

# Department of Public Safety and Correctional Services

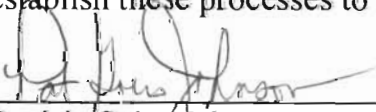
## Clinical Services & Inmate Health



### Operations Manuals

Administration	Medical Records
Chronic Disease Management	Pharmacy Services
Infection Control	Pregnancy Management
Infirmatory Care	Sick Call
Inmate Deaths	Substance Abuse
Medical Evaluations	

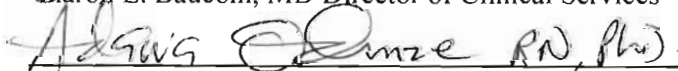
By signing this cover page, DPSCS officials responsible for the care and treatment of persons confined to their facilities give approval that the policies and procedures, reviewed and updated as needed annually and found herein, formally establish these processes to be acceptable to DPSCS.

  
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Patricia Goins-Johnson, Executive Director Field Support Services

  
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Sharon L. Baucom, MD Director of Clinical Services

  
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Adaora Odunze, RN, PhD, Director of Nursing

Date	1/2013
Reviewed	11/2014
	1/2015
	2/20/2016



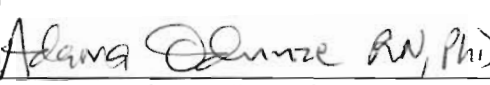
# Department of Public Safety and Correctional Services

## Clinical Services & Inmate Health



## Chronic Disease Management Manual

Date Reviewed	2/22/2012
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	1/2015
	2/20/2016


Patricia Goins-Johnson, Executive Director Field Support Services

Sharon L. Baucom, MD Director of Clinical Service

Adaora Odunze, RN, PhD, Director of Nursing

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONS SERVICES  
OFFICE OF CLINICAL SERVICES/INMATE HEALTH  
CHRONIC DISEASE MANAGEMENT MANUAL

Chapter 1  
CHRONIC CARE CLINICS

Section A  
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 decompensation. Informed consent for any and all medical/dental/mental health treatments, a “Consent to Treatment” form shall be completed before any medical/dental/mental health treatment or procedure may be performed. If the inmate is a minor, “Consent to Treatment” shall be obtained from the appropriate responsible person authorized to provide such a consent for that minor before any medical procedure is performed. (See Medical Records Manual Chapter 1).
- II. For all diseases referenced for chronic care that do not reference specific guidelines or standards , contractors will adhere to practice patterns generally consistent with the recommendations provided in “Up To Date” an online medical text.
- III. 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 electronic 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. Inmates in chronic care clinics shall be evaluated at a minimum of every three months by a CRNP or midlevel provider.
2. At a minimum of every 6 months, the evaluations must be conducted by a physician.
3. 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 exceed the routine quarterly chronic care clinic visits and shall be conducted by an RN or higher clinician.

#### C. Data

1. A computerized data base using a database program or format approved by the Agency shall be maintained to electronically track inmates' participation in chronic care clinics.
2. The data elements must include but not to 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/Inactivity
- r. Date of inactivity
- s. Discharge Date

#### D. Medical Evaluations

1. At a minimum, chronic care clinics visits conducted by a clinician shall consist of **a review of the patient's hard copy and electronic medical records**, routine preventative medical evaluations consistent with 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 ((T, P, R and BP), 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.
- h. When indicated, chronic care medications will be ordered for 120 days but must be reviewed and renewed during each chronic care visit

#### 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 "Release of Responsibility: 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 electronic 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:
  - i. Repeat the refusal process documentation/education.
  - ii. Advise the inmate that failure to show for his 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.

IV. Reference: "UP TO Date" online medical text 2015

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

VI. Date Issued: July 15, 2007  
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DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONS SERVICES  
OFFICE OF CLINICAL SERVICES/INMATE HEALTH  
CHRONIC CARE MANAGEMENT MANUAL

Chapter 1  
CHRONIC CARE CLINICS

Section B  
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. They shall 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 (including steroids) and peak flow testing done in the past.
    2. Lung function
    3. Peak Expiratory Flow Rate (PEFR) variability
    4. Associated symptoms (rhinitis, sinusitis, gastro-esophageal reflux disease (GERD)).
    5. Diagnostic/lab evaluation
    6. PEFR/ (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 the past 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. Target 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. Education review for drugs that exacerbate respiratory conditions
17. The studies as medically indicated for diagnostic and management purposes including: complete blood count (CBC with differential), 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, classifying the severity of the disease and in determining the plan of care, include:
  - a. PEFR % of predicted or personal best of >70 %, 50-70%, or <50%
  - b. Response to  $\beta$ 2-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 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. PaO<sub>2</sub>  $< 60$  mm Hg or SaO<sub>2</sub>  $< 90\%$
9. PCO<sub>2</sub>  $< 40$  mm Hg
10. Speech-mute or only single words secondary to inability to breathe
11. Hypotension
12. Cannot perform peak flow test
13. Pulse oximetry is less than 90
14. Un-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  $\beta$ 2-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, the Stepwise Approach for Managing Asthma in Audits:

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 of 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 three to six 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 functions 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 = two days per week
    - b. Symptoms = two nights per 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 functions 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 =three days per week
    - b. Symptoms > two nights per 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 months and be monitored in chronic care clinic.
3. “Moderate Persistent Asthma” can be identified:
- a. Daily symptoms
  - b. Symptoms > one night per week
  - c. PEF or FEV1 > 50% but < 70%
  - d. PEF variability > 30%
  - e. Daily use of inhaled short-acting  $\beta$ 2-agonists
  - f. Exacerbation affects activity
  - g. Exacerbations > two per week; may last days
  - h. Treatment to be ordered by the clinician includes:
    - i. Preferred treatment should include: Low to medium dose inhaled corticosteroids and long-acting inhaled  $\beta$ 2-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  $\beta$ 2-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  $\beta$ 2-agonists as needed for symptoms. Intensity of treatment will depend on severity of exacerbation: up to three 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  $\beta$ 2-agonists > two per 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 the 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 asthmatic episodes that require 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-agonist 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. PaO<sub>2</sub> < 55 mm Hg or SaO<sub>2</sub> < 90% at rest
    - ii. PaO<sub>2</sub> < mm Hg or SaO<sub>2</sub> < 80% with exercise
    - iii. PaO<sub>2</sub> < 55 mm Hg or SaO<sub>2</sub> < 89% during sleep
    - iv. Evidence of pulmonary hypertension or Cor-pulmonale, mental or psychological impairment, or polycythemia and a PaO<sub>2</sub> of 56 to 59 mm Hg or SaO<sub>2</sub> < 90% at any time.

7. Documentation in the EPHR and/or the paper medical record (in the event of unavailability of the EPHR) 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 Maryland DPSCS Asthma/COPD Clinic Flow sheet.
  - b. Documentation of data on the asthma/COPD Flow sheet shall always be accompanied by a progress note detailing the recent medical history, pertinent physical examination finding (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 asthma/COPD flow sheet.
  - d. Health professionals will document all chronic diseases on the problem list along with any significant clinical event, such as intubations or 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 Institute of Health. Expert Panel Report 3: Guidelines for Diagnosis and Management of Asthma
- C. Global Initiative for Chronic Obstructive Lung Disease ("GOLD")

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



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DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

CHRONIC DISEASE MANAGEMENT MANUAL

Chapter 1

CHRONIC CARE CLINIC

Section C

PSYCHIARTY 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. For new detainees, the medical contractor shall perform a medical receiving screening not later than 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 possible new onset/current/chronic mental illness.
    2. Reporting having a current mental illness.
    3. Having current or history of suicide ideation.
    4. Having a history of unstable mental health.
    5. Presenting a history of psychotropic drug use.
    6. 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 provide mental health sick call clinics five days a week and shall continue clinics until every patient scheduled has been seen.
- D. 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 Patient Health Record (EPHR) to document patient behavior and referrals received for mental health for assessment.
1. A hard copy of any mental health forms or materials is to be included in the patient records along with documentation into the agency’s patient health record/EPHR.
  2. The contractor shall provide to its staff, and its staff shall abide by, Agency approved, comprehensive mental health Protocol and Procedure Manuals, including, but not limited to those regarding the Mental Health Component.
- E. The mental health contractor shall provide all diagnostic studies including laboratory services necessary to implement the mental health services chronic care program.
1. A psychiatrist shall review all lab results within 48 hours after receipt of the tests to assess for follow-up care.
  2. On-call psychiatrists shall be notified immediately of all stat lab reports and consult with the medical provider for management.
- F. 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

- G. Special confinement mental health inmates shall have the same access to chronic care clinics as the general population.
- H. Juvenile offenders shall be managed for chronic mental health disorders consistent with relevant State and Federal guidelines, and community standards.

III. References:

- A. CS- 130—Clinical Services Medical Evaluation Manual
- B. RFP 2.2.1.6.3
- C. RFP 2.2.1.6.3.7
- D. COMAR DHMH Title 10
- E. Health place.com

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DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES  
OFFICE OF CLINICAL SERVICES/INMATE HEALTH  
CHRONIC DISEASE MANAGEMENT MANUAL

Chapter 1

CHRONIC CARE CLINIC

Section D

SEIZURE/NEUROLOGY CLINICS

1. Policy: All MD 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 clonic 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.
2. 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 E: "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, and 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 seizure since the last visit.
  3. Poor control: characterized by more than one 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 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 factor. 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 the frequency of seizures the greater the frequency of visits.

D. Content of follow-up visit 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 Maryland 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 seizures have been treated and have abated.
  - 3. Establishing IV line and administration of an 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 mono-therapy.
  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. Person with a new onset seizure should have a magnetic resonance imaging (MRI) or computerized tomography (CT) study of the brain if the 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 seizure.
    - g. If a patient 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 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. Patient has a known or suspected organic cause for seizures

3. 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 Clinic Guidelines for Correctional Facilities. [www.ncchc.org](http://www.ncchc.org) 2003
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4. Rescissions: DCD MEDICAL 130-100-118D Primary/Specialty Medical Services Seizure/Neurology Clinic

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DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES  
OFFICE OF CLINICAL SERVICES/INMATE HEALTH  
CHRONIC DISEASE MANAGEMENT MANUAL

Chapter 1

CHRONIC CARE CLINIC

Section E

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 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 “dèjà 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, déjà 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 functions 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
Depakene	Divalproex sodium	125mg	EC tab	bid-tid
Depakene	Divalproex sodium	250mg	ECtab	bid-tid
Depakene	Divalproex sodium	500mg	ECtab	bid-tid
Dilantin	Phenytoin sodium	100mg	Cap	tid
Dilantin-125	Phenytoin sodium	125mg/5ml	Susp	bit-tid

Lamictal	Lamotrigine	100mg	Tab	bit-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	2bid
Topamax	Topiramate	25mg	Tab	for titration

C. Antiepileptic Drug Serum Level monitoring should be monitored according to community standards.

1. Indicators for Monitoring Antiepileptic Drug (AED) Levels

a. After an AED has been started, usually 2-3 weeks after initiation of therapy or deletion of an AED during polypharmacy therapy.

b. When the individual has to take other medication that may affect the metabolism of the AED(s).

c. Any time an unexpected response occurs.

d. At the first sign of clinical or laboratory toxicity.

e. When medical problems develop, particularly problems involving hepatic, renal, or hematopoietic function.

f. Any unexplained change in clinical status, e.g. “breakthrough” seizure, change in mental status.

g. If compliance with medication regime is a possible issue.

h. If clinical toxicity occurs an AED level may not be necessary depending on the plan of care determined by the treating/consultation physician. For instance, if a plan of care to reduce the dose is made, a medication level is not necessary unless symptoms persist.

2. Community based guidelines for Antiepileptic Drug Serum Level monitoring can be found in the attachment below.

D. 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 absences: 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 (valproic 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 seizure 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
- D. Standards for Health Services in Prisons, National Commission on Correctional Health Care, 2003.
- E. American Epilepsy Society (2004). Clinical Epilepsy. Retrieved on September 6, 2005 for the World Wide Web: [http://www.aesnet.org/visitors/Professional\\_Development/MedEd/ppt/ppts03/clinicore.pdf](http://www.aesnet.org/visitors/Professional_Development/MedEd/ppt/ppts03/clinicore.pdf).
- F. LabCorp Directory of Services and Interpretive Guide (2005). Available from LabCorp; 358 South Main Street; Burlington, NC 27215
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IV. Rescissions: DCD MEDICAL 130-100-118D Primary Special Medical Services Seizure/Neurology Clinic

V. Date Issued; July 15, 2007  
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## Community Based Antiepileptic Drug Serum Monitoring Recommendations

Antiepileptic (AED) Medication	Baseline	Repeat	Annually	Notes
PHENOBARBITAL	CBC, ALT (formerly SGPT), AST, creatinine	CBC, ALT, and AST annually thereafter	←	
PHENYTOIN (DILANTIN)	CBC, ALT (SGPT), AST, creatinine	CBC, ALT and AST in 6 months	CBC, ALT and AST annually thereafter	
PRIMIDONE (MYSOLINE)	CBC, ALT (SGPT), AST, creatinine	CBC, ALT, and AST in 6 months	CBC, ALT, and AST annually thereafter	
VALPROIC ACID (DEPAKENE, DEPAKOTE)	CBC, ALT (SGPT), AST, creatinine, and urinalysis	CBC, ALT, and AST in 3 months	CBC, ALT, and AST, annually thereafter	
CARBAMAZEPINE (TEGRETOL)	CBC, retic count, ALT (SGPT), AST, and creatinine	CBC, ALT, and AST every 3 months for 6 months, then annually.	←	Erythromycin or "Erythromycin-Type" antibiotics may cause Carbamazepine levels to rise to toxic range.
CLONAZEPAM (KLONOPIN)	CBC, ALT (SGPT), AST and creatinine	CBC, ALT, and AST if clinically indicated	←	
ETHOSUXIMIDE (ZARONTIN)	CBC, ALT (SGPT), AST, and creatinine	CBC at 3 months	CBC, ALT, and AST annually thereafter	
FELBAMATE (FELBATOL)	CBC, differential, retic count, AST, ALT, GGT, Bili, creatinine, urinalysis	Liver Functions and CBC every month for 3 months then every 3 months thereafter	←	
GABAPENTIN (NEURONTIN)	CBC, ALT, AST, and creatinine	CBC and creatinine, if clinically indicated	←	
LAMOTRIGINE (LAMICTAL)	CBC, ALT, AST, creatinine	AST, ALT, and/or creatinine, if clinically indicated	←	
CLORAZEPATE (TRANXENE)	CBC, ALT, AST, and creatinine	CBC, ALT, AST annually thereafter	←	
TOPIRAMATE (TOPAMAX)	CBC, CMP, and urinalysis	CBC, BMP, and urinalysis in 3 months and annually thereafter	←	
TIAGABINE (GABITRIL)	CBC, ALT, AST, and creatinine	CBC, ALT, and AST annually thereafter	←	
OXCARBAZEPINE (TRILEPTAL)	CBC, BMP, creatinine, retic count	BMP and CBC annually	←	
ZONISAMIDE (ZONEGRAN)	CBC, ALT, AST, creatinine, urinalysis	CBC, ALT, AST and urinalysis in 6 months, and annually thereafter	←	
LEVETIRACETAM (KEPPRA)	CBC, ALT, AST, creatinine	CBC, ALT and AST annually thereafter	←	

# OFFICE OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

## OFFICE OF CLINICAL SERVICES/INMATE HEALTH

### CHRONIC DISEASE MANAGEMENT MANUAL

#### Chapter 1

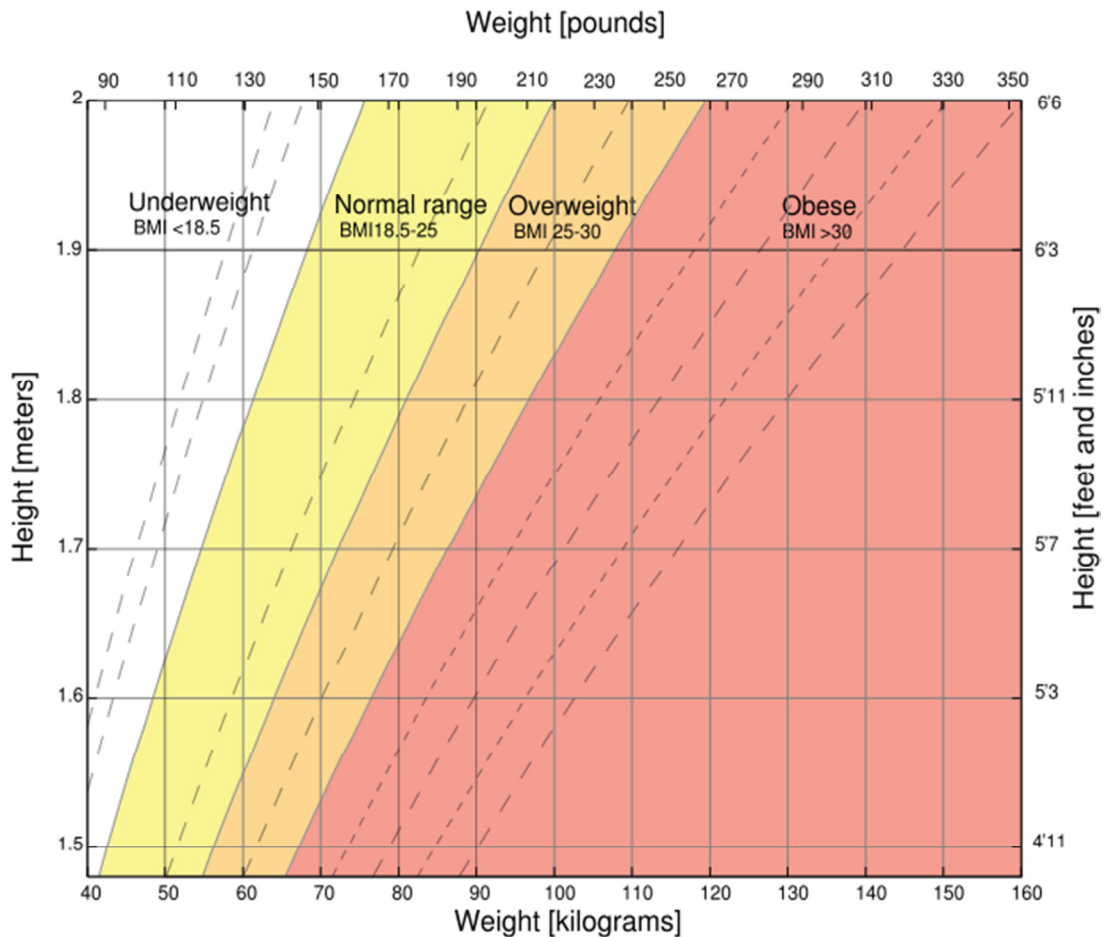
#### CHRONIC CARE CLINICS

#### Section F

#### 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, after proper education and training be permitted to self-inject insulin under professional supervision within appropriate security parameters.
- 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/gL 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/gL 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/gL or higher, the inmate will be offered fasting blood glucose test to establish the diagnosis of diabetes mellitus.
  - a. Body mass index is defined as the individual's body weight divided by the square of their height.
  - b. BMI can 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.



3. 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 24<sup>th</sup> and 28<sup>th</sup> 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. Fasting plasma glucose greater than 126 mg/dL is diagnostic of diabetes if confirmed by at least one other confirmatory fasting plasma glucose greater than 126 mg/dL.

- D. Inmates with classic symptoms of diabetes such as polyphagia, polyuria, polydipsia, and weight loss can be diagnosed with diabetes with 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 educations, diet and oral glucose-lowering 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 for a comprehensive eye and visual examination for all inmates diagnosed with diabetes annually and when clinically indicated, regardless of patient's age.
- 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 assessments, including foot exams, and diabetic education will be provided for all inmates with diabetes. The nurse will document all findings and education activity on the Diabetic Flow Sheet/EMR Template.
  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 weekly.
  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.

- a. Medical history;
- b. Targeted physical examination of the cardiovascular system, feet, skin, and nervous system;
- c. Annual fundoscopic 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;
- h. Foot examination (minimally every month).

G. Medical Management of diabetes includes a goal of medical therapy that achieves 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 medication at dosing frequencies that are consistent with their treatment plan and medical direction in corrections and meal times. 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 follow their progress. Complete ultrasound 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. 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 Capillary Blood Glucose (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 or restrictive housing 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 injectable insulin with details about onset (the length of time before insulin reaches the bloodstream and begins to lower blood glucose) Type 1 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
<b>+ +Rapid-Acting</b>				
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	
<b>Short-Acting</b>				
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	
<b>Intermediate-Acting</b>				
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	
<b>Long-Acting</b>				

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

K. To treat type 2 diabetes, there are four 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.

2. Biguanides have been available in the U.S. since 1995, but have been used in other countries for 30 years. They work in the liver to stop the release of too much glucose, and to reduce insulin resistance in muscle cells.
  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.
  4. Thiazolidinediones have been on the market since 1997. They work in muscle cells, making them more sensitive to insulin, thereby helping the body's own insulin do its' job more efficiently.
- L. All diabetes chronic care clinic evaluations by a clinician shall be documented on the Maryland DPSCS Diabetes Clinic Flow Sheet/EMR Template.
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 assessment 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 food care inspection, insulin sites, diet, exercise, and eye care shall be documented by nursing staff no less than monthly.

III. References:

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IV. Rescissions: Diabetes Mellitus Manual Diabetes Clinic

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DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES  
OFFICE OF CLINICAL SERVICES/INMATE HEALTH  
CHRONIC DISEASE MANAGEMENT MANUAL

Chapter 1

CHRONIC CARE CLINIC

Section G

HYPERTENSION CLINIC

- I. Policy: To provide standardized guidelines for the medical management of hypertension in all Department of Public Safety and Correctional Services (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 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 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 or 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. SBP 140-159 DBP 90-99 (Stage 1/mild hypertension) –Hypertension will be confirmed by nursing staff repeating second and third blood pressure readings within two months. Patients with confirmed mild hypertension should be referred to a clinician for baseline evaluation within 1 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 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 1 week.
  - d. SBP 210 or greater, DVP 12 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. Cardiovascular 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 minutes, using correct cuff size
      - i. Take two readings at least two minutes apart.
      - ii. Take readings from both arms.
    - c. Fundoscopic exam for retinopathy 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 distention.

- 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:
- 1. Medication compliance, symptoms, CV risk factors
  - 2. PE-weight, vital signs, carotids, femoral checks
  - 3. A control assessment meeting the following descriptions:
    - a. Good control (< 140/90)
    - b. Fair control (140-160/90-105)
    - c. Poor control (>160-106)
  - 4. Treatment will include:
    - a. The use of non-pharmacologic interventions (weight control, diet, appropriate exercise) in all patients.
    - b. A trial of non-pharmacological treatment alone in high-normal.
    - c. Diuretics as initial pharmacological treatment
    - d. Beta-blockers added as a secondary pharmacological treatment.
    - e. ASA prophylaxis, unless contraindicated.
    - f. Urgent treatment consists of Clonidine 0.2 p.o., then 0.1 q hr up to six hrs
    - g. Sublingual Nifedipine will NOT be used in hypertensive crisis in the presence of acute CNS and CV
    - h. Renal or retinal damage requires ER transfer.
  - 5. Special considerations in the determination of treatment needs will include:
    - a. Black patients may respond better to calcium channel blockers (CCBs) than to beta-blockers.

- b. All diabetics should be on ACE inhibitors.
  - c. All patients with Left ventricular hypertrophy (LVH) or coronary artery disease (CAD) should be on ACE inhibitors.
6. Inmates seen for hypertension will receive patient education on the following subjects at a minimum:
- a. Weight control
  - b. Diet
  - c. Exercise
  - d. Alcohol use
  - e. Tobacco
  - f. Medication adherence
  - g. Risk reduction
  - h. Hypertensive emergency care
7. Quarterly follow-up evaluations for inmates diagnosed with hypertension will include:
- a. Baseline and evaluation by a physician every six months, and at least a mid-level in the intervening visits.
  - b. Patients education regarding lifestyle modifications, medication side effects, and complications of untreated hypertension.
8. Patients are not limited to quarterly visits and should be seen upon report of any clinical indicators of hypertension.
9. The following laboratory studies will be measured annually for all inmates evaluated in hypertension clinics:
- a. Urinalysis, chem. 12 optometry/fundoscopy evaluation.
  - b. End stage organ evaluation.
  - c. Other laboratory tests shall be ordered as medically indicated.
10. 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:
- a. SBP greater than or equal to 180
  - b. DBP greater than or equal to 110



- c. Angina pectoris
  - d. Intermittent claudication
  - e. New cardiac rhythm or murmur
  - f. Rales, increasing peripheral edema, or weight gain greater than 10 lbs.
  - g. New abnormal or worsening laboratory findings
11. All quarterly hypertension clinic visits and other evaluations for hypertension by a clinician shall be documented on the Maryland DOC 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.
12. Routine blood pressure checks by nursing staff shall be documented on the progress notes.
13. Medical records for each inmate diagnosed with hypertension will include, at a minimum:
- a. Documentation of classification
  - b. Documentation of end-organ damage assessment
  - c. Documentation of risk reduction interventions
  - d. Documentation of good control
  - e. Documentation of patient education
- E. All inmates with hypertension will be entered into the state's chronic disease data base.

III. References:

- IV. The seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7)
- V. American Heart Association 2013 ACC/AHA Guidelines on the treatment of blood Cholesterol to reduce Atherosclerotic Cardiovascular Risk in Adults
- VI. Rescissions: DOC 130-118A Issued June, 1993
- VII. Date Issued: October 15, 2007  
 Reviewed: November 2010  
 November 14, 2011  
 October 17, 2012  
 July 11, 2013  
 November 2014

December, 2015



DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES  
OFFICE OF CLINICAL SERVICES/INMATE HEALTH  
CHRONIC DISEASE MANAGEMENT MANUAL

Chapter 2

TERMINAL ILLNESS

Section A

PALLIATIVE CARE (Hospice Care)

- I. Policy: The Department of Public Safety and Correctional Services shall provide comprehensive palliative care services, including medical, mental health care and necessary psychosocial services, for inmates with terminal and life limiting illnesses and or injury who elect palliative medical care, and who voluntarily accept such services. The Palliative Care Program shall be coordinated with medical services, security, social work, mental health, religious service, dietary services and volunteer/relevant community service personnel.
- II. Procedure:
  - A. Assessment and Referral
    1. All inmates with terminal illnesses/life limiting illness and or injury shall be counseled by the attending physician in accordance with the Medical Order for Life Sustaining Treatment (MOLST) 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 or life limiting illnesses who desire or are referred for palliative care shall be counseled by the attending physician regarding the division's palliative care program with its associated services. Inmates who choose to participate in the palliative care program shall sign the Palliative Care Program Consent Form [Form 130-100dR Rev. 8/2012] 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.
3. Inmates who are unable to provide informed consent due to physical or mental health limitations may be considered for the division's palliative care program if approved by two physicians in addition to the caring physician.
  4. Inmates with terminal or life limiting illnesses who are candidates for the division's palliative care program shall be referred by attending physician for consideration of medical parole.
  5. If medical parole is considered to be appropriate, the regional medical director will initiate request for medical parole (see Medical Parole Policy: Chronic Disease Management Manual Chapter 2, Section B).
  6. If the regional medical director determines that the inmate is a candidate for the palliative care program, he/she shall complete the DPSCS Palliative Care Program Referral Form [Form 130-100eR {8/2012}] and shall forward the referral to the palliative care team of the region. The palliative care team shall compose of the following at a minimum:
    - a. Agency contract operations manager
    - b. Regional social work supervisor
    - c. Regional director of nursing
    - d. Regional medical director
    - e. Custody representative
    - f. Infirmary physician
    - g. Chief of psychiatry or designee
    - h. Chief of psychology or designee
    - i. Chaplain
    - j. Dietary services
    - k. Infirmary charge nurse
    - l. Discharge planners
    - m. Case management
  7. Upon referral by a medical or mental health provider, the regional social work supervisor shall ensure that a psychosocial assessment is completed within

- five (5) working days utilizing the DPSCS Guideline for Psychosocial Assessment for palliative care services and shall forward the psychosocial assessment to the palliative care team.
8. If an interregional infirmary transfer is required, the sending medical director communicates with the receiving regional medical director on the availability of needed services for continuity of care. All transfers should be approved by the EPSCS executive director for clinical services. Transfer/receiving screening and documentation shall be completed at the time of transfer, to include the status of medical parole and planned care.
  9. The department's director of social work and or designee shall ensure that the receiving infirmary's regional social work supervisor is notified of the inmates transfer for palliative care services.

#### 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 bi-weekly to review the inmate's current treatment plan. The attending physician and nurse shall document (in the inmate's medical record) any changes in medical, nursing, or support service treatment recommendations.
3. All inmates participation in 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 services, and medical personnel. A medical release of information shall be signed by the inmate and placed in the medial record whenever community agency's resources are utilized (e.g. volunteers).

### 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 improves and palliative care is no longer indicated.
  - 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 chaplain shall provide support for medical and mental health staff when indicated and family members per protocol.

### E. Bereavement Services

1. The regional social work 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.
  - a. The chaplain will, as needed, facilitate and provide bereavement counseling to volunteers, health care staff, other infirmary residents and correctional staff as appropriate.

### F. Palliative Care Program Inmate Aides

1. Inmate aides for the palliative care program shall be certified in accordance with the DPSCS inmate observation certification process and Palliative Care Aide Manual.
2. Inmate aides for the palliative care program shall not provide any nursing care or medical services to assigned inmates in the palliative care program in accordance with the DPSCS Office of Clinical Services/Inmate Health inmate worker policy.

3. External hospice agency volunteers may be used for additional training for inmate observers and custody staff volunteering to assist inmates identified in hospice or palliative care.

G. The following information shall be documented in the inmate's medical record by the health care providers:

1. Bi-weekly update of the palliative care plan.
2. Daily RN assessment notes if in the infirmary.
3. Reports on the use of volunteer services.
4. Physician closure note upon discharge, withdrawal from the program, or inmate death.

III. References:

- A. MOLST Policy
- B. Medical Parole Policy
- C. Inmate Death Policy
- D. Transfer Screening Policy
- E. Infirmary Care General Policies
- F. Inmate Observation and Palliative Care Aide Manual (under revision)
- G. Compassionate Notification for Illness, Injury, or Death
- H. Quality Guidelines for Hospice and End-of-Life Care in Corrections. National Hospice and Palliative Care Organization 2009.

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

V. Date Issued: September 15, 2007  
Revised: September 2009  
Reviewed: November 2010  
September 20, 2011  
Reviewed/Revised: July 2013  
Reviewed: December 2014  
Reviewed: December 2015



Appendix 1

Palliative Care Program Consent Form

I have received counseling from my attending physician regarding my medical condition and have decided to participate in the DPSC Palliative Care program with the following understanding:

1. I can receive supportive palliative medical treatments for my condition without participating in the Palliative Care Program.
2. I may discontinue my participation in the Palliative Care program to seek alternative treatments for my illness.
3. My doctors can discontinue my participation in the Palliative Care program if alternate treatments become medically indicated.
4. My doctor may discontinue my participation in the Palliative Care Program for security reasons, but I will still continue palliative medical care.
5. Medical Information may be shared with non-medical personnel participating in my Palliative Care Program such as chaplains and palliative care volunteers from the community.
6. My housing assignment in a regional infirmary will be determined by collaboration of Medical and Custody staff based on my personal needs, medical care needs, and security issues.

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Inmate Name/Number	Inmate Signature	Date
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Attending Physician (Printed)	Physician Signature	Date
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Appendix 2

DPSC Palliative Care Program referral Form

\_\_\_\_\_

Inmate Name (printed)	ID Number	Date of Birth	Date of Referral
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Referral Made To: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

Circle One

1. The inmate's condition is terminal defined as death is expected Yes / No within twelve months.

2. The inmate's condition is not terminal but is serious and merits Yes / No palliative care.

3. Medical Order for Life Sustaining Treatment (MOLST) or other Do Not Resuscitate (DNR) status is documented Yes / No in the inmate's medical record.

4. The inmate has expressed his or her desire for palliative care in Yes / No writing and has signed an informed consent for program participation.

5. Diagnoses with ICDM-9 Codes: \_\_\_\_\_  
\_\_\_\_\_

6. Summary of treatment provided: \_\_\_\_\_

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

CHRONIC DISEASE MANAGEMENT MANUAL

Chapter 2

TERMINAL ILLNESS

Section B

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.
1. 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 the 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 individuals receive that form within 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 chief medical officer; and
  - d. The director of social work and addiction services.
- B. Social Work and Case Management 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. 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 fifteen 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.

4. The case management administrator shall review and forward the signed 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.
- C. The warden/designee shall either approve or disapprove the recommendation for medical parole.
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 and addiction services by the nineteenth workday after receipt of the Physician Evaluation for Medical Parole.
- D. Copies of all paperwork submitted to the director of social work and addiction services shall be filed in Section II of the inmate base file and in the inmate's medical record.
- E. A Division of Correction Headquarters Review shall include the following:
1. The director of social work and addiction 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 chief medical officer.
  2. Unless additional information is deemed necessary, the DPSCS chief medical officer and the director of social work and addiction services/ designee shall submit the medical parole paperwork with their recommendations and rationale for or against medical parole to the commissioner/designee within 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.
- F. A Maryland Parole Commission (MPC) review will occur and:
1. The MPC, upon review of the request for medical parole consideration, may request additional information as necessary from the DPSCS Chief Medical

Officer, the Director of Social Work and Addiction 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 Chief Medical Officer and the director of social work and addiction services. The commissioner shall ensure distribution to the director of case management and the warden.

G. 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 and addiction services, who shall forward the information to the case management department for placement in Section II of the inmate's base file. The same information will be forwarded to the DPSCS chief medical officer and the regional medical director. The assigned social worker will also complete and implement 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 regarding 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 and addiction services shall immediately notify the regional supervisor of social work 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 working days 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 Performances Scale
- B. DCD 100-11, Parole Procedures
- C. DCD 126-500, Social Work
- D. DOC Manual 100.0002, Case Management
- E. Commitment Procedure Manual

IV. Rescission: DCD 130-100, Section 190, date June 9, 1984  
DOC 130-8 Medical Parole

V. Date Issued: October 15, 2007

Revised: November 2010

Reviewed: September 22, 2011 (no changes)

Reviewed: October 17, 2012

Reviewed: July 5, 2013

Reviewed: November 2014

Reviewed/Revised December 2015

