Minnesota Department of Corrections

Policy:	**500.052**
Title:	**Chronic Disease Management Program**
Effective Date:	**11/7/17**

PURPOSE: To ensure patients with chronic diseases are identified, monitored regularly and, if applicable, enrolled in a chronic disease management program to enhance continuity of care, decrease the frequency and severity of symptoms, prevent disease progression and complication, and foster improved function.

APPLICABILITY: Minnesota Department of Corrections (DOC); all department facilities

DEFINITIONS:
Chronic disease – diseases included in the chronic disease management program are Diabetes, Hypertension, Seizures, Asthma and Coronary Artery Disease.

Chronic disease management program (CDMP) appointments – periodically-scheduled practitioner/nurse appointments for patient offenders/residents with a designated chronic disease requiring periodic care and treatment.

PROCEDURES:

A. Facility health service practitioners assess offenders/residents for chronic disease and refer for follow up periodically based on stability of disease and as clinically indicated. Practitioners must reference professionally-recognized chronic care guidelines as approved and directed by a contracted medical vendor and the DOC medical director.

1. If patients are diagnosed with more than one chronic disease, the practitioner determines the primary diagnosis and the patient is seen for all chronic disease needs during the same visit.

2. Vital signs, including weight, blood pressure, pulse, respirations and O2 saturation are taken at each clinic visit.

3. Patient offender education is individualized based on current knowledge, cognitive functioning, level of education and other factors identified. Education is provided in a format best suited to meet the individual's needs and includes:
   a) Disease information;

   b) Risk factors;

   c) Symptom recognition and appropriate actions;

   d) Medication information;

   e) Importance of adherence to recommended treatment plan;

   f) Promotion of healthy lifestyles; and

   g) Self-care and management.

4. Co-payments are not assessed for appointments that are part of the chronic disease management program (CDMP).

5. Offender/resident participation is optional.
   a) If an offender/resident chooses not to participate, the practitioner must discuss the benefits and the risks of not participating in the CDMP and document the discussion.

   b) Written education material is sent to the offender/resident if he/she refuses to meet with the nurse or practitioner when scheduled.

   c) Periodic appointments continue to be scheduled at practitioner-recommended intervals, whether or not the previous appointment was attended by the offender/resident.

   d) A refusal of services form must be presented for the offender/resident to sign at each interval when that offender/resident would normally be seen for a periodic appointment.

   e) Refusal of services must be documented in the medical record.

B. Identification and evaluation of patient offender/resident
1. Patient offenders/residents are identified for chronic health condition management through various means, including such examples as intake initial health screening, transfer intake screening, provider referral, sick call, and medication or diagnostic services review.

2. Patient offenders/residents with chronic disease must be added to the Corrections Offender Management System (COMS) and the CDMP tracking log.

3. An offender/resident identified on intake health screening with a significant health condition, including conditions identified in CDMP, is referred for a comprehensive health appraisal within 14 days of arrival at the facility. An offender/resident identified upon transfer from another DOC facility with a significant health condition, including conditions identified in CDMP, is referred to a medical practitioner for a CDMP visit at the interval established at the last practitioner visit, or sooner if indicated by health screening and nursing assessment.

4. The Health Services Intake/Transfer Review Worksheet (attached) is retained by the registered nurse supervisor for six months of care, and also retained in the offender's/resident's medical record. CDMP visits must also be documented in the medical record.

5. Patient offenders/residents with significant medical needs that require additional medical review must be referred to a specialist for disease management as clinically indicated.

6. Patient offenders/residents with significant medical needs that extend beyond the offender's/resident's release date must be referred to the case manager and the medical release planner. Refer to DOC Division Directive 500.187, "Medical Release Planning."

C. Chronic disease management program encounters
1. The primary care team must prepare for visits by retrieving and reviewing relevant patient management information, which may include the following data:

a) Current medications;

b) Vital signs, including weight and O2 saturation;

c) Diagnostic test results, including blood glucose monitor data; and

d) Interval to next appointment.

2. The following activities, at minimum, must occur at each encounter:
   a) Obtain history from the date of the last visit to the date of the current visit;

   b) Review current medications, complaints or problems;

   c) Assess adherence with the chronic disease program, and provide education;

   d) Review results of laboratory tests, diagnostic studies, monitoring, and reports from specialty referrals;

   e) Order or renew medications as indicated until the next CDMP appointment;

   f) Document the encounter in the medical record; and

   g) Enter the Chronic disease encounter in COMS.

D. Chronic disease management program tracking log
1. The tracking log must be established and maintained by each facility health services administrator or designee.
   a) The health services administrator or designee must review chronic disease COMS encounters and comparing with medication prescriptions from the contracted pharmacy and other pertinent information to determine primary chronic disease.

   b) The patient offender/resident must be placed on the primary chronic disease tracking list as determined by his or her practitioner.

2. The CDMP tracking log must include the following patient offender/resident information at a minimum:
   a) Offender identification number;

   b) Last name, first name; and

   c) Next visit due date.

3. The health services administrator or designee is responsible for updating the tracking log quarterly and as indicated.
   a) Medication lists must be obtained from the pharmacy and compared to the chronic disease management program tracking log for comparison and updating quarterly.

   b) The tracking log must be updated and maintained locally at each facility.

   c) The CDMP Tracking Log must be uploaded to the private health services iSHARE page quarterly.

E. Areas of responsibility

1. The DOC and contract medical directors and pharmaceutical and therapeutic committee **(**P & T**)** must:
   a) Review and designate preferred disease management guidelines annually;
   b) Review chronic disease quality audit data quarterly; and
   c) Review health care outcome measures annually.

2. Practitioners must:
   a) Diagnose and clinically monitor chronic diseases;
   b) Maintain the medical record problem list with current problems;
   c) Use clinical judgment to determine appropriate individualized plans of care; and
   d) Reference national disease management guidelines as designated by P&T.

3. The health service administrator must:
   a) Ensure chronic disease care is being coordinated and scheduled per policy and care guidelines;
   b) Ensure that quarterly quality audit data is tracked, completed and forwarded to the director of nursing as directed; and
   c) Ensure that annual health care outcome measures are tracked, completed and forwarded to the director of nursing as directed.

4. The registered nurse supervisor or designee must:
   a) Maintain a tracking system to ensure that lab work, other tests and appointments are carried out per practitioner order;
   b) Maintain patient education materials and availability as directed;
   c) Conduct regular medical record documentation audits as directed; and
   d) Complete and submit quarterly quality audits as directed.

INTERNAL CONTROLS:

A. Documentation of chronic care is maintained in the offender medical record.

B. The Health Services Intake/Transfer Review Worksheet is retained by the registered nurse supervisor for six months.

ACA STANDARDS: 1-HC-1A-07 (4-4350), 1-HC-4A-07 (4-4414), 1-HC-1A-16 (4-4359)

REFERENCES: NCCHC Standards for Health Services in Prisons 2014 P-G-01
ADA, AHA, CDC and NCCHC Guidelines for Disease Management
Federal Bureau of Prisons Clinical Practice Guidelines
Centurion Disease Management Guidelines
Division Directive 500.187, "Medical Release Planning"

REPLACES: Policy 500.052, "Chronic Disease Management Program," 6/30/15.
All facility policies, memos, or other communications whether verbal, written, or transmitted by electronic means regarding this topic.

ATTACHMENTS: Instructions for establishing Baseline CDMP Tracking Log (500.052A)
Instructions for use of Health Services Intake/Transfer Review Worksheet (500.052B)
Health Services Intake/Transfer Review Worksheet (500.052C)
Chronic Care Tracking Log – Blank (500.052D)

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