OFFICE OF TREATMENT SERVICES

OFFICE OF INMATE HEALTH SERVICES

CHRONIC DISEASE MANAGEMENT MANUAL

Date Issued:	01/07/2008
Dates Reviewed:	07/15/2008
	09/29/2009

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All Policies and Procedures will be reviewed, at a minimum, annually by Office of Inmate Health Services Staff

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

CHRONIC DISEASE MANAGEMENT MANUAL

Chapter 1
CHRONIC CARE CLINICS

Section 1
GENERAL PROCEDURES

I. Policy:

The Department of Public Safety and Correctional Services (DPSCS) shall provide a comprehensive chronic care program that insures that conditions requiring chronic care management are appropriately diagnosed, treated, monitored and controlled to prevent and minimize decomposition.

II. Procedures:

A. Enrollment in Chronic Care Clinics

1. Inmates with chronic medical conditions shall be identified during the Receiving Screening/Intake Process and other clinical encounters, (e.g. sick call, periodic physical) and scheduled for evaluation in chronic care clinics within one month of their incarceration and within one month after each and every transfer to a new DPSCS facility.

    a. Inmates identified as chronically mentally ill, shall be referred to the Mental Health Services Contractor by the Medical Health Care Contractor immediately upon identification.

2. All chronic diseases shall be listed on the Problem List of the medical record and updated by the physician.

3. Individualized treatment plans through periodic outpatient evaluations that minimize acute hospital care services and prevent misuse of primary care services, shall be developed and implemented.

4. All initial medical evaluations of inmates in chronic care clinics shall be conducted by a CRNP or a physician.

B. Subsequent Encounters

1. Subsequent chronic care visits may be conducted by a PA with a physician review and co-signature within 48 hours.
2. Inmates in chronic care clinics shall be evaluated at a minimum of every three (3) months by a CRNP or midlevel provider.

3. At a minimum of every six (6) months, the evaluations must be conducted by a physician.

4. Additional RN nursing and clinician chronic care clinic evaluations shall be scheduled when medically indicated based on the specific diagnosis and disease severity.

    a. A monthly evaluation and education session regarding treatment plan compliance shall be scheduled for complicated patients whose encounters with a provider exceeds the routine quarterly chronic care clinic visits and shall be conducted by a RN or higher clinician.

C. Data

1. A computerized data base using a database program or format approved by the DPSCS shall be maintained to electronically track an inmates' participation in chronic care clinics.

2. The data elements must include but not be limited to:

    a. Inmate Number

    b. Intake Date

    c. Update Date

    d. Last Name

    e. First Name

    f. Middle Initial

    g. Race

    h. Date of Birth

    i. Service Area

j. Facility

k. Diagnosis #1

l. Diagnosis #2

m. Diagnosis #3

n. Date of Baseline exam

o. Date of last clinical evaluation

p. Date of next clinical evaluation

q. Active/Inactive

r. Date of inactivity

s. Discharge Date

D. Medical Evaluations

1. At a minimum, chronic care clinic visits conducted by a clinician shall include routine preventative medical evaluations consonant with good medical practice and shall include at least the following “SOAP” formatted documentation within the medical record,

    a. Patient medical history and complaints; date and time of the clinical encounter,

    b. Measurement of vital signs, weight, and baseline height shall be documented in the medical record for each clinic visit;

    c. Targeted physical examination relevant to the chronic disease; abnormal clinical and laboratory test results documentation,

    d. Indication of a disposition by poor, fair, good, with respect to disease control management included in the assessment

    e. Dietary, medication and disease education as medically appropriate,

    f. Screening and diagnostic laboratories as medically indicated by the Agency approved clinical pathways and community guidelines

g. An individualized treatment care plan that includes a medication compliance review.

E. Failed Clinic Appointments

1. Each failure to appear for a clinic appointment shall have a reason documented by a clinician in the progress notes for chronic care clinics.

2. If an inmate fails to appear for chronic care clinic as a result of the inmate refusing an evaluation or treatment, the clinician shall have the inmate sign a “Refusal of Care” form.

a. The form shall be placed in the medical record in the standard record format.

b. The inmate shall receive counseling/education regarding the impact of his refusal on his health, renewal of his chronic care medications, and the signs and symptoms of the serious potential morbidity or mortality as a result of not being monitored. The physician shall document the encounter in the medical record.

c. The inmate should be scheduled for another chronic care appointment with the physician within 30 days of the refusal or sooner, if clinically indicated for an additional opportunity to reconsider his/her decision.

d. If the inmate, after counseling, elects to continue his refusal for chronic care disease monitoring, revisit the signs and symptoms indicating a potential problem.

i. Repeat the refusal process documentation/education,

ii. Advise the inmate that failure to show for his/her next scheduled appointment may result in a discharge from chronic care clinic monitoring.

iii. The inmate should be advised to place a sick call encounter slip for any problems experienced as a result of his refusals.

iv. The encounter shall be documented and the witness to the counseling documented in the medical record

III. Reference: None.

IV. Rescissions: DCD 130-100, Section 118, Chronic Care Clinics all issuances and versions

V. Date Issued: July 15, 2007

VI. Date Reviewed: September 29,2009

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CHRONIC DISEASE MANAGEMENT MANUAL

Chapter 1
CHRONIC CARE CLINICS

Section 2
ASTHMA/COPD CLINICS

I. Policy:

Inmates with asthma shall be identified and classified at the time of intake. Every inmate encounter shall have a measurement of peak flow and pulse oximetry taken, be enrolled in Chronic Care Clinics, and monitored in accordance with the guidelines established to treat these conditions as referenced by national and community guidelines. Asthma medications /inhalers shall be “Keep On Person”. Patients whose exacerbations do not respond promptly to inhaled beta agonists shall be admitted to the infirmary or hospitalized.

II. Procedure:

A. Inmates with clinically suspected chronic lung disease shall receive a baseline medical evaluation by a licensed provider that has an asthma-related focus and shall include, at a minimum:

1. A complete medical history including age at onset of asthma, allergies and precipitants hospitalizations, intubations, ER visits, Medication use (steroids) , peak flow testing done in the past

2. Lung function

3. PEFR variability

4. Associated symptoms (rhinitis, sinusitis, gastro-esophageal reflux disease (GERD)

5. Diagnostic/Lab evaluation

6. Peak Expiratory Flow Measurement (spirometry w/questionable diagnosis)

7. Chest X-ray (CXR) to exclude alternative diagnosis, and a chest radiograph baseline if clinically indicated or not done within one year;

8. Bronchial provocation if spirometry is normal

9. Sinus X-ray or CT scan

10. GERD evaluation

11. Request for old medical records

12. Targeted physical examination including thorough evaluation of the upper and lower respiratory tracts and cardiovascular system;

13. Spirometry – (PEFR); right peak flow

14. Pulse oximetry

15. EKG (if 45 or older)

16. Medication review for drugs that exacerbate respiratory conditions.

17. Other studies as medically indicated for diagnostic and management purposes including: complete blood count (CBC with differential), sinus radiographs, pulmonary function tests, sputum examination for eosinophilia, rhinoscopy, pulmonary consultation etc.

18. Physical Indicators include a pulse per minute <100 , 100-120; > 120

19. Functional Assessment parameters the clinician will use in classifying the severity of the disease and in determining the plan of care include:

    a. PEF % of predicted or personal best of > 70 %, 50-70 %, or< 50%

    b. Response to ß2-agonist is “Sustained for > 4 hrs”, “Sustained for 2-4 hrs”, or “Sustained less than 2 hrs”

    c. Once determined the detainee has a chronic lung condition, the clinician will class the severity of the disease as “Mild Intermittent”, “Mild Persistent”, “Moderate Persistent”, or “Severe Persistent”

20. Once identified, inmates diagnosed with asthma/COPD shall be routinely evaluated by clinicians and nursing staff in accordance with community standards, the medical contract, and chronic care clinic procedure.

21. Physician assistants and nurse practitioners shall refer all inmates to a physician when the following complications of asthma/COPD have been identified:

    a. Reduction in PEFR to 300 liters/min or less or reduction in PEFR > 20% from baseline or any evidence by history or physical examination that asthma/COPD is poorly controlled.

    b. Oxygen saturation less than 95% for asthmatics or reduction below baseline for inmates with COPD.

    c. Change in cardiac status: new murmur, bradycardia or tachycardia, arrhythmia, or evidence of congestive heart failure.

B. Indications for immediate transfer to a hospital emergency room include any one of the following:

1. Mental Status-Lethargy, Confusion

2. Cyanosis

3. Syncope or near syncope

4. Paradoxical pulse greater than 11 mm Hg

5. PEFR < 50% from baseline

6. PEFR < 150 liters/min

7. Failure of PEFR to improve at least 10% after initial treatment

8. Pa02 < 60 mm Hg or Sa02 < 90%

9. PC02 > 40 mm Hg

10. Speech-mute or only single words secondary to inability to breath

11. Hypotension

12. Cannot perform peak flow test

13. Pulse oximetry is less than 90

14. Skin appears cyanotic

15. Non-responsive

C. Goals of treatment for all patients with chronic lung disease include:

1. Minimal or no chronic symptoms day or night

2. Minimal or no exacerbations

3. No limitations on activities

4. Prevent recurrent exacerbations.

5. Maintain (near) normal pulmonary function

6. Minimal use of short-acting inhaled ß2-agonists, and provide optimal pharmacotherapy with minimal or no adverse effects

D. Asthma and COPD shall be treated in accordance with current community standard of medical care including, as applicable, guidelines from the American College of Thoracic Society. The following general principles are applicable for treating inmates with asthma: Stepwise Approach for Managing Asthma in Adults.

1. The clinical features of severity are evaluated before the treatment is determined.

2. The presence of one of the features of severity is sufficient to place a patient in that category. An individual should be assigned to the most severe step in which any feature occurs. The characteristics are general and may overlap because of the variability of the illness.

3. Step up to the next level if control is not maintained.

4. Before increasing medications, assess reasons for poor control. (i.e., inhaler technique, medication adherence, and environmental exposures or triggers).

5. Consider stepping down to the next level after 3-6 months of control on the minimal dosage of medications.

6. Gain control of symptoms as quickly as possible. Gaining control may require a course of systemic corticosteroids or higher dose of inhaled corticosteroids.

7. Persistent asthma is most effectively controlled with daily long-term-control medication, specifically, anti-inflammatory therapy.

8. A rescue course of systemic corticosteroids may be needed at any time at any step.

9. Decrease treatment to the minimal dosage of medication necessary to maintain control.

10. At each step, patients should control their environment to control factors that make their asthma worse.

11. Exacerbations may occur at any step and may be mild, moderate or severe in nature.

12. Some patients with intermittent asthma experience severe and life-threatening exacerbations separated by long periods of normal lung function and no symptoms.

E. The following severity levels are used in determining treatment paths and modalities:

1. “Mild Intermittent Asthma”, can be identified:

a. Symptoms = 2days/week

b. Symptoms = 2 nights/month

c. PEF or FEV1 = 70% predicted

d. PEF variability < 20%

e. Asymptomatic and normal PEF between exacerbations

f. Exacerbations are brief (few hours to a few days).This patient may not be a candidate for daily medications.

g. Severe exacerbations may occur, separated by longer periods of normal lung function and no symptoms. A course of systemic corticosteroids is recommended.

h. Provider encounter – Q 3 months, monitor in CCC.

2. “Mild Persistent Asthma”, can be identified:

   a. Symptoms = 2/week but = 1/day

   b. Symptoms > 2 nights/month

   c. PEF or FEV1 = 70%

   d. PEF variability 20-30%

   e. Exacerbations may affect activity. Clinician may recommend a trial of low dose inhaled corticosteroids

   f. An alternative therapy may include Leukotriene modifiers, theophylline, nedocromil or cromolyn

   g. Person should have a physician visit – every three (3) months and be monitored in chronic care clinic.

3. “Moderate Persistent Asthma” can identify:

   a. Daily symptoms

   b. Symptoms > 1 night/week

   c. PEF or FEV1 > 50% - < 70%

   d. PEF variability > 30%

   e. Daily use of inhaled short-acting ß2-agonists

   f. Exacerbation affects activity

   g. Exacerbations > 2/week, may last days

   h. Preferred treatment to be ordered by the clinician includes:

      i. Low to medium dose inhaled corticosteroids and long-acting inhaled ß2-agonists

      ii. Alternative treatment may include: Increase inhaled corticosteroids within medium-dose range OR Low-to-medium dose inhaled corticosteroids and either leukotriene modifier or theophylline.

iii. Person should have a physician visit monthly and be monitored in the chronic care clinic

4. “Severe Persistent Asthma” can be identified:

a. Continual symptoms

b. Frequent exacerbations

c. Limited physical activity

d. Frequent nighttime symptoms

e. PEF or FEV1 = 50%

f. PEF variability > 30%

g. Preferred treatment is high dose inhaled corticosteroids AND long-acting inhaled ß2-agonists AND (if needed) corticosteroid tablets long-term

h. Person should have a physician visit weekly and be monitored in the chronic care clinic.

i. Quick Relief includes short-acting bronchodilator: inhaled ß2-agonists as needed for symptoms. Intensity of treatment will depend on severity of exacerbation: up to three (3) treatments at 20-minute intervals or as a single nebulizer treatment as needed. Course of systemic corticosteroids may be needed.

5. Use of short-acting inhaled ß2-agonists > 2/week in intermittent asthma (daily or increasing use in persistent asthma) may indicate the need to initiate (increase) long-term-control therapy and to monitor therapy for a short period in the infirmary to assure compliance.

F. Additional treatment considerations include:

1. An inmate with moderate to severe asthma, upon transfer to another DPSCS institution, shall be seen and evaluated by a physician within 72 hours following transfer at the receiving institution.

2. Any inmate who has recently been hospitalized for an acute asthma episode shall be observed and monitored in a regional infirmary for 24 hours before being released to general cell population.

3 All attempts must be made to ensure that inmates with asthma receive their necessary medications. If an inmate has not received scheduled asthma medications within a 48-hour time period, nursing staff will notify security personnel and request that the inmate be taken to either the dispensary or infirmary to receive the medications. Refusal to take medication must be documented in the medical chart. Inmates shall be educated to bring their inhaler with them when requesting renewals.

4. All inmates with an asthma condition and fever of 101° will be admitted to the regional infirmary if they experience more than two (2) asthmatic episodes, requiring nebulizer treatments within a 24-hour time period. Acute tracheal-bronchitis can complicate asthmatic conditions. Admission to a community hospital may be required on a 911 basis, if aggressive medical management is unsuccessful in an infirmary setting.

5. Unless otherwise contraindicated, inmates with asthma and COPD shall receive pneumococcal vaccination and annual influenza vaccinations.

6. The following general principles are applicable specifically for treating inmates with COPD:

    a. Ipratropium and inhaled beta-agonists are the mainstay of treatment for COPD and are equally efficacious. Oral beta-agonists should not be used instead of inhaled agents due to the high incidence of side effects.

    b. The benefits of oral theophylline and corticosteroids in treating COPD are undefined. These agents should be prescribed on a case by case basis if not contraindicated and only continued if shown to be efficacious.

    c. Supplemental oxygen is medically indicated for hypoxemic inmates with COPD according to the following criteria:

        i. Pa02 < 55 mm Hg or Sa02 < 89% at rest

ii. Pa02 < mm Hg or Sa02 < 89% with exercise

iii. Pa02 < 55 mm Hg or Sa02 < 89% during sleep

iv. Evidence of pulmonary hypertension or corpulmonale, mental or psychological impairment, or polycythemia and a Pa02 of 56 to 59 mm Hg or Sa02 < 90% at any time.

7. Documentation in the EMR and/or the paper medical record in the unavailability of the EMR) is required of all personnel seeing, treating, or evaluating detainees with chronic lung disease:

a. All quarterly asthma/COPD clinic visits and other evaluations by a clinician shall be documented on the DPSCS Asthma/COPD Clinic Flow Sheet

b. Documentation of data on the DPSCS Asthma/COPD Clinic Flow Sheet shall always be accompanied by a progress note detailing the recent medical history, pertinent physical examination findings (not included on flow sheet), explanation of treatment plan, and plans for medical follow-up.

c. Any changes in the inmate's treatment regimen shall be documented on the DPSCS Asthma/COPD Clinic Flow sheet.

d. Health professionals will document all chronic diseases on the problem list along with any significant clinical event e.g.: intubations, respiratory failure.

e. The treatment plan will be evaluated and updated as necessary at every visit.

G. Patient Education shall include avoidance (when possible) of offending allergens, inhaler abuse, medication side effects, and when to seek care for asthma.

III. References:

A. Correctional Medical Services Clinical Pathway Asthma Management

B. National Asthma Education and Prevention program. Expert Panel Report 2: Guidelines for the Diagnosis and Management of Asthma,

National Institutes of Health Pub. No. 97-4051. Bethesda. MD. 1997.

IV. Rescissions: DPSCS 130-100-118B Primary Care Services/Specialty Medical Services: Asthmas/COPD Clinics

V. Date Issued: July 15, 2007
Reviewed: September 29, 2009

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CHRONIC DISEASE MANAGEMENT MANUAL

Chapter 1
CHRONIC CARE CLINICS

Section 3
PSYCHIATRY CLINIC

I. Policy:

All inmates requiring chronic mental health care shall have access to appropriate healthcare by a qualified mental health professional in accordance with community and national mental health guidelines.

II. Procedure:

A. The Medical Contractor shall provide sick call clinics five (5) days a week and shall continue clinics until every patient scheduled has been seen. For new detainees, the medical contractor shall perform a medical receiving screening not later than two (2) hours after the inmate is received into the facility, and immediately refer for mental health assessment and treatment any inmate identified as:

1. Having signs and symptoms of a current/chronic mental illness.

2. Reporting having a current mental illness.

3. Medical screening indicating the possibility of mental illness.

4. Having current or history of suicide ideation.

5. Having a history of unstable mental health.

6. Presenting a history of psychotropic drug use.

7. Presenting a history of hospitalization for mental illness.

B. The mental health contractor shall provide mental health intake assessments and evaluations daily for pretrial detainees and at intake facilities.

1. Inmates found to have chronic mental health diseases shall be identified and referred for enrollment in a mental health chronic care clinic. The diagnosis shall be placed on the Problem List and be assigned an ICD-9 and a CPT code.

2 The inmate in mental health chronic care will see a mental health provider monthly and a psychiatrist at a minimum of quarterly each year.

3. Documentation of the encounters will include at a minimum, vital signs, weight, medication compliance, improvement in symptom complaints, drug levels, outcome of prescribed drugs, and lab results where indicated, individualized treatment plan, medication disposition, and follow-up appointment when indicated.

C. The mental health contractor shall maintain an electronic "mental health chronic care database" using a data base program or format approved by the agency via its Electronic Medical Record (EMR) to document patient behavior and referrals received for mental health for assessment.

1. A hard copy of any mental health forms or material is to be included in the patient record along with documentation into the agency's patient health record/EMR.

2. The contractor shall provide to its staff, and its staff shall abide by DPSCS-approved, comprehensive mental health clinical pathways, Protocol and Procedure Manuals, including, but not limited to those regarding the Mental Health Component.

D. The mental health contractor shall provide all diagnostic studies including laboratory services necessary to implement the mental health services chronic care program.

1. Laboratory and diagnostic services in excess of $200.00 will require approval by the utilization contractor unless they are part of a treatment protocol.

2. A psychiatrist shall review all lab results within 48 hours after receipt of the tests to assess for follow-up care.

3. On-call psychiatrists shall be notified immediately of all stat lab reports and consult with the medical provider for management.

4. Documentation of abnormalities along with a treatment care plan shall be placed in the medical record.

E. All psychiatric medications shall be ordered as “watch take” and orders shall be consistent with DPSCS-approved mental health clinical prescribing guidelines and pharmacy manual.

F. Special confinement mental health inmates shall have the same access to chronic care clinics as the general population.

G. Juvenile offenders shall be managed for chronic mental health disorders consistent with relevant State and federal guidelines, and community standards.

III. References:

A. DCD 130-100-110 – Medical Intake Evaluation

B. RFP 2.2.1.6.3

C. RFP 2.2.1.6.3.7

D. COMAR DHMH Title 10

E. Healthy place.com

IV. Rescissions: DPSCS 130-100-118E Primary / Specialty Medical Services Psychiatry Clinic

V. Date Issued: July 15, 2007
Date reviewed: September 29, 2009

OFFICE OF TREATMENT SERVICES
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CHRONIC DISEASE MANAGEMENT MANUAL

Chapter 1
CHRONIC CARE CLINICS

Section 4
SEIZURE/NEUROLOGY CLINICS

I. Policy:

All DPSCS inmates diagnosed with seizure disorders or chronic neurological problems characterized by abnormal electrical activity in the brain that may result in events such as loss of consciousness, involuntary tonic or colonic muscle activity, or disturbances of the autonomic nervous system, shall receive routine evaluations and treatment in accordance with national clinical and community standards. They shall be identified if possible during the intake process and enrolled in a Chronic Care Clinic to provide monitoring of the condition on a scheduled basis. They shall receive education and medication appropriate for the type of epilepsy diagnosed.

II. Procedure:

A. An assessment of persons suspected to have seizure disorders on entry to the system includes, but is not limited to:

1. An initial history that emphasizes identification of the exact seizure type. This should be identified on the problem list. The International Classification of Epileptic Seizures (or some variation) should be used to classify seizure types. See This Chapter, Section 5: “International Classification of Epileptic Seizures”. A history of abuse is important in identifying possible causes of seizures.

2. The initial physical examination should include a mini-mental status evaluation as well as an evaluation of physical signs for medication side effects. In addition, a thorough neurological examination must be documented.

3. Baseline laboratory studies shall be ordered to establish liver and kidney function stability following the DPSCS lab flow and will include CBC, liver function enzymes, urinalysis,

Blood Urea Nitrogen (BUN), creatinine, medication drug levels.

4. An oral hygiene exam with referral to the dentist for baseline gingival assessment shall be done.

5. Any diagnosis of epilepsy/seizure disorder should be verified. This is especially true for long-term facilities. Every attempt should be made to acquire the patient's old medical records from the community .When old records, including EEG records, are not available, it is important from the history to reestablish the diagnosis. Some tests including EEG may have to be repeated.

6. For patients with known epilepsy, a system must be in place to ensure that medications will continue without interruption.

B. Documentation of seizure treatment characterized by entry into the progress note should note the level of seizure management as:

1. Good control: characterized by an absence of seizure activity since the prior visit.

2. Fair control: characterized by one (1) seizure since the last visit.

3. Poor control: characterized by more than one (1) seizure since last visit

C. Follow up visits to the clinician should include enrollment in Neurology Chronic Care Clinic and:

1. Patients in good control shall be seen at a minimal of every three (3) months by the provider and nurse.

2. Patients whose seizure control is fair or poor should be assessed for medication adherence and other exacerbating factors. Physicians should consider placing these patients on directly observed therapy (DOT), when serum drug levels are low, and when patients experience seizures.

3. Patient with poor control (continued failure of seizure control) should receive prompt consideration of neurology consultation for treatment modification. The greater frequency of seizures the greater the frequency of visits.

D. Content of follow-up visits to the clinician includes:

1. An updated history. The clinician should inquire about the frequency and description of occurring seizures since the patient's last visit. Medication adherence and any exacerbating factors should be addressed.

2. Objective data: The medication administration record shall be reviewed for compliance or non-compliance at each visit.

3. Evaluation of signs of medication toxicity or other medication complications should be documented (e.g. nystagmus)

4. Performance of relevant parts of a neurological examination should be documented when indicated.

5. Laboratory monitoring with serum blood levels, complete blood count, and liver function tests should be performed and documented on the chronic care flow sheet as indicated.

6. An assessment for drug interactions.

7. A documented assessment of:

    a. The degree of control (of the seizure activity) as being good, fair, or poor.

    b. The status (of the seizure activity) in relationship to the previous visit as improved, unchanged, or worsened.

        i. Improved status: when the number of seizures has diminished since the patient's last visit.

        ii. Unchanged status: when the frequency of seizures since the last visit has remained the same.

        iii. Worsened status: when the number of seizures has increased since the last visit.

8. An indication that environmental controls are being addressed including:

a. Patients with recurrent seizures have been counseled about or removed from potentially hazardous work assignments (e.g., use of power equipment).

b. Patients with a history of seizures have been assigned to lower bunks.

c. Where pseudo seizures are a concern, consideration of observation in an infirmary.

E. Required documentation includes at a minimum:

1. All seizure/neurology clinic visits and other evaluations by a clinician shall be documented on the DOC Seizure Clinic Flow Sheet.

2. Documentation of data on the DOC Seizure Clinic Flow Sheet shall always be accompanied by a progress note detailing the recent medical history, pertinent examination findings not documented on the flow sheet, treatment plan, and plans for medical follow-up.

3. Any/all changes in the inmate's treatment regimen shall be documented on the flow sheet.

4. Nursing assessments shall be documented in the progress notes.

F. Acute management of new onset seizure activity includes the following considerations and treatment steps:

1. For jails, new onset seizures at intake should result in prompt workup for secondary causes of seizures with MRI/CT scan, metabolic studies and EEG. Alcohol or other drug withdrawal and brain trauma should be excluded prior to housing the patient in the general population.

2. Patients with alcohol and other drug withdrawal seizures do not require treatment with antiepileptic drugs once the withdrawal seizure has been treated and has abated.

3. Establishing IV line and administration of anticonvulsant as ordered by the physician.

4. The inmate should have at least 23 hours of direct observation by medical staff immediately following the seizure.

5. Consultation with a neurologist should be considered.

6. Patients with epilepsy that requires drug treatment should be treated with an appropriate antiepileptic regimen for their particular epilepsy syndrome.

7. Use of a single drug as few times a day as appropriate and with the fewest side effects possible is preferred. All newly diagnosed patients who require therapy should be started on monotherapy.

8. The goal of therapy is complete seizure control without unacceptable side effects. For patients without complete seizure control or with refractory epilepsy, referral to a neurologist should be considered.

9. Diagnosis will include a detailed history to ascertain whether or not the episode in question was indeed a seizure on all patients who present with seizure activity. Mimics of seizures such as syncope, transient ischemic attacks, migraine episodes, hysterical “pseudo-seizures,” Such mimicking behavior needs to be excluded. (Often, inmates may be misclassified as having epilepsy when their seizures are secondary to alcohol and other drugs. Such patients should not require anticonvulsant therapy.)

    a. Release of Information signed by the patient to receive old records.

    b. Persons with a new onset of seizure should have a magnetic resonance imaging (MRI) or computerized tomography (CT) study of the brain if an MRI is unavailable,

    c. EEG and blood tests (glucose, electrolytes, blood urea nitrogen (BUN), magnesium, phosphorus, calcium, etc) to exclude secondary causes of seizures.

    d. Depending on the presentation of the patient with new onset of seizures, other studies (e.g., lumbar puncture (LP) or cardiac studies)

e. When diagnosis is uncertain, specialty consultation (neurology) is recommended

f. Providers should always assess the medication levels, along with adherence, drug interactions, and exacerbating factors if patients are having continued seizures.

g. If a patient is shows evidence of having an increase in seizures, the clinician should order the medication to be directly observed therapy.

G. Clinical indications for imaging include:

1. Focal or progressive neurological deficit

2. First focal seizure

3. First generalized seizure when history and laboratory studies are negative. Some focal seizures may become secondarily generalized so rapidly that the focal nature of the seizure may not be apparent clinically

4. Elderly patients (age greater than 60 years)

5. Change in a seizure pattern or prolonged altered mental state in patients with epilepsy

6. Persistently altered mental state

7. Fever other than typical febrile seizure

8. History of significant head trauma

9. Persistent headache

10. Suspected primary malignancy of the brain

11. Patients on anticoagulants

12. AIDS

13. Chronic epilepsy with a poor therapeutic response

H. Clinical indications for referral to a neurologist include:

1. Unclear diagnosis

2. Unsatisfactory response to initial treatment

3. Need for medical management of inmates with seizures uncontrolled by a single agent, status epilepticus, or other serious complications.

4. Patients has a known or suspected organic cause for seizures

III. References:

A. Ambulatory, Primary, and Pharmaceutical Care, Health Management Guidelines. Milliman & Robertson, Inc. Volume 5, November 1997.

B. MD DPSCSD #118D, Seizure/Neurology Clinic.

C. National Commission on Correctional Health Care Clinical Guidelines for Correctional Facilities. www.ncchc.org 2003.

D. Standards for Health Services in Prisons, National Commission on Correctional Health Care, 2003.

IV. Rescissions: DCD MEDICAL 130-100-118D Primary/Specialty Medical Services Seizure/Neurology Clinic

V. Date Issued: July 15, 2007
Reviewed: September 29, 2009

OFFICE OF TREATMENT SERVICES
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CHRONIC DISEASE MANAGEMENT MANUAL

Chapter 1
CHRONIC CARE CLINICS

Section 5
INTERNATIONAL CLASSIFICATION OF EPILEPTIC SEIZURES

I. Policy:

DPSCS will ensure consistency in the identification of seizure activity by providing an accepted tool for use in classifying seizures for use by all medical and mental health contractors providing services to DPSCS detainees.

II. Procedure: All clinical staff will follow the following criteria for classifying seizure activity and ordering appropriate medications.

A. Partial (Focal) Seizures are those seizures that begin in a limited part of one cerebral hemisphere. Partial seizures are classified primarily on the basis of whether or not consciousness is impaired during the attack. When consciousness is impaired the seizure is classified as a complex partial seizure. Impairment of consciousness may be the first clinical sign, or simple partial seizures may evolve into complex partial seizures. In patients with impaired consciousness, some aberration of behavior may occur. A partial seizure may not terminate, but instead progress to a generalized motor seizure. Impaired consciousness is defined as the inability to respond normally to outside stimuli or altered awareness and/or responsiveness. Partial seizure can be classified into three fundamental groups:

1. Simple partial seizures: Seizures begin focally, and may progress to more generalized seizure activity. Consciousness is impaired. Automatic behaviors are associated often. An “aura” is usually present which may include “déjà vu” phenomenon, bad smell, or sensation of falling.

a. with motor symptoms (simple jerking of a limb)

b. with sensory symptoms (localized tingling)

c. with autonomic symptoms (butterflies in the stomach, sweating)

d. with psychic symptoms (fear, deja vu)

2. Complex partial seizures

a. with impairment of consciousness at onset

i. with automatisms (purposeless simple repetitive movements

ii. without automatisms

b. Simple partial at onset with later loss of consciousness.

3. Partial seizures evolving to generalized tonic-clonic seizures

a. Simple partial evolving to generalized

b. Complex partial evolving to generalized

c. Simple partial evolving to complex partial evolving to generalized

B. Medications used in epilepsy/seizure disorder management include:

1. Tegretol and Dilantin are first line treatments in adults. Depakote may also be used.

2. Serum levels of these drugs should be monitored to prevent toxicity, as there is variability of absorption and metabolism. There are many drug interactions, which can also affect the serum levels of these agents. Patients on long-term treatment with Tegretol need periodic monitoring of complete blood counts (CBC) and liver function tests.

3. Lamictal (lamotrigine), Neurontin (gabapentin), and Topamax (topiramate) have been approved as adjunctive or add-on treatments for this disorder. They all need to be carefully titrated and the prescribing literature should be consulted prior to use.

4. Table of Agents for Complex Partial Seizures

Trade Name	Generic Name	Strength	Dosage Form	Dosing Interval
Depakene	Valporic acid	250mg	cap	tid
Depakene	Valporic acid	250mg/5ml	susp	tid
Depakote	Divalproex sodium	125mg	EC tab	bid-tid
Depakote	Divalproex sodium	250mg	EC tab	bid-tid
Depakote	Divalproex sodium	500mg	EC tab	bid-tid
Dilantin	Phenytoin sodium	100mg	cap	tid
Dilantin-125	Phenytoin sodium	125mg/5ml	susp	bid-tid
Lamictal	lamotrigine	100mg	tab	bid-tid
Lamictal	lamotrigine	150mg	tab	bid-tid
Lamictal	lamotrigine	200mg	tab	bid-tid
Lamictal	lamotrigine	25mg	tab	2 bid
Neurontin	Gabapentin	100mg	cap	1-2 tid
Neurontin	Gabapentin	300mg	cap	tid
Neurontin	Gabapentin	400mg	cap	tid
Phenobarbital	Phenobarbital	100mg	tab	qd-tid
Phenobarbital (generic)	Phenobarbital	30mg	tab	qd-tid
Phenobarbital (generic)	Phenobarbital	60mg	tab	qd-tid
Phenobarbital (generic)	Phenobarbital	15mg	tab	qd-tid
Phenobarbital (generic)	Phenobarbital	20mg/5ml	elixir	qd-tid
Phenobarbital (generic)	Phenobarbital	100mg	tab	qd-tid
Tegretol	Carbamazepine	200mg	tab	qd-tid
Tegretol	Carbamazepine	100mg	tab	tid
Topamax	topiramate	200mg	tab	bid-tid
Topamax	topiramate	100mg	tab	2 bid
Topamax	topiramate	25mg	tab	for titration

C. Generalized seizures are those in which the first clinical changes indicate early involvement of both hemispheres. Consciousness may be impaired, and this first impairment may be the initial manifestation. Motor manifestations are bilateral. The EEG patterns are bilateral and reflect discharges that are widespread in both hemispheres.

1. Absence seizures' descriptions include

a. Typical absence: Brief, abrupt loss of contact with eyelid flutter and immediate return of awareness

b. Atypical absence: Longer and less abrupt episodes with changes in muscle tone or behavior

c. Diagnostic testing for Absence Seizures include that the EEG shows bursts of bilateral

synchronous and symmetric spike and wave activity.

d. Imaging is not routinely indicated.

e. Depakene (valporic acid) or Depakote (divalproex sodium) are the treatments of choice. Agents for Petit Mal Seizures may be added.

Trade Name	Generic Name	Strength	Dosage Form	Dosing Interval
Depakene (generic)	valporic acid	250mg	cap	tid
Depakene (generic)	valporic acid	250mg/5ml	syrup	tid
Depakote	divalproex sodium	125mg	EC tab	bid-tid
Depakote	divalproex sodium	250mg	EC tab	bid-tid
Depakote	divalproex sodium	500mg	EC tab	bid-tid
Klonopin (generic)	clonazepam	0.5mg	tab	qd-tid
Klonopin (generic)	clonazepam	1mg	tab	qd-tid
Klonopin (generic)	clonazepam	2mg	tab	qd-tid
Zarontin	ethosuximide	250mg/5ml	syrup	bid-tid
Zarontin	ethosuximide	250mg	cap	bid-tid

2. Myoclonic seizures: Single or multiple jerks of limb or body without clear loss of contact.

3. Clonic seizures: Convulsive events with repetitive high-amplitude jerking of limbs.

4. Tonic seizures: Convulsive events with continuous stiffening of limbs, sometimes with rotation of the head or body to one side.

5. Tonic-clonic seizures: Sudden loss of contact with a cry and tonic stiffening of the limbs and the body. Later the stiffness gives way to mostly synchronous shaking that increases in amplitude while decreasing in frequency. The attack may last a number of minutes before the shaking stops suddenly or gradually decreases in amplitude. The person is then unresponsive for minutes to hours.

6. History and physical findings include:

   a. Loss of consciousness with witnessed tonic/clonic movements.

   b. May have post ictal confusion and amnesia

   c. May have Todd's paralysis

d. Myalgia is usually prominent after tonic/clonic seizures

e. Evidence of tongue biting and incontinence are important clues.

f. Diagnostic Testing for tonic-clonic seizures where there is no clear clinical precipitant (alcohol or drugs, sleep deprivation, fever, or electrolyte imbalance), should include an EEG and brain imaging.

g. Medical treatment for these seizures is Tegretol and Dilantin as first line treatment in adults.

h. Depakene (valporic acid) or Depakote (divalproex sodium) are also helpful in most patients.

i. Serum levels of these drugs should be monitored to prevent toxicity as there is variability of absorption and metabolism. There are many drug interactions, which can also affect the serum levels of these agents. Patients on long-term treatment with Tegretol need periodic monitoring of complete blood counts (CBC) and liver function tests.

j. Lamictal (lamotrigine), Neurontin (gabapentin), and Topamax (topiramate) have been approved as adjunctive or add-on treatments for this disorder. They all need to be carefully titrated and the prescribing literature should be consulted prior to use.

7. Atonic seizures: Cause the sudden loss of muscle tone, which can cause a fall with injury.

8. Unclassified Epileptic Seizures: Some seizures cannot be classified because of inadequate or incomplete data. Some defy classification into the existing categories. Many of these are seizures occurring in neonates.

III. References:

A. Ambulatory, Primary, and Pharmaceutical Care, Health Management Guidelines. Milliman & Robertson, Inc. Volume 5, November 1997.

B. MD DPSCSD #118D, Seizure/Neurology

Clinic.

C. National Commission on Correctional Health Care Clinical Guidelines for Correctional Facilities. www.ncchc.org 2003.

D. Standards for Health Services in Prisons, National Commission on Correctional Health Care, 2003.

IV. Rescissions: DCD MEDICAL 130-100-118D Primary/Specialty Medical Services Seizure/Neurology Clinic

V. Date Issued: July 15, 2007
Reviewed: September 29, 2009

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

CHRONIC DISEASE MANAGEMENT MANUAL

Chapter 1
CHRONIC CARE CLINICS

Section 6
DIABETES CLINIC

I. Policy:

All DPSCS inmates diagnosed or suspected as having diabetes mellitus during any medical encounter or clinical evaluation at any point through the intake, detainment, sentencing, or confinement will receive focused evaluation and treatment in accordance with the guidelines set forth by the American Diabetes Association and established community guidelines. They shall have the opportunity to be enrolled into Chronic Care Clinics and be monitored in such a way that allows inmates to self-manage their disease and to proactively avoid poor outcomes. Inmates with insulin dependent diabetes should be permitted to self-inject insulin with a health care professional supervising and security maintained.

II. Procedure:

A. At all DPSCS intake facilities, inmates reporting a history of family diabetes or who exhibit symptoms suggestive of diabetes (polypro, polytypic, and polyphonic) will be offered a random blood glucose-screening test. If test results are 200 mg/dL or higher, the inmate will be offered a fasting blood glucose test to establish the diagnosis of diabetes mellitus.

B. Medication and medical nutrition therapy (MNT) shall be continued for known diabetics without interruption, upon entry into the DPSCS correctional system. Therapeutic or pharmaceutical equivalents may be substituted when clinically indicated. Additionally:

1. At all DPSCS intake facilities, insulin treated inmates should have a capillary blood glucose determination within 1-2 hours of arrival. The screening test of choice is the fasting plasma glucose level. A fasting glucose level >126 mg/dL is an indication for further diagnostic testing. If a random

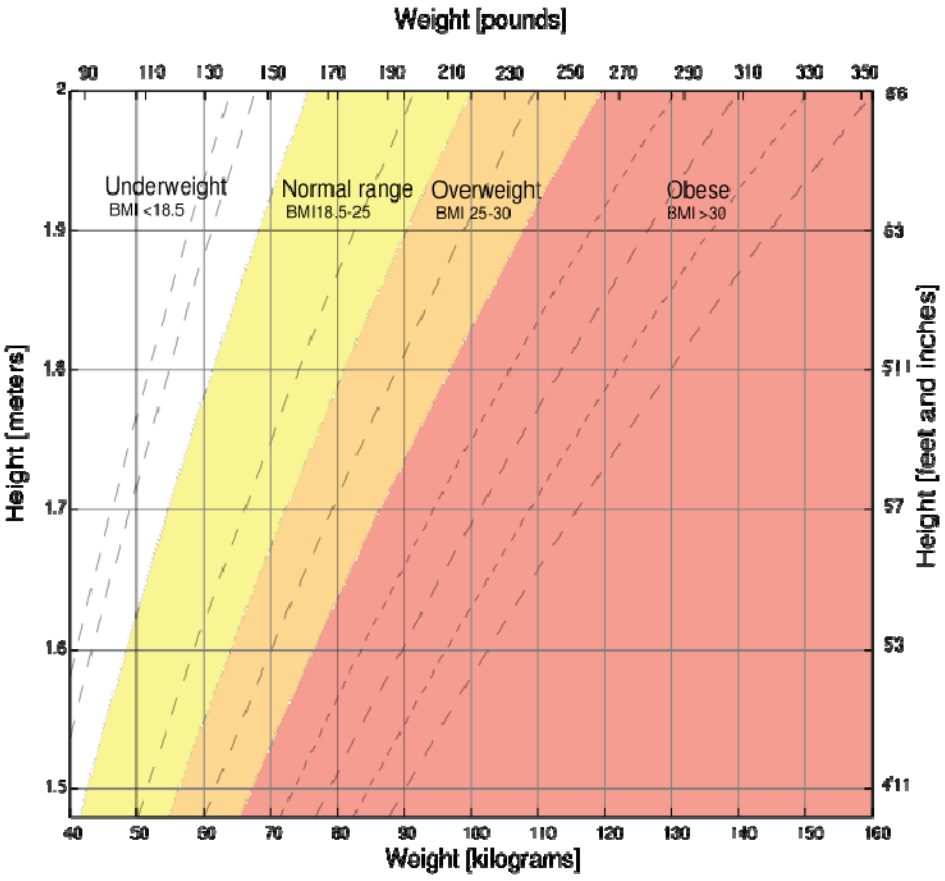
plasma glucose test is obtained, a glucose level greater than or equal to 200 mg/dL is an indication for obtaining fasting plasma glucose.

2. At all DPSCS intake facilities, inmate markedly obese (defined as having a Body Mass Index (BMI) of 30 or better will be offered a random blood glucose screening test. If test results are 200 mg/dL or higher, the inmate will be offered fasting blood glucose test to establish the diagnosis of diabetes mellitus.

   BMI is defined as the individual's body weight divided by the square of their height. Body mass index may be accurately calculated using the formula below.

$$\mathrm{BMI} = 703 \times \frac{weight\ (\mathrm{lb})}{height^2\ (\mathrm{in}^2)}$$

   BMI can also be determined using a BMI chart, which displays BMI as a function of weight (horizontal axis) and height (vertical axis) using contour lines for different values of BMI or colors for different BMI categories.



2. Additionally, the following inmate groups will be tested or offered testing:

    a. Inmates with a pregnancy history complicated by gestational diabetes, prematurely or birth weight greater than nine pounds.

    b. Pregnant women between the 24th and 28th week of pregnancy will be tested according to the community standard.

    c. Inmates with potential complication of diabetes such as retinopathy, neuropathy or proteinuria will be tested with a fasting plasma glucose test.

    d. Inmates with recurrent skin, genital or urinary tract infections will be tested with a fasting plasma glucose test.

C. Asymptomatic inmates with a positive random screening test for diabetes should have a follow-up fasting plasma glucose test. A fasting plasma glucose greater than 126 mg/dL is diagnostic of diabetes if confirmed by at least one other confirmatory fasting plasma glucose greater that 126 mg/dL.

D. Inmates with classic symptoms of diabetes such as polypro, polydipsia, and weight loss can be diagnosed with diabetes with a random plasma glucose greater than 200 mg/dL.

E. All inmates diagnosed with diabetes shall receive a baseline medical history and physical examination by a licensed provider.

1. Diagnostic, and laboratory studies shall include but not be limited to the following:

    a. Targeted examination of the cardiovascular system, thyroid, skin, feet, and nervous system including vital signs with documentation of additional cardiovascular risks;

    b. Ophthalmoscopic examination with dilatation baseline then annual eye exam to include dilation when indicated;

    c. Fasting blood glucose;

d. A1C Glycosylated hemoglobin (HbA1c) determination at minimum twice yearly;

e. Fasting lipid profile, treatment goals of LDL < 100, HDL > 40, Triglycerides < 150 mg./dL;

f. Serum creatinine;

g. Thyroid function tests;

h. Electrocardiogram (ECG);

i. Glomerular Filtration Rate (GFR);

j. Urinalysis.

2. A treatment plan shall be developed for all newly evaluated inmates with diabetes and shall include at least the following:

a. Initiation of a treatment plan with diabetic education, diet, and oral glucose-lowing agents or long acting insulin alone or an appropriate combination when medically indicated.

b. Consultation with a registered dietician to determine an appropriate medical diet and to provide dietary education.

c. Diabetes education consistent with the Standards of Medical Care for Patients with Diabetes Mellitus by the American Diabetes Association to include instruction on evaluating blood and urine glucose as medically appropriate.

d. A referral to an ophthalmologist or optometrist (if an ophthalmologist is unavailable) for a comprehensive eye and visual examination for all inmates diagnosed with diabetes annually and when indicated clinically.

F. Inmates diagnosed with diabetes will be evaluated by nursing staff or clinicians and shall be monitored and managed in a Chronic Disease Clinic. All known diabetics shall be entered into a Chronic Care database irrespective of a refusal for treatment.

1. Diabetes will be placed on the Problem List in the medical record.

2. Inmates who refuse to enroll in the chronic care clinic will receive education related to the impact of a lack of treatment on their life.

    a. They will be asked to sign a refusal of treatment form, and

    b. They will be called to clinic on a monthly basis to receive education and an opportunity to be treated.

    c. Non compliance with medication is addressed under the directives for medication administration.

3. Baseline and quarterly evaluations will be performed by a physician for all inmates with Type 1, insulin-dependent diabetes (unless more frequent evaluations by a physician are clinically indicated).

4. Baseline and quarterly evaluations by a clinician will be performed for all inmates with Type 2 diabetes (unless more frequent evaluations by a physician are clinically indicated).

5. Monthly nursing assessment, foot care and diabetic education will be provided for all inmates with diabetes. The nurse will document education activity on the Diabetic Flow Sheet.

6. Inmates initiated on insulin therapy should be monitored on a daily basis until glucose control is stabilized. Once stabilized, inmate may require two (2) or three (3) finger-stick glucose determinations daily.

7. Inmates initiated on a medical diet or oral glucose-lowering agents should be monitored on a weekly basis until glucose control is stabilized. Daily blood glucose determinations may be indicated until the blood sugar is within normal parameters.

8. All follow-up evaluations by clinicians shall include a:

    a. Medical history;

b. Targeted physical examination of the cardiovascular system, feet, skin, and nervous system;

c. Annual funduscopic evaluation by an ophthalmologist or an optometrist;

d. Glycosylated hemoglobin A1C at least semiannually, quarterly for Type 1 diabetic inmates and Type 2 diabetic inmates receiving insulin;

e. Fasting plasma glucose may be useful to judge glycemic control in patients with Type 2 diabetes;

f. Total cholesterol, triglycerides, and HDL cholesterol drawn annually;

g. Urinalysis with GFR obtained twice each year.

G. Medical Management of diabetes includes a goal of medical therapy that achieves a Hemoglobin A1C<7, and avoids the complications of diabetes associated with poor control (eye, kidney, heart disease). Enteric-coated aspirin, along with preventive measures related to weight management, smoking cessation, and diabetic foot care are mainstays of good control.

1. The practice of using a “sliding scale insulin dose” as a daily management strategy is to be discouraged.

2. Patients should have access to medications at dosing frequencies that are consistent with their treatment plan and medical direction in corrections, meal times and other barriers to care may create some difficulties.

3. Each sick call should be used by clinicians to evaluate behaviors that will impact diabetes such as canteen or commissary choices.

4. The following guidelines shall be considered in the medical management of Type 1 and Type 2 diabetes mellitus along with the DPSCS contractor-approved Clinical Pathways for Diabetes:

a. Inmates with Type 1 diabetes shall have their blood glucose monitored at least twice daily (using finger-sticks) until consistent tight control of the blood

glucose has been established.

b. Diabetic inmates with vision-threatening retinopathy may be completely asymptomatic; therefore annual screening of all diabetic inmates is indicated.

c. Inmates identified by screening or symptoms with macular edema, moderate to severe non-proliferative retinopathy, or any proliferative retinopathy shall be referred to an ophthalmologist for subspecialty evaluation and treatment.

d. Women with diabetes who become pregnant should have a specialist in OB-GYN and endocrinology follows their progress. Complete ultra sound and stress tests should be done as needed to evaluate the maternal and fetal health. The clinician will follow recommendations of the American College of Obstetrics and Gynecology which includes a comprehensive eye examination in the first trimester and close follow-up throughout pregnancy.

e. Hospital admission for inmates with diabetes shall be considered by the attending physician. Treatment for diabetic ketoacidosis and hyperosmolar hyperglycemic nonketotic syndrome is best carried out in a hospital setting. Transfer of the inmate to a local community hospital is required.

f. Angiotensin-converting enzyme (ACE) inhibitors are superior to conventional anti-hypertensive medications in reducing renal injury in diabetic nephropathy. ACE inhibitors should be considered in the treatment regimen of inmates with diabetic nephropathy with or without systemic hypertension.

5. Nursing staff shall notify a physician of all CBG results outside of a specified range, as determined by the treating physician (e.g. <50 or >350 mg./dL)

H. Insulin dependent diabetics, who are placed on segregation status, shall have access to their medications, and receive treatment for diabetes consistent with the general population.

I. Appropriate medical staff (RN or above) should be trained to administer glucagon for low blood sugar symptoms.

J. The following chart lists the types of inject able insulin with details about onset (the length of time before insulin reaches the bloodstream and begins to lower blood glucose) Type1 Diabetes Lantus is only administered once a day (and should be administered at the same time each day). Keep in mind that long-acting insulin may need to be given with shorter-acting insulin products (determined by the clinician on a case by case basis) that will likely need to be "timed" with mealtime.

Type of Insulin & Brand Names	Onset	**Peak	Duration	+ --Role in Blood Glucose Management
+ +Rapid-Acting				
Humalog or lispro	15-30 min.	30-90 min	3-5 hours	Rapid-acting insulin covers insulin needs for meals eaten at the same time as the injection. This type of insulin is used with longer-acting insulin.
Novolog or aspart	10-20 min.	40-50 min.	3-5 hours	
Apidra or glulisine	20-30 min.	30-90 min.	1-2 hours	
Short-Acting				
Regular (R) humulin or novolin	30 min. -1 hour	2-5 hours	5-8 hours	Short-acting insulin covers insulin needs for meals eaten within 30-60 minutes
Velosulin (for use in the insulin pump)	30 min.-1 hour	2-3 hours	2-3 hours	
Intermediate-Acting				
NPH (N)	1-2 hours	4-12 hours	18-24 hours	Intermediate-acting insulin covers insulin needs for about half the day or overnight. This type of insulin is often combined with rapid- or short-acting insulin.
Lente (L)	1-2 hours	3-10 hours	18-24 hours	
Long-Acting				
Ultralente (U)	30 min.-3 hours	10-20 hours	20-36 hours	Long-acting insulin covers insulin needs for about 1 full day. This type of insulin is often combined, when needed, with rapid- or short-acting insulin.
Lantus	1-1 hour	No peak time; insulin is delivered at a steady level	20-24 hours	
Levemir or detemir(FDA approved June 2005)	1-2 hours	6-8 hours	Up to 24 hours	
Pre-Mixed*				
Humulin 70/30	30 min.	2-4 hours	14-24 hours	These products are generally taken twice a day before mealtime.
Novolin 70/30	30 min.	2-12 hours	Up to 24 hours	
Novolog 70/30	10-20 min.	1-4 hours	Up to 24 hours	
Humulin 50/50	30 min.	2-5 hours	18-24 hours	
Humalog mix 75/25	15 min.	30 min.-2 hours	16-20 hours	

*Premixed insulins are a combination of specific proportions of intermediate-acting and short-acting insulin in one bottle or insulin pen (the numbers following the brand name indicate the percentage of each type of insulin).

****** Peak (the time period when the insulin is the most effective in lowering blood glucose) and **duration** (how long insulin continues to lower blood glucose). These three factors may vary, depending on your body's response.

Note: The recently approved inhaled insulin, Exubera, has an onset and peak that are comparable to the rapid-acting insulins; however, its duration appears to be more comparable to regular insulin.

K. To treat Type 2 diabetes, there are four (4) different classes of oral agents to control blood glucose levels, in addition to the use of insulin injections to help overcome insulin resistance.

1. Sulfonylureas HAVE been used for 40 years in the United States. They work in the pancreas, stimulating it to produce more insulin. Brand names include Amaryl, Diabeta, Diabinase, Dymelor, Glucotrol, Glucotrol- XL, Micronase, PresTab, Orinase, and Tolinase.

2. Biguanides has been available in the U.S. for two (2) years since 1995, but has been used in other countries for 30 years. It works in the liver to stop it from releasing too much glucose and reduces insulin resistance in muscle cells. Brand name is Glucophage.

3. Alpha-Glucosidase has been available in the U.S. since 1996. It works in the intestines slowing the digestion of some carbohydrates so that post meal blood glucose levels are lower. Brand name is Precose.

4. Thiazolidinediones are on the market in 1997. It works in muscle cells, making them more sensitive to insulin, thereby helping the body's own insulin do its job more efficiently. The brand name is Rezulin.

L. All diabetes chronic care clinic evaluations by a clinician shall be documented on the DPSCS Diabetes Clinic Flow Sheet

1. Documentation of data on the flow sheet shall always be accompanied by a brief progress note detailing relevant medical history, pertinent physical examination data not included on the flow sheet and an explanation of the initiation or alteration in the treatment plan.

2. Routine nursing assessments shall be documented in the progress notes of the inmates' medical chart.

3. All medical charts should contain blood sugar test results in a specified, readily accessible section.

4. Diabetic education related to foot care inspection, insulin sites, diet, exercise etc. Shall be documented by nursing staff monthly.

III. References:

A. Standards of Medical Care for Patients with Diabetes Mellitus Guidelines of the American Diabetes Association, Diabetes Care, Vo. 20, Supplement 1, January 1997.

B. Management of Diabetes in Correctional Institutions-American Diabetes Association: Clinical Practice Recommendation 2003.

C. Clinical Practice In Correctional Medicine, Puisis, DD, 1999

IV. Rescissions: Diabetes Mellitus Manual Diabetes Clinic

IV. Date Issued: August 15, 2007
Reviewed September 29, 2009

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

CHRONIC DISEASE MANAGEMENT MANUAL

Chapter 1
CHRONIC CARE CLINICS

Section 7
HYPERTENSION CLINIC

I. Policy:

To provide standardized guidelines for the medical management of DPSCS inmates diagnosed with hypertension, all DPSCS inmates diagnosed with hypertension will receive routine evaluation, treatment and follow-up for their disease in accordance with national and community guidelines.

II. Procedure:

A. All DPSCS inmates will be evaluated for hypertension during their intake medical evaluation, at periodic medical evaluations, and during sick call visits, infirmary stays etc.

1. Blood pressures will be measured by averaging two (2) or more readings with the inmate seated (arm at heart level) using appropriate cuff size. If there are elevations in the BP readings that exceed the recommended standards, BP readings should be taken in the sitting, standing and supine positions in both arms.

2. The diagnosis of hypertension is confirmed by three (3) separate elevated readings averaging 90 mm or greater for diastolic blood pressure (DBP) and over 140 mm for systolic blood pressure (SBP) or by any single SBP of 210 mm mercury (Hg) or greater or DBP is 120 mm or greater.

3. If the initial blood pressure reading is elevated, the inmate shall be referred for further evaluation in accordance with the following guidelines:

a. <u>SBP 140-159 DBP 90-99</u> (Stage 1/mild hypertension) – hypertension will be confirmed by nursing staff

repeating second and third blood pressure readings within two (2) months. Patients with confirmed mild hypertension should be referred to a clinician for baseline evaluation within one month.

b. SBP 160-179, DBP 100-109 (Stage 2/moderate hypertension) – nursing staff will refer the inmate to a physician for confirmatory blood pressure readings and a baseline evaluation within one (1) month.

c. SBP 180-209, DBP 110-119 (Stage 3/severe hypertension) – nursing staff will refer to a physician for confirmatory blood pressure readings and a baseline evaluation within one (1) week.

d. SBP 210 or greater, DBP 120 or greater (Stage 4/very severe hypertension) – nursing staff will refer to a physician for baseline evaluation and treatment immediately.

B. The Intake Medical Evaluation will include the elements necessary to make a diagnosis of hypertension.

1. Patient history will document :

a. Date of onset of symptoms or elevated readings,

b. Family History of hypertension,

c. Signs and symptoms for or knowledge of end-organ damage,

d. CV Risk factors including but not limited to tobacco use, weight changes, diet issues such as salt intake, alcohol /drug use etc, .

2. Physical exam will document:

a. Weight

b. BP taken with patient seated, at rest for at least five (5) minutes, using correct cuff size.

i. Take two (2) readings at least two (2) minutes apart.

ii. Take readings from both arms

c. Fundoscopic exam for retinopathy and will be followed with an annual eye exam with fundoscopic assessment for vascular disease, and a check for glaucoma.

d. Neck-carotid bruits, thyroid, venous distension

e. Coronary rate, rhythm, size, heave, murmurs, gallops

f. Absence or presence of rales in the lungs

i. Abdomen-bruits, masses, aortic pulsation,

ii. Pulsations, bruits, edema of extremities

C. Laboratory studies will include"

1. UA and Chem 12 at initial visit

2. EKG

3. Other optional studies, as necessary such as creatinine clearance, microalbuminuria, thyroid panel

D. Inmates diagnosed with hypertension will be enrolled in the Chronic Care Clinic for Hypertension where the following will be documented at every visit:

a. Medication Compliance, Symptoms, CV Risk factors

b. PE-Weight, vital signs, carotids, femoral checks

c. A Control Assessment meeting the following descriptions:

i. Good Control (< 140/90)

ii. Fair Control (140-160/90-105)

ii Poor Control (> 160/106)

d. Treatment will include:

i. The use of non-pharamacolic interventions Weight control, diet, appropriate exercise) in all patients.

ii. A trial of non-pharmacological treatment alone in High-Normals.

iii. Diuretics as initial pharmacological treatment.

iv. Beta-blockers added as a secondary pharmalocical treatment.

v. ASA prophylaxis, unless contraindicated

vi. Urgent Treatment consists of Clonidine 0.2 p.o., then 0.1 q hr up to six

vii. Sublingual nifedipine will NOT be used in hypertensive crises in the presence of acute CNS, CV,

viii. Renal or Retinal damage requires E. R transfer.

e. Special considerations in the determination of treatment needs will include:

i. Black patients may respond better to CCBs than to Beta-blockers

ii. All Diabetics should be on ACE inhibitors

iii. All patients with LVH or CAD should be on ACE inhibitors

f. Inmates seen for hypertension will receive patient education on the following subjects at a minimum:

i. Weight control

ii. Diet

iii. Exercise

iv. Alcohol use

v. Tobacco

vi. Med Adherence

vii. Risk Reduction

viii. Hypertensive Emergency Care

g. Follow-up Evaluations for inmates diagnosed with hypertension will include:

i. Baseline and annual evaluation by a physician and evaluation by a clinician every six months

ii. Quarterly evaluations by either nursing staff or clinicians by nurses and clinicians which shall include patient education regarding lifestyle modifications, medication side effects, and complications of untreated hypertension.

iii. The need for additional routine evaluations by clinicians and nursing staff in hypertension clinics will be determined by the evaluating physician based on the stage of hypertension, evidence of target-organ damage, the degree of blood pressure control, and the presence of complicating illnesses.

h. The following laboratory studies will be measured annually for all inmates evaluated in hypertension clinics:

i. Urinalysis, chem. 12, optometry/fundoscopic evaluation,

ii. End stage organ evaluation

iii. Other laboratory shall be ordered as medically indicated.

i. When evaluating hypertensive inmates, physician assistants and nurse practitioners shall refer all inmates to a physician for evaluations when the following problems have been identified:

i. SBP greater than or equal to 180

ii. DBP greater than or equal to 110

iii. Angina pectoris

iv. Intermittent claudication

v. New cardiac rhythm or murmur

vi. Rales, increasing peripheral edema, or weight gain greater than 10 lbs.

vii. New abnormal or worsening laboratory findings

j. All quarterly hypertension clinic visits and other evaluations for hypertension by a clinician shall be documented on the DPSCS Hypertension Clinic Flow sheet and shall always be accompanied by a brief progress note detailing relevant medical history, pertinent physical examination data not included on the flow sheet, and an explanation of the initiation or alteration in the treatment plan.

k. Routine blood pressure checks by nursing staff shall be documented on the progress notes.

l. Medical records for each inmate diagnosed with hypertension will include, at a minimum:

i. Documentation of classification

ii. Documentation of end-organ damage assessment

iii. Documentation of risk reduction interventions

iv. Documentation of good control

v. Documentation of patient education

E. All inmates with hypertension will be entered into the State's Chronic Disease Data Base.

III. References:

A. NCCHC Chronic Care Guidelines; 2004

B. CMS Clinical Guidelines Hypertension 2006

IV. Rescissions: DOC 130-118A Issued June, 1993

V. Date Issued: October 15, 2007
Reviewed: September 29, 2009

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

CHRONIC DISEASE MANAGEMENT MANUAL

Chapter 2
TERMINAL ILLNESS

Section 1
PALLIATIVE CARE

I. Policy

DPSCS shall provide comprehensive palliative care services, including medical care and necessary social services, for inmates with terminal illnesses who elect palliative medical care and who voluntarily accept such services. The Palliative Care Program shall be coordinated with security, social work, mental health, religious service, and volunteer service personnel.

II. Procedure

A. Assessment and Referral

1. All inmates with terminal illnesses shall be counseled by the attending physician in accordance with the "Do Not Resuscitate (DNR) Policy". The inmate's diagnosis, prognosis, DNR status, and advance directives (when applicable), shall be documented in the inmate's medical record.

2. Inmates with terminal illnesses who desire palliative care shall be counseled by the attending physician regarding the Palliative Care Program with its associated services. Inmates who choose to participate in the palliative care program shall sign the DPSCS Palliative Care Program Consent Form that shall be placed in the inmate's medical record. Explicit in the informed consent is the inmate's option to withdraw from the palliative care program at any time and seek aggressive treatment interventions for his/her disease.

3. Inmates with terminal illnesses who are unable to provide informed consent due to physical limitations may be considered for the Palliative Care Program if further resuscitative efforts are deemed futile and DNR status is documented in the medical record.

4. Inmates with terminal illnesses who are candidates for the Palliative Care Program shall be referred by the attending physician to the regional medical director who shall conduct a case review and evaluation that shall include at least the following:

   a. A review of the inmate's medical record to confirm the inmate's diagnosis and prognosis, documentation of counseling and DNR.

   b. An interview with the inmate to confirm that the inmate desires palliative medical care only, wishes to participate in the palliative care program, and has provided informed consent.

   c. The initiation of medical parole, if considered to be appropriate by the regional medical director.

5. If the regional medical director determines that the inmate is a candidate for the Palliative Care Program he/she shall complete the DPSCS Palliative Program Referral Form and shall forward the referral to the:

   a. Agency Contract Operations Manager

   b. Director of social services

   c. Regional social work supervisor

   d. Regional director of nursing

6. The regional social work supervisor shall ensure that a psychosocial assessment is completed within five (5) working days utilizing the DOC Guidelines for Psychosocial Assessment for palliative care services and shall forward the psychosocial assessment to the director of social work and addiction services.

7. If an interregional infirmary transfer is required by this decision and it is approved by DPSCS medical director, the sending regional medical director shall review the inmate's treatment plan with the receiving regional medical director with documentation that includes Transfer Screening.

8. The Director of Social Work Services and or designee shall ensure that the receiving infirmary's Regional Social Work supervisor is notified of the inmates transfer for hospice service.

B. Treatment

1. Upon an inmate's acceptance into the Palliative Care Program the inmate's attending physician shall convene a palliative care team that shall develop a treatment plan outlining the inmate's medical care and plans for social services. The palliative care team shall determine the need for additional services including but not limited to psychology, pastoral, and volunteer services.

2. The palliative care team shall convene at least weekly to review the inmate's current treatment plan. The attending physician, nurse, and social worker shall document (in the inmate's medical record) any changes in medical, nursing, or support service treatment recommendations.

3. All inmates participating in the Palliative Care Program shall be housed in a medical infirmary when medically indicated. An inmate may continue to remain within general population until that time.

4. Community resources may be utilized by the palliative care team, when indicated, to provide consultation and training for security, social service, and medical personnel. A medical release of information shall be signed by the inmate and placed in the medical record whenever community agency's resources are utilized (e.g. volunteers).

5. The palliative care team will notify the managing officer/designee of all inmates assigned to the Palliative Care Program. The managing officer/designee shall designate a security liaison to consult with the palliative care team to ensure the following:

    a. Implementation of the inmate's care plan does not compromise security,

    b. The inmate's treatment plan does not compromise the security of the infirmary and the institution.

C. Discharge

1. An inmate will be considered for discharge from the Palliative Care Program if any of the following occur:

    a. The inmate's condition is deems for to be treatable and no longer terminal.

b. The inmate decides to withdraw from the program.

c. The inmate's behavior is a security risk for involvement with the program.

2. The palliative care team shall determine if the inmate's discharge from the Palliative Care Program is indicated.

3. The inmate's discharge from the program shall be documented in the inmate's medical record by the attending physician/physician designee.

D. Inmate Death

1. The inmate's death shall be documented in the medical record by the inmate's attending physician/physician designee.

2. The inmate's social worker shall provide facilitative support for medical and mental health staff when indicated and family members per protocol.

E. Bereavement Services

1. The regional supervisor/designee will ensure that social work or another support service professional makes contact by telephone with the inmate's family or significant others and offers to refer anyone in need to an appropriate community agency.

2. The regional supervisor/designee will, as needed, facilitate a meeting for the volunteers, health care staff, and as appropriate, other infirmary residents for bereavement counseling.

F. The following information shall be documented in the inmate's medical record by the health care providers, social work, psychology, mental health etc.:

1. Weekly notes by the palliative care team.

2. Infirmary notes

3. Regular reports on the use of volunteer services.

4. Inmates death summary

5. A closing summary completed by the regional Supervisor/designee within one week of the inmate's death or departure from the program.

6. Closing notes on any bereavement counseling, completing within one week of its provision by the regional . Supervisor/designee.

III. References:

A. Do Not Resuscitate Policy

B. Medical Parole Policy

C. Inmate Death Policy

D. Transfer Screening Policy

E. Infirmary Care General Policies

F. Compassionate Notification for Illness, Injury, or Death

III. Rescissions: DCD 126-700, Hospice Supports Services, October 1, 1993
DCD 130-100-162 (7/1/1996)

IV. Date Issued: September 15, 2007
Revised September 17, 2009

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

CHRONIC DISEASE MANAGEMENT

Chapter 2
TERMINAL ILLNESS

Section 2
MEDICAL PAROLE

I. Policy: To establish criteria for inmate eligibility for medical parole consideration and procedures for evaluating potentially eligible inmates, an inmate may be considered for medical parole if, in the opinion of the regional medical director, the inmate will not jeopardize public safety if released, and the inmate:

- Has a terminal condition and an expected survival time of less than one year;
- Has a medical condition that incapacitates the inmate to the extent that continued imprisonment is not required to ensure public safety;
- Has a medical condition that, if the inmate were released, would more appropriately be treated through direct access to community treatment facilities; or,
- Has a condition which will require extended inpatient or skilled nursing care that exceeds the ability of the medical staff to manage.

II. Procedure:

A. The regional medical director shall be responsible for initiating procedures for medical parole.

!. The regional medical director/physician designee shall medically evaluate all inmates who are candidates for medical parole.

2. If an inmate meets the DPSCS criteria (noted in Policy Statement) for medical parole consideration, the regional medical director/physician designee shall inform the inmate of the process for consideration for medical parole.

a. The inmate shall sign consent for release of medical information (relevant to his/her qualification for medical parole) addressed to the head of the case management department, the warden, and to community support services essential to the development of an aftercare plan.

b. The signed consent for release of medical information shall be placed in the inmate's medical record.

3. The regional medical director shall complete and sign the Physician Evaluation for Medical Parole form, and ensure that the following four (4) individuals receive that form within five (5) working days:

a. The case management manager/supervisor or facility administrator at the facility housing the inmate, as appropriate;

b. The Regional Social Work supervisor;

c. The DPSCS medical director; and

d. The Director of Social Work Services.

B. Social Work Responsibilities include that:

1. Upon receipt of the Physician Evaluation for Medical Parole form, the regional social work supervisor shall assign the inmate's case to a social worker who shall develop an aftercare plan. Consultation and assure that other disciplines (such as psychology) shall be consulted and brought into discussion regarding the aftercare plan for the inmate as needed.

2. An outline of the aftercare plan shall be recorded on the Clinical Case Management Program Aftercare Plan.

3. By the fifteenth workday following receipt of the Physician Evaluation for Medical Parole form, the social worker assigned to the inmate's case shall submit the completed Clinical Case Management Program Aftercare Plan to the case management manager and forward a copy to the regional Medical Director.

C. Case Management Responsibilities include that:

1. Upon receipt of the Physician Evaluation form, the case management administrator shall immediately assign the inmate's case to a case manager to complete an Automated Pre-Parole Summary.

2. The chronological synopsis outline in the Automated Pre-Parole Summary shall begin with an entry of the inmate's last parole hearing and the results of that hearing.

    a. The assigned case manager shall make a recommendation for or against medical parole based on his or her analysis of the synopsis.

    b. This recommendation shall be based solely on public safety considerations. The case manager shall provide a rationale for the recommendation.

3. If the inmate has a detainer, the following steps shall be taken to resolve the detainer:

    a. The case manager shall notify the case management manager and shall then contact the agency that issued the detainer and advise the agency that the inmate is being considered for medical parole. The manager shall request that the agency consider lifting the detainer if the inmate is approved for medical parole.

    b. The manager shall request a written response from the agency holding the detainer within five workdays. All actions taken by the case manager shall be documented on the Inmate Progress Sheet and on the Automated Pre-Parole Summary.

        i. The documentation shall include the name of the agency contacted, the name of the person at the agency to whom the manager spoke, the agency telephone number, and the results of the telephone conversation.

        ii. If needed by the agency holding the detainer, a written request shall be sent to that agency.

iii. A copy of the agency's written response shall be forwarded to the commitment office for filing in the commitment file.

c. If the agency issuing the detainer fails to respond in writing within five (5) workdays or does not lift the detainer, the case manager shall initiate a follow-up telephone call to the agency to inquire about the status of the detainer.

i. The follow-up agency contact and response shall be documented on the Inmate Progress Sheet and the Automated Pre-Parole Summary.

ii. If the agency holding the detainer fails to respond to the follow-up request within two (2) workdays, the case management manager shall advise the director or chief of case management.

4. The case manager shall sign and forward the completed Automated Pre-Parole Summary to the case management administrator by the fifteenth workday after the initial Physician Evaluation form was received.

5. The case management administrator shall review and forward the signed Automated Pre-Parole Summary, the Physician Evaluation form and the Clinical Case Management Program Aftercare form to the warden to obtain his/her recommendation for or against medical parole, not later than the seventeenth workday after receipt of the Physician Evaluation form.

D. The warden/designee shall either approve or disapprove the recommendation for medical parole in the space provided on the Automated Pre-Parole Summary.

1. The warden/designee shall also provide rationale for his/her recommendation for or against medical parole.

2. Regardless of his/her recommendation, the warden shall forward all paperwork to the Director of Social Work Services by the nineteenth workday after receipt of the Physician Evaluation for Medical Parole.

E. Copies of all paperwork submitted to the Director of Social Work Services shall be filed in section II of the inmate base file and in the inmate's medical record.

F. A Division of Correction Headquarters Review shall include the following:

1. The Director of Social Work Services shall document receipt of the medical parole paperwork submitted by the warden and conduct an immediate review of the inmate's case in consultation with the DPSCS medical director.

2. Unless additional information is deemed necessary, the DPSCS medical director and the Director of Social Work Services/designee shall submit the medical parole paperwork with their recommendations and rationale for or against medical parole to the Commissioner/designee within (5) five workdays of the sequence noted above in Steps A through E...

3. The Commissioner/designee shall review the case and either approve or disapprove the recommendation.

G. A Maryland Parole Commission (MPC) Review will ensue and:

1. The MPC, upon review of the request for medical parole consideration, may request additional information as necessary from the DPSCS medical director, the Director of Social Work Services and the Director of Case Management.

2. The MPC shall review the medical parole request and forward its decision to the Commissioner, the DPSCS medical director and the Director of Social Work Services. The Commissioner shall ensure distribution to the Director of Case Management and the Warden.

H. The medical parole decision and implementation will include the following:

1. If approved by the Commissioner/designee, the inmate's case records and all related information shall be forwarded to the MPC for review.

2. Whether approved or disapproved, written notification shall be sent to the warden by the Director of Social Work Services, who shall forward the information to the case management office for placement in section II of the inmate's base file. The same information will be forwarded to the DPSCS Medical Director and the regional medical director. The assigned social worker will also

complete and implements a detailed aftercare treatment plan that includes, at a minimum, the following provisions:

a. Residence after release

b. Primary medical care

c. Financial support, and

d. Notifies the release unit of the MPC of the specifics of the completed aftercare plan so that the earliest possible release date can be established.

3. Upon receipt of the medical parole decision, the Director of Social Work Services shall immediately notify the Regional Social Work supervisor who shall notify the case management administrator and the regional medical director of the decision.

4. Upon receipt of the parole decision, the assigned social worker and the assigned case manager shall, as a team, meet with the inmate to inform him/her of the decision.

5. Once the MPC has established a release date for an inmate granted medical parole, the assigned social worker shall notify the case management manager of the exact date that the inmate will be paroled.

a. The case management manager shall ensure that the case manager, the inmate, and appropriate institutional personnel responsible for processing release are notified of the release date.

b. The facility administrator and the case management manager shall contact the agency / agencies) that placed a detainer(s) against the inmate and request that written authorization to lift the detainer be immediately faxed to the appropriate commitment office. Upon receipt of the written authorization to lift the detainer, commitment office staff shall follow the procedures described in the commitment procedure manual.

c. If for any reason the aftercare plan cannot be implemented within ten workdays of the MPC approval, the assigned social worker shall notify the regional supervisor of social work and the director of social work and addiction services.

III.	References:	A.	Karnofsky Performance Scale
		B.	DCD 100-11, Parole Procedures
		C.	DCD 126-500, Social Work Case Management
		D.	Commitment Procedure Manual
IV.	Rescission:		DCD 130-100, Section 190, dated June 9, 1994 DOC 130-8 Medical Parole
V.	Date Issued:		October 15, 2007
	Revised:		September 17, 2009