NH DEPARTMENT OF CORRECTIONS POLICY AND PROCEDURE DIRECTIVE	CHAPTER Health Services STATEMENT NUMBER 6.46
SUBJECT: **SPECIAL HEALTH CARE PROGRAMS** PROPONENT: Robert MacLeod, Administrative Dir. *Name/Title* Medical/Forensic Services 271-3707 *Office* *Phone #*	EFFECTIVE DATE 05/01/08 REVIEW DATE 05/01/09 SUPERSEDES PPD# 6.46 DATED 02/01/06
ISSUING OFFICER: ____________________ *William Wrenn, Commissioner*	DIRECTOR'S INITIALS ______ DATE ______ APPENDIX ATTACHED: YES ______ NO ______
REFERENCE NO: See reference section on last page of PPD.	

I. PURPOSE:
To describe special health care programs that are available to inmates and to outline procedures required for implementation of special health care programs.

II. APPLICABILITY:
To all staff and inmates, especially to those who are involved in the management and operation of health care services.

III. POLICY:
It is the policy of the Department of Corrections to write individual plans for each inmate with special health care needs. A qualified health practitioner will develop the plan. The plan shall include a statement of short/long term goals and provision for treatment either on-site or by referral. The following special programs are available:

A. Chronic care
B. Convalescent care
C. Detox from alcohol and drugs
D. Health Education Program
E. Care for handicapped
F. Contagious disease

IV. PROCEDURES:

A. Treatment plan
A written, individual treatment plan that includes directions to health care and other personnel regarding their roles in the care and supervision of the patient will be developed by

the appropriate physician, dentist or qualified mental health practitioner. This plan at a minimum must include presenting problem as identified by, diagnoses, and care plan.

B. Planning

Identification of these patients shall be made through staff referral, sick call, physical examination or inmate self-referral.

C. Chronic Care

The physician shall maintain an up-to-date list of all patients diagnosed as having chronic diseases, such as diabetes, heart disease, asthma or similar disorders with support from nursing staff. If the practitioner identifies during the initial physical, a chronic disease, he or she will write an order to enter this patient into the chronic care program and schedule an initial chronic care appointment. The patients listed as chronically diseased shall be seen at least annually, and more frequently as clinically determined by the health care staff. If appropriate, classification will be informed of special needs relative to housing, work assignment restrictions or special other restrictions. Chronic Care will be monitored using Attachment 1, 2, and 3. All orders documented on these forms must be transcribed onto a physician's order form for appropriate processing e.g. lab work, medication changes. These forms will be filed in the progress note section of the chart for ease of tracking and enhancement of continuum of care.

D. Convalescent Care

The staff physician shall be responsible for determining the placement of patients requiring close observation during post-operative recovery or recovery for other illnesses or injuries. Such patients shall be admitted as soon as medically possible to the Health Services Center.

E. Detoxification

1. Whenever the designated physician has diagnosed a patient as chemically dependent, the patient will be transferred to a hospital for gradual detoxification if the individual's health requires such transfer.
2. Upon return to the Health Services Center an inmate who has been detoxified will be referred to Mental Health for referral and development of an individual treatment plan to meet their needs.
3. If a need for continued treatment exists upon the release of an inmate, the CC/CM in collaboration with Mental Health will refer and prepare a discharge plan with the inmate to appropriate community agencies.

REFERENCES:

Standards for the Administration of Correctional Agencies
Second Edition Standards

Standards for Adult Correctional Institutions
Fourth Edition Standards

4-4350; 4-4359; 4-4376

Standards for Adult Community Residential Services
Fourth Edition Standards

Standards for Adult Probation and Parole Field Services
Third Edition Standards

Other

MACLEOD/pf

Attachments

Attachment 1
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Chronic Disease Clinic Initial Baseline Medical Data

Check all that apply and complete appropriate clinic HX:

- ☐ Pulmonary/Asthma/COPD
- ☐ General Medical
- ☐ Liver Disease/HCV
- ☐ Other: ____________________
- ☐ HTN/CV
- ☐ Seizures
- ☐ Diabetes
- ☐ TB
- ☐ HIV

Personal Risk Factors:			**Family History:**			**Surgeries/Hospitalizations:**
Y	N		Y	N		
O	O	Smoking: Pack year	O	O	Anemia	
O	O	High Blood Pressure	O	O	Asthma	
O	O	High Cholesterol	O	O	Cancer: types	
O	O	Sedentary Lifestyle				
O	O	Obesity	O	O	Diabetes	
O	O	Diabetes	O	O	Heart Disease	
O	O	Alcohol	O	O	High Blood Pressure	
O	O		O	O	Kidney Disease	
O	O	Substance Abuse:	O	O	Mental Illness	
O	O		O	O	Sickle Cell	
O	O	Injection Drug use	O	O	Tuberculosis	
O	O	Multiple sexual partners				
O	O	Unsterile tattooing/body piercing				

General Description/Chief Complaint:(Attach medication profile or list medications)

Cardiovascular/Hypertension/Diabetes (Date of onset of symptoms:)

Y	N		Y	N		Y	N		Y	N	
☐	☐	Chest Pain	☐	☐	Leg Swelling	☐	☐	Dyslipidemia	☐	☐	Weight Gain/Loss
☐	☐	Shortness of Breath	☐	☐	Claudication	☐	☐	Headache	☐	☐	Blurred Vision
☐	☐	Palpitation	☐	☐	Heart attack/surgery	☐	☐	Syncope/Dizziness	☐	☐	Foot problems
☐	☐	PVD	☐	☐	CVA/Stroke	☐	☐	Hypoglycemic Episodes	☐	☐	Nocturia
☐	☐	Orthopnea	☐	☐	Rheumatic fever	☐	☐	Kidney Disease	☐	☐	Polyuria

Details of boxes checked **Y**:

Inmate Name:	Number:	Institution:	Date:

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Seizures (Date of onset of symptoms:)

Y	N		Y	N	
☐	☐	Aura	☐	☐	Gum Disease: ______________
☐	☐	Postictal State	☐	☐	Date of Last Seizure
☐	☐	Number of Seizures in past 3 mos. ____	☐	☐	LOC
☐	☐	Type of Seizures ______________________________			
☐	☐	Other Neurological Symptoms? (headache, incontinence, paralysis)			

Details of boxes checked **Y**: ____

HIV/HCV Infection (Date of onset of symptoms:)

Y	N		Y	N		Y	N	
☐	☐	Anorexia	☐	☐	Weight Loss/Gain	☐	☐	Abnormal Pap Smear
☐	☐	Malaise	☐	☐	Peripheral Neuropathy	☐	☐	Hx Previous Antiviral Tx (list drugs below)
☐	☐	Oral Lesions (herpes/thrush)	☐	☐	TB Infection/Tuberculosis	☐	☐	Jaundice
☐	☐	Nausea/Vomiting	☐	☐	Hx Pneumonia	☐	☐	Joint Pain
☐	☐	Constipation	☐	☐	Opportunistic Infections	☐	☐	Pruritis
☐	☐	Diarrhea	☐	☐	AIDS Diagnosis			
☐	☐	Anorectal pain/lesions	☐	☐	Abdominal Pain/Swelling			
☐	☐	Stool Changes						

Details of boxes checked **Y**: ____

Asthma/Pulmonary/COPD/Tuberculosis (Date of onset of symptoms:)

Y	N		Y	N	
☐	☐	Wheezing	☐	☐	# Asthma Attacks per week ____
☐	☐	Nighttime Awaking Symptoms ____ per week	☐	☐	Exposure to Environmental Risk (asbestos, chemical exposure, etc.)
☐	☐	Hospitalized for Asthma within the last year	☐	☐	Hemoptysis
☐	☐	Number of ER Visits in past 3 Months ____	☐	☐	Fever
☐	☐	History of Intubations	☐	☐	Liver Disease
☐	☐	Short Acting Inhalers use ____ times per week	☐	☐	Night Sweats
☐	☐	Prior Systemic Steroids	☐	☐	Weight Loss
☐	☐	Activity Intolerance	☐	☐	Persistent Cough (> 3 weeks)
☐	☐	GERD	☐	☐	Prior TB History
☐	☐	Allergies			

Details of boxes checked **Y**: ____

Inmate Name:	Number:	Institution:	Date:

Physical Exam

Vital Signs:

Temp:	Blood Pressure:	Pulse:	Resp:	Height:	Weight: (Lbs).	Peak Flow:	Pain Scale:	Functional Assessment:

HEENT ______________________________

____

Neck: ______________________________

Heart: ______________________________

Lungs: ______________________________

____

Abdomen: ______________________________

____

Extremities: ______________________________

____

GU/rectal: ______________________________

____

Other: ______________________________

____

____

Labs:

Hgb A1C:	Hct:	ALT:	T. Chloe:	Triglycerides:
CD4 Cell:	Hgb:	BUN:	LDL:	INR:
HIV RNA VL:	AST:	Creatinine:	HDL:	Other:

Assessment: diagnoses

	Degree of Control			
	G	F	P	N/A
1.	☐	☐	☐	☐
2	☐	☐	☐	☐
3	☐	☐	☐	☐
4	☐	☐	☐	☐
5	☐	☐	☐	☐

Inmate Name:	Number:	Institution:	Date:

Education Provided: (describe below)

Disease process/abnormal labs: ______________________________

____

____

Medication Mgmt (purposes, side effects): ______________________________

____

Nutrition: ______________________________

____

Smoking/Tobacco use: ______________________________

____

Exercise: ______________________________

____

Alcohol/substance abuse ______________________________

____

Other: ______________________________

____

PLAN:

Medication Changes: ______________________________

____

____

Diagnostics:

- ☐ EKG
- ☐ Chest x-ray
- ☐ Lipid Studies
- ☐ Chemistry
- ☐ HgbA1C
- ☐ Urine Micro albumin
- ☐ CBC
- ☐ Medication Levels
- ☐ HIV Antibody
- ☐ CD4 count
- ☐ Viral Load
- ☐ HCV
- ☐ Hepatitis Panel A/B/C
- ☐ Toxoplasmosis AB
- ☐ RPR
- ☐ Pap Smear
- ☐ Platelet
- ☐ UA
- ☐ Liver Enzymes
- ☐ LFT
- ☐ Sputum AFB Smear
- ☐ Sputum AFB Culture

Immunizations:

- ☐ Influenza Vaccine
- ☐ Pneumococcal Vaccine

Other Tests: ______________________________

____

____

Monitoring:

BP: ___times per day/week/month Glucose: _____ times per/day/week/month Peak Flow: ______________

Other: ______________________________

Referral:

Specialist (indicate specialty and priority level): ______________________________

____

____

Other Chronic Care Program? (specify): ______________________________

Inmate Name:	Number:	Institution:	Date:

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Number of days to next visit: ☐ 30 ☐ 60 ☐ 90 ☐ Other: ______________________

Additional Information: ______________________

Clinician Signature/Credential Date

Inmate Name:	Number:	Institution:	Date:

Attachment 2

Chronic Disease Clinic Follow-Up

Inmate Name:	
Number:	Institution:

List chronic diseases:

1)	3)	5)
2)	4)	6)

Attach pharmacy profile or list current medications: ____

Subjective:

Asthma: # attacks in last month?_______ # short acting beta agonist canisters in last month?_______ # times awakening with asthma symptoms per week?_____	Seizure disorder: # seizures since last visit?_______ Diabetes mellitus: # of hypoglycemic reactions since last visit?_____ Weight loss/gain ? ? _____ #lbs
CV/hypertension (Y/N): Chest pain?_______ SOB?_______ Palpitations?________ Ankle edema? ________	
HIV/HCV (Y/N): Nausea/vomiting? _______ Abdominal pain/swelling? _______ Diarrhea? _______ Rashes/lesions?_________	

For all diseases, since last visit, describe new symptoms: ____
____
____
____
____

Patient adherence (Y/N): with medications?_________ with diet?_________ with exercise?_________

Vital signs: Temp________ BP__________ Pulse______ Resp_____ Wt ______ PEFR_______ INR_______
Labs: Hgb A1C _______ HIV VL_______ CD4_______ Total Chol_______ LDL_______ HDL_______ Trig______
Range of fingerstick glucose/BP monitoring: ____

PE:

HEENT/neck:	Extremities:
Heart:	Neurological:
Lungs:	GU/rectal:
Abdomen:	Other:

Assessment:	Degree of Control				Clinical Status			
	G	**F**	**P**	**NA**	**I**	**S**	**W**	**NA**
1	☐	☐	☐	☐	☐	☐	☐	☐
2	☐	☐	☐	☐	☐	☐	☐	☐
3	☐	☐	☐	☐	☐	☐	☐	☐
4	☐	☐	☐	☐	☐	☐	☐	☐

Plan:
Medication changes: ____

Diagnostics: ____

Labs: ____

Monitoring: BP:______X day/week/month Glucose:____X day/week/month Peak flow:______ Other: ____________

Education provided: ☐Nutrition ☐Exercise ☐Smoking ☐Test results ☐Medication management ☐Other: ____________

Referral (list type): Specialist:____ Chronic care program:________________________ #

days to next visit? ☐90 ☐60 ☐30 ☐Other:____________ Discharged from CCC: [name] ____________________

Advance Level Provider Signature:	Date:

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Attachment 3

Nursing Chronic Disease Flowsheet	Clinic(s):	
Inmate's Name:	Inmate Number:	Institution:

☐ Influenza vaccine: (date)__________________ ☐ Entry into CCC database

DATE:	DATE:	DATE:	DATE:
Vital signs: PEFR:_____ T ______ P______ R_____ Wt._______ BP________	Vital signs: PEFR:_____ T ______ P______ R_____ Wt._______ BP________	Vital signs: PEFR:_____ T ______ P______ R_____ Wt._______ BP________	Vital signs: PEFR:_____ T ______ P______ R_____ Wt._______ BP________
Medication Compliance: Compliant Non-Compliant **TX Plan Compliance:** Compliant Non-Compliant **Dietary Compliance:** Compliant Non-Compliant Other:	**Medication Compliance:** Compliant Non-Compliant **TX Plan Compliance:** Compliant Non-Compliant **Dietary Compliance:** Compliant Non-Compliant Other:	**Medication Compliance:** Compliant Non-Compliant **TX Plan Compliance:** Compliant Non-Compliant **Dietary Compliance:** Compliant Non-Compliant Other:	**Medication Compliance:** Compliant Non-Compliant **TX Plan Compliance:** Compliant Non-Compliant **Dietary Compliance:** Compliant Non-Compliant Other:
Education: Diet Disease Process Exercise Tobacco Cessation ETOH Cessation Other:	**Education:** Diet Disease Process Exercise Tobacco Cessation ETOH Cessation Other:	**Education:** Diet Disease Process Exercise Tobacco Cessation ETOH Cessation Other:	**Education:** Diet Disease Process Exercise Tobacco Cessation ETOH Cessation Other:
Medications: Actions Side effects Handouts	**Medications:** Actions Side effects Handouts	**Medications:** Actions Side effects Handouts	**Medications:** Actions Side effects Handouts
LAB DATA: Hgb/HCT:	**LAB DATA:** Hgb/HCT:	**LAB DATA:** Hgb/HCT:	**LAB DATA:** Hgb/HCT:
Hgb A1C:	Hgb A1C:	Hgb A1C:	Hgb A1C:
*LDL/HDL:	*LDL/HDL:	*LDL/HDL:	*LDL/HDL:
Chol/Tri:	Chol/Tri:	Chol/Tri:	Chol/Tri:
UA Microalb:	UA Microalb:	UA Microalb:	UA Microalb:
AST/ALT:	AST/ALT:	AST/ALT:	AST/ALT:
HCV VL:	HCV VL:	HCV VL:	HCV VL:
HIV VL:	HIV VL:	HIV VL:	HIV VL:
CD-4:	CD-4:	CD-4:	CD-4:
*FBS:	*FBS:	*FBS:	*FBS:
Thyroid:	Thyroid:	Thyroid:	Thyroid:
Drug Levels:	Drug Levels:	Drug Levels:	Drug Levels:
INR:	INR:	INR:	INR:

*Lipid studies should be fasting.

Nurse:	Nurse:	Nurse:	Nurse:
Clinician Initials:	Clinician Initials:	Clinician Initials:	Clinician Initials:

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