I. AUTHORITY: TCA 4-3-603, TCA 4-3-606, and TCA 41-21-204.

II. PURPOSE: To ensure that appropriate levels and continuity of health care are available to accommodate inmate health care needs.

III. APPLICATION: Wardens, Superintendent, Associate Wardens of Treatment (AWTs), Deputy Superintendent (DS) health administrators, health care staff, and privately managed institutions.

IV. DEFINITIONS:

A. Chronic Care: Health care services that are provided to inmate/patients for a specifically identified illness that is ongoing or recurring. For the purposes of this policy, the following conditions are defined as chronic care conditions: congestive heart failure, diabetes mellitus, hypertension, pregnant offenders, chronic respiratory diseases to include asthma and COPD, neurological disorders to include epilepsy, physical impairments that impact an individual's ability to function in a correctional environment, geriatric care, terminal illness, and infectious diseases, to include Hepatitis C, and Human Immunodeficiency Virus (HIV).

B. Clinic Care: Care for ambulatory patients with health care conditions that are evaluated and appropriately treated.

C. Comprehensive Clinical Health Record Review: A periodic review of the clinical health records (physical and behavioral health) to ensure that inmate's clinical files are completely and fully documented.

D. Convalescent Care: Health care to assist a patient in recovery from an illness or injury.

E. Emergency Care: Immediate medical evaluation and treatment for a medical condition that reasonably appears to a prudent person to represent an immediate threat to life or limb, possible permanent impairment in one or more body functions.

F. Extended Clinical Services: Specialty treatment services utilized to meet the inmate's physical health, mental health, and/or developmental needs. Treatment services may include but are not limited to geriatric, psychiatric, psychological, physical therapy, occupational therapy, hospice, end-of-life care, and intensive sex offender treatment.

G. Infirmary Care: Care for an illness or medical condition as diagnosed by an appropriate health care provider that requires medical/nursing observation and/or management in the facility infirmary.

H. Self-Care: Care for a condition which can be solely treated by the inmate and may include "over the counter" (OTC) products.

I. Sub-Acute Care: Infirmary-based care for an illness or medical condition as diagnosed by an appropriate health care provider that requires care above medical/nursing observation but does not require care at the level of extended clinical services.

V. POLICY: The health administrator, in cooperation with the AWT/DS, shall develop a coordinated health care delivery program that ensures access of the inmate to the appropriate level of care for his/her health needs.

VI. PROCEDURES:

A. Self-care: All inmates shall be encouraged to assume responsibility for their own health through self-care.

1. A self-care program shall include health education. (See Policy #113.40)

2. Each TDOC facility shall have a written procedure indicating how commonly used over-the-counter preparations are made available to inmates. Personal hygiene products (including feminine hygiene items at institutions with female inmates) and approved OTCs may be made available in the institutional commissary upon approval by the TDOC Chief Medical Officer.

3. When health care professionals feel that self-care is appropriate for an inmate, the inmate shall receive the necessary training and equipment. If any self-care requires a level of privacy in order to be performed, the health administrator/designee will notify the AWT/DS/unit manager so that appropriate accommodations may be arranged.

B. First-Aid: The institutional emergency care policy/plan shall clearly describe provisions for access to first aid, including staff responsibilities and the location of first aid equipment and supplies. First aid supplies, including those carried on vehicles shall be regularly inspected. (See Policy #113.02)

C. Emergency Care: Each TDOC facility shall have a written plan to ensure the availability of emergency medical, mental health, and dental services on a 24-hour basis. (See Policy #113.30)

D. Clinic Care: Each TDOC facility shall provide regularly scheduled ambulatory care services. (See Policy #113.31) Protocols and procedures shall be developed indicating referral procedures to the appropriate level of care.

E. Infirmary Care:

1. Each TDOC facility with an infirmary shall make suitable arrangements for the provision of 24-hour nursing coverage whenever there is a patient in the infirmary.

2. Procedures which guide institutional infirmary services and which define the scope of services available shall be developed by each applicable institution and shall include but not be limited to the following:

    a. All care shall be rendered in compliance with applicable local, state, and federal laws.

    b. If infirmary care is not available on-site at the institution where the inmate is housed, procedures shall specify the transfer mechanism for movement to an institution where such care is available in accordance with Policy #113.34.

    c. Each facility's Medical Director, Health Administrator, and Behavioral Health Administrator shall draft a nursing care procedure manual containing the facilities infirmary services scope of care, admission and discharge procedures, technical nursing functions, and treatment procedures. The drafted manual shall be located in the clinic of each institution designated to provide infirmary care as indicated in Section VI.(E)(6) of this policy. The approved TDOC Infirmary Protocol shall be utilized to develop the facilities infirmary nursing care procedure manual.

    d. All inmates requiring infirmary care shall be within the sight or sound of medical staff at all times.

    e. Infirmary Protocols

        1. The TDOC approved global infirmary protocols shall be used as a guide and addendum to the facility infirmary protocol.

        2. Each local infirmary shall have facility-specific infirmary protocols which take into account the limitations of the physical plant and the resources available at that location. See Policy #113.01.

3. An institutional or contract physician shall be responsible for the quality of care in the infirmary and shall be available on-call 24-hours per day.

4. Nursing services shall be under the direction of a full-time registered nurse. Licensed health care personnel shall be on duty and present 24-hours per day whenever an inmate remains in the infirmary.

5. The health record shall be maintained and documentation shall reflect the care rendered during the infirmary stay. This documentation shall be located in the "Infirmary" Section, section seven, of the health record in accordance with Policy #113.50.

6. The following institutions shall provide on-site infirmary care as indicated:

    a. Bledsoe County Correctional Complex (infirmary)

    b. DeBerry Special Needs Facility (Regional Sub-Acute Infirmary)

c. Hardeman County Correctional Facility (infirmary)

d. Morgan County Correctional Complex (Regional Sub-Acute Infirmary)

e. Northeast Correctional Complex (infirmary)

f. Northwest Correctional Complex (infirmary)

g. Riverbend Maximum Security Institution (infirmary)

h. South Central Correctional Center (Regional Sub-Acute Infirmary)

i. Tennessee Prison for Women (Regional Sub-Acute Infirmary)

j. Trousdale Turner Correctional Facility (Regional Sub-Acute Infirmary)

k. Turney Center Industrial Complex (infirmary)

l. West Tennessee State Penitentiary (Regional Sub-Acute Infirmary)

m. Women's Therapeutic Residential Center (Regional Sub-Acute Infirmary)

n. Whiteville Correctional Facility (infirmary)

Residents housed at the Mark Luttrell Transition Center who require infirmary care or higher will be transferred to an institution equipped to provide the appropriate level of care.

7. The TDOC Chief Medical Officer/designee shall have authority to direct the transfer of a patient from another TDOC institution to the DSNF Health Care Center for skilled nursing care. If the inmate is a patient in a local hospital, the collaboration of the institutional physician shall be obtained prior to the transfer.

8. DSNF shall designate a long term nursing care unit for special needs inmates who are not in need of skilled nursing care but have unique physical restrictions and/or medical conditions which create a need for them to be in special housing.

   a. Upon identifying a need for placement in the Long Term Nursing Care Unit, the institutional physician or designee shall submit a written request to the DSNF Medical Director. The request shall include a detailed justification for the placement, including a copy of the inmate's most recent physical examination; the Health Classification Summary, CR-1886; the Major Problem List, CR-1894; treatment plan; and any other pertinent consultations or reports that substantiate the need for long term nursing care placement.

   b. The DSNF Medical Director shall evaluate the request based on the following criteria:

      (1) Age and its effect on and relation to disability

(2) Multiple chronic illnesses and/or degeneration

(3) Type(s) and severity of physical disabilities, restrictions, and individual dependency and the patient's inability to perform activities of daily living.

(4) Type(s), severity, and number of medical restrictions and risk factors

(5) Mental status, capabilities, and restrictions

(6) Level of need for medical observation

(7) Appropriate utilization of sick call and on-site health services

(8) Frequency of specialty appointments, hospital, or emergency care

(9) Accessibility of emergency resources in institution and community

c. The DSNF Medical Director or designee shall notify the classification coordinator at DSNF and the appropriate institutional physician or designee of all approvals for placement in, and clearances for discharge from, the Long Term Nursing Care Unit. The classification coordinator shall then make the transfer in accordance with Policy #403.01. The DSNF Medical Director may also direct internal transfers between the Health Care Center and the Long Term Nursing Care Unit when necessary.

d. Placement shall occur upon the availability of space in the designated unit and based on priority of need.

F. Health Criteria for Placement in a Minimum Security Annex

1. The institutional classification coordinator at each time-building institution shall provide a list of all inmates recommended for transfer to its annex to the health administrator. Prior to transferring an inmate to an annex, the health administrator shall ensure that a review of the current health status of the inmate is done to assure that the individual is compatible with the mission of the annex. This review shall be conducted by the physician, mid-level provider, or a registered nurse and shall consist of an evaluation of the inmate's health record.

2. The following health-related conditions are not considered compatible with placements in a minimum security annex:

a. Inmates with a frequent or predictable need for close access to emergency care, including those with severe cardiac conditions, uncontrolled seizure disorders, or uncontrolled diabetes

b. Inmates who require frequent access to specialty physicians, or dental care, or other services not readily available

c. Inmates in poor health requiring frequent medical attention

d. Inmates requiring access to 24-hour nursing services

e. Inmates on extensive/complicated drug therapy requiring frequent monitoring

f. Inmates on extended controlled drug medication therapy

g. Inmates with unstable mental health conditions.

G. Chronic Care: Each TDOC/privately managed institution shall have a written plan to provide for chronic care for those inmates requiring ongoing or recurring care. The Chronic Disease Clinic Treatment Plan, CR-3624, shall be developed for each chronic care patient and shall be maintained consistent with Policy #113.50.

1. All treatment plans shall include:

a. Current medications

b. Any special therapies (e.g., physical, speech)

c. Special orders (e.g., diet, exercise, laboratory and other diagnostic tests).

d. Opt out HCV testing is to be ordered, unless previously obtained.

e. Frequency of follow-up

f. Evaluation and outcome criteria

g. Patient education needs and goals (See Policy #113.40)

h. Other identified pertinent information about the individual patient

2. Inmates with stable conditions including but not limited to: congestive heart failure, diabetes mellitus, hypertension, chronic respiratory diseases, COPD, neurological disorders to include epilepsy, Human Immunodeficiency Virus (HIV) shall be seen no less than every six months by a practitioner, and annually by a physician. Inmates with the above conditions whose condition becomes unstable shall be seen at least every three months by a midlevel provider and by a physician at least every six months. The associated conditions shall be documented on the Major Problem List, CR-1894.

3. All other chronic care conditions shall be seen no less than every six months by a medical practitioner and no less than annually by a physician.

4. Terminally ill shall be seen at least every three months by a provider and more frequently per providers discretion.

5. Pregnant offenders (See Policy #113.90).

6. Any deviation from this schedule shall be approved by the TDOC Chief Medical Officer or designee. For Hepatitis C patients please refer to the *TDOC Chronic HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C*.

7. If the level of chronic care exceeds that available through the facility's health care resources, appropriate arrangements and procedures, consistent with Policy #113.04, shall exist to ensure that the care is available by transfer to DSNF (TPFW for females) or another TDOC institution.

8. Comprehensive Clinical Record Review: The Health Service Administrator/designee and Behavioral Health Administrator/designee shall conduct a comprehensive clinical record review of every health record for inmates with a chronic care/mental health treatment plan within 60 days of (before or after) the inmates birth month. This review shall be documented on the Comprehensive Clinical Record Review, CR-4201, with the health administrator/behavioral health administrator's signature, time, date and language indicating "record reviewed for completeness".

9. Refusal: When an inmate refuses a scheduled chronic care visit complete a Refusal of Medical Services, CR-1984, and reschedule a follow-up chronic care visit in 90 days.

H. Convalescent Care: Each TDOC/privately managed institution shall have a written plan to ensure that convalescent care for inmates recovering from an illness or injury is available either on-site, by interdepartmental referral, or by community arrangements. Patients requiring convalescent care shall receive care based on an individual treatment plan approved by the appropriate medical, dental, or mental health practitioner.

I. Nursing Coverage: Each facility with a capacity of 500 or more shall have a supervising registered nurse on site 24 hours per day, seven days per week.

J. Transfers of Inmates: Each institution shall have a written plan to ensure that the records of inmates who are physically disabled, geriatric, seriously mentally/physically ill, or developmentally disabled are reviewed, prior to transfer, by the responsible clinician (or designee) for appropriate care availability at the receiving institution.

VII. ACA STANDARDS: 4-4144, 4-4350, 4-4351, 4-4352, 4-4359, and 4-4399.

VIII. EXPIRATION DATE: March 31, 2023.

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH CLASSIFICATION SUMMARY

Name: _____ TDOC ID#: _____ Date of Birth: _____

Physical Exam Date: _____ Dental Exam Date: _____

Allergies: _____

Health Classification (Code):	Code	Description
	A	Class A – No Restrictions
	B	Class B – Moderate Restrictions
	C	Class C – Severe Restrictions

Level of Care (LOC): _____ *Based on health record information provided by Mental Health Treatment Team*		
	LOC 1	No Mental Health Services
	LOC 2	Outpatient
	LOC 3	Supportive Living Services (SLU) Moderate Impairment
	LOC 4	Supportive Living Services (SLU) Severe Impairment
	LOC 5	None

Clinical Alert: _____ Date: _____ Note: _____

Health Related Conditions (Codes): _____
(Circle all applicable codes)

Code	Health Conditions	Code	Health Conditions
A	Visual Impairment	P	Neurological Disease/Disorder ☐ Dementia
B	Hearing Impairment	Q	Arthritis
C	Speech Impairment	R	Obesity (BMI >40)
D	Orthopedic Disease/Disorder ☐ Documented Hx of Back Problems	S	Aging (>60)
		T	Dermatological Disease/Disorder
E	Amputation/Missing Extremity	U	Prosthetic Device Associated with Disability
F	Pregnancy ☐ 1st ☐ 2nd ☐ 3rd (Trimester)	V	(Specify)_____
G	Cancer		
H	Asthma/Hay Fever	W	Permanently confined to a Wheelchair/Mobility
I	Allergies a)Drug: _____ b)Other: _____	X	Sleep Apnea
		Y	G. U. Disease
J	Diabetes ☐ BS >300	Z	Surgery within last 6 months (abdominal, chest, back, or upper extremity)
K	Seizure Disorder		
L	Cardiovascular Disease/Disorder	AA	Other: _____
M	Hypertension		
N	Pulmonary Disease/Disorder	BB	Acute Injury/Serious Medical Condition: Specify _____

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH CLASSIFICATION SUMMARY

Name: _____ TDOC ID#: _____ Date of Birth: _____

Specific Restrictions (Codes): _____
(Circle all applicable codes)

Specific Accommodations (Codes): _____
(Circle all applicable codes)

Code	Restrictions
A	Complete bed rest or limited activity(C)
B	Sedentary work only-lifting 10 lbs. maximum, occasional walking or standing (C)
C	No heavy lifting-20lbs. maximum, able to frequently lift or carry objects up to 10 lbs. (B)
D	Light work only-lifting 50 lbs. maximum, able to frequently lift or carry objects weighing up to 20 lbs.(B)
E	Medium work only-lifting 100 lbs. maximum, able to frequently lift or carry objects weighing up to 50 lbs.(B)
F	Limited strenuous activity for extended periods of time:>1hr (B); 1hr (C); <1hr (C) Note:
G	Continuous standing or walking for extended periods of time:>1hr (B); 1hr (C); <1hr (C) Note:
H	Repetitive stooping or bending (B)
I	Acute need to be housed on first floor/bottom bunk(B)
J	Climbing and balancing (uneven ground) (B)
K	Exposure to loud noises or work detail with prolonged exposure (B)
L	Avoid areas or work details with exposure to skin irritants (B)
M	Participation in weight lifting or strenuous athletics(B)
N	Activity involving potentially dangerous machinery or equipment
O	Operation of motor vehicles (B)
P	Activity involving food preparation/handling (B)
Q	Prolonged exposure to sun or high temperatures (B)
R	Outside work detail during Spring or Summer (B)
S	Exposure to chemicals producing fumes or equipment producing dust (B)

Code	Accommodations
A	Prosthetic Limbs
B	Altered Accommodation (furniture, cell, etc.)
C	Air way assists (Oxygen, CPAP, BiPAP, etc.)
D	Sleeping Accommodation (pillow, blanket, mattress, etc.)
E	Ostomy Supplies
F	Catheter Supplies
G	Assist Devices (cane, crutches, walker, braces, wheel chair)
H	Inmate helper
I	Minimal Assistance for transporting in a van or bus
J	Wheel chair, bus or van required for transport
K	Non-emergency ambulance required for transport
L	Housed on first floor
M	Bottom bunk in housing assignment
N	Special footwear required

Notes:

_____

_____

_____

_____

_____ _____
Medical Practitioner Signature Date

REVIEWED

_____ _____
Medical Practitioner Signature Date

TENNESSEE DEPARTMENT OF CORRECTION

COMPREHENSIVE CLINICAL RECORD REVIEW

_____
INSTITUTION

INMATE NAME: _____ TDOC ID: _____

Health Services Review:

Applicable Items identified as complete:

☐ Advance Directives

☐Conservatorship

☐Major Problem List, CR-1894- Diagnosis Current/Resolved

☐Chronic Disease Clinic Treatment Plan, CR-3624

☐Medication orders/renewed

☐Teaching /Counseling Plan, CR-2742

☐Immunization/TB Control Record, CR-2217

☐Inmate/Employee Tuberculosis Screening Tool CR-3628

☐Health Classification Summary, CR-1886

☐Report of Physical Examination, CR-3885

☐Health History, CR-2007

☐Progress Notes

☐Signatures/dates/full legible

☐CR-2178

Behavioral Health Services Review:

Applicable Items identified as complete:

Major Problem List-CR-1894

☐LOC ☐Diagnosis Current/Resolved

☐Treatment Plan

☐Medication orders/ renewed

☐Consent

☐Mental Health Evaluation

☐Referrals

☐Annual Psychiatrist Review

☐Intrasystem Transfers signed within 14 days

☐Signatures/dates full/legible

☐CR-4050

_____ _____
Health Services Administrator/Designee Date

_____ _____
Behavioral Health Services Administrator/Designee Date

TENNESSEE DEPARTMENT OF CORRECTION

CHRONIC DISEASE CLINIC
TREATMENT PLAN

Inmate Name _____

TDOC ID _____ Institution _____

LIST CHRONIC DISEASES

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

Either list or refer to pharmacy profile for current medications:

_____

***SUBJECTIVE*:**

Asthma: # attacks in last month? _____
short acting beta agonist canisters in last month? _____
times awakening with asthma symptoms per week? _____
CV/hypertension (Y/N): Chest pain? _____ SOB? _____ Palpitations? _____ Ankle edema? _____
HIV/HCV (Y/N): Nausea/vomiting? _____ Abdominal pain/swelling? _____ Diarrhea? _____ Rashes/lesions? _____

Seizure disorder: # seizures since last visit? _____
Diabetes mellitus: # hypoglycemic reactions since last visit? _____
Weight loss/gain ↑ ↓ _____ lbs.

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

_____

***OBJECTIVE*:**

Patient adherence (Y/N): with medications? _____ with diet? _____ with exercise? _____
Vital signs: Temp _____ BP _____ Pulse _____ Resp _____ Wt _____ PEFR _____ INR _____
Labs: Hgb A1C _____ HIV VL _____ CD4 _____ Total Chol _____ LDL _____ HDL _____ Trig _____
Range of fingerstick glucose/BP monitoring: _____

Physical Evaluation (PE): _____

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

Additional Comments: _____

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

***Degree of Control**: *G-Good F-Fair P-Poor NA-Not Applicable*
***Clinical Status**: *I-Improved S-Same W-Worse NA-Not Applicable*

PLAN:

Medication changes:
Diagnostics: _____
Labs: _____
Monitoring: BP _____ x day/week/month Glucose _____ x day/week/month Peak flow _____ Other: _____
Education provided: ☐ Nutrition ☐ Exercise ☐ Smoking ☐ Test results ☐ Medication management ☐ Other: _____
Referral (list type): _____ Specialist: _____
days to next visit? ☐ 90 ☐ 60 ☐ 30 ☐ Other: _____ Discharged from Chronic Clinic (specify clinic): _____
Additional Comments: _____

_____ _____
Mid-Level / Physician Signature Date

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES

MAJOR PROBLEM LIST

_____
INSTITUTION

Name: _____ TDOC ID: _____
Last First Middle

Date of Birth: _____ Gender: ☐ M ☐ F Race: _____

Allergies: _____

PROBLEM NUMBER*	DATE IDENTIFIED/ RECORDED	MAJOR CLINICAL CONDITIONS/PROBLEMS	RESOLVED *(Please check "√" if resolved)*	RESOLVE DATE

Conservator Name: _____

Primary Phone: _____ Secondary Phone: _____

* Major medical problems considered medical or surgical in nature are identified by Roman numerals, i.e., **I** – Diabetes, **II** – Laminectomy.
* Psychiatric, or serious psychological problems, are identified by capital letters, i.e., **A** – Schizophrenia, **B** – Self-Mutilative Behavior.

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES
REFUSAL OF MEDICAL SERVICES

INSTITUTION: _____

Date _____ 20 _____ Time _____ AM/PM

This is to certify that I _____ (Inmate's Name), _____ (TDOC ID)

have been advised that I have been scheduled for the following medical services and/or have been advised to have the following evaluations, treatment, or surgical/other procedures:

_____

_____

_____

I am refusing the above listed medical services against the advice of the attending physician and/or the Health Services staff. I acknowledge that I have been informed of the risks involved by my refusal and hereby release the State of Tennessee, Department of Correction, and their employees from all responsibility for any ill effects which may be experienced as a result of this refusal. I also acknowledge this medical service may not be made readily available to me in the future unless an attending physician certifies my medical problem as a medical emergency.

Signed: _____ _____ _____
(Inmate) (TDOC ID) (Date)

Witness: _____ _____ _____
(Signature) (Title) (Date)

The above information has been read and explained to,

_____ _____ but has refused to sign
(Inmate's Name) (TDOC ID)
the form.

Witness: _____ _____ _____
(Signature) (Title) (Date)

Witness: _____ _____ _____
(Signature) (Title) (Date)