

## 2008 Definitions of Disease Control and Clinical Status

| Clinic  | Good Control   | Fair Control*   | Poor Control*   | Improved Status  | Unchanged Status   | Worsened Status**  |
|---|--|---|---|--|--|--|
| Cardiac/HTN <sup>1</sup><br><br>HTN+Diabetes <sup>1,2</sup> | Systolic <140 mm/Hg<br>Diastolic <90 mm/Hg<br><br>Systolic <130 mm/Hg<br>Diastolic <80 mm/Hg                             | Systolic 140-160 mm/Hg<br>Diastolic 90-100 mm/Hg<br><br>Systolic 130-150 mm/Hg<br>Diastolic 80-95 mm/Hg   | Systolic >160 mm/Hg<br>Diastolic >100 mm/Hg<br><br>Systolic >150 mm/Hg<br>Diastolic >95 mm/Hg   | Blood pressure reading is lower than at the previous CIC visit   | Blood pressure, weight, and/or baseline laboratory values have not changed since the previous CIC                        | An increase in blood pressure, weight, baseline laboratory values; nonadherence to treatment plan; or development of more acute symptoms |
| Dyslipidemia <sup>1</sup>                                   | LDL-C at goal  | Based on Coronary Equivalents AND Risk Factors<br>See Table on "Assignment of Risk Status in Relation to Medication Treatment Initiation and Definition of Good Control"*** | Based on Coronary Equivalents AND Risk Factors<br>See Table on "Assignment of Risk Status in Relation to Medication Treatment Initiation and Definition of Good Control"*** | Lipid levels have improved or reached goal level since the previous CIC visit  | Lipid levels have not changed since the previous CIC visit   | Lipid levels have worsened or nonadherence with the treatment plan   |
| Diabetes <sup>1</sup>                                       | HbA1C = 7% or less   | HbA1C = 7.1% to 9.0%  | HbA1C = 9.1% or higher  | Reduction in HbA1C or the average of finger-stick levels; or for type 2 diabetes, intentional weight loss of 5% or more due to diet and exercise | HbA1C and the average of finger-stick levels are the same as previously recorded, and the weight is relatively unchanged | Increase in HbA1C or the average of finger-stick levels; or for type 2 diabetes, a weight gain of 5% or more                             |
| HIV Infection <sup>1,3,4</sup><br><br>(On ART >90 days)     | HIV viral load is undetectable<br>CD4 is rising<br>Weight is >90% of ideal body weight<br>No active OI's or malignancies | HIV viral load is <5000 copies<br>CD4 is unchanged<br>Weight is >85% of ideal body weight<br>No active OI's or malignancies   | HIV viral load is >5000 copies<br>CD4 is <50 or declining<br>Weight is <85% of ideal body weight<br>New active OI's or malignancies   | Clinical status and adherence has improved since the previous CIC visit  | Clinical status and adherence has not changed since the previous CIC visit   | Clinical status and adherence has worsened since the previous CIC visit  |

| Clinic  | Good Control  | Fair Control*   | Poor Control*  | Improved Status   | Unchanged Status   | Worsened Status**   |
|---|---|---|--|---|--|---|
| HIV Infection <sup>1,3,4</sup><br><br>(Not on ART or on ART <90 days) | Patient is asymptomatic<br><br>HIV viral load is <50,000 copies<br>CD4 count is >350 mm <sup>3</sup><br>Weight is >90% of ideal body weight<br><br>No active OI's or malignancies | Patient is asymptomatic<br><br>HIV viral load is <100,000 copies<br>CD4 count is 200-350 mm <sup>3</sup><br>Weight is >85% of ideal body weight<br><br>No active OI's or malignancies | Patient is symptomatic (wasting, thrush, unexplained fever for >2 weeks)<br>HIV viral load is <100,000 copies<br>CD4 count is <200 mm <sup>3</sup><br>Weight is <85% of ideal body weight<br><br>New active OI's or malignancies | Clinical status and adherence has improved since the previous CIC visit | Clinical status and adherence has not changed since the previous CIC visit | Clinical status and adherence has worsened since the previous CIC visit                         |
| Pulmonary <sup>1</sup>  | <1 beta-agonist MDI refill per month<br><br>No visits to on-site ER<br><br>No nighttime awakening with asthma symptoms  | <1 beta-agonist MDI refill per month<br><br><2 on-site ER visit for asthma in past month<br><br><2 weekly nighttime awakening with asthma symptoms                                    | >1 beta-agonist MDI refill per month<br><br>>2 on-site ER visit for asthma in past month<br><br>>2 weekly nighttime awakening with asthma symptoms   | Less use of beta-agonist MDIs and less frequent symptom presentation    | Both the use of beta-agonist and frequency of symptoms are unchanged       | Greater use of beta-agonist, more acute symptoms, or an increase in emergency department visits |
| Seizure <sup>1</sup>  | No seizure activity since previous CIC visit  | One seizure activity since previous CIC visit   | More than one seizure activity since previous CIC visit  | Number of seizures has diminished since previous CIC visit              | Number of seizures has remained the same since previous CIC visit          | Number of seizures has increased since previous CIC visit                                       |

\* For patients determined to be Fair or Poor disease control, the clinician (MD, DO, NP, PA) must document treatment plans for getting the patient's condition under **GOOD** control.

\*\* For patients whose disease status since the last CIC has **WORSENERD**, the clinician (MD, DO, NP, PA) must document treatment strategies in an attempt to improve patient's status.

\*\*\* NCHC's Clinical Guideline for the Treatment of High Blood Cholesterol

To be assessed in Good disease control, the patient must meet ALL criteria within the given disease category. For example, a hypertensive patient with a blood pressure of 132/84 should be assessed as Good disease control. If a patient does not meet all criteria, the clinician should select the category of lowest disease control. For example, if a pulmonary patient has required only 1 beta-agonist MDI refill and has had no visits to the on-site ER, but has had 5 weekly nighttime awakenings with asthma symptoms, the clinician should assess this as Poor disease control. An HIV patient on ART who has an undetectable viral load but is at 85% of ideal body weight should be assessed as Fair disease control.

References:

1. National Commission on Correctional Health Care. Recommended Correctional Clinical Guideline on Diabetes Chronic Care. *Journal of Correctional Health Care* (Fall 2001), Vol. 8, Issue 2, pp. 97-156.
2. American Diabetes Association. Standards of Medical Care for Patients With Diabetes Mellitus. *Diabetes Care* (January 2002), Vol. 25, Suppl. 1, pp. S33-S89.
3. Centers for Disease Control and Prevention. Guidelines for Using Antiretroviral Agents Among HIV-Infected Adults and Adolescents. *MMWR* (May 17, 2002), Vol. 51, No. RR-7.
4. American Medical Association. Consensus Statement: Antiretroviral Recommendations of the International AIDS Society-USA Panel. *JAMA* (July 10, 2002), Vol. 288, No. 2, pp.222-235.

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For current version go to: <http://www.ncchc.org/resources/clinicalguides.html>