ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.32	Page 1 of 1
	Effective Date: March 15, 2022	
	Distribution: A	
	Supersedes: N/A	
Approved by: Lisa Helton		
Subject: LEVELS OF CARE		

POLICY CHANGE NOTICE 22-11

INSTRUCTIONS:

Please strike Section VI.(E)(6)(i) and add Section VI. (E) (6) (c) to read as follows and renumber remaining subsections accordingly:

"c. Debra K. Johnson Rehabilitation Center"

Please change Section VI.(G)(7) to read as follows:

"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 (DJRC for females) or another TDOC institution."

Please change Section VI.(G)(8) to read as follows:

"8. Comprehensive Clinical Record Review: The Health Service Administrator/designee and Behavioral Health Administrator/designee shall conduct an annual comprehensive clinical record review of every health record for inmates within 60 days of (before or after) the inmate's birth month. This review shall be documented on the Comprehensive Clinical Record Review, CR-4201, with the health administrator/behavioral health administrator/designee's signature, and date."

Please change Section VII. to read as follows:

"ACA STANDARDS: 5-ACI-2C-13, 5-ACI-6A-07, 5-ACI-6A-08, 5-ACI-6A-09, 5-ACI-6A-18, and 5-ACI-6C-06."

Please strikethrough the CR-1886 on page 8, the CR-3624 and the CR-4201 on page 9 of this policy and insert the attached pages 11 and 12 containing updated versions of the CR-1886, CR-3624, and the CR-4201, and renumber policy pages accordingly.

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 weightlifting 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	Airway 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, wheelchair)
H	Inmate helper
I	Minimal Assistance for transporting in a van or bus
J	Wheelchair, bus, or van required for transport
K	Non-emergency ambulance required for transport
L	Housed on the 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

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

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