**MONTANA STATE PRISON**
**HEALTH SERVICES OPERATIONAL PROCEDURE**

<table>
<tr><td>Procedure No.: MSP HS F-1.0</td><td colspan="2">Subject: CHRONIC DISEASE SERVICES</td></tr>
<tr><td colspan="2">Reference: NCCHC Standard P-F-01, P-B-01, P-E-09, 2018, DOC 4.5.22, Offender Health Care Continuity, DOC 4.5.24, Offender Health Education and Promotion</td><td>Page 1 of 3 and no attachments</td></tr>
<tr><td colspan="2">Effective Date: November 1, 2010</td><td>Revised: December 31, 2019</td></tr>
<tr><td colspan="3">Signature / Title: /s/ Cindy Hiner / Medical Bureau Chief</td></tr>
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## I. PURPOSE

To identify patients who have chronic disease, other significant health conditions, and disabilities and assure they receive multidisciplinary care aligned with evidence-based standards through a Chronic Care program. The goal, to provide quality patient care, decrease frequency and severity of symptoms, prevent disease progression and complication, and improve patient outcomes. Clinical protocols will be used for the management of chronic illness and will be consistent with national clinical practice guidelines.

## II. DEFINITIONS

Chronic Care Program – an institutional program which incorporates a treatment plan and regular clinic visits. The clinician monitors the patient's progress during clinical visits and, when necessary, changes prescribed treatment plans. The program also includes patient education for symptom management.

Treatment Plan - a series of written statements specifying a patient's course of therapy and the roles of qualified health care professionals in carrying it out.

Chronic Disease – an illness that affects an individual's well-being for an extended interval, usually at least six months, and generally is not curable but can be managed to provide optimum functioning within any limitations the condition imposes on the individual.

Clinical Practice Guidelines – systematically developed, science-based statements designed to assist the practitioner and patient with decisions about appropriate health care for specific clinical circumstances. These guidelines are used to assist clinical decision making, assess and assure quality of care, educate individuals and groups about clinical disease, guide allocation of health care resources, and reduce the risk of legal liability for negligent care.

National Clinical Practice Guidelines – guidelines presented by national professional organizations and accepted by experts in the respective medical fields.

## III. PROCEDURES

### A. Guidelines

1. The responsible physician should develop a program, using nationally recognized clinical guidelines, to decrease the frequency and severity of symptoms, prevent disease progression and complication, and foster improved function.

2. Patients will be enrolled in the chronic care program upon initial provider physical intake assessment and/or throughout the remainder of their incarceration as identified.
   a. Patients enrolled in chronic care will be seen for their chronic disease within one month of initial enrollment.
   b. A qualified healthcare professional will be assigned to administer the chronic care program and will track and monitor all inmates in the program.
3. All orders for enrollment into chronic care will be given to the chronic care nurse. The chronic care nurse will be responsible for entering those patients into the chronic care database and tracking them for the remainder of their incarceration and/or discontinuation from chronic care.

4. Chronic diseases monitored through the chronic care program are: Diabetes, Hypertension, Hyperlipidemia, Pulmonary Disorders, Hypo/Hyper Thyroid, Seizure Disorder, Cardiovascular Disease, HIV/AIDs, and Sickle cell, Tuberculosis Mood disorders, and psychotic disorders. Chronic illnesses requiring a treatment plan will be listed on the master problem list in the patient chart.

5. Laboratory tests and diagnostic tests for chronic care visits will be ordered at chronic care visit and completed prior to the chronic care appointment, to allow for a review of the data at the time of the patient encounter with the practitioner.
   a. Laboratory and diagnostic testing will be ordered in accordance with accepted national clinical practice guidelines. Providers will use the *Chronic Care Follow-up* forms as a guideline for timely lab and follow-up intervals.
   b. All labs and diagnostic testing ordered by providers for the purpose of Chronic Care visits will be discussed by the provider with the patient at the next Chronic Care appointment following the lab or test.
   c. The chronic care nurse will review each chart following the chronic care visit to assure appropriate labs and diagnostic tests were ordered, as indicated. If labs and /or diagnostic tests were not ordered and are due, the chronic care nurse may write an order for those needed labs and diagnostic tests within accepted national clinical practice guidelines.

6. Documentation for each chronic care visit will be filed in the patient's health record under the chronic care tab and on the appropriate chronic care visit flow sheets and chronic care follow up forms.
   a. The nurse assigned as the clinic nurse on the day of the chronic care encounter will enter the patient's most recent lab result on the *CC Flowsheet Form.docx* under the appropriate chronic disease prior to the chronic care visit. Vitals for each visit will also be noted in the appointed area at the top of the flow sheet.
      1) Patient's chronic disease will be highlighted on the chronic care flow sheet and will be highlighted and circled on the chronic care follow-up form.
   b. The *Chronic Care Follow-up form* will be completed by the provider, and all areas of the form will have documentation.
      1) The provider may write additional information or other condition information in the progress note as long as the chronic care follow-up form is completed.
      2) The provider will document all health education and instruction in self-care from the appointment on the Chronic Care Follow-up form.
      *3)* The provider will document improvement or digression of disease progress and appropriate follow-up using the appropriate areas on the *Chronic Care Follow-up form.*

4) The provider will indicate on the Follow-up form the type and frequency of diagnostic testing and therapeutic regimens. (i.e. diet, exercise, medication)
5) The chronic care nurse will review each chart following the chronic care visit to verify that each area of the follow-up form has been addressed.

c. The same forms are used for the above listed chronic care diseases except for HIV/AIDs. This disease has a separate *HIV/AIDs flow sheet*. This flow sheet will be filled in by a qualified health care professional prior to appointment with the provider.

d. The forms are reminders of guidelines for practice, monitoring, and documentation. Any clinically indicated deviations from the guidelines are to be documented and explainedFollow-up orders and, when indicated, labs and diagnostic tests will be ordered after every patient’s chronic care visit based on the guidelines and/or the provider's examination and treatment.

e. Follow-up orders for chronic care will be based on the patient’s health at the time of the visit and will follow guidelines from the Chronic Care Follow-up form. Any deviation from those standards will be documented per the provider. Should the provider fail to write orders for follow-up appointments or labs, the chronic care nurse will schedule the patient for a chronic care visit within the timelines prescribed on the Chronic Care Follow-up form.

7. Follow-up appointment and labs will be entered into the computer system by laboratory and scheduling.
   a. Labs will be entered through lab and scheduled for draw based on time period ordered for next chronic care appointment.
   b. Scheduling will then receive the order and will schedule a chronic care appointment within the time period ordered by the provider and within a two-week time period after the lab draw is scheduled.
   c. All providers’ orders for chronic care will be routed to the chronic care nurse. The chronic care nurse will track information concerning the appointment and the next scheduled appointment into the chronic care database.

8. All charts seen for chronic care will be given to the chronic care nurse for review and data entry into the database.
   a. The chronic care nurse will enter all current lab work, diagnostic tests, and other pertinent information as it pertains to that patient's chronic disease, into the chronic care database, (ie: hypertension will have blood pressures, pulmonary will have peak flows, etc.)
   b. This is the time when the providers’ documentation and orders will be reviewed by the chronic care nurse.

9. The chronic care nurse may be requested by the practitioner to follow-up with chronic care patients to help assure compliance with medication, diet, and treatment plan as well as education on their disease and self-care.
   a. The chronic care nurse may also initiate education to inmates individually or in groups through the use of classes, audio and videotapes, brochures and pamphlets, or other available medical information. The education will be based on chronic diseases, self care, medication compliance, diets, exercise, and other medical and healthy lifestyle needs.
   b. All health education and instruction in self-care done by the Chronic Care nurse will be documented in the patient health care record.

10. Patients may be discontinued from the chronic care program if they have been asymptomatic subjectively and objectively (including labs) for two years while off all medications or treatments and the clinician writes orders and documents rational for discontinuation from chronic care.

11. All refused Chronic Care appointments will be documented and rescheduled including utilizing the Refusal of Appointment form as per procedure.

## IV. CLOSING

Questions concerning this operational procedure will be directed to the Clinical Services Manager.

## V. ATTACHMENTS: None