SUBJECT: CHRONIC DISEASE SERVICES

POLICY: Patients who have chronic illnesses are identified and enrolled in chronic disease plans. The goal of this chronic disease program is quality patient care and outcomes. The plan will include monitoring according to recognized standards for common chronic diseases.

Monitoring and Clinical guidelines will be consistent with national clinical practice guidelines, where available. Clinical practice guidelines are defined as systematically developed, science-based statements designed and used to assist clinical decision making, assess and assure the quality of care, educate individuals and groups about clinical disease, guide the allocation of health care resources. These guidelines help clinicians to practice the best medicine, aimed at improving patient outcomes.

National clinical practice guidelines are those presented by national professional organizations and accepted by experts in the respective medical fields. Not all chronic diseases have National Clinical Practice Guidelines.

REFERENCE: NCCHC Standard P-G-01
NCCHC Standard P-G-02-Patients with Special Health Needs
NCCHC Standard MH-G-03
BHS # P-C-04-Mental Health Codes and Levels of Service
BHS # P-C-18-Treatment Planning

PROCEDURE:

A. The Medical Director will annually approve clinical guidelines that are consistent with national clinical practice guidelines. Clinical guidelines will include recommendations on data collection, treatment recommendations, outcome measures, indicators of the severity of the patient’s condition and whether the condition is stable, improving, or deteriorating, and the frequency of chronic disease monitoring for patients with chronic illnesses. Patients may be monitored more frequently than required by this policy as determined by the responsible treating practitioner. The nurse processing practitioner orders will input the identified chronic disease patient in the “Special Needs” category of the AS400 Inmate Health Plan (IHP).

B. Chronic illnesses with guidelines include, but are not limited to:

1. Asthma/Respiratory
2. Diabetes
3. HIV/AIDS
4. Hypertension/Cardiovascular Diseases
5. Lipid Disorders
6. Seizure Disorders
7. Hepatitis C / Chronic Hepatitis
8. Liver Cirrhosis
9. Serious mental illness
10. Sickle Cell
11. Tuberculosis
12. Chronic Pain

Chronic Disease Forms are located in the DOC computer system following the pathway: U:Drive\Health Services\All Staff-Public\Policies and Procedures\Special Needs Forms Special Needs Forms

C. Chronic diseases not having DOC guidelines will be seen by a treating practitioner and have a written plan of care. The written plan of care will serve as that patient’s individualized monitoring and treatment plan.

D. Laboratory tests for chronic disease clinic visits shall be scheduled by the nurse according to the chronic disease guidelines. These are to be done prior to the chronic disease clinic appointment, when possible, to allow for a review of the data at the time of the patient encounter with the practitioner.

E. The practitioner will document each chronic disease health encounter in the patient’s health care record on the appropriate Chronic Disease form(s). The practitioner may write additional information or other condition information in the progress note, as long as the Chronic Disease form is filled out and filed in the appropriate place. The guidelines and forms are reminders of practice, monitoring, and documentation. Aspects of evaluation, test data, monitoring, treatment, patient status, and follow up are to be documented. Clinically indicated deviations from the guidelines are explained.

The focus of the appointment is the patient’s chronic disease. Medical problems unless urgent, not related to the chronic disease may be dealt with at another appointment.

F. The nurse processing the practitioner orders will ensure that the patient’s chronic diseases are listed on the face sheet.

G. The nurse processing practitioner orders will input the identified patient and chronic disease in the “Major Diagnosis” category of the AS400 Inmate Health Plan (IHP).

1. Select option #4, Major Diagnosis”, press enter.
2. Input the patient SID number, press enter. If the SID number is unknown, press F4 and enter the patient’s name, last name first, press enter.
3. Press F6 to create a chronic disease condition code, if the condition is not already identified. For a list of condition codes, press F4 and scroll down to chronic disease code and press enter to select, press F3 to exit.
4. Tab to input any comments, the diagnosis date and last seen date, when applicable. Enter twice to update condition code(s).
5. Repeat steps 3 and 4 for each chronic disease diagnosis. Please note that newly created condition codes are not immediately visible in the “Work with Special Needs” screen. Press “Page Up” to view.
6. With cursor on “Opt” field, press F10 to write a narrative note. This field can be used for a synopsis of follow-ups, medications, patient teaching, etc. Press enter to add. Press enter again to exit.

An appointment with a treating practitioner will then be made by using the “Schedule Entries” of the IHP.

7. Select option #2, Schedule Entries, press enter.

8. Cursor will be positioned on provider field. Input provider code or press F4 to open a list. Scroll down to the appropriate provider code and press enter. (The provider’s monthly schedule will appear in the upper right-hand corner of the screen. Highlighted days should reflect the provider’s schedule.)

9. Press F8 to advance date forward or F7 to go back. The cursor will position itself to the SID number field.

10. Input the patient’s number. If the SID number is unknown, press F4 and enter the patient’s name, last name first, press enter.

11. Tab to the time field and input appointment time. At provider’s request, extra time can be added to the scheduled appointment by tabbing to the “Extra” field and inputting Y. This will give you a longer appointment.

12. Tab to the “Cond” field, and input the chronic disease condition code, only when patient is being seen for a chronic disease.

13. Tab to the next field and input “Chronic Disease Treatment Planning.”

14. Tab to “Loc” and input place of appointment.

15. Press enter twice and the patient is now scheduled.

I. The nurse assisting with the chronic disease clinic is responsible for assuring that all scheduled patients are seen. "No shows" or refusals are to be noted on the IHP and discussed with the practitioner for clinical review and further instructions. Documentation of this chart review will be made by the practitioner.

J. Follow-up appointments are ordered by the practitioner and scheduled via the “Schedule Entries” of the IHP, following the same process listed in H. of this policy.

K. Nurses may be assigned to follow chronic disease patients to help assure compliance with medication, diet and the chronic disease treatment plan in between practitioner visits. Physical exams shall be performed by a practitioner, practitioner assistant or nurse practitioner, unless specifically indicated otherwise in this policy.

L. A patient may be dropped from the Chronic Disease clinic list by a provider if there is no evidence of substantiate the diagnosis or if they have been asymptomatic subjectively and objectively (including labs) for two years while off all medications or treatments and their primary practitioner documents the discontinuation in the progress notes and on the practitioner orders.

M. As patients are transferred to other Department of Corrections facilities, the receiving nurse is responsible for scheduling Chronic Disease patients for follow up clinic appointments as indicated.
N. A Mental Health Code (MH0/MH1/MHR/MH2/MH3) is assigned to a patient if they have been assessed by a Mental Health Treatment Provider. A patient is assigned a MHR/MH2/MH3 Code based on diagnosis and acuity level (mild, moderate, severe) and are referred to a prescriber or QMHP based on the MH Treatment Services Schedule. Patients with the highest treatment need (MH3) or severe need (MH2) are assigned to a QMHP for case management and a Prescriber for medication management and may be referred for individual and group skills training. Patients with a MH2/MH3 Code will have an individualized treatment plan based on mental health needs. Patients with a MHR/MH2/MH3 Code are restricted to institutions where there are mental Health Services on site. The Mental Health Treatment Provider will document on the Prescriber Service Record (PSR) the most severe diagnosis so that the Office Specialist II can enter the correct MH Code in the CTSDB.

O. A Developmental Delay (DD) CODE (DD0/DD1/DD2/DD3) is assigned to a patient if they have been assessed by a Mental Health Treatment Provider. An inmate is assigned a DD2 (IQ 70 -79) or DD3 (IQ below 70) Code based on IQ testing and impaired adaptive functioning directly related to the intellectual disability and not as a result of any mental/emotional disorder, substance abuse, personality disorder, learning disorder or sensory impairment. Patients with a DD2 or DD3 Code are assigned to a QMHP for case management services and may be referred for individual skills training with identified target behaviors related to ADL activities or group skills training based on the DD Treatment Services Schedule. Inmates with a DD2/DD3 Code will have a Treatment Plan focused on assistance with housing, adjustment to prison and areas of impaired functioning. Inmates with a DD2/DD3 Code are restricted to institutions where there are mental Health Services on site. The Mental Health Treatment Provider will document on the Prescriber Service Record (PSR) the DD Code so that the Office Specialist II can enter the correct DD Code in the CTSDB.

Effective Date: ______________
Review date: November 2016
Supersedes P&P dated: November 2015
CHRONIC DISEASE SCHEDULING AND LABORATORY

Skill Level: RN, LPN - Scheduling may be done by clerical staff.

Definition: To specify routine appointment and routine testing scheduling for patients enrolled in chronic disease clinics. To enable collection of appropriate data in connection with Chronic Disease guidelines before provider visits.

If a patient is enrolled in one of the following special needs clinics, the nurse may schedule the following number of chronic disease care appointments. The listed laboratory and other information should be obtained for these scheduled visits.

1. **ASTHMA/RESPIRATORY** (PEFR can be done at the time of the provider visit)
   
   a. Baseline Information: Pulmonary function test or Peak Expiratory Flow Rate (PEFR), sA02.
   
   b. Schedule a Special Needs appointment every 4-12 months with: Peak Expiratory Flow Rate (PEFR).
      
      1. If Intermittent Asthma (step 1), every 12 months.
      2. If Mild Persistent Asthma (step 2), every 6 months.
      3. If Moderate or Severe Persistent Asthma (step 3 or 4), every 4 months.

2. **DIABETES MELLITUS**
   
   a. Baseline information: Electrocardiogram (EKG), fasting blood sugar (FBS), Hemoglobin A1c, Lipid panel, Complete metabolic profile (CMP).
   
   b. Schedule a Special Needs appointment every four months with: blood pressure, weight; and Hemoglobin A1c, and/or finger stick glucose review.
      
      1. If patient on no medication for Diabetes, schedule every 12 months.

3. **HEPATITIS C**
   
   a. Baseline Information (HCVINT--intake or HCVEVL--evaluation): Complete Blood Count (CBC) and CMP.
   
   b. Schedule a Special Needs Visit every 6-12 months with CBC and CMP.
      
      1. If HCVCON (Contraindication to medication treatment), every 6 months.
      2. If HCVLTM (Long Term Management), every 12 months.
Chronic Disease Scheduling And Laboratory

4. HIV/AIDS
   a. Baseline Information: Weight, temperature, blood pressure, CBC, CMP, CD4 count, HIV Viral Load, Hepatitis screening panel, CXR.
   b. Schedule a Special Needs Visit every three months with: Weight, BP, CBC, CMP, HIV viral load, CD4 count.

5. HYPERTENSION/CARDIOVASCULAR
   b. Schedule a Special Needs Visit every 4-6 months with: Weight, blood pressure, pulse.
      1. If control last visit was Good, schedule visit in 6 months.
      2. If control last visit was Fair, schedule visit in 4 months.
      3. If control last visit was Poor, schedule visit in 3 months.
   c. Annual clinic requirements, if stable: CBC, CMP.

6. MENTAL HEALTH
   a. Appointments will be scheduled by the mental health treatment provider based on MH CODE and acuity.

7. SEIZURE DISORDER
   a. Baseline Laboratory: Anti-epilepsy medication blood level(s), CMP, and CBC.
   b. Schedule a Special Needs appointment every 4-12 months.
      1. If control last visit was Good, schedule visit in 12 months.
      2. If control last visit was Fair, schedule visit in 6 months.
      3. If control last visit was Poor, schedule visit in 4 months.
   c. Annual clinic requirements: same as Baseline.

SPECIAL NEEDS OTHER THAN ABOVE WILL BE SCHEDULED FOR ROUTINE FOLLOW UP APPOINTMENTS EVERY 4-12 MONTHS AT PROVIDER DISCRETION, DEPENDING ON NATURE OF THE CONDITION, AND LEVEL OF CHRONIC CONTROL.
Chronic Disease Medical Care Guidelines

ODOC Chronic Disease medical guidelines are based on recognized national medical recommendations.

The following Chronic Disease and Special Needs forms are located in the computer files at U:\Operations\Health Services\Special Needs\2015 Chronic Disease Forms, and have been reviewed and approved as of March 2015. They have all been updated to current 2015 guidelines except HTN and Diabetes have been reviewed and approved, though minor updates are pending.

Asthma March 15
Baseline From
Chronic Pain 3_2015
Diabetes March 09
Epilepsy March 15
HTN March 09
Lipids SNR Jan 2015 ATP4
Liver Cirrhosis Feb15
Preventive Health Services
Sickle Cell 2015

[Signature]
Medical Director for ODOC Health Services
3/9/2015
Date

__________________________   _______________________
Chief Medical Officer   Date

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Facility