications, treatment and care. The HIV Uninsured Care Programs can help people with partial insurance or who have a Medicaid "spend down" requirement. www.health.state.ny.us/diseases/aids/resources/adap