U.S. Department of Justice
Federal Bureau of Prisons

P R O G R A M S T A T E M E N T
OPI: HSD/HPB
NUMBER: 6031.05
DATE: May 14, 2024

Patient Care

/s/
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1. PURPOSE AND SCOPE

To effectively provide medically necessary healthcare to inmates.

a. Summary of Changes

Policy Rescinded
6031.04 Patient Care (June 3, 2014)

The following changes were made:

- The terms "staff" and "staff member (s)" have been replaced with the term "employee (s)."
- The term "SENTRY" has been replaced with the term "applicable Bureau inmate information system."
- Section 2. Removed Director of Nursing (DON) responsibilities.
- Section 9. Revised language for Four-Minute Response Time and Continuous Healthcare Coverage.
- Section 13. HSA and CD responsibilities revised.
- Section 18. Added HSA requirements for notification of pregnancy confirmation. CD or designated physician replaced with institutional Social Worker or Regional Social Worker will contact the Administrator, Women and Special Populations Branch, regarding expenses for neonatal care and child placement. Added women are referred to institutional or Regional Social Worker for postpartum care.
- Section 20. Added the HSA or designee will track enrolled inmates in CCCs to assure timely follow-up, diagnostic testing, and medication management. Removed requirement of a physician to review and approve any additions to CCCs. Revised providers responsibilities conducting 14-day evaluations and CCCs.

- Section 21. Added requirements for completing clinical encounter notes no later than the following business day unless exigent circumstances. Revised use of Telephone and Verbal orders. Revised on-site and off-site consultation documentation.
- Section 31. Added Gender Affirming Surgeries requests and processing.
- Section 43. Revised Reentry Services to include 90-day requirement for release and treatment planning.
- Section 44. Added new section on Radiology.

b. **Program Objectives**. The expected result of this program is:

Healthcare will be provided to inmate patients in accordance with proven standards of care without compromising public safety concerns inherent to the agency's overall mission.

c. **Institution Supplement.** Each institution will develop an Institution Supplement. Regional legal review is recommended when the Institution Supplement is developed and must include the following, if applicable:

- Procedures for responding to emergencies 24 hours daily, to include CPR and AED.
- Medical Observation Room.
- Procedures for a serious illness, serious injury, and death, contacting the local coroner or medical examiner, and facilitation of the creation and implementation of an advance directive and Do-Not-Resuscitate (DNR) orders.
- Procedures to address the management of durable medical equipment.
- Procedures to ensure quality and safety in the provision of dialysis services.
- Procedures for Rehabilitative Services.
- Procedures for social work services (for facilities with authorized Social Workers).
- Procedures for radiology.
- Procedures for short stay units, if applicable.
- Procedures for ambulatory care as provided in Section 13.

CONTENTS

Section 1. **DEFINITIONS**

a. **Health Services Unit (HSU)**. The HSU is the organizational unit that provides health services at all Bureau of Prisons (Bureau) institutions. The HSU at a Medical Referral Center (MRC) delivers inpatient and outpatient services to inmate patients with serious medical and mental health needs. The HSU at non-MRC institutions delivers ambulatory care services to inmate patients who are essentially healthy or have manageable acute or chronic health needs. Generally, the Medical Director will approve the range and capacity of services offered to the inmate population. The approved range of services will be specific for each institution or correctional complex based on the availability of internal and external healthcare resources. Changes to the range or capacity of services offered must be approved in advance by the HSD Medical Director.

b. **Inpatient Care**. Inpatient care refers to the care of patients whose conditions require admission to a healthcare facility or unit having 24-hour nursing care (long-term care unit, medical center, short stay unit, etc.).

c. **Outpatient Care.** Outpatient care, also known as ambulatory care, is any healthcare service provided to an inmate patient who is not admitted to an inpatient unit or inpatient facility. Outpatient care may be provided in a doctor's office, outpatient clinic, or medical center outpatient department. The outpatient clinic includes examination rooms, treatment rooms (including an area to assess and treat emergencies), dental clinic, radiology and laboratory areas, pharmacy, waiting areas, and administrative offices. It may also include observation areas, airborne infectious isolation rooms, suicide prevention rooms, and short-stay units (at designated facilities).

d. **Observation Area.** The observation area provides accommodations of limited duration for inmate patients who are being treated for noncritical illnesses, recovering from surgery, or requiring observation for medical and/or mental health conditions, and who do not require acute care hospitalization or continuous 24-hour nursing care.

e. **Short Stay Unit (SSU).** The Short Stay Unit is the area within Health Services that provides services exceeding those of an Observation Area, but which do not meet the criteria for an inpatient hospital setting. Nursing care is provided 24 hours per day when patients are in the SSU. Institutions operating an SSU must be approved by the Medical Director.

f. **Medical Referral Center (MRC).** MRCs provide a full range of diagnostic and therapeutic services consistent with the individual mission, and a wide range of inpatient specialty consultative and treatment services.

The Medical Director will designate the missions at each MRC. Services provided at MRCs

include, but are not limited to:

- Inpatient Services.
- Long-Term Care Services.
- Behavioral Health Services (Inpatient and Outpatient).
- End-of-Life Care Services.
- Surgical Services.
- Enhanced Laboratory Services.
- Outpatient Services.
- Physical Therapy and Rehabilitation Services.

g. **Team Medicine**. Team Medicine is the conceptual framework by which clinical, administrative, and ancillary healthcare personnel (employed and contracted) work collaboratively to deliver health services to inmates.

h. **Advance Directive.** For purposes of this Program Statement, an advance directive is a written instrument (sometimes referred to as a "living will" or other similar document) by which a patient expresses their healthcare wishes in the event of a terminal or irreversible condition. The advance directive will be utilized by medical providers to guide care when the patient lacks the capacity to make his/her own healthcare decisions.

The advance directive may address the patient's wishes concerning the withholding or withdrawal of resuscitative, life-sustaining, or other types of medical care.

The advance directive may prescribe the appointment of a non-Bureau proxy decision-maker for these healthcare decisions.

i. **Proxy Decision Maker.** For purposes of this Program Statement, a proxy decision maker is a person authorized to make healthcare treatment decisions for a patient who is incapacitated and unable to make and/or communicate such decisions themself. The term "proxy decision maker" is used generally in this Program Statement and may refer to a person named in an advance directive, formally executed power of attorney, or as appointed by a court. The authority, parameters, and procedures for creating such proxies are governed by the laws of the state in which the institution operates.

Under no circumstances will another inmate be appointed as proxy decision maker. Additionally, a Bureau employee will not be appointed as a proxy decision maker.

j. **Life Sustaining or Life Prolonging Procedures.** Life sustaining or life prolonging procedures include any medical intervention or procedure that uses artificial means to sustain a

vital function or artificially prolong life. Two examples are mechanical ventilation and dialysis.

k. **Terminal Condition.** A terminal condition means an incurable or irreversible medical condition for which, in the attending physician's opinion, death will likely occur within a short time regardless of the application of medical interventions.

l. **"Do Not Resuscitate" (DNR) Order.** A Do-Not-Resuscitate order is the attending physician's directive, recorded in the inmate's health record, to withhold or withdraw extraordinary life-sustaining measures.

m. **Electronic Health Record (EHR).** The Electronic Health Record is used by authorized employees at all Bureau facilities to document medical, dental, mental health, and ancillary support care or treatment. Refer to the Program Statement **Health Information Management** for further information.

n. **Catastrophic Care**. A catastrophic care case meets one of the following criteria and the cost threshold set by the Medical Director:

- A single community-based hospitalization of seven or more days.
- A readmission for the same diagnosis within 30 days of discharge.
- A recurring medical need (e.g., dialysis for kidney failure, chronic ventilation, wound care) requiring ongoing community-based healthcare services.

o. **Medical Classification**. Medical classification is a system that matches inmate healthcare needs with an institution's ability to meet those needs by assigning a medical and mental health care level to both the inmate and the institution.

p. **Telehealth**. Telehealth refers to the use of electronic communication technologies to facilitate access to care, provide healthcare services, and improve the health of inmates.

Section 2. **PROGRAM RESPONSIBILITY**

The Clinical Director (CD) is the physician manager responsible for the clinical care of inmates at Bureau institutions. He/she provides direct patient care, is the local clinical decision-making authority, and supervises other clinical providers having medical privileges, practice agreements, and protocols.

The Health Services Administrator (HSA) is responsible for the administration of HSU operations and supervises the administrative, ancillary, and technical healthcare workers. The CD and HSA collaborate to assure the delivery of effective and efficient health services.

Section 3. **MEDICAL CLASSIFICATION**

Medical Classification is the system of assigning a care level to each Bureau institution, and a medical and mental health care level assignment to each inmate. The system has four care levels. The Health Services Division (HSD) assigns institution care levels based on an analysis of the physical plant, community-based resources, local labor market, and impact on other correctional programs. HSD will increase staffing levels at institutions that have higher care level assignments.

Medical Care levels are:

- **Care Level 1** institutions house inmates that are generally healthy but may have limited medical problems easily managed by Health Services employees and supplemented by existing community resources.
- **Care Level 2** institutions house inmates that have stable chronic conditions managed by Health Services employees and supplemented by existing community resources. Care Level 2 inmates generally self-manage their conditions and need infrequent visits to medical specialists or community facilities.
- **Care Level 3** institutions house inmates having more complex medical conditions and are more fragile. They require frequent clinical contacts with Health Services employees and more visits to community medical specialists. They may also periodically require hospitalization to stabilize their conditions.
- **Care Level 4** institutions are the agency's MRC. Inmates housed at MRCs may require extensive medical and nursing care. Some inmates may require 24-hour nursing care including assistance with activities of daily living such as feeding, toileting, and dressing. These inmates may have frequent visits to medical specialists or hospitalizations for specialized medical care that isn't available in the MRC.

The CD or designee makes a care level assessment upon an inmate's arrival, and regularly reviews and revises medical care levels as the inmate's health needs change. Each institution will develop a process for reviewing and updating inmate medical care levels. The Chief Psychologist or designee makes a mental health care level assessment upon an inmate's arrival, and regularly reviews and revises mental health care levels as inmate needs change. The Medical Director and Psychology Services Administrator will issue guidance regarding medical and mental health care level criteria.

Section 4. **SCOPE OF SERVICES**

The scope of health services required to deliver medically necessary care to inmate patients in Bureau facilities includes:

- Ambulatory care services.
- Emergency services.
- Urgent care services.
- Short stay services (at designated facilities).
- Observation services.
- Preventive health services.
- Rehabilitative services.
- Social work services.
- Specialty services.
- Inpatient services (primarily at MRCs and facilities authorized by the Medical Director to operate long-term care units).
- End-of-life care (primarily at MRCs and facilities authorized by the Medical Director to operate long-term care units).
- Telehealth services.

In addition to the onsite scope of services at each HSU, supplemental health services are delivered by consultation specialists and Bureau specialty and primary care providers, through virtual technology (telehealth) and other communication media. Specialized medical, mental health, and dental services that cannot be provided within facilities will be contracted in the community.

Section 5. **CATEGORIES OF CARE**

The Bureau provides four major categories of care that define health services provided to inmate patients. Dental care is defined in the Program Statement **Dental Services**.

Ordinarily, non-sentenced inmates, and inmates who have less than 12 months to serve, are ineligible for health services described below in subsections 5.c. and 5.d. The Regional Medical Director (RMD) must approve care in subsection 5.c., and the Bureau Medical Director must approve care in subsection 5.d. for these inmates.

a. **Medically Necessary.** Medically necessary care is defined as:

(1) **Medically Necessary – Emergency.** Medical emergencies are conditions of an immediate, acute, or emergent nature that without care would cause rapid deterioration of the inmate's health, significant irreversible loss of function, or life-threatening consequences. Treatment for conditions in this category is essential to sustain life or function and warrants immediate attention. Examples of conditions considered acute or emergent include, but are not limited to:

- Myocardial infarction.
- Severe trauma such as head injuries.
- Hemorrhage.
- Stroke.
- Status asthmaticus.
- Precipitous labor or complications associated with pregnancy.
- Detached retina, sudden loss of vision.
- Suicide attempt and/or overdose

(2) **Medically Necessary – Non-emergency**. Non-emergency medical conditions that require medically necessary care are conditions that are not immediately life-threatening, but without care the inmate could not be maintained over time without significant risk of:

- Serious deterioration of an otherwise manageable condition leading to premature death.
- Significant reduction in the possibility of repair later without present treatment.
- Significant pain or discomfort that impairs the inmate's participation in activities of daily living.

Examples of conditions considered medically necessary but non-emergency include, but are not limited to:

- Chronic conditions (e.g., diabetes, heart disease, schizophrenia).

- Cancer treatment
- Perinatal care in pregnancy.
- Infectious disorders in which treatment allows for a return to previous state of health or improved quality of life (e.g., HIV, tuberculosis).
- Age and gender-appropriate preventive health services (e.g., immunizations, cancer screening).

b. **Medically Acceptable - Not Always Necessary**. Medical care is considered medically acceptable but not always necessary (i.e., elective) when the intervention may improve the inmate's quality of life while incarcerated. Relevant examples in this category include, but are not limited to:

- Joint replacement.
- Septoplasty.
- Anterior cruciate ligament reconstruction of the knee.
- Carpal or cubital tunnel release.

These therapeutic interventions ordinarily require two levels of utilization review: local review by the Utilization Review Committee and approval by the Clinical Director (CD); and regional review and approval by the Regional Medical Director (RMD). Elective care should always be evaluated with respect to the inmate's current capacity to perform activities of daily living within the correctional setting.

Relevant factors to consider in approving the elective care include, but are not limited to:

- The risks and benefits of the treatment.
- Available resources.
- Natural history of the condition.
- The effect of the intervention on inmate functioning in his/her activities of daily living.

c. **Limited Medical Value**. This category of medical care delineates interventions that provide little or no medical value, are unlikely to result in substantial long-term gain, or are expressly for the inmate's convenience. Interventions in this category are usually excluded from the scope of services provided to Bureau inmates. Examples of conditions for which care has limited medical value include, but are not limited to:

- Minor conditions that are self-limiting.
- Cosmetic repair (e.g., blepharoplasty).
- Excision of non-cancerous skin lesions such as skin tags or lipomas.

Elective interventions require two levels of utilization review: local review by the Utilization Review Committee and approval by the Clinical Director; and regional review and approval by the Regional Medical Director. However, routine treatment for uncomplicated non-cancerous skin lesions (e.g., medicated removal of a wart) causing significant discomfort (e.g., irritation due to friction of clothing or the performance of activities of daily living [ADL]) may be provided by Bureau physicians or Advanced Practice Providers (APPs) having documented competencies without local URC or regional level review and approval.

d. **Extraordinary.** Medical interventions are deemed extraordinary if they affect the life of another individual, such as in some organ transplantation, are considered investigational in nature, or are otherwise deemed an exceptional medical intervention. Any treatment provided in this category requires the Medical Director's review and approval, with notification to the Regional Director.

Section 6. **UTILIZATION MANAGEMENT**

a. **Utilization Review Components**. Utilization review (UR) is a comprehensive approach to healthcare management that involves a continuous assessment of inmate health needs, the resources required to meet those needs in the most effective and efficient manner, and the specified timeliness of service delivery. Every Bureau institution will implement a UR program. Components of the UR program are:

- **Prospective** (prior to service delivery and use of resources) review of requests for specialized medical, mental health, and dental services that cannot be provided in the HSU.
- **Concurrent** (during service delivery and use of resources) review of the use of inpatient medical and mental health beds and specialty services; monitoring the span of treatment and length of inpatient stay; tracking orders for services to ensure services are completed in a timely manner; and managing catastrophic care cases by providing care in a cost-effective setting.
- **Retrospective** (after service delivery and use of resources) review of the efficacy of care and resource utilization.

(1) **Prospective Utilization Review**. When medically necessary services cannot be provided through existing HSU resources, individual practitioners must request that an inmate receive specialty services through established contracts or redesignation to other Bureau institutions that have the required services.

Requests for specialty care that require prospective utilization review are:

- **In-House Contracted Specialists**. Initial specialty evaluations conducted in-house by contracted specialists for health problems that are not actively being managed in a chronic care treatment plan (e.g., orthopedic clinic, cardiology, gastroenterology, urology, general surgery, etc.). Subsequent visits for the same problem or episode do not require approval but should be strictly limited to specialty care.
- **Community-Based Contracted Specialists**. Non-emergency specialty evaluations and procedures (surgical, medical, or dental) conducted at a specialist's community-based office or by specialty providers at community-based facilities.
- **In-House Diagnostic Testing by Contracted Technicians**. Diagnostic testing performed in-house by contracted technicians using mobile and/or in-house units (MRIs, CT scans, etc.).
- **Community-Based Diagnostic Testing**. Non-emergency diagnostic testing performed at a community-based facility.
- **Limited Medical Value Services.** Services delineated in the "Limited Medical Value" category of care (see Section 5.c.).

- **Extraordinary Care Services**. Services delineated in the "Extraordinary Care" category of care (see Section 5.d.).

Requests for services that **do not** require prospective utilization review are:

- Emergency services (medical, dental, and mental health emergencies).
- Requests for routine screening consultations (e.g., optometry services for visual acuity or visual fields testing; routine chronic care follow-up procedures, such as replacement of medical devices such as pacemakers or in-dwelling medication pumps per manufacturer's specifications).
- Routine preventive health screening and diagnostic evaluation for chronic care management (e.g., age-appropriate mammography screening for females, annual diabetic retinal evaluation by an ophthalmologist, screening for colon cancer, etc.).

Specialty care consultation data will be documented in the EHR and used to evaluate and prioritize requests and risk management.

(2) **Concurrent Utilization Review**. Utilization review will also be conducted for ongoing hospitalizations and emergency referrals, catastrophic care cases, continuity of care cases requiring a reassessment of resource suitability and monitoring pending orders for services. Specifically, concurrent review includes:

- Review of inmates who are inpatients at community-based hospitals monitoring length of stay, interventions, and complications (from a procedure, adverse drug event, or iatrogenic), particularly hospital readmissions within 30 days of a previous hospital admission for the same diagnosis or related complications.
- Cases for which current case management is straining resources. Local UR reassessment is conducted to evaluate alternative targeted interventions to reduce extraordinary or unnecessary healthcare costs, or reassignment to other Bureau healthcare assets (e.g., re-designation to a medical center). Locally, the CD and Health Services Administrator will identify catastrophic care cases.
- Tracking and management of requested services to assure completion in a timely manner:
  - Past-due requests for consultations, labs, x-rays, and procedures, including a corrective plan to complete these requests in a timely manner.
  - Cases that were cancelled and require rescheduling.
  - Requests sent for regional review including the final decision.
  - Pending re-designation and transfer requests to ensure appropriate follow up and ongoing care are provided.
  - Cases assigned medical hold status. The URC will develop a process for placing a

medical hold in the EHR and the applicable Bureau inmate information system when the UR approves a new request for specialty services. Existing medical hold assignments will be reviewed and cancelled when no longer necessary.

- Institutions with 24-hour nursing units will conduct bed utilization meetings to ensure timely delivery of necessary healthcare services, monitor admission and length of stay criteria, and provide periodic updates to the CD. Bed utilization data will also be reported through Central Office Utilization Review employees to the Medical Director to assess national use of resources. The UR employees at the MRCs will conduct structured reviews of 24-hour nursing care beds, both medical and mental health, to ensure they are optimally utilized. HSD will establish the format and tools used for bed management. Central Office Utilization Review employees will monitor all MRC length of stay (LOS) cases using automated tools.
- The CD will develop and provide weekly reports to the RMD for concurrent review of hospitalizations, catastrophic cases, and cases in which necessary healthcare resources or services are not readily available locally. The HSA will develop and provide monthly updates on past due consults, labs, procedures, and x-ray requests to the Regional Health Services Administrator.

(3) **Retrospective Utilization Review**. The retrospective UR enables the institution to identify ways to improve the quality and timely delivery of specialty services and evaluate the effectiveness of its system for monitoring completion of approved services:

- Cases sent to the community hospital during hours when no Bureau healthcare provider was on duty at the institution.
- Inmates transported for community-based emergency care.

b. **UR Process.** The institution Utilization Review Committee (URC) conducts prospective, concurrent, and retrospective reviews. Most UR decisions are made at the local level; however, the URC will need to refer some requests for specialty services for Regional or Central Office review. The Medical Director has ultimate authority to determine which services require local, regional, or national review, and may delegate that authority to the Regional Medical Directors (RMD). The Medical Director may periodically require RMD review for certain types of cases (e.g., high risk, high cost, questionable efficacy). The Medical Director will notify CDs and institution CEOs by memorandum when regional review requirements are required.

(1) **Local Review**. Each institution will establish a local URC chaired by the Clinical Director. Other recommended URC members include, but are not limited to:

- HSA and/or Assistant HSA.
- Chief Dental Officer (as applicable for scheduling and updating the status of dental specialty care cases).
- Chief of Rehab services (as applicable).
- Clinical and dental provider(s) directly involved in the inmate's care to present the case (as applicable).
- Chaplain, Social Worker, or other employees who serves as the inmate advocate (as applicable).
- Director of Nursing (as applicable).
- Captain or designee to address security concerns.
- Assigned facilitator for the URC meeting.
- Assigned health services assistant or other administrative employees who schedule outside medical trips.

The HSA and CD will coordinate the development of local URC operating procedures and assign an employee to facilitate the URC (health services assistant, nurse, etc., at non-MRCs; UR Specialist at MRCs). The volume of cases and specific institution needs will determine the frequency of URC meetings. Weekly URC meetings are recommended for MRCs, Care Level 3 facilities, and all complexes. Bimonthly meetings are recommended for USPs, FCIs, camps, and detention centers. MRCs typically have a significant volume of requests for specialized services; therefore, the CD may assign primary review of requests to the UR coordinator and secondary review to the CD.

The provider requesting specialty consultation, diagnostics, or procedures (or locally determined alternate employee) will present the case for committee review and discussion. The URC will make one of the following recommendations:

- Approve the request and assign a due date.
- Defer the request to a staff physician/requesting provider for further evaluation.
- Disapprove the request and document the reason (contraindicated, not medically necessary, etc.).
- Refer for Regional review.

As chair of the URC and local clinical authority, the CD makes the final local URC decisions. The CD may refer a case to the respective RMD for review. When the URC reviews recommendations from specialty consultants, the CD is not obligated to approve the consultant's recommendation if in his/her clinical judgment the recommendation is not medically necessary. When a CD does not approve a consultant's recommendation, he/she will document the clinical rationale in the inmate's EHR.

The CD or designee (e.g., the UR coordinator) will notify inmates in writing when URC decisions are made and document the notification and reason(s) for disapproval in the EHR. Inmate notification may be made electronically or by paper copy. If the request for specialty services is disapproved, the inmate will be counseled about continuation of the existing treatment plan and assured that specialty services will be reconsidered when medically indicated.

The URC will maintain meeting minutes that document attendees, data on the required review items noted above, key details of cases reviewed, URC recommendations, and CD's decisions. UR data will be tracked and reported to the local Governing Body at its quarterly meetings.

(2) **Regional Review**. The CD will request a prospective regional review by the Regional Medical Director (RMD) for specialty services in the "Medically Acceptable – Not Always Necessary" and "Limited Medical Value" categories of care that were approved at the local level. The RMD or designee will review the referred case documentation and approve/disapprove the consultation. The CD (or designee) documents the RMD's final decision in the EHR and notifies the inmate as described in Section 5.a.

(3) **Central Office Review**. The Medical Director or designee will prospectively review and approve/disapprove all requests for services delineated in the "Extraordinary Care" category of care. The CD (or designee) documents the final decision in the inmate's EHR and notifies the inmate about the decision.

The HSD Chief of Health Programs will convene and chair a standing National Utilization Review Advisory Board to establish MRC bed utilization metrics, monitor MRC bed utilization, oversee elective care services, and make recommendations for approval criteria for elective services and extraordinary care requests.

The Health Services Division (HSD) will establish the format and provide automated software tools for the UR program to assist with efficiency of operations.

(4) **Dental Utilization Review.** Dental specialty cases will be managed per Dental Services policy which states that the Regional Chief Dentist is the approving authority for local institution oral health cases. The institution's Chief Dental Officer (CDO) will ensure that all pertinent materials will be included in the Electronic Health Record for decision considerations. The CDO will work with the local URC to keep the healthcare team apprised of the consultation status and the continued need for a medical hold if applicable.

Refer to the Program Statement **Dental Services** for further guidance regarding dental UR.

Section 7. **PRIVACY**

Employees will provide inmates the opportunity to discuss their medical complaints without other inmates being present. The location and degree of privacy should be appropriate to the services being performed and should address the safety and security of the inmate, employees, and institution.

Section 8. **CHAPERONES**

Chaperones should be made available during sensitive physical examinations, or for safety when a disruptive inmate is being examined or at employees' request. For sensitive examinations, the identified gender of the inmate should be taken into consideration when requesting a chaperone. If HSU employees are unable to secure a preferred chaperone, the appointment may be rescheduled if clinically appropriate. For all other examinations or requests for a chaperone, HSU employees will be mindful of the identified gender of the inmate; however, the examination may proceed.

Section 9. **EMERGENCY/URGENT CARE**

a. **Continuous Healthcare Coverage**. Each institution will provide 24-hour medical, dental, and mental health care. Full-service operations, including medical and dental appointments, the sick call system for inmates to report new health complaints, directly observed therapy (i.e., medication distribution), preventive health visits, emergency care, ancillary services (pharmacy services, physical therapy, social work services, etc.), medical specialty clinics (optometry clinic, orthopedic clinic, etc.), administrative services (health record management, clerical services, etc.) and diagnostic testing (laboratory services, radiology services, etc.), will typically be scheduled during the day shift. Limited services (e.g., directly observed therapy, emergency care, intake screening for new admissions) will be provided by clinical employees during locally established hours. Institutions housing inmates requiring 24-hour skilled nursing care (MRCs, institutions having an infirmary, etc.) will have clinical employees on site 24 hours.

b. **Four-Minute Response Time**. Employees are trained to respond within four minutes when a medical emergency is identified. The four-minute response time begins when a medical emergency is identified, and it encompasses the time it takes for employees to be notified and arrive at the emergency scene to begin applicable assessment and administer life-saving interventions when the scene is safe and accessible. See American Heart Association guidelines. Institutions having multiple facilities physically separated by a significant distance (e.g., complexes, distant satellite facilities) will develop procedures to meet the required four-minute response time and manage medical emergencies at all facilities.

c. **Advanced Cardiac Life Support (ACLS)**. Ordinarily, non-MRCs are not authorized to provide ACLS coverage unless approved by the Medical Director. Medical Referral Centers that have trained employees to perform ACLS 24 hours/7 days per week will provide ACLS coverage. Refer to the Program Statement Pharmacy Services and to the National Formulary for guidance on emergency/urgent medications.

d. **Institution Supplement**. The CD and HSA will develop and implement an Institution Supplement that establishes procedures for responding to emergencies 24 hours daily. When developing its procedure, each institution should consider its authorized staffing complement, local EMS resources, and proximity to local hospital emergency departments for medical and trauma care. The HSA should periodically consult local EMS resources to discuss the institution's needs and become familiar with available EMS services. The Institution Supplement will address:

- Arrangements for on-site first aid and life-saving interventions.
- Provision and use of one or more HSU urgent treatment rooms, and an alternative urgent treatment area if the HSU becomes inoperable.

- Provision and use of an HSU emergency medical vehicle for transporting inmates across the compound. HSU employees will be trained in the use of transport equipment (stretchers, wheelchairs, etc.) and any HSU medical emergency transport vehicles (e.g., medical emergency cart) for transferring inmates from any location on the compound to HSU.
- Arrangement for transfer and escort of the inmate patient from the institution to a community medical facility.
- Provision of EMS services when no Bureau healthcare providers are on site.

New HSU employees will review the Institution Supplement on Emergency/Urgent Care during initial orientation to the HSU; all employees will review it annually thereafter. Annual review of this supplement by all HSU employees may be documented as in-house continuing professional education.

e. **Basic Life Support (BLS)**. HSAs, AHSAs, physicians, dentists, healthcare practitioners, and other health services employees who provide direct patient care will maintain CPR and Automated External Defibrillator (AED) certification to the Healthcare Provider level or AHA BLS Instructor level.

Bureau CPR instructors will maintain American Heart Association (AHA) CPR/AED Instructor certification. Employees holding active AHA CPR/AED Instructor certification are not required to take the AHA BLS training mandated for all Bureau employees because the corresponding knowledge and techniques are included in the instructor-level certification.

Lieutenants will maintain a minimum level of American Heart Association (AHA) Heartsaver CPR/AED certification or AHA CPR/AED Instructor certification.

All other primary and secondary law enforcement employees will complete basic CPR/AED training during Annual Refresher Training (see the Program Statement **Employee Development Manual**). All other employees may request and complete the CPR/AED training required for certification. Upon completion of CPR/AED certification, those employees will receive certification documentation. During medical emergency events, Bureau personnel are expected to perform only basic life support techniques consistent with their documented training.
The HSA approves the contents, number, location, and procedures for monthly inspections of all AEDs. The HSA will be responsible for maintenance and supplies in accordance with the manufacturer's recommendations.

f. **Mass Casualty Exercises**. The HSU will conduct two emergency mass casualty exercises per year, ideally in conjunction with the institution's scheduled major emergency drills. These exercises will be critiqued to identify deficiencies and opportunities to improve responses to emergencies. The exercises must include multiple victims having a variety of injuries and

requiring a range of clinical skills that simulate the response needed in a real-life disaster. The HSA will develop and maintain summary documentation that outlines the scenario, actions of responders, appropriateness of emergency care, effectiveness of institution-wide communication, improvement action plan, and locally prescribed details. The HSA will also maintain documentation evaluating the effectiveness of any improvement activities and evidence of sustained improvements.

Section 10. **MEDICAL OBSERVATION STATUS**

Institutions may provide limited observation bed space. These beds are not used in lieu of transfer to a community hospital or MRC. Observation beds will only provide limited outpatient services for short stay inmates. Health Services employees will provide coverage for inmates in the observation areas that require medical monitoring as determined by the Clinical Director.

Ordinarily, observation beds are located in the HSU. Neither patient examination rooms nor the Urgent Care Room will be used as observation rooms. Inmates placed on observation status **do not** require medical treatment(s) normally provided in an MRC or community hospital setting.

a. **Appropriate Use**. HSU observation rooms may be used in cases that ordinarily do not require 24-hour skilled nursing care. Examples of appropriate observation room use include:

- Preparation of inmates for diagnostic studies such as upper/lower G.I. series, fasting purposes, etc.
- Return to the institution from outpatient surgery to assist with post-operative care (monitoring new medication regimens or wound sites; assistance with manipulating crutches, cane, casts, etc.).
- Post-operative recovery from dental surgery.
- Control of pain associated with known kidney stones.
- Rule out suspected non-airborne contagious condition (hepatitis A, herpes zoster, etc.,) requiring isolation procedures, but not the use of the negative pressure controlled Airborne Infectious Isolation (AII) room.
- Routine post-operative care, such as managing indwelling catheters (status post prostate surgery), or surgical drains.
- Outpatient IV administration when applicable.

A physician will review the need for continued observation after the first 24 hours and every 24 hours subsequently.

Observation rooms will never be used to manage inmates who require urgent evaluation for potentially life-threatening conditions. Examples include, but are not limited to:

- Rule out myocardial infarction.
- Manage inmates suddenly incontinent of bowel or urine.
- Rule out stroke.
- Administrative reasons (e.g., restricting an inmate from recreation or other activities due to persistent complaints of back pain).

Refer to the Program Statements **Psychiatric Services, Psychiatric Evaluation and Treatment, Use of Force and Application of Restraints,** and **Treatment and Care of Inmates with Mental Illness** for management of inmates with mental health diagnoses.

b. **Required Written Procedures**. Each institution using observation beds will establish standard operating procedures delineating their use, consistent with this policy and the Master Agreement. These will include:

- Designation of the physical location of observation beds.
- Admission and discharge criteria for observation beds.
- Frequency of evaluation by the healthcare provider.
- Sight and sound requirements (e.g., nurse call system, visual monitoring system, or inmate companion).
- Level of care provided (limited circumstances for which 24-hour on-site clinical coverage is required. Examples are inmates who need temporary assistance with ADLs, inmates needing short term IV hydration, etc.).
- Supervision requirements. Local procedures will be developed to provide qualified (medical versus non-medical employees) coverage for observation rooms located in areas not already covered by employees on a continuous basis in accordance with the Master Agreement.
- 30-minute irregular rounds
- Documentation requirements.
- Orientation of the inmate to life safety and fire evacuation procedures.

c. **Admission and Discharge**. Observation rooms may only be used in accordance with the following actions. If the inmate is in observation status for dental indications, the dental officer will be responsible for these actions:

- A physician or APP (nurse practitioner or physician assistant-certified) after consultation with a physician (or dental officer for dental cases) may authorize admission/discharge of the patients for medical (or dental) observation. A provider may admit or discharge observation status via a telephonic order. If the provider is a non-LIP, the order must be co-signed by a physician.
- The CD (or Chief Dental Officer for dental cases) or designee will notify the Warden and other appropriate institution employees (e.g., Unit Team, Captain) of the inmate's observation status and regularly advise them of the inmate's medical condition and monitoring recommendations.
- Orders to place an inmate on observation status will be documented in EHR.
- After hours, a LIP may order medical observation telephonically but must evaluate the inmate in person within 12 hours.
- A physician or LIP (or Dental Officer for dental cases) will evaluate the inmate in person

once daily, including weekends and holidays. This evaluation will be documented in EHR.

- The institution will have a plan to transfer the inmate patient to a community hospital in an emergency.
- If the room is used for suicide prevention, requirements of the Program Statement **Suicide Prevention Program** apply.

The HSA will collaborate with Correctional Services and Computer Services to manage inmates with equipment or devices having IT or wireless requirements to ensure security issues are addressed.

Section 11. **SHORT STAY UNITS (SSU)**

The Medical Director may authorize the use of a Short Stay Unit (SSU) at a limited number of institutions, specifically those with expanded medical missions (e.g., a Care Level 3 institution) having the physical space, monitoring system, community resources, and enhanced institution staffing, to include 24-hour dedicated medical staffing as determined by the Clinical Director, to support the unit. An SSU, commonly known as an infirmary, typically has multiple beds and is equipped to provide 24-hour medical care on a temporary basis. At least one RN will be assigned to each shift unless otherwise approved by the Regional Medical Director (RMD) when inmates are admitted to the SSU. If the Clinical Director determines that an inmate's length of stay may exceed 90 days, he/she will consult with the RMD and consider alternative placement (a nearby institution having the required resources, re-designation to an MRC, transfer to a contracted community facility, etc.).

SSU's are effectively utilized to manage patients who do not require the services of a community hospital, but who temporarily require 24-hour skilled medical care. The HSA and CD will determine the following:

- Physical location of the SSU.
- Admission and discharge criteria.
- Frequency of evaluation, including re-assessments.
- Scope of services provided, including protocols.
- Transfer of inmate patients to community-based facilities when care needs exceed the resources of the unit.
- Orientation of the inmate to life, safety, and fire evacuation procedures.

SSU's will never be used for administrative reasons (e.g., restricting an inmate from recreation or other activities due to persistent complaints of back pain) or for medical emergencies that require transport to a local emergency department.

Section 12. **AIRBORNE INFECTION ISOLATION ROOM (AII)**

Refer to the Program Statement **Infectious Disease Management** for proper utilization and maintenance of the Airborne Infection Isolation (AII) Room. Institutions without these rooms will isolate and immediately transfer inmate patients with suspected active tuberculosis or other highly contagious airborne diseases to a community hospital or other Bureau institution within close proximity with AII capability.

Section 13. **AMBULATORY CARE SERVICES**

a. **Written Standard Requirements**. The HSA and CD will develop and implement written standard requirements for providing ambulatory care services in accordance with this policy and the Master Agreement. Essential elements should include, but are not limited to:

- Intake screening.
- Initial comprehensive physical examination.
- Emergency services (including life-saving skills such as CPR and emergency diagnostic services such as stat EKG interpretation).
- Urgent care services.
- Chronic care management in disease-specific clinics.
- Oral health services.
- Pharmacy services.
- Basic diagnostic services (laboratory and radiology services).
- Ancillary services in institutions having special missions (e.g., social work services, restorative therapies, nutritional services).
- System for evaluation and provision of necessary medical specialty services not available onsite.
- Management of inmates with mental illnesses or disorders.
- Sick call process (triage and appointment system).
- Preventive health services.
- Prenatal care.
- Performance of minor surgical procedures with informed consent.
- Provision of necessary medical devices (corrective eyewear, hearing aids) and durable medical equipment (crutches, wheelchairs).
- Accident/injury assessment, treatment, and reporting.
- Infection Control program.
- Poison control services.
- Medical duty status designation.
- Treatment of patients in Special Housing Units and detention status.
- Occupational inmate health services (hearing conservation measures, hepatitis B immunization, etc.).
- Advance directives.
- Autopsies for inmate deaths.
- Privacy and confidentiality.
- Utilization Management program.

b. **Team Medicine**. All institutions will work within a Team Medicine model in which administrative, clinical, and ancillary healthcare employees collaborate in the delivery of health services to maximize resources and achieve optimal inmate health outcomes.

The CD and HSA will develop and monitor teams anchored by the physician(s) and APP(s). The team caseloads will be developed in a manner to ensure continuity of care. When a vacancy occurs in the roster, the CD and HSA will set priorities in providing clinical care (history and physicals, sickest inmates, etc.). The CD is ultimately the responsible clinical authority and will work with the RMD to manage inmates within the Team Medicine model.

Roles and responsibilities for each provider type are described in the Program Statement **Health Services Administration** and within approved position descriptions.

Section 14. **ALTERNATIVE RESTRICTIVE UNIT/CELL (RESTRICTED FROM GENERAL POPULATION)**

All Health Services Units will have standard requirements and quality control systems to ensure continuity of medical and psychiatric care for inmates housed in restrictive units/cells. The HSA and CD will collaborate with the Captain to develop and implement standard requirements and a system for notifying Health Services when an inmate is admitted to a restrictive unit/cell. This notification procedure should take into account the medical and mental health needs of the inmate, such as timely delivery of medically necessary medications and therapies.
Procedures governing care during an inmate's assignment to a restrictive unit/cell will include:

- When notified that an inmate is assigned to a restrictive unit/cell, HSU employees review the inmate's EHR to ensure continuation of prescribed medications, necessary prescribed medical devices, and ongoing care on a case-by-case basis.
- The HSA or designee will at a minimum make weekly administrative rounds. These rounds will be recorded using existing official monitoring systems.
- A credentialed healthcare provider (e.g., APP, RN, Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Paramedic) will conduct daily rounds to determine any urgent requests for care and arrange for timely evaluations as clinically indicated.
- The HSA will develop and implement a mechanism for inmates in restrictive units/cells to notify medical employees about their need for healthcare.
- An HSU healthcare provider will deliver directly administered therapy at locally established intervals, and directly observe the inmate take medications that would otherwise be administered on general population pill line.
- All segregated unit/cell inmate clinical encounters will be documented in EHR.

In restrictive housing units where wireless connectivity to the local network is available, medication administration will be documented at the point of care in the EHR (e-MAR). Otherwise, medication administration will be documented on a printed, paper MAR and scanned into the EHR.

When available, wireless connectivity may also be used to review inmate health information during daily rounds.

Inmates who are on suicide watch will continue to receive medical care as clinically indicated. See the Program Statement **Suicide Prevention Program**.

Section 15. **ACCESS TO CARE**

a. **Sick Call**. Sick call is defined as an inmate-initiated request for care. The sick call complaints are to be made by the inmate in person. The sick call complaint will be processed and documented in the EHR (including applicable vital signs and disposition) by credentialed employees (e.g., Paramedic, LPN, LVN, RN, APP, or physician). Inmate presenting with urgent conditions will be evaluated expeditiously; inmates presenting with routine complaints will be scheduled for a reasonably future sick call appointment (ordinarily within two weeks). Assessment, diagnosis, and treatment will be conducted by credentialed employees.

The Clinical Director determines which national nursing/paramedic protocols are to be used by credentialed employees. The Clinical Director will ensure documented training and competency for employees utilizing protocols.

If no follow-up appointment is warranted, the screening clinician will advise the inmate of other options (obtaining over-the-counter medications from Commissary, submitting a written request for appointment, etc.). Clinicians will ordinarily conduct sick call and scheduled appointments weekdays (except on Federal holidays) during the HSU's operating hours.

Inmates who are evaluated by one or more clinicians on three separate occasions for the original complaint without a definite diagnosis or response to treatment will be referred to the Clinical Director or physician by the third encounter and evaluated by a physician within a reasonable time frame based on the severity of the medical condition.

b. **Appointments**. Virtually all medical and dental services will be scheduled as appointments set several days to weeks in advance.

Healthcare providers may schedule inmate appointments to conduct sick call, make chronic care visits, evaluate ongoing treatment through follow-up visits, or counsel inmates on health issues.

Emergency or urgent care services (injuries, chest pain, asthma attacks, potentially infectious conditions, etc.) will be available 24 hours daily, either by on-site providers, on-call providers, or community emergency services.

c. **Examination Areas**. Employees will conduct the clinical encounter with inmates individually in a private examination area. Other inmates will not be present except in emergencies or extraordinary circumstances.

The examination room will have adequate space, running water, and seating for both the examiner and inmate. The examiner will have desk space, access to a computer configured to

support the EHR, and applicable legacy paper records during all inmate visits. Other requirements for examination rooms include:

- An examining table.
- Copies of approved standardized forms, equipment, and supplies for assessment and treatment.
- A biohazard sharps disposal container preferably mounted to the wall in all rooms where needles and syringes are used.
- Appropriately labeled biohazardous waste containers.
- Regular cleaning of examination rooms by inmate orderlies, including disinfection of examination tables and contaminated surfaces.
- Disinfection of the exam table or table paper changed between each patient.
- Personal protective equipment (PPE) must be readily available.

When patient encounters are conducted in a satellite area such as restrictive housing, industry location, camp, unit with difficult egress, etc., adequate space and equipment will be available consistent with the above requirements.

d. **Inmate Injury Assessment**. Medical employees must document an inmate injury assessment in the EHR and schedule a follow-up appointment as clinically indicated. This will include assessment of any injury, regardless of severity or cause; work-related, recreational, assault-related, accidental, or self-inflicted.

Employees completing the injury report should exactly quote the patient when describing how the injury occurred. All reports of injury will be documented regardless of the severity of the injury. A LIP will review and co-sign all injury reports as soon as possible, ordinarily the next working day.

Employees will send a copy of completed inmate work-related injury assessments to the Environmental and Safety Compliance Manager for inclusion in the Occupational Safety and Health Administration (OSHA) tracking logs.

e. **Medical Duty Restrictions/Convalescence**. Medical Duty Status (MDS) restrictions must reflect the inmate's medical and/or mental health condition. The physician, dentist, or APP conducting the clinical evaluation will determine the need for an MDS restriction and document the order in the EHR. Updates to the applicable Bureau inmate information system will be done in accordance with local procedures. MDS restrictions include:

- **Medical Idle**. Maximum of three calendar days for recuperation from an acute illness or injury. The inmate is restricted to his/her quarters except for meals, religious services, and

medical call-outs or pill lines.

- **Medical Convalescence**. Maximum of 30 calendar days for extended recuperation from an illness, injury, or surgery. Convalescence is specifically indicated to facilitate recuperation by not subjecting the inmate to the rigors of his/her job assignment, or to minimize the risk of injury to the inmate, other inmates, or employees at the work site due to the inmate's medical condition. The provider issuing the medical convalescence will schedule a follow-up visit to evaluate the efficacy of treatment before the 30-day restriction expires. MDS restrictions may be renewed if clinically indicated.

Inmates on convalescent status may attend other programs, including education classes, drug awareness programs, etc. Restrictions on recreational activities will be written on a case-by-case basis. For example, an inmate patient who is rehabilitating from orthopedic surgery may need access to the recreation facilities to walk or do specific exercises prescribed by healthcare providers.

Section 16. **INTAKE SCREENING**

a. **Newly Incarcerated Inmates**. Health Services credentialed healthcare providers ordinarily conduct an initial screening assessment of each newly incarcerated inmate upon arrival (i.e., within 24 hours of his/her arrival). If screening cannot be completed within 24 hours, those circumstances will be documented accordingly in the EHR. This assessment will be documented in the EHR using the appropriate Intake Health Screen, except at Federal Transfer Centers (FTCs). FTCs may use rapid paper intake health screening forms for holdover inmates with approval from the Assistant Director of the Health Services Division or designee. The intake screening is performed to identify:

- Urgent medical, oral health, or mental health care needs.
- Signs of acute drug or alcohol intoxication or symptoms of withdrawal.
- Restrictions on housing or temporary work assignments.
- Presence of transmissible skin, respiratory, or gastrointestinal infections.
- Pregnant female offenders (screen for pregnancy as soon as practical upon admission, but prior to the initial comprehensive physical examination).
- Disabilities (sensory, cognitive, and physical) requiring further evaluation and potential accommodation.
- Medication and medication reconciliation.
- MAT/MOUD Screening.
- Any recent PREA history.

Inmates with perceived immediate medical/dental/mental health needs will be referred to the appropriate healthcare employees or psychologist for evaluation.

If the newly arriving inmate requires a higher level of care than can be provided at the institution, the inmate should be transferred to the local emergency department in consultation with the Clinical Director.

This initial health screen is mandatory and cannot be waived. An inmate who refuses any portion of the initial screening will not be housed in general population until screening is completed; applicable disciplinary action will be taken.

b. **Bureau Intra-System Transfers**. The receiving institution clinical employees will review the Bureau EHR Exit Summary to determine the medical needs of the inmate upon arrival, including at in-transit facilities.

The credentialed healthcare provider will initiate a new intake screening to review and update the inmate's health documentation and needs.

It is prohibited to transfer inmates between Bureau institutions, including holdover status inmates (Drug Enforcement Administration, U.S. Marshals Service, Immigration and Customs Enforcement, FBI, etc.), who have not been screened for TB. Screening for TB will be defined consistent with the Program Statement **Infectious Disease Management** and current guidance from the Medical Director. This prohibition does not apply to court-related activities or inmates being transferred on writ (to non-Bureau institutions).

c. **Transfer Between Facilities in the Same Institution (Intra-Complex Transfers)**. Transfer of an inmate from one facility to another within the same complex does not require the completion of a transfer summary, continuity of care document, or medication reconciliation. The receiving clinician will review the EHR and schedule the inmates enrolled in chronic care clinic for evaluation with a physician within 30 days of arrival.

d. **Bureau Inmates in Non-Bureau Custody**. Inmates who leave Bureau custody (go to county jail, writ, bail, etc.) for more than 7 days will have an updated intake screening evaluation completed within 24 hours of their return to Bureau custody. Referrals to appropriate healthcare providers will be made when medical, dental, and/or mental health needs are identified.

Section 17. **PHYSICAL EXAMINATIONS**

a. **Newly Incarcerated Inmates**. Health Services credentialed healthcare provider will perform a comprehensive physical assessment on each newly incarcerated inmate to assess, diagnose, and treat medical needs (refer to the Program Statements **Dental Services** for dental examination requirements and **Psychology Services Manual** for mental health appraisal requirements). All inmates will receive a health record review by a credentialed healthcare provider at screening, which will be co-signed by a LIP. At the time of screening, the inmate will be scheduled to be evaluated by an APP or LIP within the timeframes identified:

- If no medical or mental health concerns are noted: 30 days.
- Inmates with chronic conditions (medical or mental health concerns): 14 days.

Credentialed health care providers will document the results of the assessment in the EHR using the History and Physical encounter. The APP or LIP completing the history and physical will enroll inmates with chronic conditions into the appropriate chronic care clinic.

Laboratory and diagnostic tests and immunizations ordered or performed during the comprehensive physical assessment include:

- Human Immunodeficiency Virus (HIV) – universally unless an inmate chooses to "opt out," which requires a signed refusal and scanned into EHR.
- Hepatitis screening – universally unless an inmate chooses to "opt out," which requires a signed refusal and scanned into EHR.
- Sickle cell screening (hemoglobin electrophoresis) if clinically indicated.
- Sexually transmitted disease (STD) testing if clinically indicated.
- Pregnancy testing for females of child-bearing age if clinically indicated (if not done at intake).
- Offer of MMR immunization for females of child-bearing age who report they have never received MMR as an adult (rule out pregnancy prior to immunization).
- Chest x-ray if clinically indicated (rule out pregnancy in female inmates of child-bearing age).
- EKG if clinically indicated.
- Age-appropriate testing for preventive healthcare.

APPs and/or LIPs will review laboratory or other diagnostic testing. Any results requiring intervention must be documented in the EHR as an administrative note or as part of a clinical encounter when applicable.

b. **Bureau Intra-System Transfers**. Intra-system transfers do not need a second initial physical

evaluation as long as one has been completed for this period of confinement. Inmates who are intra-system transfers and present with any new medical problems at intake screening will be referred to an APP for assessment as described in Section 16, Intake Screening of this Program Statement.

Inmates who are intra-system transfers and have both a documented comprehensive physical assessment and a chronic care clinic assignment will be scheduled for a chronic care visit and evaluated by a physician within 30 days (or sooner if clinically indicated) to assess the current treatment plan.

c. **Bureau Inmates in Non-Bureau Custody**. If an inmate has been in continuous custody, healthcare providers do not need to complete a new comprehensive physical assessment on an inmate having one documented in the EHR, unless clinically indicated.

A complete physical examination will be required for inmates who are out of continuous custody for more than 30 days. Examples of inmates who will need a new exam include: furloughs other than medical furloughs, writ execution (if continuous custody is not maintained), or a Residential Reentry Center (RRC) failure that returns to a Bureau-managed facility.

d. **Periodic Health Examinations**. The Clinical Director will ensure the availability of age-specific preventive health examinations (e.g., cancer screening) for the inmate population. The content and frequency of these examinations will be outlined in preventive health guidance issued by the Medical Director.

Information regarding these examinations will be made available to inmates through the A&O process and individual patient education associated with clinical encounters.

e. **Food Handlers' Examinations**. Inmates will not be assigned to Food Service work details until they are cleared by Health Services. If a complete history and physical examination has been documented but is more than one year old, a brief in-person examination will be conducted to update the inmate's history and screen for the conditions listed below. This examination will be documented as a clinical encounter in the EHR and the date of clearance for Food Service will be updated in the applicable Bureau inmate information system.

Upon orientation to Food Service, Food Service employees will provide inmates with an information sheet instructing them to report to their detail supervisor should they display symptoms of any of the following:

- Inflammatory conditions of the respiratory system.
- Skin conditions.

- Intestinal infections (vomiting or diarrhea).
- A communicable disease known to be transmitted via food.

Inmate patients with Human Immunodeficiency Virus (HIV), Hepatitis B virus (HBV), Hepatitis C virus (HCV) infection or latent Tuberculosis (TB) are not precluded from working in Food Service based on this status alone, because these infections pose no risk of foodborne transmission. The APP or physician will determine the inmate's suitability for Food Service.

Section 18. **FEMALE HEALTHCARE**

Intake Screening. All healthcare should be provided through a gender responsive approach. An increased need exists for gender responsive healthcare and such care should be provided utilizing a trauma-informed lens.

The following screenings will be conducted:

- Sexually transmitted infection (STI) testing if clinically indicated.
- Pregnancy testing for females of child-bearing age if clinically indicated.
- Offer of MMR immunization for females of child-bearing age who report they have never received MMR as an adult (rule out pregnancy prior to immunization).
- Chest x-ray if clinically indicated (rule out pregnancy in female inmates of child-bearing age).

a. **Initial Physical Exam**. Ordinarily, female-specific assessments will be completed as part of the initial physical exam. Review intake screening for any history of sexual abuse. Female-specific assessments include:

- A gynecological and obstetrical history, including sexual activity and any recent rape history.
- A clinical breast and pelvic examination (including instruction in self-breast exam). A female employee will be present when a male provider performs breast and pelvic examinations (except in emergency situations when a female employee is not available).
- A Pap smear and collection of a vaginal, endo-cervical, and/or anal tissue sample to culture for chlamydia, gonorrhea, or other STIs when clinically indicated (see the Medical Director's guidance on preventive health to schedule follow-up routine Pap smears).

b. **Preventive Health**. The Clinical Director will ensure the availability of evidence-based gender-appropriate and age-specific preventive health examinations (e.g., cervical, breast, and routine and high-risk mammography screening) for female offenders. Refer to the Medical Director's current published guidance.

c. **Mammography**. Mammography will be used as a screening and diagnostic tool:

- **Sentenced Inmates**. A baseline mammogram for sentenced female offenders will be offered to females at high risk of breast cancer and at intervals established in the Medical Director's preventive health guidance. If the inmate refuses recommended screening, a BP-A0358, Medical Treatment Refusal form will be signed and uploaded into the EHR.
- **Pretrial/Holdover Inmates**. Perform baseline mammography for pre-sentenced or holdover inmates who have been continuously housed for 12 months in Bureau custody. When the 12-

month interval is reached, baseline mammography should be scheduled within 30 days and completed before the end of the 24 months in Bureau custody. If the inmate refuses recommended screening, a BP-A0358, Medical Treatment Refusal form will be signed and uploaded into the EHR.

When a breast mastectomy is performed in the treatment of cancer, breast reconstruction is categorized as Medically Necessary, Not Emergent, and is processed through the institution URC.

d. **Prescription Birth Control**. Refer to the current version of the National Drug Formulary for restrictions on the use of prescription birth control medications and delivery systems.

Sterilization, intrauterine devices (IUDs), or other implanted contraceptive devices will not be made available to female offenders while housed in a Bureau facility, excluding RRCs, as a form of birth control.

Clinicians will advise inmates with these devices in place about possible complications associated with continued use and document the counseling in the EHR. These devices may be removed upon the inmate's request.

e. **Pregnancy**. When pregnancy is confirmed, the female offender will be referred to a physician within 14 days for an initial examination and management of the pregnancy. Psychology Services will also be notified.

The HSA or designee will notify the inmate's Unit Manager and Social Worker if applicable, when pregnancy is confirmed. Refer to the Program Statement **Female Offender Manual** for coding in the applicable Bureau inmate information system.

All pregnant inmates will be tested for Human Immunodeficiency Virus (HIV) unless the inmate chooses to "opt out" of HIV testing. **If the inmate refuses recommended testing, a BP-A0358, Medical Treatment Refusal form will be signed and uploaded into the EHR.**

Inmates who request abortion will be counseled and managed in accordance with the Program Statement **Female Offender Manual**.

f. **Childbirth**. The CD or designated physician, in consultation with an employee/contract OB-GYN specialist and community-based facility for delivery, will manage the perinatal period for pregnant offenders. The institutional Social Worker or the Regional Social Worker will contact the Administrator, Women and Special Populations Branch, regarding expenses for neonatal care and child placement. Refer to the Program Statement **Female Offender Manual** for further

guidance.

g. **Post Partum Care**. Women are referred to the institution or Regional Social Worker for postpartum care. Female offenders are allowed to pump their breast milk. The breast pump will be considered durable medical equipment. Refer to the Program Statement **Female Offender Manual**.

h. **Pregnancy Statistic Reporting Requirements**. The Health Services Division will report statistics related to all live births and all pregnancies that end in other than a live birth (abortion, miscarriage, premature birth, or stillbirth) to the Bureau Director at regular intervals determined by the Director.

i. **Feminine Hygiene Products.** Refer to the Program Statement **Female Offender Manual**.

Section 19. **INMATE IMMUNIZATIONS**

Refer to the Program Statement **Infectious Disease Management**. Employees will notify inmates of the availability of immunizations through A&O and posted information in the HSU.

Health Services employees document all immunizations administered in the EHR. Inmates may request a copy of their immunization record through procedures outlined in the Program Statement **Health Information Management**.

Section 20. **CHRONIC CARE CLINICS (CCC)**

The CD, staff physician, or advanced practice provider will enroll inmates who have chronic medical needs in a regularly scheduled chronic care clinic. The HSA or designee will track the enrolled inmates using the EHR to assure timely follow-up, diagnostic testing, and medication management. Patients with multiple co-morbidities will be assigned to each applicable chronic care clinic (CCC). The physician will evaluate all inmates assigned to a CCC no less than once every 12 months, and more frequently if clinically indicated (e.g., inmates prescribed high-risk medications, or having medically complex or poorly controlled conditions).

The CD will execute a signed practice agreement with APPs that delineates the authorized scope of practice. The CD may also execute a practice agreement with qualified pharmacists or therapists that defines an expanded scope of practice in disease state management.

The physician will determine, and communicate to the inmate's APP, the frequency of follow-up care between physician encounters based on clinical need. The APP will conduct interim follow-up encounters and refer the inmate to the physician if there is a significant change in health status. The physician will review and cosign documentation of the APP's CCC follow-up encounters in the EHR.

The Medical Director will issue clinical guidance for management of specific disease states or high-risk conditions.

Clinicians will fully document assessment and treatment plan decisions in sufficient detail to ensure continuity of care through clear communication between team members.

Inmates who are intra-system transfers and have both a documented comprehensive physical assessment and a CCC assignment will be scheduled for a chronic care encounter and be evaluated by a physician within 30 days of arrival (or sooner if clinically indicated) to assess their current treatment plans and any pending consultations.

The physician or APP can evaluate and approve addition(s) of inmates to a CCC. Only the physician may delete inmates from a CCC. The RMD may authorize CCC encounters via telehealth.

Providers conducting evaluations and CCCs will review and revise current Medical Care Level and Screening Medical Care Level assignments at each encounter to ensure the inmate's health needs can be met locally. Medical Care Level should also be reviewed and revised after each major change in the inmate's health status (recent hospitalization, development of complications related to disease progression, etc.).

Ordinarily, providers will address all chronic diseases in the same visit. All clinically significant conditions should be documented in the clinical encounter note at each CCC visit. Providers will update the Health Problems list in the EHR regularly to include a current active list of diagnoses.

The CD retains overall administrative and clinical responsibility for managing CCC inmates. The CD or responsible physician will provide requisite consultation to APPs, pharmacists, and therapists collaborating in CCC management in accordance with properly executed practice agreements.

Section 21. **DOCUMENTATION**

The CD or HSA will ensure the EHR is used to document the healthcare received by inmates and the information is accessible to Health Services employees and inmates when requested.

a. **Clinical Encounter Notes**. Visits will be documented using the clinical encounter function in the EHR. The clinical encounter note details the subjective, objective, assessment, treatment plan, and patient education elements of a clinical evaluation. The CD will ensure all providers are trained and appropriately use the EHR to document patient care.

b. **Administrative Notes**. Administrative notes are notes documenting issues important to the inmate's care when the inmate is not physically evaluated by the provider at the time of entry in the EHR. An administrative note does not equate to a clinical encounter note. Examples of appropriate administrative notes are:

- Provider review of laboratory and radiology results.
- Provider review of consultant reports.
- Provider updates of an inmate's status during community-based hospitalizations.
- For medication refills, refer to the Program Statement **Pharmacy Services**.
- Instances when the inmate does not report for a scheduled appointment.
- Counseling visits in which no physical assessment is performed.
- Social work case management notes and psychoeducational sessions.

AT NO TIME are administrative notes to be used to document clinical encounters.

c. **Telephone/Verbal Orders (TO/VO)**. The use of TO/VOs is limited to prevent medical, dental, or medication errors from occurring. TO/VO may be used as outlined below:

- Providers authorized to give TO/VOs are physicians, dentists, and APPs (physician assistant, nurse practitioner, and clinical pharmacist) having valid and current practice agreements stipulating their scope of practice not otherwise restricted by national policy or the Bureau National Drug Formulary.
- Clinical employees authorized to receive TO/VOs are APPs, nurses, paramedics, and EMTs (as allowed by CD-approved EMT protocols). Pharmacists are authorized to receive TO/VO medication orders.
- Providers (physicians, dentists, and APPs) are ordinarily responsible for documenting their own orders for medications and clinical interventions. Examples of situations in which TO/VOs may be used include, but are not limited to:
  - Authorized clinical employees performing intake screening in the Receiving and Discharge area, and telephonically requesting a medication order from an authorized

prescriber working in the Health Services Unit.

- An authorized provider working in a location other than his/her assigned duty station without access to the EHR.
- The ordering provider is providing emergency care to a patient and needs assistance with administering emergency medication or emergency interventions.

The receiving clinical employees transcribe the order in the EHR noting the ordering provider, verify the order by reading it back to the ordering provider, and document the verified order. The transcriber will prompt the authorizing provider's co-signature using the EHR TO/VO function. The ordering provider will sign the TO/VO by his/her next working day.

When the TO/VO is a medication order, the drug name, dose, route, frequency, indication, date, and time to be administered to the inmate must be documented in the note.

Authorized clinical employees may transcribe written physician orders contained in the locally established protocols approved by the Clinical Director.

A TO/VO must be obtained if there are any deviations from the established nursing/paramedic protocols.

TO/VOs will not be used to order blood products.

d. **Request for Consultation**. All requests for on-site or community-based consultation by a contracted healthcare provider must be submitted using the consultation function in EHR.

(1) **Consultations Between Bureau Providers**. Providers will use the appropriate functionality within the EHR to establish internal referrals between providers. Sufficient clinical information should be detailed in the consultation request or referenced from other documents in the inmate's health record, to describe the inmate's complaint or condition and the information sought by the referring provider.

(2) **Consultations Between Bureau Providers and Medical Specialists or Contract Medical Services**. A physician or APP will review the inmate's EHR and examine the inmate prior to referral to an outside consultant, unless emergency or urgent care necessitates timely access to the consultant. Consultation requests will be submitted for review and disposition by the URC, as outlined in the section on Utilization Management in this Program Statement.

Provider examinations are not required for routine consultations such as optometry evaluations, annual ophthalmology exams for diabetic retinopathy, etc.

If the consultation is provided on-site, consultants having approved computer security clearance may document their findings directly in the EHR. Consultants without security clearance or off-site visits will document via paper. HSU employees will scan a copy of the signed consultation into the EHR. The APP or LIP will electronically review, date, and sign all consultation reports, and document any resulting orders or related consultation requests.

After the consultant has documented the assessment and recommendation, clinical employees (Paramedic, LPN, RN, Pharmacist, or APP) may transcribe the recommendation(s) into the EHR using an Admin Note for physician co-signature. The APP or LIP will review the transcribed recommendation(s) and document any resulting orders or related consultation requests.

The physician is under no obligation to follow consultant recommendations. If the consultant's recommendations are not followed, the physician will document his/her justification in the EHR.

Section 22. **SURGICAL SERVICES/SURGICAL PATHOLOGY**

For on-site procedures performed in Bureau facilities, Health Services employees will ensure that a patient is counseled about the risks and benefits of recommended surgery; the inmate completes and signs the OF-522, Medical Record – Request for Administration of Anesthesia and Performance of Operations and Other Procedures form for:

- All ambulatory-type surgical procedures.
- Local anesthesia for diagnostic and therapeutic purposes.
- Removal of toenails.
- Laceration repair, including on the face, or when facia or tendon sheaths require closure.
- Joint injections.
- Flexible endoscopy.

Histology/cytology specimens removed during a surgical procedure will be sent to an approved pathologist for examination. The order for the evaluation of these specimens will be documented in the EHR. All specimens will be packaged in preservative as indicated by type of specimen and local procedures. Specimens will be labeled with:

- Inmate's full name.
- Register number.
- Date of collection.
- Source/site of specimen.
- Collector's full name.

Once received, all pathology reports will be scanned into the EHR. The pathology reports will be reviewed and signed by the physician or dentist.

Refer to the Program Statement **Dental Services** for information regarding dental pathology procedures.

Section 23. **SERIOUS ILLNESS, SERIOUS INJURY, AND DEATH PROCEDURES**

The HSA will develop a Serious Illness, Serious Injury, and Death Institution Supplement that describes local procedures for the actions listed below:

- Notification procedures to next of kin, including appropriate privacy and release of information procedures.
- Pronouncement of death in accordance with State law.
- Notification of the coroner or medical examiner.
- Implementation of the inmate advance directive/living will.
- Request for consideration of reduction in sentence (compassionate release).
- Implementation of "do not resuscitate" (DNR) orders.
- Declaration of advanced directives at MRC's and care level 3 facilities.

Refer to the Program Statement **Escapes/Deaths Notifications** for related information.

The Warden, Regional Director, and Medical Director must review and approve the Serious Illness, Serious Injury, and Death Institution Supplement. Supplements will be negotiated locally prior to implementation.

Regional and local Bureau legal employees should be consulted in drafting Institution Supplements under this section, prior to local bargaining.

The HSU will implement the following principles and procedures when an inmate's medical condition becomes life threatening and death may be imminent:

- The Bureau remains committed to the principle of preserving and extending life. A seriously ill or dying inmate patient will be provided care consistent with this goal.
- When a seriously ill or dying inmate patient is in a community hospital, the Bureau retains authority regarding administrative decisions (visitors, movement of the inmate, limits on medical services the Bureau will authorize, etc.); the hospital retains authority for professional medical decisions (drug regimen, laboratory tests, x-rays, treatment performance, etc.).
- End-of-life care authorized by the Clinical Director (RMD or Medical Director in the absence of the Clinical Director) will continue regardless of care setting (MRC, community-based facility, etc.) as long as the treatment does not exceed the scope of medical services the Bureau provides and the inmate, inmate's family, or proxy decision maker does not request discontinuation of ongoing treatment. If authorized to discontinue treatment, the inmate patient will be provided with comfort/palliative care.

When the seriously ill or dying inmate patient is receiving care in a community facility, and the facility has policy and procedures regarding the involvement of next of kin, the Bureau will adhere to the following:

- The hospital will be permitted to follow its established bylaws concerning seriously ill or dying inmate patients (initiating DNR orders, discontinuing mechanical life support, etc.)
- The Bureau will be kept informed of the treatment the inmate is receiving, but the hospital's medical personnel will retain authority for decisions concerning treatment.

a. **Serious Illness or Serious Injury**. When an inmate patient is seriously ill or sustains a serious injury, the HSA will notify the Warden or his/her designee and the Chaplain by phone or in person of the inmate's condition as soon as possible, and the Warden or designee will arrange to notify the family. The CD or staff physician will subsequently submit a memorandum or electronic mail message to the Warden or their designee confirming the inmate patient is seriously ill or has sustained a serious injury. Serious injury includes any injury resulting in hospitalization or the potential for permanent disability (e.g., amputation).

The notification will briefly describe the illness or injury and, if possible, provide a prognosis. A copy of the notification will be sent to the Chaplain.

A seriously ill or seriously injured inmate is an immediate concern to the inmate's family. The institution will notify next of kin promptly. If approved by the Warden, the HSA will describe the inmate's medical condition to the immediate family member (next of kin). Coordination and addressing visitation needs, including limitations placed on visiting, will generally be done by Unit Management employees.

While the Bureau will continue to control conditions under which a family member may visit, consideration will be given to providing the maximum opportunity for visitation consistent with safety and security constraints (refer to the Program Statement **Visiting Regulations**).

If an inmate becomes seriously ill, sustains a serious injury, requires major surgery, or dies, the Warden or designee will also notify the U.S. Attorney's Office and, in the case of a serious illness or serious injury of a pretrial inmate, the committing Court (refer to the Program Statement **Escapes/Deaths Notifications**).

Any inmate patient who becomes seriously ill should be considered for transfer to a higher level of care facility.

When inmates are suitable candidates for early release through a Reduction in Sentence (RIS), also known as compassionate release, and the inmate and family agree to the arrangement, the institution will expedite processing of the request. When a referral is made for RIS, medical

employees will provide complete medical documentation for consideration. The information should include recent medical records, consultations, nursing notes, and a statement about estimated life expectancy (refer to the Program Statement **Compassionate Release/Reduction in Sentence**; **Procedures for Implementation of 18 U.S.C. §§ 3582(c)(1)(A) & 4205(g)**).

Medical furlough requests should be processed consistent with the Program Statement **Inmate Furloughs**.

In case of death, the Warden or the Warden's representative will notify the family about the deceased as described above in the section on serious illness notification.

b. **Autopsies**. Inmates who die as a result of a known terminal illness do not routinely require an autopsy. However, some state laws require autopsies for anyone who dies while incarcerated. Each institution should conform to the respective state law governing autopsies. State laws vary greatly; when legal questions arise, the Regional Counsel should be contacted. State law provisions on when to contact the coroner or medical examiner will be incorporated into the Institution Supplement on Serious Illness, Serious Injury, and Death, and a copy forwarded to the Regional Counsel (refer to the Program Statement **Autopsies** and BP-A0797, Autopsy Authorization form).

Before initiating an autopsy or embalming, the institution will determine the inmate's religious preference and consult with Religious Services employees to ensure no religious prohibitions exist.

Each institution will develop procedures describing when to contact the local coroner or medical examiner regarding:

- Performing an autopsy.
- Who will perform the autopsy.
- Obtaining state-issued death certification.
- Local transportation of the body.

c. **Advance Directives and "Do Not Resuscitate" (DNR) Orders.** Inmates and healthcare providers are increasingly confronted with difficult and sensitive decisions regarding healthcare, including the decision to have extraordinary means of care and life support withheld or withdrawn in cases of a terminal condition or irreversible illness. Inmates may direct, in advance, to withhold or withdraw certain medical treatments when recovery or cure is not medically possible.

Inmates may appoint, in advance, proxy decision makers who will make critical healthcare

decisions for them should they become incapacitated and unable to make such decisions for themselves; however, this proxy decision maker will not be another inmate or Bureau employee.

The Bureau's withholding or withdrawal of resuscitative or life-support services pursuant to an Advance Directive or DNR order is consistent with judicious medical practice and is not equivalent to assistive suicide, voluntary euthanasia, or expedition of the inmate's death.

The patient's right to refuse medical treatment is not absolute and, in all cases, will be weighed against legitimate Government interests, including the security and orderly operation of correctional institutions.

d. **Incorporation of Advance Directives and DNR in the Institution Supplement**. To facilitate the creation and implementation of an advance directive and DNR orders, each institution will develop an Institution Supplement describing local implementation procedures.

(1) **Advance Directive**. Each Institution Supplement addressing an advance directive must:

- Provide information that complies with the law of the state where the institution is located. A copy of the relevant state's law should be an attachment to the Supplement.
- Include a sample standard form for inmate use, if available from the relevant state statutes on advance directives.
- Include instructions for inmates wishing to execute an advance directive before or after the onset of a seriously debilitating or terminal illness, including the option to retain private legal counsel for assistance at the inmate's expense.
- Require filing an inmate's executed advance directive in the inmate's EHR via the Document Manager function, with the original retained per state law. A notice that an advance directive is on file is entered into the Alerts section of the EHR.

The community healthcare organization is responsible for honoring the advance directive.

(2) **DNR Orders**. Each Institution Supplement addressing DNR orders must:

- Provide information that complies with the law of the state where the institution is located. A copy of the relevant state's statutes should be attached to the Institution Supplement if available. This includes state laws addressing non-liability of healthcare practitioners who implement an advance directive in good faith.
- Instruct that in all cases, decisions expressed by a competent inmate supersede any previously executed advance directive to the contrary.
- Include that DNR orders will only be invoked and honored when an inmate is housed at a Care Level 4 facility (MRCs) or Care Level 3 facilities having a long-term care or inpatient

mission approved by the Medical Director. Emergency resuscitative measures must always be performed on an inmate patient who suffers cardiopulmonary arrest at a general population institution. The Clinical Director may consult with the Regional Medical Director regarding terminally ill inmates housed at facilities not providing in-patient care.

- Include that a validly executed advance directive will only be invoked and honored while the inmate patient is under a physician's direct care at a community healthcare facility, Care Level 4 facility (MRCs), or Care Level 3 facility having an approved long-term care or inpatient mission. Community healthcare facilities will implement the advance directive in accordance with their medical bylaws and relevant state and local laws.

The Institution Supplement will also include the following procedures for implementing DNR orders:

- DNR orders written for inmates in MRCs and Care level 3 institutions must be approved by the CD or acting CD.
- A valid DNR order must be documented in the EHR and include:
  - Standard terminology (i.e., "Do Not Resuscitate").
  - Signature by the ordering physician and a signed paper copy retained if required by State law.
  - Inmate's diagnosis.
  - Inmate's prognosis.
  - Inmate's written advance directive or other authorized expression of healthcare decisions, as well as available documentation of the inmate's informed consent.
  - Documentation regarding the inmate's competence when the decision to enter a DNR is based on his/her expressed request.
  - Wishes of immediate family member(s) if available.
  - Decisions and recommendations of other medical employees or consultants, including documentation of identifying information (name, credential, etc.).
- DNR orders are subject to annual review by the ordering physician.
- Inmates with DNRs in their EHR remain entitled to maximal therapeutic efforts short of resuscitation.
- Bureau physicians at facilities authorized to implement DNRs may not be compelled to sign a DNR when the patient's expressed decisions conflict with their clinical judgment or ethical or religious convictions.

To protect the interests of both the inmate and the Government, the Government may, in some cases, seek judicial or administrative review of the declaration in an Advance Directive.

When the inmate patient is unconscious or otherwise unable or incompetent to participate in the decision, every reasonable effort will be made to obtain written concurrence of one or several

immediate family members. The attending physician must document these efforts in the health record.

A DNR order may be the result of the attending physician's decision that the inmate patient is in terminal illness status and further medical treatment is futile. When a DNR order conflict exists between the primary care physician and the inmate patient or the inmate's proxy decision maker, a referral to the MRC/Care level 3 ethics committee will be made.

Should the committee be unable to resolve the conflict, the issue will be referred to the Bureau's Medical Director for final determination.

Section 24. **ORGAN DONATION BY INMATES**

The Bureau will consider requests from currently incarcerated inmates who seek approval to donate an organ(s) to a known recipient or an organ exchange program. The following conditions apply:

- The costs of the organ donation procedures, including pre-donation testing, travel for the inmate donor to the medical facility where the donation will occur, Correctional Services or guard services costs, and applicable costs incurred by the U.S. Marshals Service are the responsibility of the organ recipient (or responsible adult if the recipient is a minor child). The Bureau will incur no costs associated with the organ donation, including follow-up care and post-donation complications.

The inmate must sign a statement indicating the desire to donate an organ to the known recipient. The consent must include the inmate:

- Understands the risks of the surgery.
- Agrees of his/her own free will.
- Provides evidence that funds are available to cover the expenses of the procedure or provides documentation that a third party with evidence of available funds, has agreed to be financially responsible.
- Acknowledges the Government will not be held responsible for any complications or financial responsibilities.

The CD will review documentation from the transplant specialists verifying the inmate is a suitable donor, estimating the pre- and post-operative length of stay, and detailing the plan for follow-up care. This information, the inmate statement described above, and a memorandum from the CD will be forwarded to the RMD for review, with a copy of the memorandum sent to the Warden and the Regional Director. The memorandum will be completed with the following information:

- The name of the recipient needing organ donation.
- The diagnosis causing organ failure and the specific organ needed.
- A summary of the inmate's pertinent medical history.
- Summary of history: crime, sentence, PRD, custody level, security level, and disciplinary history.

If the RMD concurs with the donation, the packet will be forwarded to the Medical Director for final review and approval.

It is the inmate's responsibility to provide/request documentation from the transplant specialist with assistance from Health Services employees (e.g., Health Information Management employees), as appropriate.

If an inmate is appropriately designated as community custody, the inmate may request consideration for a medical furlough in accordance with the Program Statement **Inmate Furloughs**.

The local institution will coordinate activities such as transportation, custody, classification, compatibility determinations, evaluation, hospitalization, furlough status, etc.

Inmates are not authorized to donate blood or blood products. Bone marrow transplants may be considered.

Inmates may specify instructions in a properly executed Advance Directive that they wish to be posthumous organ donors. In the event an inmate is terminally ill or has an irreversible condition, and they are in the care of a community hospital with organ donation capabilities, the Medical Director may approve the execution of this instruction prior to harvest of the organ(s).

If an inmate without an Advance Directive for posthumous organ donation is terminally ill or has an irreversible medical condition, the inmate or next of kin may request the Medical Director's approval for posthumous donation. If an inmate cannot give consent for a posthumous donation, or a next of kin cannot be located to provide consent, the organs may not be donated.

If the Medical Director determines that the organ donation request is the explicit desire of an inmate patient, and is medically indicated by the community standard, the inmate will be approved to undergo surgery at an appropriate transplant center in accordance with Bureau policy, transplant center regulations, and state and Federal laws.

Transplant Surgical consultants may recommend, but not compel the Bureau to authorize an inmate to donate an organ. Any circumstances not covered by the above stipulations will require the review and consent of the Medical Director.

Section 25. **INMATES AS RECIPIENTS OF ORGAN TRANSPLANTATION**

Organ transplantation, including stem cell transplantation, is extraordinary care that requires review and prior authorization by the Bureau Medical Director.

When the treatment plan for an inmate's medical condition includes consideration for organ transplantation as recommended by an appropriate medical specialist, the Clinical Director will determine:

- If an organ transplant is medically indicated.
- If Bureau medical criteria for reduction in sentence/compassionate release are met (see the Program Statement **Compassionate Release/Reduction in Sentence; Procedures for Implementation of 18 U.S.C. §§ 3582(c)(1)(A) & 4205(g)**.
- Whether to manage the case locally or request a transfer to a Bureau MRC if housed at a general population institution.

The Clinical Director or designee will submit a comprehensive transplant evaluation to the Medical Director or designee for review by the Bureau Transplant Advisory Board. The evaluation includes all pertinent medical, surgical, mental health, social work, case management, and correctional information as described in the Bureau Clinical Practice Guideline (CPG) on Organ Transplantation.

At general population institutions, a more limited evaluation sufficient to determine basic transplant eligibility criteria may be performed in non-emergent cases for which consultation with a transplant specialist is more appropriately accomplished after transfer to an MRC.

In emergent cases, initial consultation with a transplant specialist may be obtained without prior authorization, but approval by the Medical Director is still required prior to transplantation.

Requests for corneal transplants are reviewed in accordance with the utilization review procedures in Section 6 of this Program Statement.

The Bureau Transplant Advisory Board membership is comprised of the Chief of Health Programs (who chairs the Board), the National Health Systems Administrator, Chief Nurse, Chief Social Worker, Psychologist, Chaplain, and OGC-appointed Attorney-Advisor. The Transplant Review Board will submit their recommendations to the Medical Director.

If the Medical Director determines that an organ transplant is medically indicated, the inmate will be approved for surgery at an appropriate transplant center in accordance with Bureau policy, transplant center regulations, and State and Federal laws.

If the transplant involves a living organ donor, the Bureau will pay medical care and hospitalization costs associated with living organ donation. These expenses are limited specifically to costs directly related to the transplant procedure itself.

Section 26. **AUTOLOGOUS BLOOD BANKING**

The CD will authorize autologous blood collection when it is medically necessary. For example, autologous blood banking may reasonably be authorized for an inmate with an extremely rare blood type who undergoes surgery that predictably will require a blood transfusion.

Surgical consultants may recommend, but not compel, the Bureau to authorize autologous blood banking for an inmate prior to surgery. Recommendations by consultants will be considered on a case-by-case basis.

Section 27. **BODY SEARCHES FOR CONTRABAND**

Laxatives, enemas, or emetics (any form) will not be used to induce a bowel movement or vomiting to help remove contraband. If an existing medical condition requires the use of laxatives, enemas, or emetics for medical management, the CD must order this medication weighing the potential danger to the inmate if contraband is present and document an administrative note discussing the decision.

When a Warden authorizes a cavity search as defined in the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**, qualified healthcare personnel will perform the cavity search.

The use of a fluoroscope, major instrument (including anoscope or vaginal speculum), urinary catheter, or surgical intrusion will only be authorized for medical reasons and used with the inmate's consent.

If radiographic examination is determined necessary for the safety and security of the institution, the Warden, with the Regional Director's approval, may authorize the physician to order a non-repetitive radiograph to determine if concealed contraband is present in or on the inmate. The inmate does not have to consent to this imaging (refer to the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas** for further direction). In addition to the preliminary screening for contraband, these x-rays will be reviewed and interpreted by a qualified radiologist. The image and the report will be maintained in the inmate's health record consistent with radiography for diagnostic purposes.

Refer to the Program Statements **Ion Spectrometry Device Program** and **Whole Body Imaging** for guidance pertaining to full body scanners.

Section 28. **NUTRITION MANAGEMENT**

a. **Medical Diets**. A medical diet is defined as a diet that supplements a medical regimen. Medical diets will be provided by mainline self-selection from the items on the National Menu for that meal unless menu items fail to meet the medical requirement. Self-selection is in accordance with the Program Statement **Food Service Manual.**

Self-selection of common medical diets, including but not limited to diabetic, sodium-controlled, fat-controlled, and cholesterol-controlled can be met through self-selection of food indicated as heart healthy on the Bureau National Menu.

Menu item replacements may not always be provided when inmates may have to avoid certain foods in the self-selection process. Medical diets that will be provided by self-selection may be ordered by any APP, CD, registered dietitian, staff physician, staff psychiatrist, or staff dentist. If there is concern the medical diet self-selection process is not adequate to meet the nutritional needs, a Bureau registered dietitian should be consulted to determine if a special diet is indicated.

b. **Special Diets**. Also referred to as a therapeutic diet. May be ordered when self-selection of a medical diet is not possible. Special diets include ordering of supplemental feedings.

Special diet orders are situation-specific and should only be written after establishing an accurate diagnosis and initiating effective treatment or management of the underlying medical problem. A special diet should be ordered only when it is known to be effective for the inmate's specific medical condition and it has been determined nutrition needs will not be able to be met through self-selection of foods on the Bureau National Menu.

Special diets determined by a registered dietitian for offering at all institutions are listed in the Guidance for Medical Diets. For special diets not addressed in the Guidance for Medical Diets, MRCs should consult with an institutional registered dietitian. Non-MRCs should consult with a Central Office registered dietitian.

Special diets will be prescribed only by the CD, staff physician, staff psychiatrist, staff dentist, or APPs. Registered dietitians at MRCs may prescribe a special diet, but it must be countersigned by the primary physician. A Central Office registered dietitian may prescribe a special diet at any Bureau institution, which requires a countersignature by the primary physician.

Medical conditions that require a time-limited adherence to a special diet of less than seven days (post-operatively, bowel prep protocols, or other diagnostic procedures) should be managed at the institution in cooperation with the Food Service Administrator.

c. **Nutritional Counseling**. As clinically indicated, nutritional counseling will be provided as part of the treatment regimen; inmates will receive general information on how to choose foods that support a healthy lifestyle and prevention and management of medical conditions. Documenting patient education regarding diet recommendations in the EHR is the responsibility of the prescribing provider and registered dietitian. If there is no full-time dietitian, it is highly recommended institutions arrange for a Central Office registered dietitian to provide counseling services and patient education onsite or via telehealth.

Section 29. **INMATES WITH DISABILITIES**

Inmates with disabilities (cognitive, sensory, and physical) may require accommodations specific to their needs to enable optimal engagement in activities of daily living and institutional programming. Assessment of disabilities will be conducted at intake screening, with appropriate referral for further evaluation based on the needs of the inmate. Referrals for treatment and determination of applicable accommodation should be completed in a timely manner based on the urgency of the inmate's need. Institutions will coordinate a multi-disciplinary approach with Unit Management, Psychology Services, and Education to assess and accommodate inmates with disabilities utilizing the institution disabilities committee model outlined in the Program Statement **Management of Inmates with Disabilities**. A Social Worker (local or regional) will provide an individualized reentry plan 90 days prior to release to facilitate continuity of services. Refer to the Program Statement **Management of Inmates with Disabilities** for applicable coding in the applicable Bureau inmate information system.

Section 30. **DURABLE MEDICAL EQUIPMENT AND DEVICES (DME)**

Each institution will maintain a program and tracking system to manage the assignment of durable medical equipment and devices (DME). The tracking system will include the inmate's name and register number, equipment/device issued, time frame for issuance, and any additional information required locally. (Note: The institution may choose to utilize the Medical Duty Status report for a tracking system.) The HSA will develop written procedures regarding the management of DME, including storage, retrieval of DME assigned as a temporary aid to restoration of unaided functionality, and accountability for DME as property to ensure safe and secure management of the correctional environment. The HSA, in collaboration with the Captain, will determine procedures for retention of DME when an inmate is placed in restrictive housing. Clinical employees assigning DME to inmates will document issuance in the EHR and indicate the time frame for approved use. Clinicians will reassess the need for DME before extending assignment of DME.

In the event of a power outage, every effort should be made to accommodate those inmates requiring ongoing use of durable medical equipment to include relocation of the inmate and equipment to an area of the institution with appropriate utilities (e.g., power, running water, etc.).

DME must accompany the inmate when transferring to another facility, upon release to an RRC, or upon direct release to the community.

Local written procedures will address the management of specific equipment and devices that may raise local security concerns (continuous positive airway pressure [CPAP] machines, Transcutaneous electrical nerve stimulation [TENS] machines, etc.). The HSA and CD will coordinate communication of the medical necessity for DME when justifying issuance and protocol for inmate use of DME. Guidance for select examples of DME is outlined below.

a. **Eyeglasses**. The Bureau will furnish prescription eyeglasses to any inmate who has a documented need for corrective lenses and a valid written prescription.

Inmates may purchase reading glasses at commissaries that stock them. The HSA, in consultation with the CD and consultant optometrist, may elect to stock a supply of reading glasses in various magnifications that the optometrist may dispense when the inmate only requires magnification.

Inmates may retain personal eyeglasses at admission. Such eyeglasses are subject to inspection for contraband. The Bureau will not repair personal eyeglasses. Inmates will not be allowed to obtain prescription glasses from outside sources. If an inmate chooses not to retain personal eyeglasses at admission, they will be disposed of as indicated in the Program Statement **Inmate**

Personal Property.

Inmates will be provided no more than two pairs of prescription eyeglasses per year unless there is documented evidence that a significant change in refraction (visual acuity) has occurred.

b. **Contact Lenses**. Contact lenses will only be prescribed when, in the clinical judgment of a Bureau or contract optometrist or ophthalmologist, and with the concurrence of the CD and HSA, an eye-refractive error is best treated by contact lenses. Specific eye conditions appropriate for treatment are included in guidance provided by the Medical Director.

When the recommendation of a consultant is inconsistent with guidance issued by the Medical Director, the CD will defer to the Medical Director's guidance.

HSU employees will evaluate sentenced inmates arriving at an institution with contact lenses and refer them to a Bureau or contract optometrist or ophthalmologist to determine whether they may retain the lenses. Unless contact lenses are medically necessary, HSU employees will inform the inmate that prescription glasses will be obtained and issued by the Bureau.

The only exception to the above is non-sentenced inmates who are housed in Bureau institutions.

Once the eyeglasses are received, the contact lenses must be returned to the inmate's personal property per the Program Statement **Inmate Personal Property** or mailed home.

HSAs will ensure adequate contact lens cleaning and disinfection supplies are available in the HSU or commissary for inmates having an authorized prescription for contact lenses, non-sentenced inmates, or those awaiting ordered eyeglasses.

c. **Hearing Aids**. The CD, in consultation with an audiologist or otolaryngologist, will determine if a hearing aid is medically necessary. Health Services will supply hearing aids and batteries if there is a documented medical necessity.

If an inmate brings a personal hearing aid into the institution, he/she will be allowed to keep it when the medical necessity has been verified. However, the inmate may not purchase a personal hearing aid once admitted to an institution. The Bureau may replace an existing hearing aid that is ill-fitting or malfunctioning based on the results of the most recent hearing test.

d. **Medical Footwear**. The Bureau is responsible for providing each inmate with one pair of safety shoes suitable for his/her job assignment. Refer to the Program Statement **Inmate Personal Property** for instructions on allowable footwear that inmates may bring into the institution or purchase in the commissary at their own expense.

Clinical employees will issue a “soft shoe permit” to inmates assessed and diagnosed with specific medical conditions that limit the use of an authorized safety shoe. If a “soft shoe permit” is issued to replace the institution-issued safety shoe, the inmate will be assigned to a job that does not require a safety shoe. “Soft shoe permits” will not exceed 12 months. Clinicians will evaluate the need for soft shoes prior to reissuance of “soft shoe permits”.

Occasionally, custom shoes or orthotic devices may be medically necessary to accommodate a significant foot deformity or to decrease the chance of injury to feet with impaired sensation. For example, an inmate with a diabetic neuropathy may need an extra-deep, extra-wide toe box to minimize irritation and prevent diabetic lesions.

The CD must approve all requests for purchase of custom shoes and orthotic devices. The HSA will purchase custom shoes or orthotic devices through the institution’s Health Services Cost Center.

The need for custom shoes or orthotic devices will be re-evaluated annually on the anniversary of issuance (or sooner as determined by the CD). The re-evaluation visit will be scheduled to coincide with the annual CCC evaluation by the physician if the inmate is enrolled in a CCC. If the physician recommends renewal of the custom shoes or orthotic device, the CD will review before approving renewal.

e. **Blood Glucose Meters**. Inmates diagnosed with diabetes are authorized to have blood glucose meters (glucometers) to self-monitor their blood sugar levels. Diabetes is an insidious disease that can lead to long-term complications, including loss of vision, impaired kidney function, and amputation of extremities if not properly controlled. Glucometers enable the diabetic to measure and better control blood sugar levels. Each institution will develop local procedures regarding issuance of glucometers and related supplies, disposal of used glucometer supplies, and replacement of glucometers.

Section 31. **TRANSGENDER INMATES**

See the Program Statement **Transgender Offender Manual** for detailed management information, and the Medical Director's published guidance on transgender inmates for specific treatment recommendations.

Gender Affirming Surgeries are extraordinary medical procedures that require review and prior authorization by the Bureau Medical Director.

When the treatment plan for an inmate's medical condition includes consideration for gender affirming surgeries by the primary care team and Psychology Services, it will be referred to the Medical Director after it has been administratively reviewed, discussed, and referred by the Transgender Executive Council (TEC).

The case will undergo a medical review by the Transgender Utilization Review Advisory Group (TURAG), comprised of healthcare professionals appointed by the Medical Director. The TURAG will complete a comprehensive evaluation of all pertinent medical, surgical, and mental health histories including an interview with the patient and submit a final recommendation to the Medical Director.

The Bureau Medical Director will review the TURAG recommendations and supporting clinical documentation to ensure medical, surgical, and mental health concerns are addressed and in accordance with current standards. A summary of the medical review and decision will be conveyed to the Institution Clinical Director and Warden. When approved, the inmate patient will be referred to a transgender surgeon for consultation in accordance with established Bureau policy and procedures.

Section 32. **FERTILITY**

Inmates are not authorized for fertility preservation services (sperm/egg banking), even when infertility is an expected side effect of medically necessary treatment e.g., chemotherapy, pelvic radiation, or gender affirming treatment. Inmates are not authorized to donate sperm or eggs.

Inmates will not be sterilized, except for bona fide medical indications (e.g., as the result of surgical treatment for cancer of the reproductive organs).

Section 33. **DIALYSIS**

Inmates with renal disease requiring dialysis (peritoneal or hemodialysis) will be referred to the Medical Designator for transfer to an MRC or other institution capable of providing dialysis. Dialysis units will be organized and managed consistent with current medical standards. Each dialysis unit will develop and implement policies and procedures to ensure quality and safety in the provision of dialysis services.

Section 34. **SEXUALLY TRANSMISSIBLE INFECTIONS**

Refer to the Program Statement **Infectious Disease Management**.

Section 35. **STANDARD PROCEDURES FOR DETERMINING ALCOHOL INTOXICATION**

Employees may be asked to determine whether an inmate is intoxicated. Two procedures are used most often to determine alcohol intoxication:

- The Captain or designee may administer a breathalyzer test to determine the presence of alcohol. Use of a breathalyzer will remain a non-medical function.
- Clinical employees may be asked to obtain a blood sample to determine alcohol content.

Blood alcohol testing will be reserved for situations in which this information is needed as part of a criminal investigation or specifically requested by the Warden. When blood alcohol testing is performed, clinical employees will:

- Draw blood and forward it to an approved laboratory for testing.
- Complete all chain-of-custody documentation in accordance with documented court, law enforcement, or institution specifications.

The inmate's consent is required before blood is drawn, except during medical emergencies in which the inmate's health is threatened and his/her condition interferes with the ability to consent.

Section 36. **MEDICALLY SUPERVISED SUBSTANCE WITHDRAWAL FOR INMATES.**

Refer to clinical guidance for Medically Supervised Withdrawal for inmate patients with Substance Use Disorder.

Section 37. **REHABILITATION SERVICES**

Bureau-staffed Rehabilitation Services are ordinarily limited to medically designated inmates at MRCs or institutions with advanced medical missions. Each affected facility will have written local procedures outlining at least the following topics:

- Scope of services.
- Referral process from healthcare providers.
- Referral process to healthcare providers.
- Use of inmate workers in the department.
- Quality Improvement Program.
- Preventive maintenance of equipment.
- Infection control.
- Procurement of durable medical equipment and supplies.
- Safety and security.

Inmates at institutions without Occupational and/or Physical Therapy services onsite occasionally require assessment and treatment by a Rehabilitation Specialist. Occupational or Physical Therapists in the local community may be used in clinically appropriate cases. CDs should consider contacting a Bureau Occupational or Physical Therapist to discuss management options for difficult cases. Telehealth for therapy issues may be used when clinically applicable in institutions that have the technical capability.

The CD or HSA will refer inmate patients requiring extended occupational or physical therapy for redesignation to a facility with those services.

The CD may discuss the inmate's diagnosis and current condition with a Bureau therapist prior to submitting the BP-A0770, Medical/Surgical and Psychiatric Referral Request form requesting redesignation to determine if the transfer is appropriate, the inmate will benefit from Rehabilitation Services, or another treatment recommendation is more efficacious.

Section 38. **SOCIAL WORK SERVICES**

At the local and regional level, Social Workers are responsible for providing aftercare/discharge planning, identification of reentry resources, and continuity of care services to inmates with significant medical and mental health issues who are returning to the community. Social Workers act as a liaison between inmates, inmate families, institutions, and community resources to ensure continuity of care at release.

The Bureau Chief Social Worker develops guidance for the use of social work resources for inmates, particularly in the area of release planning. Refer to the Social Work Orientation Manual.

Each facility with authorized Social Workers will have written local procedures for social work services outlining the following topics:

- Scope of services, including LIP privileges.
- Referral process from healthcare providers.
- Referral process to healthcare providers.
- Quality Improvement Program.
- Transitional care/release planning, pregnancy counseling, end-of-life care, and development/implementation of an advance directive.

Section 39. **SEXUAL ASSAULT PREVENTION AND INTERVENTION**

a. **Prevention**. General training requirements for employees will comply with the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program**. Medical employees will refer to Psychology Services all inmates who have been identified as victims of:

- Sexually aggressive behavior.
- Sexual pressure.
- Sexual harassment.
- Sexual assault.

b. **Intervention**. When an inmate patient reports being sexually assaulted, medical employees document the inmate's complaint and subjective/objective findings using the injury encounter function in the EHR. A copy of this report will be provided to investigative employees when requested.

To avoid compromising medical evidence on an inmate patient who reports a recent sexual assault, it is recommended the inmate be transported to a community facility/rape crisis center that is equipped (in accordance with local laws) to evaluate and treat sexual assault victims. Refer to the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program** for further instructions.

Institutions housing high security level inmates or having limited access to local community resources providing specialized services for sexual assault victims, may contract with on-call clinical providers to render sexual abuse/assault evidence collection and treatment on site.

The CD and HSA will ensure that:

- Appropriate testing for infectious disease is performed.
- Medical examination and physical evidence collection have been conducted.
- All related reports are obtained, copies sent to the institution Special Investigative Supervisor (SIS), and pertinent medical information filed in the inmate's EHR.

Refer to the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program** for specific procedures on evaluating and treating victims of sexual abuse/assault.

If an alleged perpetrator is identified, medical employees will document and provide treatment, as appropriate.

Section 40. **EXAMINATION BY NON-BUREAU PROVIDERS**

a. **Conditions for Non-Bureau Provider Visits**. Inmates are not generally permitted to use non-contracted physicians or other providers from the community, including those with whom they had a prior relationship, whether on a reimbursable or non-reimbursable basis. There is no prohibition if a provider currently contracted by the Bureau happens to have been a prior healthcare provider to the inmate; however, this is discouraged.

If a private physician was treating an inmate prior to incarceration, and it is clinically appropriate for the physician to have one or more follow-up contacts with the inmate, an inmate may request to be examined by that physician during incarceration. The Warden, upon consultation with the Regional Director and Medical Director, may permit such a visit for examination only at the inmate's expense.

Such action will not be routine and should be infrequent. If permission is granted for such a visit, the Warden will ensure reasonable time and space for the examination are provided. The inmate will execute the BP-A0621, Authorization for Release of Medical Information. The visiting provider will be licensed by the State in which the institution is located. The Health Services Administrator or designee will verify the license in accordance with the Program Statement **Health Care Provider Credential Verification, Privileges, and Practice Agreement Program.**

The institution CD or staff physician will meet with the visiting physician, freely discuss the case, and be present during the exam. The Bureau physician will have authority from the Warden to terminate the examination if inappropriate actions are witnessed.

Upon request, the institution will provide the visiting physician a printed copy of the inmate's health record for review only. The Bureau physician should freely discuss the record, particularly in response to the visiting physician's questions.

The visiting physician will provide a written report. The Bureau physician will review any recommendations and documentation provided by the visiting physician but is under no obligation to carry out the visitor's recommendations.

If the private physician's recommendations are not followed, an entry will be made in the inmate's health record explaining the decision.

Any documents the visiting physician provided will be scanned into the EHR. The Bureau physician will document the visit in the EHR.

b. **Examinations to Determine Eligibility for Federal Program Benefits at Reentry**. In light of the agency's commitment to facilitate inmates' successful reintegration into their communities, institutions may permit non-Bureau providers to perform examinations for determining eligibility for Social Security Disability Insurance (SSDI), Veterans Health Administration (VHA), and other Federal program benefits that initiate upon release.

The Warden will determine security requirements for allowing non-Bureau providers to perform these physical assessments onsite or stipulate any conditions for transporting the respective inmate to a Federal agency's authorized community-based site for these evaluations. Bureau providers will not perform evaluations for determining eligibility for SSDI, VHA, and other Federal program benefits unless approved by the Medical Director on a case-by-case basis.

Section 41. **INVOLUNTARY MEDICAL TREATMENT/REFUSAL OF TREATMENT BY INMATES**

Refer to the Program Statement **Psychiatric Evaluation and Treatment** for guidance regarding involuntary medication and/or hospitalization for psychiatric illness.

When an inmate patient refuses recommended diagnostic testing, counseling, or treatment, clinical employees document the refusal in the EHR, complete a BP-A0358, Medical Treatment Refusal form signed by the inmate and the witnessing employee(s), and have the signed form scanned into the EHR. If an inmate patient refuses care, and the clinician determines that the clinical need continues to exist, the clinician should address the issue with the inmate at subsequent clinical encounters and document each discussion.

An inmate's refusal of treatment will not preclude the inmate patient from reconsidering his/her decision and accepting care in the future. However, if the potential beneficial outcome of the proposed diagnostic testing or treatment has been compromised by the delay resulting from the inmate's refusal, the inmate will be reevaluated to determine what treatment is clinically indicated. The clinician will communicate and document this circumstance in the inmate's electronic health record (e.g., delay in accepting recommended treatment for cancer affects its efficacy).

If the inmate patient refuses to sign, two employee witnesses will sign the BP-A0358, Medical Treatment Refusal form, attesting to their observation that the clinician explained the consequences of refusing the proposed care in a language the inmate understood.

As a general rule, medical and dental treatment, including medication, are only given when the inmate patient consents to treatment. Exceptions may be made when a Bureau physician determines:

- There is a danger to life or of serious permanent injury to the inmate.
- The inmate poses a risk to others by refusing treatment (e.g., infectious tuberculosis).
- There is a court order for evaluation or treatment to be provided.
- There exists a mental health emergency, as defined by the Program Statements **Psychiatric Evaluation and Treatment** and **Psychiatric Services**.

The CD and/or HSA should consult with Bureau legal employees whenever questions arise regarding involuntary medical treatment. However, in emergency situations, the provider renders immediate care, then consults legal employees if needed. Consultation with Psychology Services is strongly encouraged to increase collaboration in the mental health treatment of the inmate.

Diagnostic procedures related to potentially communicable disease may be mandatory for the protection of the inmate, other inmates, and employees. Refer to the Program Statement **Infectious Disease Management** for specific transmissible infections. These procedures include, but are not limited to:

- Tuberculin screening tests.
- Chest x-rays.
- Blood specimens for hepatitis or HIV (post-exposure incidents).

Refusal of these procedures will require an incident report. The CD will determine whether medical isolation is clinically indicated.

Section 42. **EXPERIMENTATION AND PHARMACEUTICAL TESTING**

Inmates in the custody of the Bureau of Prisons will not be used as subjects for any non-therapeutic medical experimentation.

This does not preclude the use of approved clinical trials that may be warranted for a specific inmate's diagnosis or treatment, when recommended by the CD and approved by the Medical Director. When the Medical Director approves an inmate's participation in a clinical trial, the inmate must give written informed consent and the clinical trial must be conducted according to the standards for the protection of human subjects established by the National Institutes of Health and the Bureau's Research Review Board (see the Program Statement **Research**).

Research regarding disease prevalence, response to accepted therapeutic interventions, etc., may be performed if the protocols meet the requirements of the Program Statement **Research**.

Section 43. **REENTRY SERVICES**

Prior to release of an inmate for home confinement or RRC placement, proper medical clearance is required to ensure successful reintegration to the community. Medical clearance is determined through a health record review and will be documented on the appropriate form within the Exit Summary tab within the EHR. An Exit Summary ensuring medical clearance and continuation of medications will be generated and sent with the inmate upon release. This will require communication and coordination with multiple divisions, including Correctional Programs, Reentry Services, and Health Services.

The institutional or Regional Social Workers will be involved in cases requiring ongoing care upon release from Bureau facilities. Social Workers will provide release and treatment planning for all Care Level 3 and 4 medical and mental inmates with serious/chronic medical and mental health issues at least 90 days prior to release. When applicable, they provide release and treatment planning for Care Level 2 medical and mental health inmates with significant needs (including disabled, HIV, transgender, elderly, and chronically ill populations) at least 90 days prior to an inmate's release.

The Clinical Director remains the clinical authority on medical clearance. Where the release destination has been determined, once the patient has been released from the Bureau facility the Bureau Medical Director or designee will assume the clinical authority for these inmates. In cases of differing clinical opinions regarding patient management, the Bureau Medical Director or designee will retain final clinical authority.

Upon arrival at the release destination, if ongoing medical needs are not achievable and require return to a Bureau facility, a BP-A0770, Medical/Surgical and Psychiatric Referral Request form will be generated and sent to the Chief of Health Programs and Sector Administrator of the release destination.

Section 44. **RADIOLOGY**

Radiology services provided or made available by the Bureau will be designed to meet the needs of patients in accordance with professional practices and legal requirements. Appropriate radiographic or fluoroscopic diagnostic and treatment services will be provided or made available.

a. **Staffing.** A registered Radiologic Technologist is required to perform radiology exams when radiologic services are available at an institution. The registered Radiologic Technologist will be a graduate of a program in radiologic technology and are registered by the appropriate accrediting bodies.

b. **Procedure Manual.** Each institution will have written procedures which cover:

- Identification of the current director of radiology.
- Scheduling.
- Examinations performed.
- Administration of diagnostic materials.
- Infection control procedures.
- Management of isolation patients.
- Management of emergency patients (STAT and Urgent procedures).
- Care of the critically ill.
- Preventive maintenance.
- Radiation safety/safety precautions.
- Disaster plans.
- Required records and reports.
- Preparation of patients.
- Calibration and safe use of equipment.
- Inspection of x-ray safety equipment for defects.
- Radiation exposure precautions.
- Precious metal recovery if the radiology department still retains radiology film.
- Lead disposal (see the Program Statement **National Occupational Safety and Health Policy**).

c. **Record keeping.** A daily radiology log, in a ledger or in electronic form, will be established in the Radiology Department. The log will contain:

- Register number.
- Patient name.
- Date the exam was completed.
- Ordering provider name.
- Type of study.

- Number of exposures.
- Name of person performing study.

A monthly log, in a ledger or in electronic form, will be established in the Radiology Department. The log will contain:

- Reason for and number of retakes.
- Date exam was sent for interpretation.
- Date report returned.

X-ray images will have the following information:

- Institution name.
- Patient name.
- Register number.
- Date of birth.
- Sex.
- Date of exam.

d. **Privacy.** A concerted effort will be made to ensure patient privacy at all times, particularly for undressing and dressing, examination, waiting in the Radiology Department, and evacuation of contrast media. The changing area and patient bathroom will connect directly with the examination room when physical location and resources permit. There may be circumstances when a Radiologic Technologist or contractor requests an employee chaperone. If a chaperone is requested, one will be provided. For an examination of intimate areas, such as genitals or breasts; a chaperone of the same gender of the inmate being examined is required, if the technologist performing the exam is the opposite gender of the inmate having the exam.

e. Ordering Radiographic Examinations. Diagnostic radiology services will be performed only upon the written request of a physician, dentist, or APP. A radiology exam request will be generated in the electronic health record by the ordering provider. Radiology exam requests other than the standard electronic generated radiology requests may be used, if they are the designated form of a contractual, non-Bureau radiology service. All radiology exam requests must contain:

- Patient's full name and register number.
- Birth date and sex.
- Examination requested.
- Name of requesting provider.
- Reason for the examination.
- Due date of requested examination.
- Name of the institution.

Employees will ask female offenders of childbearing age about the possibility of being pregnant prior to taking any mammography and confirm through a review of the EHR. When the mammography is ordered, pregnancy status will be notated.

f. **Evaluation/Interpretation of Radiographic Images.** The ordering provider will review all STAT or Urgent exam images/reports on the same date as ordered and will note abnormal findings in the EHR. Ideally, routine images should be reviewed within two working days of the examination by the ordering provider to identify for abnormalities such as active TB or fractures which require immediate attention. Images will be sent for a radiologist's interpretation. A radiologist will interpret all x-ray examinations; the interpretations will be recorded in a radiology report and entered into the inmate's EHR. The radiologist who interpreted the images must sign or e-sign (authenticate) all completed radiology reports.

g. **Distribution of Reports.** Authenticated, dated reports of all examinations performed will be entered into the inmate's electronic health record. Completed radiographic reports will be reviewed within two working days by the ordering provider and/or reviewing physician. The reviewing physician must ensure that timely, appropriate follow-up actions are initiated on all abnormal findings, and that any actions taken are documented in the EHR.

h. **Filing/Transfer/Retention of Radiographic Files.** Radiographic images will be archived in a picture archiving communication system (PACS). Radiographic images of inmates being transferred to other federal institutions will be sent via electronic media by mail or secure electronic methods to the receiving institution within five working days, after the request is made by the transfer institution for images. All available radiologic reports will be located in the inmate's electronic health record at the time of transfer. Radiologic images and files on inmates released from federal custody will be maintained and kept for five years.

i. **Safety.** Signs will be posted on the door to the x-ray suite and prominently inside the department, instructing individuals to notify the technologist if they are pregnant. When diagnostic agents are administered, safety precautions will include provision for an emergency drug tray, oxygen, airways, and the capability to administer intravenous support. Appropriate safety equipment will be used for examinations. Leaded gloves, aprons, and gonadal shields will be visually inspected by employees and images of the shields will be taken at least once a year for defects. The images will be sent to the Radiologist for review. Documentation must include a signed review from the Radiologist. Fluoroscopy may also be used to inspect radiologic safety equipment, with signed documentation of review by a Radiologist. Precautions will be taken to minimize radiation exposure through appropriate shielding and collimation. Periodic inspection and evaluation of radiation sources, including calibration of equipment, will comply with federal, state, and local laws and regulations. OSHA and U.S. Food and Drug Administration (FDA) regulations regarding the handling, removal, and storage of any radioactive material will be followed.

j. **Radiation Monitoring.** All personnel who use or work in close proximity to radiological equipment will wear a film badge while on duty to monitor cumulative radiation exposure. Individuals will ensure that their badges are not subjected to unnecessary exposure or left in the x-ray room. Quarterly reports of cumulative exposure will be maintained by the HSA and reviewed and initialed by the CD. All reports of high exposure or overexposure will be investigated to determine the cause. FDA recommendations will be followed.

k. **FDA Radiation Survey.** The FDA requires surveys of radiographic equipment every two years. The HSA, in consultation with the RHSA, will take corrective action and prepare a response to the report. The HSA will maintain a copy of the report and the corrective action taken if appropriate.

l. **Use of X-ray for Body Searches.** If radiographic examination is determined necessary for the safety and security of the institution, the Warden, with the Regional Director's approval, may authorize the physician to order a non-repetitive radiograph to determine if concealed contraband is present in or on the inmate. The inmate does not have to consent to this imaging (refer to the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas** for further direction). In addition to the preliminary screening for contraband, these radiology images will be reviewed and interpreted by a qualified Radiologist. The image and the report will be maintained in the inmate's electronic medical record consistent with radiography for diagnostic purposes.

m. **Preventive Maintenance.** Institutions will establish a preventive maintenance program to be conducted by qualified employees (i.e., a certified biomedical employee) or establish service contracts for repair and preventive maintenance of radiographic equipment. Manufacturer's recommendations will be followed when establishing preventive maintenance procedures.

n. **Precious Metal Recovery and Lead Disposal Program.** Institutions will establish a lead disposal program for disposal of defective leaded equipment and/or metal recovery. An institution that still maintains and/or retains radiologic film must have a silver recovery program to handle precious metal-bearing waste. Written procedures will be established at institutions who maintain and/or retain radiologic films, to recover precious metals from scrap and waste film. The Safety Department will be responsible to oversee and maintain documentation of the lead disposal and metal recovery programs.

REFERENCES

Program Statements

1070.07	Research (5/12/1999)
1600.12	National Occupational Safety and Health Policy (6/1/2017)
1351.05 CN-2	Release of Information (3/9/2016)
3735.04	Drug Free Workplace (6/30/1997)
3906.22 CN-1	Employee Development Manual (2/9/2022)
4500.12	Trust Fund/Deposit Fund Manual (3/5/2018)
4700.06 CN-1	Food Service Manual (6/8/2022)
5050.50	Compassionate Release/Reduction in Sentence; Procedures for Implementation of 18 U.S.C. §§ 3582(c)(1)(A) & 4205(g) (1/17/2019)
5200.06	Management of Inmates with Disabilities (11/22/2019)
5200.07 CN-1	Female Offender Manual (7/8/2022)
5200.08	Transgender Offender Manual (1/13/2022)
5267.09	Visiting Regulations (12/10/2015)
5280.09	Inmate Furloughs (1/20/2011)
5310.16	Treatment and Care of Inmates with Mental Illness (5/1/2014)
5310.17	Psychology Services Manual (8/25/2016)
5324.08	Suicide Prevention Program (4/5/2007)
5324.12	Sexually Abusive Behavior Prevention and Intervention Program (6/4/2015)
5508.08	Inmate Personal Property (8/22/2011)
5521.06	Searches of Housing Units, Inmates, and Inmate Work Areas (6/4/2015)
5522.02	Ion Spectrometry Device Program (4/1/2015)
5522.03	Whole Body Imaging (6/15/2017)
5553.08	Escapes/Deaths Notifications (1/4/2017)
5566.06 CN-1	Use of Force and Application of Restraints (8/29/2014)
6010.03	Psychiatric Evaluation and Treatment (8/12/2011)
6010.05	Health Services Administration (6/26/2014)
6013.01	Health Services Quality Improvement (1/15/2005)
6027.02	Health Care Provider Credential Verification, Privileges, and Practice Agreement Program (10/12/2016)
6080.01	Autopsies (5/27/1994)
6090.04	Health Information Management (3/2/2015)
6190.04	Infectious Disease Management (6/3/2014)
6270.01	Medical Designations and Referral Services for Federal Prisoners (1/15/2005)
6340.04	Psychiatric Services (1/15/2005)
6360.02	Pharmacy Services (10/24/2022)
6370.01	Laboratory Services (1/15/2005)
6400.03	Dental Services (6/10/2016)

American Heart Association Guidelines

Social Work Orientation Manual
Code of Federal Regulations, Chapter 29, Part 1910.95
5 CFR §550.105
5 CFR §550.106
5 CFR §550.107
5 CFR §550.1001-550.1002
5 CFR §551.431
5 CFR §5543
5 CFR § 5547

Master Agreement Between the Federal Bureau of Prisons and Counsel of Prison Locals (Master Agreement)

BOP Forms

BP-A0358	Medical Treatment Refusal
BP-A0621	Authorization for Release of Medical Information
BP-A0770	Medical/Surgical and Psychiatric Referral Request
BP-A0797	Autopsy Authorization

Non-BOP Forms

OF-522 Request for Administration of Anesthesia and for Performance of Operations and Other Procedures

ACA Accreditation Provisions

Standards for Adult Correctional Institutions, 4th Edition: 4-4322M, 4-4344M, 4-4346, 4- 4347, 4-4348, 4-4349, 4-4350, 4-4351M, 4-4352, 4-4353M, 4-4354M, 4-4359M, 4-4360, 4- 4362M, 4-4363M, 4-4365M, 4-4367, 4-4370M, 4-4374, 4-4375, 4-4377, 4-4380M, 4- 4381M, 4-4382M, 4-4389M, 4-4397M, 4-4398, 4-4400M, 4-4401M, 4-4402M, 4-4412, 4- 4426, and 4-4427
Performance-Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-2A-45M, 4-ALDF-4A-13M, 4-ALDF-4C-01M, 4-ALDF-4C-03, 4-ALDF-4C-04, 4-ALDF-4C- 05, 4-ALDF-4C-06, 4-ALDF-4C-08M, 4-ALDF-4C-09, 4-ALDF-4C-13M, 4-ALDF-4C- 19M, 4-ALDF-4C-20, 4-ALDF-4C-22M, 4-ALDF-4C-23M, 4-ALDF-4C-24M, 4-ALDF-4C- 26, 4-ALDF-4C-27, 4-ALDF-4C-29M, 4-ALDF-4C-34, 4-ALDF-4C-35, 4-ALDF-4C-37, 4- ALDF-4D-01M, 4-ALDF-4D-02M, 4-ALDF-4D-03M, 4-ALDF-4D-15M, 4-ALDF-4D-16, 4-ALDF-4D-17M, and 4-ALDF-4D-18M
Standards for Administration of Correctional Agencies, 2nd Edition: 2-CO-1F-14

Records Retention Requirements

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) system on the Bureau's intranet site.