DEPARTMENT OF CORRECTIONS

Policy Number:	**500.052**
Title:	**Chronic Disease Management Program**
Effective Date:	**2/19/26**

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. Additionally, this program emphasizes health promotion by enabling the people we serve to increase control over, and to improve, their health.

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

DEFINITIONS:

Chronic disease – diseases in the chronic disease management program include asthma/COPD/pulmonary disease, diabetes, cardiovascular/heart disease, hepatitis/liver problems, HIV/AIDS, hyperlipidemia, hypertension, seizures, cancer and any other condition deemed as part of chronic disease management by the provider.

Chronic disease management appointments – periodically-scheduled practitioner/nurse appointments for patient with a designated chronic disease requiring periodic care and treatment.

Health Promotion – empower patients to develop knowledge and personal skills to improve their overall wellbeing and decrease long-term impact of morbidity and mortality related to chronic disease.

PROCEDURES:

A. Health Promotion Goals

1. Health Literacy

a) Provide low-barrier access to health services for all patients.

b) Provide alternative modifications to ensure meaningful access for health service education options for patients with limitations. This may include providing handouts in plain language, handouts in other languages, and/or interpretation services.

c) Provide patient-centered health education.

d) Provide education to enhance skills to promote good health.

2. Promoting Nutrition

a) Provide all patients with access to nutritional educational materials.

b) Ensure dietitian consultations are available to patients requiring complex dietary education.

3. Promoting Physical Activity

a) Provide all patients access to education on the benefits of physical activity.

b) Ensure physical therapy consultations are available to patients.

4. Awareness Education
   a) Provide all patients with access to education on chronic illness.

   b) Provide all patients with access to request one-on-one educational consultations through health services.

B. Chronic Disease Management

1. Facility health service practitioners assess patients for chronic diseases and refer them for follow ups based on the stability of disease and as clinically indicated. Practitioners must reference professionally recognized chronic care guidelines as approved and directed by the contracted medical vendor and the DOC chief medical officer.

2. 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.

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

4. Patient education is individualized based on the patients current knowledge, cognitive functioning, level of education and other factors identified. Education is provided in a format best suited to meet the patient'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.

5. Co-payments are not assessed for appointments that are part of the chronic disease management.

6. Patient participation is optional, if:
   a) A patient chooses not to participate. The practitioner must discuss the benefits of participation in chronic disease management and the risks associated with non-participation, and document the discussion.

   b) Written education material is sent to the patient if he/she refuses to meet with the

nurse or practitioner when scheduled.

c) Periodic appointments continue to be scheduled at practitioner-recommended intervals, regardless of whether the previous appointment was attended by the patient.

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

e) All refusal of services must be documented in the electronic health record.

C. Identification and evaluation of patient

1. Patients are identified for chronic disease management through various means, including, but not limited to, intake health screening, transfer intake screening, provider referral, sick call, and medication or diagnostic services review.

2. Patients with chronic disease will be tracked through the electronic health record and data management reporting systems to maintain accurate chronic disease management tracking.

3. A patient identified during the intake health screening with a significant health condition is referred for a comprehensive health appraisal within 14 days of arrival at the facility. A patient identified upon transfer from another DOC facility with a significant health condition is referred to a medical practitioner for chronic disease management visits at the interval established by the practitioner, or sooner if indicated by the health screening and nursing assessment.

4. The nurse intake screening form must be completed in the electronic health record upon intake or transfer to a facility. Referrals must be made to medical providers for chronic disease management, including but not limited to asthma/COPD/pulmonary disease, diabetes, cardiovascular/heart disease, hepatitis/liver problems, HIV/AIDS, hyperlipidemia, hypertension, seizures, and cancer. Medical providers will document their chronic care visits on the chronic care form in the electronic medical record system.

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

6. Patient with significant medical needs that extend beyond the incarcerated person's/resident's release date must be referred to the case manager and the medical release planner. Refer to policy 500.187, "Medical Release Planning."

D. Chronic disease reporting

1. Chronic disease reporting must be completed by the disease management team, specifically disease management analyst and research analyst.

2. The director of clinical operations (DCO) or designee must review and distribute the chronic disease report to nursing staff. Nursing staff will use the report to ensure chronic

care clinic visits, labs and diagnostics are completed as ordered by provider.

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 outcome audit and process audit quarterly; and
   c) Review health care outcome measures annually.

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

3. The Director of Clinical Operations (DCO) must:
   a) Ensure chronic disease care is being coordinated and scheduled per policy and care guidelines; and
   b) Ensure that quarterly quality audit data is tracked, completed and forwarded to the director of nursing as directed.

4. The registered nurse supervisor (RNS) or designee must:
   a) Review the chronic care reports created by the disease management team, 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) Assign regular medical record documentation audits to clinic coordinators as directed; and
   d) Review and submit quarterly quality audits as directed.

INTERNAL CONTROLS:

A. Documentation of chronic care is maintained in the patient electronic health record.

STATE CORRECTIONAL FACILITY SECURITY AUDIT STANDARDS: None

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

Policy 500.187, “Medical Release Planning”

REPLACES: Policy 500.052, “Chronic Disease Management Program,” 11/7/17.
All facility policies, memos, or other communications whether verbal, written, or transmitted by electronic means regarding this topic.

APPROVED BY:
Commissioner of Corrections