CHRONIC CARE

CHRONIC CARE- QUICK GLANCE

When setting up chronic care, you need to use the Nursing Chronic Disease Flow sheet, the Master Problem List, the Chronic Care Initial Data Medical Form, and the Chronic Care Tracking Log.

This is a guideline, and not a replacement for your Provider's actual treatment regimen order which is patient specific, or your own sound medical judgment.

Chronic Care Conditions to be monitored:

HIV/AIDS
Hypertension
Diabetes
Asthma
Seizures
Diagnosed Mentally Ill
Tuberculosis
Hyperlipidemia
Coumadin Therapy
Digoxin
Thyroid - TSH/Free T4

Upon placing the patient in Chronic Care for consistent monitoring.

1. The nurse will add the patient's name to the Chronic Care Tracking Log form and schedule the patient to see the Physician provider at their next on-site visit.
2. The nurse will complete the Master Problem List form and place it in the front of the patients' medical record. This form is to be used to track any condition interventions for the patient. It is an easy glance for the Physician Provider when they review chronic care charts.
3. The Physician/Provider must complete the Chronic Care Initial Data Medical Form.
4. The nurse will then schedule the patient for follow up accordingly.

HIV/AIDS

1. Refer to Medical Provider, and then based on his/her assessment, may be referred to Infectious Disease Specialist;
2. Consider Diet- double portions if weight is an issue, or if on meds. Weight to be documented monthly.
3. MVI daily; Flu Vaccine annually; Pneumovax every 5 years.
4. Labs: CD4 and HIV viral load (unless appointment with ID Specialist)

Hypertension

1. BP checks as ordered by MD
2. Flu Vaccine annually;
3. At 3 month intervals: CBC, CMP, Lipid Profile, Urine dipstick

Diabetes

1. Diet- Special diet for diabetics
2. At 3 month intervals: Lipid panel, U/A, CMP, HbA1C

Provider's Initial/Date: _____

Asthma
1. Peak Flow Meter testing at H&P, document findings
2. Flu Vaccine annually

Seizures
1. To be housed on bottom bunk, downstairs
2. Labs at Intake, or shortly thereafter: Dilantin, Depakote, (Keppra if applicable), then at 3 month, then at 6 month intervals

Diagnosed Mentally Ill Patient
Lithium at 3 months and then at every 6 month intervals, unless otherwise indicated.

Tuberculosis
If TB test is over 10mm, unless immune compromised, then 5mm:
1. CXR to be done
2. If patient is put on INH, then patient needs to be on B-6 daily. Will need LFTs monthly.
3. Use TB Flow sheet
4. Notify Health Department if confirmed positive.

Hyperlipidemia
Blood Lipid Panel and Liver Function at 3 months, and then at every 6 month interval

Coumadin Therapy
1. Patient with INR within1 week of admission date
2. Medical Provider to write orders based on results

Digoxin
1. Digoxin level on admission, or shortly thereafter, not to exceed 10 days later.
2. Level then to be drawn at every 6 month interval

Synthroid (Thyroid)
1. TSH and Free T4 level on admission, or shortly thereafter, not to exceed 10 days later.
2. Level then to be drawn at every 6 month interval

This is a guideline, and not a replacement for your Provider's actual treatment regimen order, or your own sound medical judgment.

Provider's Initial/Date:

_____

Southern Health Partners
Your Partner In Affordable Inmate Healthcare

NURSING CHRONIC DISEASE FLOWSHEET

Instructions: Nurses are to use this information in documenting medical information for chronic care patients on a monthly basis. All information is then to be reviewed by the Medical Director, with his/her initials at the bottom signifying review of such. Any additional orders are to be written by the Medical Director and done by the nursing staff. All results of such orders should then be communicated to the Medical Director timely for any additional orders or follow-up.

Patient Name (Last, First, Middle):____

Birthdate:____________________ Sex: M or F Allergies:____________________________________

Intake Date:__________________ Date entered into Chronic Care:_____________________

Condition(s)____

Review Date:	**Review Date:**	**Review Date:**	**Review Date:**
Vital Signs: BP: T: P: R: Wt:	Vital Signs: BP: T: P: R: Wt:	Vital Signs: BP: T: P: R: Wt:	Vital Signs: BP: T: P: R: Wt:
Medications:	Medications:	Medications:	Medications:
Med Compliant?	Med Compliant?	Med Compliant?	Med Compliant?
Special Diet?	Special Diet?	Special Diet?	Special Diet?
Diet Compliant?	Diet Compliant?	Diet Compliant?	Diet Compliant?
Patient Education given on Diet; Disease Process; Exercise, Smoking Cessation; ETOH Cessation? Other:	Patient Education given on Diet; Disease Process; Exercise, Smoking Cessation; ETOH Cessation? Other:	Patient Education given on Diet; Disease Process; Exercise, Smoking Cessation; ETOH Cessation? Other:	Patient Education given on Diet; Disease Process; Exercise, Smoking Cessation; ETOH Cessation? Other:
Any issues regarding condition control?	Any issues regarding condition control?	Any issues regarding condition control?	Any issues regarding condition control?
Lab Data: (circle those to be done and then list data information) CBC UA BMP Hgb A1C HIV VL CD-4 INR Flu Vaccine Drug Levels PPD Chol/Tri	Lab Data: (circle those to be done and then list data information) CBC UA BMP Hgb A1C HIV VL CD-4 INR Flu Vaccine Drug Levels PPD Chol/Tri	Lab Data: (circle those to be done and then list data information) CBC UA BMP Hgb A1C HIV VL CD-4 INR Flu Vaccine Drug Levels PPD Chol/Tri	Lab Data: (circle those to be done and then list data information) CBC UA BMP Hgb A1C HIV VL CD-4 INR Flu Vaccine Drug Levels PPD Chol/Tri
Nurse's Initials:	**Nurse's Initials:**	**Nurse's Initials:**	**Nurse's Initials:**
Clinician Initials/Date:	**Clinician Initials/Date:**	**Clinician Initials/Date:**	**Clinician Initials/Date:**

Southern Health Partners
Your Partner In Affordable Inmate Healthcare

MASTER PROBLEM LIST

Instructions: To be used as a summary of the patient's medical issues - Chronic and Acute Conditions.
Chronic Conditions are classified as (but not limited to): Diabetes (ID/NID), Hypertension, Pregnancy, HIV/AIDS, Asthma, Seizures, Diagnosed Mental Illness, CHF, Hepatitis.
Acute Conditions are classified as (but not limited to): Bone fracture; Sore Throat; or Earache.

Patient's Name: (Last/First/Middle)_____

ID#_____ DOB_____ Sex_____ Allergies_____

Intake Date_____ H&P completed_____ PPD Completed_____

Date Problem Identified	Diagnosis	Chronic Condition (✓)	Acute Condition (✓)	Medications	Date Seen by Medical	MD Initials

Page:_____ of _____

Form Updated 12/2013

SHP 000335

CHRONIC CARE CLINIC – INITIAL MEDICAL DATA FORM

Southern Health Partners
Your Partner In Affordable Inmate Healthcare

Patient Name (Last, First):_____

Site Name/State:_____ Birthdate:_____

Intake Date:_____ Date entered into Chronic Care:_____ Sex: M or F

Chronic Condition (check all that apply): ❑ Asthma/COPD ❑ Hypertension ❑ TB
❑ Seizures ❑ Diabetes ❑ HIV/AIDS
❑ High Cholesterol ❑ Pregnance ❑ Mental Illness
❑ Other:_____

To be completed by nurse:

Personal Risk Factors			**Family History**			**Surgeries/Hospitalizations**
Y	**N**		**Y**	**N**		
		Smoking: Pack/Month:			Anemia	
		High Blood Pressure			Asthma	
		High Cholesterol			Heart Disease	
		Obesity			High Blood Pressure	
		Diabetes			Diabetes	
		Alcohol:			Kidney Disease	
		Substance Abuse:			Cancer:	
		Injection Drug Use			Mental Illness	
		Multiple Sex Partners			Sick Cell Disease	
		Unsterile Tattooing/Piercing			Tuberculosis:	

Notes/General Description of above history:_____

_____

_____

_____

To be completed by nurse for chronic care condition. Circle YES answers. Mark through other conditions that do not apply.

HYPERTENSION/DIABETES/ CARDIOVASCULAR Date of Dx:	SEIZURES Date of Dx:	ASTHMA/COPD/TB/ PULMONARY Date of Dx:	HIV/AIDS/HCV INFECTION Date of Dx:
Chest Pain	Aura	Wheezing	Anorexia
Shortness of Breath	Postictal State	# of ER visits in past 3	Malaise
Palpitation	# of Seizures in past month:	months:	Oral Lesions
Leg Swelling	Type of Seizures	Hx of Intubations	Nausea/Vomiting
Previous Heart Attack	Gum Disease	Inhaler Use	Constipation
Previous CVA/Stroke	Date of Last Seizure:	Prior Systemic Steroids	Diarrhea
Rheumatic Fever		Activity Intolerance	Anorectal pain/Lesions
Headaches	LOC	GERD	Weight Loss/Gain
Syncope/Dizziness		Allergies	TB Infection
Hypoglycemic Episodes	Other Neuro Symptoms?	Exposure to Asbestos	Hx Pneumonia
Kidney Disease	Headache	Hemoptysis	AIDS Diagnosis
Weight Gain/Loss	Incontinence	Fever	Abdominal Pain/Swelling
Blurred Vision	Paralysis	Liver Disease	Abnormal PAP Smear
Foot Problems		Night Sweats	Jaundice
Nocturia		Weight Loss	Joint Pain
Polyuria		Persistent Cough	Pruritis

CHRONIC CARE CLINIC – INITIAL MEDICAL DATA FORM

NOTES: List Details of any Circled Answers:	NOTES: List Details of any Circled Answers:	NOTES: List Details of any Circled Answers:	NOTES: List Details of any Circled Answers:
List Current Medications:	List Current Medications:	List Current Medications:	List Current Medications:
Education Provided to Patient (circle)	Education Provided to Patient (circle)	Education Provided to Patient (circle)	Education Provided to Patient (circle)
Disease/Condition Medication Management Nutrition Smoking/Tobacco Use Exercise Alcohol/Substance Abuse Other:	Disease/Condition Medication Management Nutrition Smoking/Tobacco Use Exercise Alcohol/Substance Abuse Other:	Disease/Condition Medication Management Nutrition Smoking/Tobacco Use Exercise Alcohol/Substance Abuse Other:	Disease/Condition Medication Management Nutrition Smoking/Tobacco Use Exercise Alcohol/Substance Abuse Other:
Nurse's Initials/Date:	Nurse's Initials/Date:	Nurse's Initials/Date:	Nurse's Initials/Date:
Clinician's Initials/Date:	Clinician's Initials/Date:	Clinician's Initials/Date:	Clinician's Initials/Date:

The Clinician must complete the next page of the Physical Exam.

CHRONIC CARE CLINIC – INITIAL MEDICAL DATA FORM

To be completed by the Clinician Only:

PHYSICAL EXAM: Vital Signs: Temp:_____ Blood Pressure:_____Pulse:_____ Resp_____

Height:_____ Weight:_____ Peak Flow:_____

HEENT:_____

_____

Neck:_____

Heart:_____

Lungs:_____

Abdomen:_____

Extremities:_____

_____

GU/rectal_____

_____

Other:_____

_____

Labs to be done: ❑ Hgb A1C ❑ Hct ❑ALT ❑ T.Chole. ❑ CD4 Cell ❑Hgb
❑ BUN ❑ CBC ❑UA ❑ HIV ❑ AST ❑HDL
❑ Other:_____

ASSESSMENT/Diagnoses / Degree of Control:	G	F	P	N/A

PLAN:

Medication Changes:	
Immunizations	(circle) Influenza Vaccine Pneumococcal Vaccine
Diagnostics:	(circle) EKG; Chest X-ray; Lipid Studies PAP Smear RPR Hepatitis Panel
Other Tests:	
Monitoring:	BP: Check times per day/week/month Glucose: Check times per day/week/month Peak Flow: Check times per day/week/month Other:

Is any referral needed?_____ If yes, what specialist_____

What timeframe (consider jail transport)_____

Clinician's Signature/Date:_____

Nurse to take off orders as indicated and follow through. Put completed form in patient's medical record.

Southern Health Partners
Your Partner In Affordable Inmate Healthcare

Chronic Conditions include (but not limited to): Asthma, Hypertension, HIV/Aids, Diabetics (ID/NID), Pregnancy, Seizures, Diagnosed Mental Illness, CHR, Hepatitis, High Cholesterol

CHRONIC ILLNESS TRACKING LOG

Facility/State:_____

Please note all information regarding listing Chronic Condition Patients. The physician should perform initial hands-on assessment of the patient regarding their condition. Chronic condition review clinic dates will be established by the physician. This form must be maintained at the site for review by all medical staff and the site physician. Once patient information has been completed across this form, enter patient information on new form. File all completed logs in a file in medical office labeled "Chronic Illness Logs".

Name (last, first) List Chronic Condition	Intake Date	Date entered into Chronic Care Clinic	Date Seen by Physician	Next Clinic Date	Done ✓	Next Clinic Date	Done ✓