CONTINUITY OF CARE AND INFORMATION SHARING

Continuity of care is the process of delivering seamless service through integration, coordination and the sharing of information between MDT/CST members, including treatment providers. Due to the length of time many clients may be involved in treatment, the likelihood of changing providers is increased, resulting in additional challenges to continuity of care and information sharing. In an effort to maintain protective factors and reduce negative impacts to the client, it is important for all members of the current treatment team (MDT/CST) to collaborate with one another to avoid disruption to the continuity of care, keeping in mind continuity of care pertains to those clients beginning treatment, those returning to treatment, as well as those in aftercare programs. Continuity of care values the progress a client has achieved in treatment and supervision, and increases the client’s investment in treatment by aligning services with individual needs.

.000 Continuity of Care

.010 Value and benefit of continuity of care

a. Continuity increases a client’s investment in treatment and supervision, and leads to improved outcomes.
   b. Continuity values and recognizes progress that has been achieved.
   c. Continuity emphasizes the value of ongoing assessment of current needs.
   d. Continuity prevents unwarranted repetition of services.
   e. Continuity contributes to rapport building and aids in the therapeutic alliance.

.020 Members of the MDT/CST should prioritize continuity of care through collaboration with past and present service providers. Examples include, but are not limited to, a client being sentenced to the Department of Corrections after a period of community supervision, and transitions between judicial districts.

.030 Upon initiating services with a client, the MDT/CST should determine how to ensure continuity.

   a. Treatment Providers shall obtain signed releases and request previous treatment records.
   b. Treatment Providers shall have a structured process to assess current treatment needs. This process shall incorporate past records when available; however, the absence of records does not eliminate the need to assess current treatment needs.
   c. Treatment providers and evaluators shall make every reasonable effort to identify and obtain past treatment records. In the absence of such records, it is the responsibility of the Treatment Provider to conduct a thorough and collaborative treatment review with the client, to determine what treatment has been completed, what components of treatment need additional focus, and what components of treatment have not yet been completed. See Appendix X for an example.
Discussion point: Treatment decisions shall be based on individualized risks, needs and responsivity factors, and requirements to repeat previously completed work (e.g. non-deceptive polygraph examination results, completed treatment components) should only be required with documented rationale for why repetition is needed.

d. Treatment Providers shall use this information to determine current treatment needs and as a basis for initiating communication with MDT/CST members regarding treatment needs

e. Other members of the MDT/CST (including polygraph examiners and supervising officers) should communicate with previous providers to determine service needs; this may include the continuation of services or implementation of new services.

.040 MDT/CST members, including treatment providers, should determine the level of service that is needed in relationship to what has already been completed.

a. Previously approved conditions should not be modified solely based on a change in MDT/CST membership.

b. Treatment Providers shall have an identified system to gather information through collateral reports and client interviews, which gives them the ability to assess the treatment content areas outlined in the Standards. Treatment Providers shall use this information to determine level of progress, treatment areas of continued focus, and treatment areas that have been completed. A sample intake assessment form can be found in Appendix “X.”

c. Other members of the MDT/CST should have an identified system to gather information, either through collateral reports or client interviews, which gives them the ability to assess the previous services, provisions and level of community access, including 5.7 criteria and contact with minors. MDT/CST members should use this information to determine level of progress, service areas of continued focus, and level of community access.

Discussion point: This process should include individuals who can provide information related to previous services, community access, previously approved conditions and/or restrictions. This can include, but is not limited to: support persons, family members, professionals, and previous providers. MDT/CST members, including treatment providers, should be mindful of the impacts to clients, family, and the community, when previously approved conditions are modified. Rationale for such a modification should be documented and connected to risk, need, and responsivity.

9.100 Transition Points and continuity of care consideration
Throughout the continuum of services there may be a variety of transition points. The following sections are intended to provide guidance regarding some transition points, but this is not intended to be an exhaustive list of all possible transition points.

a. Clients changing treatment providers.
i. Clients who have been granted permission for community activities should not have these privileges removed solely based on a change in treatment providers, unless compelling circumstances are present.

ii. Current treatment providers may continue previously achieved conditions (e.g. contact with children) when such approval is documented by the previous treatment provider, and there is no new information to indicate such condition should be restricted.

*Discussion Point: For example, a previously granted condition, such as visitation with children, may need to be continued in the community with comparable safeguards (e.g. allowing supervised contact with children for an individual who previously had visitation within a structured environment).*

iii. Members of the MDT/CST should discuss current privileges and activities and determine if these privileges and activities can be maintained in a manner in which community and victim safety is not compromised.

b. Clients being released from the Department of Corrections (DOC) facilities who have been receiving treatment in the Sex Offender Treatment and Monitoring Program (SOTMP):

   i. Members of the CST should review basic needs that the client will need to access in the community and develop an interim safety plan to meet these needs while the client is waiting to begin treatment in the community. A sample interim safety plan can be found in Appendix “X.”

   ii. Clients who have been granted permission for privileges or activities should not have these privileges or activities removed solely based on a change in living environment, unless compelling circumstances are present.

   iii. Members of the CST should discuss current privileges and activities and determine how these privileges and activities can be maintained in a manner in which community and victim safety is not compromised.

   *Discussion Point: For example a previously granted condition such as visitation with children may need to be continued in the community with comparable safeguards (e.g. allowing supervised contact with children for an individual who previously had visitation within a structured environment).*

iv. When a client is released from the DOC SOTMP on parole or accepted into Community Corrections, the SOTMP treatment provider shall send all records, including a discharge summary and Risk Management Plan/Personal Change Contract, which:

   a. Describe the level of cooperation and institutional behavior.

   b. Describe participation in treatment, including treatment objectives addressed, completed, and left to complete.
c. Suggest specific conditions of parole, including adjunct treatment recommendations.

d. Indicate ongoing risk and protective factors

e. Identify any Approved support person(s)

f. Indicate length of time and engagement in treatment

c. Clients returning to treatment/supervision after a period of time out of treatment/supervision:
i. Members of the MDT/CST, including the treatment provider and evaluator should have an identified system to gather information through collateral reports and client interviews, which gives them the ability to assess and determine privileges, activities and the level of treatment needs. See appendix X for a sample matrix for recommendations.

9.200 Information Sharing

A. Importance of Information Sharing
a. Current provider: Treatment Provider shall request all relevant and applicable previous records and will complete an assessment in the absence of such records. See Appendix “X” for a sample intake assessment.

b. Previous provider(s): Upon receipt of a signed release of information the Treatment Provider shall release past treatment records to include: Individual Treatment Plan, Progress Summaries, summary of polygraph results, Discharge Summaries, and additional adjunct services provided.

c. Supervising officer: Facilitate the exchange of relevant and applicable records.

B. Releases of Information
a. Treatment providers, evaluators, polygraph examiners, and supervising officers shall be aware of and comply with all applicable laws and rules related to confidentiality and releasing of information (e.g. HIPAA, FERPA, 42 CFR, Mental Health Practice Act, Professional and Ethical codes of conduct).

b. Members of the CST/MDT should also comply with relevant agency policies regarding information sharing.

C. Records
a. Treatment Providers, evaluators, polygraph examiners, and supervising officers should follow applicable policy and statutes related to records retention.

b. Court files are considered a permanent record and some information, such as discharge summaries, may be filed with the courts. By logging such information in the court record, it will remain available to clients and other parties to the case, subject to the court’s discretion. It is recommended that Treatment Providers provide this information to ensure the client’s involvement in treatment is part of the permanent court record and, if appropriate, may be considered by the court in future decision making.

i. A court filing document for submitting a recommendation regarding registration for juveniles can be found in appendix X
ii. A court filing document for submitting information regarding participation in treatment for adults can be found in Appendix “X.”

c. Discharge Summaries

i. Supervising Officers: Discharge information should be recorded by the supervising officer at the termination of community supervision, and should be available in the file and should include records of:
   1. Treatment progress
   2. Successful or unsuccessful completion of treatment
   3. Auxiliary treatment
   4. Community stability
   5. Residence
   6. Compliance with the supervision plan and conditions of probation/parole/community corrections
   7. Most current risk assessment

ii. Treatment Provider: Discharge information shall be recorded by the Treatment Provider, and shall include, but not be limited to, the following:
   1. Treatment goals and objectives completed
   2. Current level of risk, including risk and protective factors
   3. Successful or unsuccessful completion of treatment
   4. Aftercare recommendations, if applicable
   5. For juveniles: A current recommendation regarding whether registration should/should not continue based on information available at the date of the report.