U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

PROGRAM STATEMENT
Patient Care

Approved by	William K. Marshall III Director, Federal Bureau of Prisons
DPI	HSD
Number	6031.06
Date	June 22, 2026

Summary of Changes

Program Statement Rescinded:

- 6031.05 CN-2 Patient Care (3/14/2025)

Changes:

- Revised organization of the program statement for ease of navigation.
- Removed Utilization Review section.
- Changed requirements for both a history and physical and a 14- or 30-day chronic care clinic, combining these assessments into a comprehensive medical evaluation.
- Added ability to declare an inmate death in certain circumstances.
- Removed Radiology section.

1. **PURPOSE AND SCOPE**

To effectively provide medically necessary health care to inmates.

a. **Program Objectives.**

- Health care will be provided to inmates in accordance with proven standards of care without compromising public safety concerns inherent to the Bureau's overall mission.

b. **Institution Supplement.** The Health Services Administrator (HSA), Clinical Director (CD), or designee will develop an Institution Supplement. Regional legal review is recommended when the Institution Supplement is developed and must include the following, if applicable:

- Standard procedures for responding to emergencies 24 hours daily, to include Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED). See

Section 8. EMERGENCY AND URGENT CARE.

- Standard procedures use of Medical Observation rooms. See Section 31. HOUSING OTHER THAN GENERAL POPULATION.
- Standard procedures for the use of Short Stay Units if approved for operation. See Section 31. HOUSING OTHER THAN GENERAL POPULATION.
- Facilitation of the creation and implementation of an advance directive and do-not-resuscitate (DNR) orders. See Section 37. ADVANCE DIRECTIVES, LIVING WILLS, AND DO NOT RESUSCITATE (DNR) ORDERS.
- Standard procedures for a serious illness, serious injury, and death, contacting the local coroner or medical examiner. See Section 33. ORGAN DONATION BY INMATES, Section 38. SERIOUS ILLNESS OR INJURY, and Section 39. DEATH PROCEDURES.

Both local and regional legal review is required when an Institution Supplement is developed or updated.

2. DEFINITIONS

a. **Advanced Practice Provider (APP).** For the purpose of this program statement, an APP is a Nurse Practitioner or Physician Assistant.

b. **Advance Directive.** For the purpose of this program statement, an advance directive is a written instrument, sometimes referred to as a living will or other similar document, by which an inmate expresses their health care wishes in the event of a terminal or irreversible condition. The advance directive will be utilized by medical providers to guide care when the inmate lacks the capacity to make their own health care decisions.

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

The advance directive may prescribe the appointment of a non-Bureau of Prisons (Bureau) proxy decision-maker for these health care decisions.

c. **Ambulatory Care (Outpatient Care).** Ambulatory Care refers to health care services provided to inmates who are housed in the general population or other routine housing settings and who present to a medical or dental treatment area to receive scheduled or unscheduled services. Ambulatory care is intended for inmates whose medical, dental, or mental health conditions can be safely evaluated and managed without continuous monitoring, nursing observation, or intense assistance with activities of daily living. Services may include routine clinical encounters, chronic care management, preventive services, diagnostic evaluation, medication administration, specialty consultation, and minor procedures. Inmates receiving ambulatory care maintain independent functioning and do not require ongoing skilled nursing intervention outside the encounter period. Inmates who receive ambulatory care return to their

housing unit after the medical service has been provided.

Examples of Ambulatory Care settings/services include but are not limited to:

- **Medical Clinic.** Designated clinical area for outpatient medical evaluation, treatment, medication administration, and follow-up services.
- **Dental Clinic.** Designated clinical area for outpatient dental evaluation, preventive care, treatment, and procedures.

d. **Clinician.** A health care professional who is both licensed or certified, and credentialed to provide direct care within the scope of their education and discipline. The duties assigned to clinicians are based on their licensure and scope of practice, and not all clinicians can perform the same responsibilities.

e. **Comprehensive Medical Evaluation (CME).** A comprehensive medical evaluation includes a thorough history, physical examination, review of diagnostic reports, formulation of an active problem list, and development of a treatment plan. This evaluation can be captured in the electronic health record through a History & Physical (H&P) encounter, a 14- or 30-day encounter, or a Chronic Care Clinic encounter.

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

g. **Durable Medical Equipment (DME).** DME is reusable, medically necessary equipment prescribed by a doctor for use in the home to manage an illness or injury.

h. **Electronic Health Record (EHR).** The EHR is used by authorized staff 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.

i. **Enhanced-Ambulatory Care (Intermediate Care).** Enhanced-Ambulatory Care (EAC)

refers to health care or observation services provided to inmates who require increased monitoring, temporary separation from the general population, or accommodation for medical, mental health, infection control, or operational reasons, but who do not require infirmary-level care or continuous on-unit nursing presence. Inmates in these settings may receive some or all health care services at the bedside or housing location due to clinical condition, security considerations, or operational necessity. Qualified health care professionals are available through institutional response procedures, but nursing personnel are not continuously stationed within the unit at all times. These settings may be used for short-term observation, isolation, quarantine, stabilization, pre- or post-procedural monitoring, behavioral observation, or transitional care

when outpatient management alone is insufficient but inpatient nursing care is not clinically indicated. Inmates who receive enhanced-ambulatory care are not housed in general population and require overnight stays to receive the intended service.

Examples of EAC settings/services include but are not limited to:

- **Airborne Isolation and Quarantine Settings.** Designated areas used to separate inmates requiring infection prevention precautions or communicable disease monitoring.
- **Medical Observation Beds.** Short-term observation beds used to monitor clinical status, treatment response, or recovery from minor procedures or acute conditions.
- **Suicide Watch/Restraint Cells.** Secure observation settings used for inmates requiring continuous behavioral or safety monitoring with coordinated medical and mental health oversight.
- **Special Housing Unit (SHU) for Medical Purposes.** SHU placement utilized for medical isolation, trip preparation, clinical monitoring, or other medically indicated purposes.
- **Stepdown Unit.** Transitional housing area used to support gradual reintegration or stabilization following higher-acuity medical or mental health care.
- **Specialized Housing Unit.** Housing area designated for inmates requiring modified environments, increased observation, or specialized operational support related to health care needs.

j. **Health Services Unit (HSU).** The HSU is the department that provides health services at each Bureau institution. The HSU is cooperatively managed by the HSA and the CD and oversees all aspects of primary care, ancillary, and specialty services, delivered on site or via telehealth, completed by Bureau staff or contractors. Staffing complements vary for each HSU, with consideration given to the total facility population size, medical and mental health care level designations, and assigned missions.

k. **Inmate.** Ward of the Attorney General in Bureau custody.

l. **Infirmary Care (Inpatient Care).** Refers to inpatient-level health care services provided to inmates whose medical, surgical, psychiatric, palliative, rehabilitative, or functional care needs cannot be safely managed in an ambulatory or enhanced-ambulatory setting and who require ongoing skilled nursing care, daily clinical monitoring, or assistance with activities of daily living for a period generally exceeding 24 hours. Infirmary-level care is defined by the scope and intensity of services provided rather than by a specific physical location. Patients receiving infirmary care require timely access to qualified health care professionals, including nursing personnel who are readily available at all times when patients are present. Care may include medication and treatment administration, wound care, rehabilitation services, behavioral health stabilization, chronic disease management, hospice or end-of-life care, or close clinical observation requiring continuous health services capability.

Admission to and discharge from infirmary-level care is governed by medical orders or approved clinical protocols. Inmates who require Infirmary Care have clinical needs that prevent them from being housed in general population or EAC settings.

Examples of infirmary settings/services include but are not limited to:

- **Nursing Care Center (at MRCs).** Designated inpatient unit providing skilled nursing and supportive care services for medically complex inmates.
- **Long-Term Acute Care.** Extended inpatient medical or nursing care provided through contracted community facilities for inmates with chronic or disabling conditions.
- **Sub-acute / Skilled Nursing Facility.** Licensed or contracted facility providing skilled nursing, rehabilitative, and supportive care services beyond the capabilities of institution outpatient care.
- **Outside Hospital Admission (e.g., acute care, long term acute care).** Community hospital placement for inpatient medical, surgical, psychiatric, or specialty treatment requiring services unavailable within the institution.
- **Dementia Unit.** Licensed or contracted facility providing specialized inpatient setting designed for inmates with cognitive impairment requiring structured supervision and supportive nursing care.
- **Short Stay Unit (SSU).** Nursing Care Center unit intended for short-duration skilled nursing care, stabilization, monitoring, or recovery from acute illness or procedures.
- **Comfort Care.** Inpatient or residential care focused on comfort, symptom management, and supportive services for terminally ill inmates.

m. **Licensed Independent Practitioner (LIP).** For the purpose of this program statement, an LIP is a licensed and credentialed physician or dentist.

n. **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 (e.g., mechanical ventilation and dialysis).

o. **Medical Classification.** Medical classification is a system by which the Bureau assigns a medical and mental health care level both to inmates and Bureau facilities. For inmates, the care level is determined by their medical needs and based primarily on the chronicity, complexity, intensity, and frequency of interventions and services that are required, as well as an inmate's functional capability. For facilities, the care level is based primarily on the clinical capabilities and resources of the institution and the surrounding community, as well as specific medical missions (e.g. dialysis, oncology, etc.). Classifying both the inmate and facility allows the Bureau to match inmate medical and mental health needs with a facility resourced to care for those needs.

p. **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.

On-site services provided include, but are not limited to:

- Inpatient Services
- Enhanced-Ambulatory Care Services
- Ambulatory Care Services
- Behavioral Health Services
- End-of-Life Care Services
- Surgical Services
- Laboratory Services
- Physical Therapy and Rehabilitation Services

q. **Next of Kin.** Next of kin refers to a person's closest living relative by hierarchy (hierarchical order varies by state):

- Surviving Spouse
- Biological or legally adopted children
- Parents
- Siblings

In the context of hospitalizations, Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules authorize the notification of next of kin, as indicated by the succession of hierarchy or established medical power of attorney.

r. **Observation Area.** The observation area provides accommodations of limited duration for inmates 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 inpatient care.

s. **Proxy Decision Maker.** For purposes of this program statement, a proxy decision maker is a person authorized to make health care treatment decisions for an inmate 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 staff member will not be appointed as a proxy decision maker.

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

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

v. **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.

3. CLINICAL RESPONSIBILITY

a. Central Office Oversight.

- The Medical Director is the final clinical authority in the Bureau and as such can exercise final authority for Bureau clinical issues and provide overarching clinical direction for inmate health care delivery.
- Medical Director approves the scope of clinical services at an institution to ensure it meets its medical mission(s), including changes to an institution's authorized range or capacity of services..
- **National clinical guidance and standards.** Issue and maintain enterprise clinical guidance used by institutions (e.g., preventive health guidance; disease-state/high-risk condition guidance) and publish guidance that drives standardized care delivery and care-level determinations.
- **Extraordinary care and final determinations.** Approve categories of care reserved for the Bureau Medical Director (e.g., organ transplant approval, organ donor approval, etc.) and serve as the final decision authority for required referrals or when clinical adjudication is necessary.

b. Regional Oversight.

- The Regional Medical Director (RMD) provides regional clinical direction, consultation, and decision support to institution CDs/HSAs and serves as the first-level clinical escalation point for issues that cannot be resolved locally, consistent with the Medical Director's role as final clinical authority.
- Non-sentenced/short time-to-serve approvals. Ensure timely regional review/approval decisions for care that requires RMD authorization for non-sentenced inmates or inmates with less than 12 months to serve.
- Establish regional consistency in scope-of-services delivery by monitoring institutions' delivery of health services to ensure regional consistency and alignment with the

institution's authorized care level and available resources; elevate proposed changes in service range/capacity requiring Central Office approval.

c. **Facility Oversight.**

- The CD is the physician responsible for the quality and appropriateness of all clinical care delivered to inmates at Bureau institutions. They provide direct patient care, are the local clinical decision-making authority, and oversee the clinical care provided by those providers with medical privileges, practice agreements, and working under protocols. For policy regarding privileges, practice agreements, and protocols, see Program Statement **Health Care Credential and Privileging Program.**
- The HSA is responsible for the administration and supervision of staff and contractors who provide technical, operational, and administrative support in the health care setting. The CD and HSA collaborate to assure the delivery of effective and efficient health services.
- **Team Medicine.** All institutions will work within a Team Medicine model in which administrative, clinical, and ancillary health care staff 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), APP(s), and Nurses/Paramedics. 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 (e.g., intake screenings, comprehensive medical evaluations, sickest inmates, etc.). The CD is ultimately the local clinical authority responsible and will work under the oversight of 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.

4. **DOCUMENTATION**

The CD or HSA will ensure the EHR is used to document the health care received by inmates and the information is accessible to health services staff and inmates when requested.

a. **Clinical Encounter Notes.** All inmate visits will be documented using a clinical encounter in the EHR. The clinical encounter note will detail the subjective, objective, assessment, treatment plan, and inmate 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 replace the need for a clinical encounter when an inmate evaluation is clinically appropriate. Examples of acceptable 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
- Chart reviews
- Instances when the inmate does not report for a scheduled appointment
- Social work case management notes and psychoeducational sessions

At no time are administrative notes to be used to document any type of clinical inmate encounters.

c. **Medication Refills.** A health care practitioner will reevaluate the clinical indication for each medication order prior to writing a renewal order. The reevaluation may include a review of relevant documentation of the inmate chart or an inmate encounter that addresses the medications being prescribed.

d. **Telephone Orders/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, APPs, and pharmacists working under an appropriate collaborative practice agreement (CPA) per Program Statement **Health Care Credential and Privileging Program**.
- Clinicians authorized to receive TO/VOs are APPs, pharmacists, nurses, paramedics, and Emergency Medical Technicians (EMTs). Pharmacists are authorized to receive TO/VO medication orders from physicians and APPs.
- There are situations in which TO/VOs may be used broadly when it is impractical or impossible to use electronic or written order systems. This may include, but is not limited to:
  - Clinicians performing intake screening in the Receiving and Discharge area and telephonically requesting a medication order from an authorized prescriber working in the HSU.
  - Clinicians verifying trip/hospital returns and telephonically requesting medication order verification from an authorized prescriber.
  - Transcribing orders from on-call providers.
  - The ordering provider is providing emergency care to an inmate and needs assistance with administering emergency medication or emergency interventions.

The receiving clinician transcribes the order in the EHR noting the ordering provider, verifies the order by reading it back to the ordering provider, and documents the verified order. The

provider's co-signature using the EHR TO/VO function is required by the provider's 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.

An authorized clinician may transcribe written physician orders contained in the locally established protocols approved by the CD.

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.

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

- **Consultations Between Bureau Providers.** Providers will use the appropriate consultation request in 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.
- **Consultations Between Bureau Providers and Medical Specialists or Contract Medical Services.** A physician, APP, or Pharmacist with a Collaborative Practice Agreement (CPA) 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 ordinarily be submitted for review and disposition by the CD, a trained clinician, or by the Utilization Review Committee (URC), as outlined in Program Statement **Healthcare Utilization Management**.

If the consultant has access to document in the EHR, consultation notes must be documented directly in the EHR with a review to the referring physician or APP. Consultants without access to the EHR will provide a paper or electronic copy of the consultation documents and HSU staff will scan a copy of the final consultation into the EHR.

The physician or APP is under no obligation to follow consultant recommendations. If the consultant's recommendations are not followed, the physician or APP will document their justification and alternate treatment plan in the EHR.

f. **Timeliness of Documentation.**

- All clinical encounters and administrative notes will be completed optimally within one

business day but must be completed within no more than 72 hours.

- Physicians and APPs will complete all report or document reviews and co-signatures, including laboratory/diagnostic reports, specialist consultations, community hospital documents, etc., within three business days of notification in the EHR.

5. 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.

If a community-based physician was treating an inmate prior to incarceration, and it is clinically appropriate for the physician to have one or more follow-up contact with the inmate, an inmate may request to be examined by that physician during incarceration. The Warden, upon consultation with the Regional Director and Bureau 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 Records. The visiting provider will be licensed by the state in which the institution is located. The HSA or designee will verify the license in accordance with the Program Statement **Health Care Credential and Privileging 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 and authorization from the inmate, the institution will provide the visiting physician with a printed copy of the inmate's health record. 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 visiting 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.** Considering the Bureau'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.

6. 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. For medical care levels, see clinical guidance on Care Level Classification for Medical Conditions or Disabilities located on the Health Services Division (HSD) page of the Bureau's intranet site. For mental health care levels, see Program Statement **Psychology Services Manual**.

The 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. Increased staffing levels and ancillary/specialty services are needed at institutions that have higher care level assignments as determined by the Assistant Director, HSD.

Medical care levels are:

- **Care Level 1** institutions house inmates who are generally healthy but may have limited medical problems easily managed by Health Services staff and supplemented by existing community resources.
- **Care Level 2** institutions house inmates who have stable chronic conditions managed by Health Services staff 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 who have more complex medical conditions and are more fragile. They require frequent clinical contacts with Health Services staff and more visits to community medical specialists. They may also periodically require hospitalization to stabilize their conditions.
- **Care Level 4** institutions are the Bureau'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 physician makes a care level assessment upon an inmate's arrival, and regularly reviews and revises medical care levels at each chronic care clinic visit, and as the inmate's health needs change. Institutions are required to review and update inmate care levels at every comprehensive medical evaluation encounter.

7. SCOPE OF SERVICES

a. **Continuous Health Care Coverage.** Each institution will provide access to 24-hour medical, dental, and mental health care.

Routine services, including medical and dental appointments, the sick call system for inmates to report new health complaints, directly observed therapy (i.e., medication administration or pill line), preventive health visits, ancillary services (e.g., pharmacy services, physical therapy, social work services, etc.), medical specialty clinics (e.g., optometry clinic, orthopedic clinic, etc.), administrative services (e.g., health record management, clerical services, etc.) and diagnostic testing (e.g., laboratory services, radiology services, etc.), will typically be scheduled during the day shift.

Limited services (e.g., directly observed therapy, intake screening for new admissions) will be provided by clinicians on evenings, weekends, and holidays during locally established hours.

Institutions housing inmates requiring 24-hour skilled nursing care (MRCs, institutions having a Short Stay Unit, etc.) will have clinicians on site 24 hours.

b. **Available Services.** All HSUs are required to deliver medically necessary care to inmates in each Bureau facility, which minimally includes:

- Emergency and urgent care services. Refer to Section 8 of this program statement for further guidance.
- Ambulatory (primary) care and Specialty services. Refer to Section 9 of this program statement for further guidance.
- Preventive health services. Refer to Section 21 of this program statement for further guidance.
- Substance use treatment. Refer to Section 22 of this program statement for further guidance.
- Rehabilitative services. Refer to Section 23 of this program statement for further guidance.
- Social work services. Refer to Section 24 of this program statement for further guidance.
- Telehealth services. Refer to Section 29 of this program statement for further guidance.

- Medical reentry planning. Refer to Section 30 of this program statement for further guidance.
- Medical observation services. Refer to Section 31 of this program statement for further guidance.

Based on assigned medical missions determined by HSD, certain Bureau facilities may also provide an expanded scope of services, including but not limited to:

- Short stay services, at designated facilities. Refer to Section 31 of this program statement for further guidance.
- Inpatient services, primarily at MRCs and facilities authorized by the Medical Director to operate long-term care units. Refer to Section 31 of this program statement for further guidance.
- End-of-life care, primarily at MRCs and facilities authorized by the Medical Director to operate long-term care units. Refer to Section 37 of this program statement for further guidance.

Specialized medical, mental health, and dental services that cannot be provided within facilities or via telehealth will be contracted in the community.

c. **Medical Furloughs.** Per Program Statement **Inmate Furloughs**, medical furloughs are permissible. The Warden has the authority to approve a furlough for private, self-funded care by inmate or family, which does not require local Health Services or HSD approval. However, if the care received will be Bureau-funded, it must first be approved through the existing Utilization Review process prior to the furlough.

d. **Appointments.** Virtually all on-site medical and dental services should be scheduled in advance as appointments. Inmates may have multiple appointments on the scheduler. If clinically indicated, an inmate's concerns should be addressed in a single encounter (e.g., combining a sick call follow-up with a scheduled chronic care clinic [CCC]). This will expedite care, reduce redundancy in appointments, and improve overall efficiency.

e. **Examination Areas.** Staff will conduct clinical encounters with inmates individually in a private examination area. Other inmates will not be present except in emergencies and/or extraordinary circumstances.

The examination room will have adequate space, hot and cold 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. Rooms must be regularly cleaned, including disinfection of examination tables and contaminated surfaces, with disinfection of the exam table or table paper changed between each inmate. Other requirements for examination rooms include:

- An examination table
- 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
- Personal protective equipment (PPE)
- Access to high volume standardized forms

When inmate 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 consistently with the above requirements.

f. **Medical Holds.** Utilizing the Medical Duty Status (MDS) form, located in the EHR, a Medical Hold will be placed for any inmate meeting the following criteria:

- Approved to undergo surgical or invasive diagnostic intervention within 60 days of the scheduled transfer date. The inmate should be placed on Medical Hold at the time of consultation approval.
- Recently underwent a surgical or invasive diagnostic procedure requiring follow-up care with the consultant who completed the procedure.
- Currently undergoing treatment, which needs to be completed prior to transfer, to include transfer to a Residential Reentry Center (RRC) or placement in home confinement. This includes, but is not limited to cancer treatment, hepatitis C (HCV), latent tuberculosis (TB), methicillin-resistant staphyloccus aureus (MRSA), varicella, and TB, etc.
- Recently was discharged from a community hospital and requires follow up care or is not stable for transfer.
- Approved to undergo an oral surgical or outside dental consultant intervention. The inmate should be placed on Medical Hold at the time of the consultation approval.
- Recently underwent a dental surgical or invasive diagnostic procedure requiring follow-up care with the consultant who completed the procedure such as clinical or radiographic assessment for traumatic injury or awaiting pathology results post biopsy procedure.
- Pending process of dental prosthetic fabrication or completion of advanced treatment plans.

Only the CD or designee can authorize removal of a Medical Hold. Only dentists can remove a Medical Hold when placed for dental purposes/procedures.

To avoid unnecessary or prolonged delays in movement, the roster of Medical Hold inmates will be reviewed and updated by the CD, ideally every two weeks but at a minimum monthly, and changes to the MDS will be made as appropriate. The URC meeting is the ideal venue to review inmates on Medical Hold, to ensure target dates are accurate, and clinical indications are unchanged. After this review, the HSA will be responsible for the distribution of the current

Medical Hold list to Inmate Systems Management, Unit Managers, Captains, Associate Wardens, and Wardens.

- **Special Circumstances.** Inmates on Medical Hold who require custodial transfer should not be transferred until there is direct communication between the sending HSA or CD and the receiving HSA or CD to ensure continuity of care.

8. EMERGENCY AND URGENT CARE

Each institution will devise a method to provide access to 24-hour medical, dental, and mental health care. The CD and HSA will develop and implement an Institution Supplement that establishes standard procedures for responding to emergencies that will include CPR certified staff in the institution for the hours medical staff are not available. Refer to the Program Statement **Health Services Administration** section on Continuous Health Care Coverage.

a. **Emergency Care.** Facilities are required to provide access to emergency care services 24-hours a day. A medical emergency is a life- or limb-threatening situation where immediate intervention is required. During hours when clinical staff are available, the inmate can be assessed to determine if the medical needs can be addressed at the facility or if transfer to a higher level of care is warranted. This may be determined after routine hours by consultation with the on-call provider or a telehealth emergency/triage consultation service. All emergencies are referred to a nearby emergency room when the necessary care exceeds the capability of the facility to provide, even when clinical staff are on site to assess the inmate.

- **Four-Minute Response Time.** All staff 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 staff to be notified and arrive at the emergency scene. After arrival, responders begin applicable assessment and administer life-saving interventions when the scene is safe and accessible.
  - For institutions with multiple facilities physically separated by a significant distance (e.g., complexes, distant satellite facilities), the HSA or designee will develop standard procedures to meet the required four-minute response time to appropriately manage medical emergencies at all facilities.
- **Basic Life Support (BLS).** During medical emergency events, Bureau staff are expected to perform only basic life support techniques consistent with their documented training.
  - All credentialed staff are required to maintain American Heart Association (AHA) BLS Provider certification. Lieutenants are required to minimally maintain AHA Heartsaver CPR/AED certification.
  - Because it is a required training element for all facility staff, the BLS training program is overseen by Human Resource Management Division, including tracking completion, scheduling, training equipment maintenance, and issuance of certification cards. See the Program Statement **Employee Development Manual**.

- **Advanced Cardiac Life Support (ACLS).** Non-MRCs are not authorized to provide on-site ACLS medications unless approved through a policy waiver. MRCs that want to utilize ACLS protocols as part of their emergency response must have an appropriate written plan in their Institution Supplement. The plan should include verification of ACLS certification training requirements, equipment maintenance, and appropriately provisioned crash carts. Refer to the Program Statement **Pharmacy Services** and the Bureau National Formulary for guidance on emergency medications.
- **Inmate Consent.** During medical emergencies in which the inmate's health is threatened and their condition interferes with the ability to consent (e.g., cardiac arrest), clinicians may perform functions (e.g. establish peripheral venous access to administer fluids, and/or collect blood samples for analysis) necessary for preservation of life. The only exception to this standard is a DNR order or Advance Directive. See Section 37. ADVANCE DIRECTIVES, LIVING WILLS, AND DO NOT RESUSCITATE (DNR) ORDERS.

b. **Emergency Equipment.** The HSA approves and periodically reevaluates the contents, number, and locations of emergency response equipment, including crash carts, go-bags, stretchers, gurneys, backboards, and AEDs. The HSA will establish procedures for monthly inspections of all AEDs, as well as other mechanical equipment such as battery-operated gurneys, and is responsible for maintenance and supplies in accordance with the manufacturer's recommendations. The plan for periodic reevaluation, contents, locations, and maintenance will be detailed in the required Institution Supplement described below.

c. **Urgent Care.** Urgent care is for minor illnesses or injuries that are not life-threatening but should not be deferred until normal business hours. If clinical staff are not available to triage the inmate, custody staff should contact the on-call provider to determine the next steps.

d. **On call.** Except for MRCs, institutions will not have clinicians on site 24 hours. All institutions have clinicians on site 8–16 hours per day based on the needs of the inmate population.

- Institutions will establish on-call schedules that best meet the unique needs of inmates at the institution. Refer to the Continuous Health Care Coverage Section in Program Statement **Health Services Administration**.

9. AMBULATORY CARE SERVICES

- **Written Standard Requirements.** The HSA and CD will implement standard procedures for providing ambulatory care services in accordance with this program statement. Essential elements should include, but are not limited to:
  - Intake screening
  - Initial comprehensive medical evaluation

- Chronic care management in disease-specific clinics
- Management of inmates with mental illnesses or disorders
- Sick call process (triage and appointment system)
- Basic laboratory and radiology services
- Preventive health services
- Oral health services
- Pharmacy-led clinics
- Ancillary services (e.g., social work services, restorative therapies, nutritional services)
- System for evaluation and provision of necessary medical specialty services not available onsite
- Prenatal/Postpartum care
- Performance of minor office surgical procedures with informed consent
- Parenteral/intravenous infusions
- Basic wound care
- Rehabilitation services
- Provision of necessary medical devices and durable medical equipment
- Accident/injury assessment, treatment, and reporting
- Infection control program
- Poison control services
- MDS designation
- Treatment of inmates in Special Housing Units (SHU) and detention status
- Occupational inmate health services (e.g., hearing conservation measures, hepatitis B (HBV) immunization, etc.)
- Advance directives
- Privacy and confidentiality

10. **INTAKE SCREENING**

Intake screening is a process to identify urgent and/or infectious medical conditions as early as possible after arrival to a facility. A thorough intake helps to ensure inmates receive medication, equipment, activity or housing restrictions, and other immediate needs that cannot be deferred to a later appointment without placing the inmate and/or facility at risk.

Qualified health care providers will conduct an intake screening assessment of each inmate within 24 hours of arrival to the facility, except where noted below, ideally while the inmate is still in Receiving and Discharge.

The intake screening will be documented in the EHR using the appropriate Intake Health Screen template, except at facilities approved by the Medical Director to use rapid paper or electronic intake health screening forms. The intake screening addresses:

- Urgent medical, oral health, or mental health care needs

- Signs of acute drug or alcohol intoxication or symptoms of withdrawal requiring prompt intervention
- 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 arrival, but prior to the initial comprehensive physical examination)
- Disabilities (sensory, cognitive, and physical) requiring further evaluation and potential accommodation
- Any new medical problem since last comprehensive medical evaluation
- Renewal of current medications via Medication Reconciliation in the EHR
- Medication for Opioid Use Disorder (MOUD)/Medication Assisted Treatment (MAT) history and needs
- Any recent Prison Rape Elimination Act (PREA) history

Inmates with immediate medical/dental/mental health needs will be referred promptly to the appropriate clinicians for evaluation. If the newly arriving inmate is sick, unstable, or 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 CD, designee, or telehealth emergency/triage consultation service. Inmates who present with a new medical problem since the last comprehensive medical evaluation will be scheduled to see an APP or physician to review the inmate's medical history, review accuracy of current medical diagnosis, adjust the treatment plan, and review accuracy and clinical indications for previously ordered consultations.

This intake screen is mandatory and cannot be waived. If screening cannot be completed within 24 hours, it will be conducted at the earliest possible opportunity with a notation in the intake encounter explaining the delay. An inmate who refuses to participate in the intake will not be housed in the general population until screening is completed; applicable disciplinary action will be taken.

All intake screenings will be reviewed and signed by a physician, who is responsible for verifying comprehensive medical evaluations, labs, imaging, and follow-ups are scheduled as clinically appropriate, and consistent with this program statement.

a. **Newly Incarcerated Inmates.** Newly incarcerated inmates should be prioritized for timely intake screening, as their medical histories and risks are unknown or oftentimes incompletely documented in pre-sentencing records. Their risk for suicidality is also increased as they enter custody, and clinicians should refer them to a mental health provider for evaluation if clinically indicated. Whenever staff determine there is concern related to current suicide potential, Psychology Services will be notified immediately in person or by telephone call. Email and voicemail messages are not acceptable under such circumstances. See Program Statement **Suicide Prevention Program**.

b. **Bureau Intra-System Transfers.** A clinician at the receiving institution reviews the Bureau EHR Exit Summary from the origin institution to determine the medical needs of the inmate upon arrival at in-transit facilities and will initiate a new Intake Screening to review and update the inmate's clinical documentation, medications, and medical needs.

It is prohibited to transfer inmates between Bureau institutions, including holdover status inmates (e.g., Drug Enforcement Administration, U.S. Marshals Service, U.S. Immigration and Customs Enforcement [ICE], Federal Bureau of Investigation, etc.), who have not been screened for TB. Procedures for TB screening are contained in Program Statement **Infection Prevention and Control** or 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 when transfer of the inmate is necessary. If for any reason an inmate with suspected active TB or other communicable disease is scheduled to appear in court or an ICE or U.S. Parole Commission (USPC) hearing, refer to Program Statement **Infection Prevention and Control**.

c. **Transfer Between Facilities in the Same Institution (Intra-Complex Transfers).** No new intake screening is required. The qualified health care provider at the receiving institution will review the EHR and schedule inmates enrolled in chronic care clinic for evaluation according to the schedule set by the sending institution; however, if the reason for the transfer is escalation in inmate care, then a CCC should be scheduled within 30 days of arrival.

d. **Bureau Inmates Returning from Non-Bureau Custody.** Inmates who are out of Bureau custody (e.g., transfer to jail, writ, bail, etc.) for more than seven days will have an updated intake screening evaluation completed within 24 hours of their return to Bureau custody.

11. COMPREHENSIVE MEDICAL EVALUATION

A comprehensive medical evaluation is a clinical encounter which documents an inmate's history, physical exam, updated medical diagnoses, and treatment plan; this can be done through H&P, 14- or 30-day evaluation, and CCC evaluation.

- **Documentation.** The initial comprehensive medical evaluation will be documented in a H&P clinical encounter and must include a comprehensive list of all medical problems (resolved and current), and the full treatment plan (diagnostics, medications, specialty consultations, preventive health, etc.).
- **Timeframes.**
  - If no history or active medical or mental health diagnosis are identified on intake screening – complete within 30 days.
  - For inmates with history or active chronic or new health concerns/conditions – complete within 14 days.
- **Follow up.** The physician or APP completing the initial comprehensive medical evaluation will enroll the inmates with chronic conditions into the appropriate CCC and schedule the

inmate for the next appropriate CCC timeframe, typically in one year, but may be sooner if medically indicated.

Physicians and/or APPs will review all laboratory or other diagnostic testing and ensure the inmate is informed of results, which can be done by electronic messaging, intra-institution mail, or use of ancillary clinical staff to relay results. If follow-up is warranted (e.g., changes in the treatment plan, interventions, follow-up referrals, etc.) it will be scheduled in an appropriate timeframe.

Providers conducting comprehensive medical evaluations are expected at a minimum to:

- Order clinically appropriate laboratory and diagnostic tests and/or immunizations including:
  - Human Immunodeficiency Virus (HIV) screening – ordered for all newly incarcerated inmates unless an inmate refuses, which requires a signed refusal scanned into the EHR.
  - Hepatitis screening – ordered for all newly incarcerated inmates unless an inmate refuses, which requires a signed refusal scanned into the EHR.
  - Sickle cell screening (hemoglobin electrophoresis), if clinically indicated.
  - Sexually transmitted infection (STI testing, if clinically indicated.
  - Pregnancy testing for females of child-bearing age, if not done at intake.
  - Basic laboratory analysis such as Complete Blood Counts (CBC), Comprehensive Metabolic Panel (CMP), Hemoglobin A1C, etc.
  - Chest x-ray, if clinically indicated. Prior to obtaining a chest x-ray, rule out pregnancy in female inmates of child-bearing age.
  - EKG, if clinically indicated.
  - Age-appropriate testing for preventive health care.
  - Immunizations as recommended in the Bureau's Immunization clinical guidance, located on the HSD page of the Bureau's intranet site, based on current age, pregnancy status, and immunization history.
- Female-specific assessments will be completed as part of the comprehensive medical evaluation. Review intake screening and review any history of sexual abuse. Additionally include:
  - A gynecological and obstetrical history, including sexual activity and any recent rape history.
  - A pelvic examination. See Section 40.c. for chaperone requirements.
  - 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.
  - Clinical breast exam, if applicable. Clinical breast exams are not recommended for breast cancer screening among average-risk women at any age, but are indicated for women

with new breast symptoms (e.g., lumps, pain, nipple discharge), and those at higher risk.

a. **Newly Incarcerated Inmates.** In addition to the Intake Screening requirements, every newly incarcerated inmate will undergo a comprehensive medical evaluation performed by an LIP or APP. Refer to the Program Statements **Dental Services** for dental examination requirements and **Psychology Services Manual** for mental health appraisal requirements.

b. **Bureau Intra-System Transfers.** Intra-system transfers without a break in Bureau custody do not require a new H&P if one has been completed for this period of confinement and there aren't any significant changes in the inmate's medical/surgical history. Inmates who had a 14- or 30-day evaluation, or CCC at another Bureau facility within the last year do not need another comprehensive medical evaluation until the next annual visit is due, unless the transfer was done due to an increase in care level or when clinically appropriate. Inmates who are intra-system transfers and present with any new, acute, or urgent medical problems at intake screening will be referred to an appropriate clinician for evaluation as described under Section 10. Intake Screening.

c. **Bureau Inmates Returning from Non-Bureau Custody.** A comprehensive medical evaluation will be required for inmates who are out of continuous custody for more than 30 days. Examples of inmates who need a new evaluation include furloughs other than medical furloughs, writ execution (if continuous custody is not maintained), or an RRC failure who returns to a Bureau-managed facility.

d. **Age Based Preventive Health.** The CD 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 are outlined in preventive health guidance issued by the Medical Director.

Information regarding these examinations will be made available to inmates through the Admission & Orientation (A&O) process and individual inmate 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 comprehensive medical evaluation or CCC has been documented but does not have sufficiently detailed information to clear an inmate for Food Service, a brief in-person evaluation will be conducted to update the inmate's history and screen for the conditions listed below. This evaluation 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 management system.

Upon orientation to Food Service, Food Service staff 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

Inmates with HIV, HBV, HCV infection or latent 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.

f. **Interagency Agreements (IAA).** Inmates or detainees housed in Bureau facilities pursuant to a Memorandum of Understanding (MOU) or IAA may be subject to medical care requirements that differ from standard Bureau policy (see Section 32).

12. CHRONIC CARE CLINICS (CCC)

A CCC is also considered a comprehensive medical evaluation. A physician or APP will enroll inmates who have chronic medical needs in a regularly scheduled CCC. The HSA will track the enrolled inmates using the EHR to assure timely follow-up, completion of diagnostic testing and labs by due date, and issuing of medications/treatments as ordered. Inmates with multiple co-morbidities will be assigned to each applicable CCC. A physician will evaluate all inmates assigned to a CCC no less than once every 12 months. In the absence of a physician at a facility, the RMD will be consulted to determine interim CCC coverage plans, which may be assigned to APPs.

- **Medical Care Level 4 inmates.** Must be seen by an APP or physician for CCC follow-up every three months, or more often as clinically indicated (e.g., prescribed high-risk medications, complex co-morbidities, poorly controlled disease states, etc.).
- **Medical Care Level 3 inmates.** Must be seen by an APP or physician for CCC follow-up every six months, or more often as clinically indicated (e.g., prescribed high-risk medications, complex co-morbidities, poorly controlled disease states, etc.).

Inpatient inmates at MRCs are not excluded from CCC enrollment. Inmates residing on an inpatient unit will be enrolled as stated above and maintain CCC encounters at the frequency established by this program statement.

The CD or attending physician will determine the frequency of follow-up care required between CCC encounters based on clinical need. The APP will conduct interim follow-up encounters.

Pharmacists working under a CPA can also conduct interim follow-up CCC encounters. APPs and pharmacists will refer or seek guidance from the physician when there is a significant change in health status. The physician will review and cosign the APP and pharmacist'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. Clinical guidance should be followed in the absence of compelling rationality to deviate based on an inmate's individual health care needs. If care deviates from clinical guidance, clinical decision making should be clearly documented in the clinical encounter.

APPs can remove inmates from a CCC with a co-signature to the attending physician.

a. **Components of CMEs.** Physicians conducting annual comprehensive medical evaluations are expected at a minimum to:

- Review and revise current medical care level or 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 confirmed or revised after each major change in the inmate's health status (e.g., recent hospitalization, development of complications related to disease progression, etc.).
- Review any length of stay designation to determine if the inmate is clinically appropriate to return to their previous facility.
- Address all chronic diseases and any new concerns. All clinically significant conditions should be documented in the clinical encounter note at each visit.
- Address any preventive health needs. Screening needs that require outside consultation (colonoscopy, lung CT, etc.) will have consultations placed no greater than 18 months prior to the target date of need. For screening due on more distant timelines, due dates will be tracked via ongoing CMEs for future ordering within the 18 month window.
- Review all health problems to ensure only active diagnosis are currently listed, and all others are resolved, in remission, or deleted as appropriate.
- Review all ordered, but not completed consultations to ensure they are still clinically necessary with appropriate target dates and to identify and discontinue duplicative consultations if needed.
- Review MDS accommodations, issued DME, and Medical Holds for appropriateness.
- Review nutritional needs and order any special Medical Diets or supplements as clinically warranted.
- Review whether Reduction in Sentence (RIS) is appropriate. See clinical guidance Compassionate Release Criteria for Requests Based on Medical Circumstances located on the HSD page of the Bureau's intranet site.

b. **Medication Discontinuation.** When a chronic care medication is discontinued for any reason (including clinical determination, suspected diversion, non-adherence, abnormal laboratory findings, or custody-related concerns) the ordering provider shall document in the EHR that the patient was notified of the discontinuation and received appropriate patient

education regarding the rationale, potential risks, expected symptoms, available treatment alternatives, and how to request reevaluation should the inmate wish to restart the discontinued medication. The provider shall also document a revised or new plan of care that addresses the patient's ongoing diagnosis or condition and identifies clinically appropriate therapeutic options to meet the patient's medical needs in the absence of the discontinued medication.

Discontinuation of medication shall not occur solely through administrative note documentation without direct patient notification and clinical reassessment.

When clinically appropriate, medications shall be discontinued using a medically indicated tapering schedule to promote patient safety and minimize risk of withdrawal, symptom exacerbation, or other adverse outcomes. Decisions regarding tapering shall be based on clinical judgment and accepted standards of care, and patient health and safety shall take precedence over operational or custody considerations, including concerns related to diversion. Any deviation from tapering due to clinical contraindication or urgent safety concerns shall be clearly documented, including the clinical justification and follow-up monitoring plan.

When medication discontinuation is related to patient non-adherence, refusal to take medication as prescribed, or behavior resulting in the inability to safely continue the medication, the provider shall obtain and document a signed refusal form. The form shall reflect that the patient was informed of the risks associated with non-adherence or discontinuation, alternative treatment options were discussed, and the patient was given the opportunity to ask questions.

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 privileges, practice agreements or protocols according to Program Statement **Health Care Credential and Privileging Program**.

13. **FEMALE HEALTH CARE**

Women utilize health services at greater rates than men. In addition to those additional requirements for female inmates included in the intake, comprehensive medical evaluation, and CCC sections above:

a. **Prescription Birth Control.** Refer to the current version of the Bureau National 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, when prescribed for birth control.

For inmates with IUDs or other implanted contraceptive devices, clinicians will seek history on the type of device, and date of implantation to appropriately advise inmates with these devices in place about possible complications associated with continued use past expiration. These devices should be removed per manufacturer's directions by a credentialed clinician and upon the inmate's request.

b. **Pregnancy.** When pregnancy is confirmed, the female offender will be referred to a physician within 14 days for an initial examination and referred to an obstetrician-gynecologist (OB-GYN) within eight weeks of pregnancy. Psychology Services will also be notified to provide counseling and other services as appropriate.

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

All pregnant inmates will:

- Be screened for HIV, hepatitis, diabetes, and hypertension unless the inmate chooses to opt out of screening.
- Have MDS restrictions indicating a prohibition from the use of restraints.
- Have MDS restrictions authorizing a lower bunk, housing closer to the medical unit, work or recreation restrictions, if clinically indicated.
- Have orders for prenatal vitamin supplements, if clinically indicated.
- Be evaluated for nutritional needs to determine if a medical diet or supplementation is necessary.

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

c. **Childbirth.** The CD or designated physician, in consultation with a staff or 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.

d. **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 and store it upon request. The breast pump is considered DME and should be documented on the MDS. Refer to the Program Statement **Female Offender Manual**.

e. **Documentation of Pregnancy Outcomes.** The CD is responsible for ensuring all delivery and pregnancy outcomes are documented in the EHR and that the pregnancy or post-partum diagnoses on the health problem list are resolved in appropriate timeframes.

f. **Feminine Hygiene Products.** Feminine hygiene products are not considered to be medical supplies or equipment and are not managed by HSUs unless there are specific related comorbidities that affect an inmate's use of institution supplied products. Refer to the Program Statement **Female Offender Manual**.

14. SEXUALLY TRANSMISSABLE INFECTIONS

Refer to the Program Statement **Infectious Disease Management** for guidance on STI management.

15. 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. The initial assessment of disabilities will be conducted at intake screening, with confirmation and appropriate care planning completed at the comprehensive medical evaluation or CCC encounter, with referral for further evaluation based on the needs of the inmate. The medical provider may refer the inmate for evaluation by Physical/Occupational/Speech Therapists, or neuropsychologists as necessary. Treatment and determination of applicable accommodation should be completed in a timely manner based on the urgency of the inmate's need. Accommodations and DME issued to inmates with disabilities should be documented in the MDS.

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 management system.

16. DURABLE MEDICAL EQUIPMENT AND DEVICES (DME)

Each institution is required to utilize the Device/Equipment section of the flow sheets in the EHR to track and manage the assignment of inmate issued-durable medical equipment and devices (DME). The HSA or designee will develop standard procedures regarding the management of DME, including storage, retrieval of DME assigned as 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 standard procedures for retention of DME when an inmate is placed in restrictive housing. Clinicians 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 the assignment of DME.

In the event of a power outage, every effort will be made to accommodate those inmates requiring ongoing use of DME 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 SHU, another facility, upon release to an RRC, or upon direct release to the community. Where security concerns may arise from possession of DME in SHU, limiting or adjusting access to DME, will occur after consultation with a clinician. If certain DME items are restricted while housed in SHU, the MDS form must be updated in the EHR to reflect any adjustments. When medical needs cannot be accommodated in SHU, and in the interest of preserving life or limb, alternative housing or disciplinary options will be pursued.

Local standard procedures will address the management of specific equipment and devices that may raise local security concerns (e.g., 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 common DME is outlined below.

There are several DME, that while infrequently used, warrant special mention due to network connectivity capabilities and the life-preserving nature of the devices (e.g., life vests, insulin pumps, holter monitors, etc.). These devices are medically necessary and cannot be removed from the inmate's possession without the approval of the CD.

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 prescription eyeglasses at admission, provided these devices do not have wireless or Artificial Intelligence components. 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.

The only exception to the above is non-sentenced inmates who are housed in Bureau institutions. These non-sentenced inmates housed in Bureau institutions may obtain prescription glasses from outside sources. Outside sources may include family members, Bureau-funded orders, etc. to ensure non-sentenced inmates have access to eyeglasses given their typical shorter length of stay before sentencing.

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, 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 staff 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 staff 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, they will be allowed to keep it when the medical necessity has been verified. Hearing aids are subject to inspection for contraband. 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. The replacement device purchased by the Bureau is not required to be the same model or brand. The HSA will purchase the most cost-effective model that meets the inmate's medical need.

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

- **Alternate Shoes.** Clinicians may authorize alternate institutional shoes (formerly "soft shoe pass") for patients who do not have insensate feet, but do have a medical condition that increases the risk of injury to the foot if safety toe boots are worn. Alternate shoes are issued through Laundry Services. Alternate shoes may be temporarily authorized for acute injuries or issued for a period not to exceed 12 months. Alternate shoe permits will not exceed 12 months. Clinicians will evaluate the need for alternate shoes prior to reissuance of the permit, document the need in the clinical encounter, and update the MDS with the alternate shoe permit and expiration date.
  - Institutional safety toe boots must be exchanged for the pair of alternate shoes. An inmate cannot work in an area requiring safety toe boots when authorized alternate shoes.
- **Medical Shoes.** Clinicians will authorize medical shoes, utilizing the MDS form located in the EHR, to accommodate a significant foot deformity or to decrease the chance of injury to feet with impaired sensation. Medical footwear should be purchased from Medline or directly through the shoe manufacturer. If a medical shoe permit is issued to replace the institution-issued safety shoe, the inmate will be assigned to a job that does not require the safety shoes. Medical shoe permits will not exceed 12 months. Clinicians will evaluate the need for medical shoes prior to reissuance of the permit, document the need in the clinical encounter, and update the MDS with the medical shoe permit and expiration date.
- **Custom Orthotics.** Occasionally, custom orthotics may be medically necessary to accommodate a significant foot deformity or to decrease the chance of injury to feet with impaired sensation. Custom orthotics are to be approved through the Utilization Review Committee and provided through the contracted Prosthetic/Orthotic company.

The need for medical shoes or custom orthotic devices will be re-evaluated annually, or sooner as determined by the CD or Chief Therapist. If the clinician recommends renewal of the medical shoes or orthotic device, the CD or Chief Therapist will review before approving renewal. The CD or Chief Therapist must approve all requests for purchase of medical shoes and orthotic devices. The HSA will purchase custom shoes or orthotic devices using the institution's Health Services Cost Center.

e. Blood Glucose Meters. Inmates diagnosed with diabetes may be authorized to have blood glucose meters (glucometers) to self-monitor their blood sugar levels as clinically indicated and prescribed by the physician, APP, or pharmacist with a CPA.

17. **DIRECTLY OBSERVED THERAPY (PILL LINE)**

a. **Procedures for clinicians.** The following procedures will be followed for directly observed therapy (DOT):

- The person administering the medication will identify each inmate by examining two forms of identification (e.g., photo ID, date of birth, registration number, name, etc.).
- The inmate will be directed to take the medication by the prescribed administration route while being observed directly by the staff member.
- The inmate will then show the empty dose cup and water cup (when applicable) to the person conducting DOT before disposal.
- The inmate will be directed to open their mouth to show the medication has not been "cheeked" or, if the medication is sublingual, that it is properly placed under the tongue and has begun to dissolve before leaving the window.
- Medication administration will be promptly documented in the EHR upon completion.
- 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 electronic medication administration record (eMAR). Otherwise, medication administration will be documented on a printed, paper MAR and scanned into the EHR.
- When using an automated dispensing cabinet (AMDC) (e.g., Pyxis), the individual removing a controlled substance from the AMDC must be the same individual who signs the eMAR except in cases of an emergency.
- When an inmate refuses to take a prescribed DOT medication, or is a "no-show," that decision is documented on the eMAR.

Persons administering DOT medications must follow all administrative restrictions, to include crushing requirements, per Bureau National Formulary.

b. **Procedures for non-health care clinicians.** Any appropriately trained staff member (e.g., correctional officer, food services employee, education employee, etc.), who is willing and competent to perform medication administration and distribution, may be permitted to distribute or administer medications if the following requirements are met:

- The staff member completes the EMAR: EMR Fundamentals training available on the HSD Health Informatics page of the Bureau's intranet site to gain access to the EHR to document pill line administration and medication distribution.
- The staff member completes AMDC access training available on the HSD Health Informatics page of the Bureau's intranet site.
- The institution has a locally established pill line and medication distribution role and responsibilities orientation.
- The staff member has demonstrated competency as documented on the "Non-Health Care Clinician (NHCC) Pill Line and Distribution Competency Assessment" utilizing the

standardized, national competency form available on the HSD page of the Bureau's intranet site.

The institution will ensure its Pharmacy & Therapeutics (P&T) Committee reviews this utilization of staff at each meeting, ensuring quality of care is maintained and medication errors are addressed appropriately. All medication errors will be reported as required by Program Statement **Pharmacy Services**.

The Regional Medical Director and Regional HSA will be consulted prior to an institution utilizing a non-health care clinician for pill line and medication distribution. Approval notification will be made to the Warden.

18. **MEDICAL CONVALESCENCE AND IDLE**

Medical Duty Restrictions/Convalescence. 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 management system will be made 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 their quarters except for meals, religious services, and medical call-outs or DOT (i.e., pill line).
- **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 their job assignment, or to minimize the risk of injury to the inmate, other inmates, or staff 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.

  If clinically appropriate, inmates on convalescent status may attend sedentary 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 who is rehabilitating from orthopedic surgery may need access to the recreation facilities to walk or do specific exercises prescribed by health care providers.

19. **SICK CALL**

Sick call is the process that allows inmates access to health care providers for acute issues (e.g., a "walk-in" inmate-initiated visit). Clinicians will ordinarily conduct sick call and schedule

appointments on weekdays, except on federal holidays, during HSU's operating hours. Sick call concerns must be:

- made by the inmate in person.
- assessed and triaged by a qualified health care provider (Paramedic, Registered Nurse (RN), APP). Licensed Practical Nurses (LPN)/Licensed Vocational Nurses (LVN)/Medical Assistants cannot triage an inmate independently but can help in the triage process (e.g., take vital signs, gather basic medical history/chief complaint, and perform tasks per protocol or at RN/APP direction).
- documented as a clinical encounter in the EHR and include history of concern, vital signs, triage exam, and disposition.
- tracked by the HSA to ensure appropriate timeliness of care and to identify trends and risks.

Inmates presenting with urgent conditions will be assessed and treated by an appropriate provider expeditiously. Inmates presenting with non-urgent complaints will be assessed to determine stability, reassured, and scheduled for follow-up according to clinical indication or wait until the next scheduled CCC.

National nursing/paramedic protocols must be utilized by all institutions as below:

- Facilities may create additional protocols to supplement those established nationally to address the unique needs of the facility or inmate population (e.g., colonoscopy prep protocols, telehealth protocols, etc.).
- The CD retains authority for annual review and implementation of protocols. Modifications may be made to the national protocols, but only after review and concurrence by the Regional Medical Director.
- The HSA and CD will ensure documented training and competency for staff utilizing protocols is offered according to Bureau policy.
- Staff working under protocols will utilize the appropriate EHR template/encounter when utilizing protocols in the facility.

If no follow-up appointment is warranted based on a sick call concern, the screening clinician will advise the inmate of other options (e.g., obtaining over-the-counter medications from Commissary, alter diet or physical activity, return to the clinic if symptoms do not improve, etc.).

Inmates who are evaluated on multiple, distinct occasions for the same, unresolved complaint without a definite diagnosis or fail to respond to treatment will be referred to the CD or physician during the third such encounter. The physician will evaluate the inmate within a reasonable time frame based on the severity of the medical condition.

Co-pays are applicable for sick calls per the Program Statement **Inmate Copayment Program**.

20. **INMATE INJURY ASSESSMENT**

Clinicians must document an inmate injury assessment in the EHR, using the appropriate injury assessment encounter type, and schedule a follow-up appointment if clinically indicated. The exam will include vital signs, assessment of any injury, regardless of severity or cause (e.g., work-related, recreational, assault-related, accidental, self-inflicted, etc.), and disposition (e.g., based on protocol or orders from the on-call APP or physician).

The inmate's symptoms and/or concerns should be documented using their own words in quotation. All reports of injury will be documented regardless of the severity of the injury. A physician will review and co-sign all injury reports as soon as possible, ordinarily by the next working day. Inmate work related injury information must be shared with Occupational Safety and Health (OSHA) Department locally as necessary for completion of the OSHA Form 300, Log of Work-Related Injuries and Illnesses and activity related to the Inmate Accident Compensation program. Refer to Program Statement **National Occupational Safety & Health** for more information regarding the Inmate Accident Compensation program.

21. **PREVENTIVE HEALTH SERVICES**

Each facility will provide preventive health evaluations and age- and risk-appropriate screenings to all inmates, consistent with generally accepted community standards of medical practice. Preventive services must be delivered in accordance with the Bureau's clinical guidance on Preventive Health and include, as applicable, health risk assessments, immunizations, cancer screenings, and evidence-based counseling interventions. Facilities are responsible for ensuring timely access to preventive services, appropriate clinical follow-up of abnormal findings, and documentation in the inmate's EHR.

a. **Inmate Immunizations.** Refer to the Program Statement **Infectious Disease Management**. Inmates will be notified of the availability of immunizations through A&O and information posted in the HSU.

b. **Additional Considerations for 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.** Pre-sentenced or holdover inmates may not remain at an institution long enough to allow for baseline mammography and follow up; however, when feasible, baseline mammography should be scheduled according to age and time intervals established in the preventive health guidance. 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.

22. **SUBSTANCE USE**

Each facility must provide substance use screening, assessment, and treatment services consistent with generally accepted community standards of care and the Bureau's currently applicable clinical guidance. Services must include evidence-based interventions across the continuum of care, including screening and diagnostic assessment, medications when clinically indicated, counseling and behavioral therapies, and coordination with Psychology Services, reentry planning, and transitional care as appropriate.

Facilities are responsible for developing a process to ensure timely access to substance use treatment, continuity of care during incarceration and transitions, appropriate clinical monitoring and follow-up, and complete documentation in the inmate's EHR as described in the clinical guidance.

a. **Procedures for Determining Alcohol Intoxication.** Two procedures are used most often to determine if an inmate is intoxicated with alcohol:

- The Captain or designee may administer a breathalyzer test to determine the presence of alcohol consistent with Program Statement **Narcotic Identification, Inmate Urine and Alcohol Surveillance and Testing Program**. Use of a breathalyzer is not a medical function.
- The Warden may also order blood alcohol testing. This is reserved for situations where this information is needed as part of a criminal investigation per Program Statement **Narcotic Identification, Inmate Urine and Alcohol Surveillance and Testing Program**.

All other blood alcohol testing ordered and performed by clinicians for a clinical indication requires consent from the inmate prior to blood draw.

b. **Medically Supervised Withdrawal for Inmates.** Refer to clinical guidance for Medically Supervised Withdrawal for inmates with substance use disorder.

23. **REHABILITATION SERVICES**

Bureau-staffed Rehabilitation Services are ordinarily limited to medically designated inmates at MRCs or institutions with advanced medical missions. The HSA or designee will implement standard procedures outlining at least the following topics:

- Scope of services
- Referral process to and from health care providers
- Use of inmate workers in the department
- Quality improvement components under HSU's Quality Improvement Program
- Preventive maintenance of equipment
- Infection control
- Procurement and issuance of DME and supplies
- Safety and security

Inmates at institutions without Speech, Occupational, and/or Physical Therapy services onsite occasionally require assessment and treatment by a Rehabilitation Specialist. Speech, Occupational, or Physical Therapists in the local community may be used in clinically appropriate cases. The CD, through URC, determines if rehabilitative services are clinically indicated. The Regional Physical Therapy Clinical Team will review the request and determine the best modality for treatment delivery (e.g., home exercise, Bureau provider, telehealth, referral to community, etc.). Depending on the needs of the inmate population at the institution, these services may be part of the comprehensive medical services contract. Management options for difficult cases should focus on self-management plans and provision of services on-site whenever possible.

The CD will refer inmates requiring extended speech, occupational, or physical therapy for redesignation to a facility with those services in consultation with the Regional Physical Therapy Clinical Team.

The CD will 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 (770) requesting redesignation to determine if the transfer is appropriate, or if there are alternative local options to exhaust.

24. **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 located on the HSD Chief Social Worker's page of the Bureau's intranet site.

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 health care providers
- Referral process to health care providers
- Quality Improvement components under the HSU's Quality Improvement Program
- Transitional care/release planning, pregnancy counseling, end-of-life care, and development/implementation of an advance directive
- RIS processing according to Program Statement **Compassionate Release/Reduction in Sentence: Procedures for Implementation of 18 U.S.C. §§ 3582 and 4205(g)**

25. AMBULATORY SURGICAL SERVICES / SURGICAL PATHOLOGY

For on-site procedures performed in Bureau facilities, Health Services staff will ensure inmates are 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 for Performance of Operations and Other Procedures form for:

- All ambulatory 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 (only at MRCs)

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 ordering provider (APP, physician, or dentist) and inmate informed of

results (in person or by letter).

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

26. **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, or pelvic radiation). 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) and upon consent of the inmate.

27. **DIALYSIS**

Inmates with renal disease requiring dialysis, peritoneal or hemodialysis, will be referred to the Office of Medical Designations and Transportation (OMDT) 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.

28. **NUTRITION MANAGEMENT**

a. **Medical Diets.** A medical diet is defined as a diet that supplements a medical treatment plan to optimize inmate outcomes. Medical diets will be provided by mainline self-selection from the items on the Bureau 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 should avoid certain foods in the self-selection process. Medical diets that will be provided by self-selection may be ordered by a physician, APP, or 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. See Guidance for Medical Diets Clinical Guidance.

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 supplemental foods.

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 clinical guidance for Medical Diets. For special diets not addressed in the clinical guidance for Medical Diets, MRCs should consult with an institution registered dietitian. Non-MRCs should consult with a Central Office registered dietitian.

Special diets will be prescribed only by a physician, psychiatrist, dentist, or APP. Registered dietitians at MRCs may prescribe a special diet, but it must be co-signed by an APP or physician. A Central Office registered dietitian may prescribe a special diet at any Bureau institution, which requires a co-signature by the primary physician.

Medical conditions that require a time-limited adherence to a special diet of less than seven days (e.g., 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 inmate 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 inmate education onsite or via telehealth.

29. **TELEHEALTH SERVICES**

Each facility will establish and maintain the capability to provide telehealth services in support of inmate health care delivery. Telehealth may be used to facilitate care by Bureau health care providers and to connect inmates with specialty providers in the community. Facilities will prioritize the use of telehealth when clinically appropriate as a means to enhance timely access to care and to reduce security risks, staffing burdens, and transportation requirements associated with off-site medical trips when such use is consistent with sound clinical judgment. Telehealth encounters must meet applicable clinical standards, ensure inmate privacy, support continuity of care, and be appropriately documented in the inmate's EHR.

Telehealth emergency/triage services are utilized to reduce emergency community hospital trips. Implementation of this service is mandatory once the contract is available at the institution.

30. **MEDICAL REENTRY SERVICES**

Prior to the 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 health care levels 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 at least 90 days prior to an inmate's release.

The CD remains the clinical authority on medical clearance. Where the release destination has been determined, once the inmate 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 inmate 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, Health Programs and Sector Administrator of the release destination.

31. **HOUSING OTHER THAN GENERAL POPULATION**

Regardless of housing location or type, inmates must continue to receive necessary medical and mental health care consistent with this program statement and applicable Bureau policy within the constraints of the correctional environment.

Inmates may require housing outside the general population for medical, mental health, or public health reasons. The following procedures apply in these situations:

a. **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 when inmates require an immediate or long-term higher level of care. Observation beds will only provide limited increased observation services on an outpatient basis for an anticipated short period of time. This is not to be confused with Medical Director approved Short Stay Units that require 24-hour nursing care services. Health Services staff will provide coverage for inmates in the observation areas that require medical monitoring as determined by the CD.

Ordinarily, observation beds are located in the HSU. Neither 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.

- **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 gastrointestinal (GI) series, fasting purposes, etc.
  - Return to the institution from outpatient surgery to assist with post-operative care (e.g., 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 (e.g., hepatitis A, herpes zoster, etc.) requiring isolation procedures, but not the use of the negative pressure controlled Airborne Infectious Isolation Room(AIIR).
  - Routine post-operative care, such as managing indwelling catheters (e.g., status post prostate surgery) or surgical drains
  - Outpatient IV administration when applicable. Most inmates on short term intermittent IV infusions do not require medical observation status, but some may benefit from increased monitoring.

  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 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.

For each institution using observation beds, the HSA or designee will implement standard operating procedures delineating their use, consistent with this program statement. These will include:

- Designation of the physical location of observation beds
- Admission and discharge criteria for observation beds
- Frequency of evaluation by the health care provider
- Sight and sound requirements (e.g., nurse call system, visual monitoring system, or inmate companion)
- Skill level of care to be provided (e.g., inmates who need temporary assistance with activities of daily living (ADL), inmates needing short term continuous intravenous (IV) hydration, etc.)
- Supervision requirements. Local procedures will be developed to provide qualified (i.e., medical versus non-medical staff) coverage for observation rooms located in areas not already covered by staff on a continuous basis.
- 30-minute irregular rounds
- Documentation requirements
- Orientation of the inmate to life safety and fire evacuation procedures

- **Admission and Discharge.**
  - Only a physician, APP, or dental officer may authorize admission/discharge of the inmates 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 an LIP.
  - The CD (or Chief Dental Officer for dental cases) or designee will notify the Warden and other appropriate institution staff (e.g., Unit Management, Captain) of the inmate's admission to observation status and regularly advise them of the inmate's health status and monitoring recommendations.
  - Orders to place an inmate on observation status will be documented in EHR.
  - After hours, an LIP or APP may order medical observation telephonically but must evaluate the inmate in person within 12 hours. The CD will be notified the next business day.
  - A physician/LIP (e.g., Dental Officer for dental cases) or APP 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 to a community hospital in an emergency.
  - If the room is used for suicide prevention, requirements of the Program Statement **Suicide Prevention Program** apply.

- **Medical Observation Minimum Cell Standards.**
  - Rooms will be well-ventilated, adequately lighted, appropriately heated, and maintained in a sanitary condition.
  - Rooms will include a mattress, blankets, a pillow, and linens for sleeping. Inmates will receive necessary opportunities to exchange linens.
  - Rooms will have access to a wash basin and toilet. Inmates will receive personal items necessary to maintain an acceptable level of personal hygiene, for example, toilet tissue, soap, toothbrush and cleanser, shaving utensils, etc. Inmates will ordinarily have an opportunity to shower and shave at least three times per week.

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

b. **Short Stay Units (SSU).** The Medical Director may authorize the use of a SSU at a limited number of institutions, specifically those with expanded medical missions (e.g., a Care Level 3 institution). Approval takes into consideration the physical space, monitoring systems, community resources, and clinical staff availability, including 24-hour dedicated medical staffing as determined by the CD, needed to support the unit. An SSU, sometimes known as an infirmary, typically has multiple beds and is equipped to provide 24-hour medical care on a short-term basis. At least one RN will be assigned to each shift unless otherwise approved by the RMD when inmates are admitted to the SSU. If the CD determines an inmate's length of stay may exceed 90 days, they will consult with the RMD and consider alternative options (e.g., a nearby institution having the required resources, re-designation to an MRC, transfer to a contracted community facility, RIS request, etc.).

SSU's are effectively utilized to manage inmates who do not require the services of a community hospital, but who temporarily require closer monitoring than observation beds allow, including 24-hour skilled medical care.

An Institution Supplement is required for all approved SSUs. It should include the same content as required for Medical Observation Beds, including:

- Physical location of the SSU
- Admission and discharge criteria
- Frequency of evaluation, including re-assessments
- Scope of services provided, including written protocols
- Transfer of inmates 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.

SSU's will conform to the same minimum cell standards outlined above under Medical Observation Status.

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

d. **Inpatient Units (Nursing Care Centers).** Inpatient units are authorized only at MRCs. Refer to Program Statement **Medical Designations & Referral Services for Federal Prisoners** for procedures governing admission and discharge criteria and management.

e. **Outside Hospitalization.** Inmates requiring inpatient care that cannot be safely or appropriately provided within a Bureau facility may be admitted to outside hospitals or long-term care facilities. Such hospitalizations/placements must be managed in accordance with the Program Statement **Healthcare Utilization Management**, including requirements for ongoing review of medical necessity, routine communication with outside hospital (as outlined in Program Statement **Healthcare Utilization Management**), and timely discharge planning. Institutions remain responsible for coordination of care, continuity of treatment, and appropriate clinical follow-up upon the inmate's return.

f. **Alternative Restrictive Unit/Cell (Restricted from General Population).** All HSUs 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 will consider 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 an inmate is assigned to a restrictive unit/cell, HSU staff 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 health care provider (e.g., APP, RN, Paramedic) will conduct daily rounds to determine any sick call or urgent requests for care and arrange for timely evaluations as clinically indicated. Licensed Practical Nurses (LPN)/Licensed Vocational Nurses (LVN)/Medical Assistants cannot triage an inmate independently but can help in the triage process (e.g., take vital signs, gather basic medical history/chief complaint, and perform tasks per protocol or at RN/APP direction).
- The HSA will develop and implement a mechanism for inmates in restrictive units/cells to notify medical staff about their need for health care.
- An HSU health care provider will administer DOT medications at locally established intervals.
- All restrictive housing unit/cell inmate clinical encounters will be documented in the EHR.
- The HSA and CD will collaborate with the Captain to designate a weekly time frame for inmates in restrictive units/cells to access routine scheduled care, including chronic care clinics, non-urgent laboratory/radiologic testing, dental visits, etc.

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

32. **INTERAGENCY AGREEMENTS (IAA)**

Inmates or detainees housed in Bureau facilities pursuant to a MOU or IAA may be subject to medical care requirements that differ from standard Bureau policy. In such cases, the specific terms of the applicable MOU or IAA governing medical care, access to services, and authorization requirements must be followed. In the absence of provisions addressing medical care, inmates boarded under an MOU or IAA must receive health care in accordance with applicable Bureau policies and clinical guidance.

Institutions housing these inmates must be familiar with the specific language of the IAA and MOU.

33. **ORGAN DONATION BY INMATES**

a. **Living Donation.** 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. Requests for organ donation must be initiated by the inmate, authorized next of kin, or power of attorney. The Bureau will not compel an inmate to be a live or posthumous organ donor. Upon explicit desire from an inmate, the requests will be considered, but the following conditions apply:

- The medical costs of organ donation procedures, including pre-donation testing, harvesting procedure, and postoperative care are the responsibility of the organ recipient,

or responsible adult if the recipient is a minor child. Travel for the inmate donor to the medical facility where the donation will occur, by Correctional Services or guard services, and applicable costs incurred by the U.S. Marshals Service can be covered by the Bureau with approval by the Director of the Bureau.

- The inmate must sign a statement indicating the desire to donate an organ to the known recipient or organ exchange program. The consent must include the inmate:
  - Understands the risks of the surgery
  - Agrees of their own free will
  - Provides evidence that recipient inmate funds (e.g., health insurance) are available to cover pre-donation testing, harvesting procedure, and post-operative care

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:

- Name of the recipient needing organ donation
- Diagnosis causing organ failure and the specific organ needed
- Summary of the inmate donor's pertinent medical history
- Summary of inmate history – crime, sentence, projected release date (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 staff (e.g., Health Information Management staff), as appropriate.

If an inmate is appropriately designated as community custody, the inmate may request consideration for 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 authorized to donate blood or blood products (e.g., through a blood drive) with Warden approval. Bone marrow transplants may also 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 harvest of the organ(s).

b. **Posthumous Organ Donation.** 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 posthumous organ 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 only be recovered if there is a valid, legally executed advance directive or living will, or if the intent to donate is explicitly documented on the inmate's driver's license or other legally recognized government-issued identification, in accordance with applicable state and federal laws.

When posthumous organ donation is determined to be consistent with the documented wishes of the inmate or authorized decision-maker and is medically appropriate in accordance with community standards and transplant center requirements, the donation process may proceed in coordination with the appropriate organ procurement organization and transplant center, consistent with Bureau policy and applicable laws.

Facilities shall ensure their institution supplement covering serious illness, serious injury, and death includes procedures governing posthumous organ donation that comply with applicable state and federal laws, regulations, and accepted community standards of medical practice.

The Medical Director shall be notified after completion of organ recovery (harvest) for any posthumous organ donation conducted under this program statement.

Transplant surgical consultants may provide clinical recommendations regarding organ donation; however, such recommendations do not obligate the Bureau to proceed with donation.

Any circumstances not addressed by the above stipulations or institution supplement shall be referred to the Medical Director for review and determination.

34. 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 CD will determine:

- If an organ transplant is medically indicated

- See the Program Statement **Compassionate Release/Reduction in Sentence: Procedures for Implementation of 18 U.S.C. §§ 3582 and 4205(g)** for guidance in determining whether an inmate meets the criteria for RIS consideration.
- Request a transfer to a transplant capable institution (e.g., MRC)

At general population institutions, the CD will submit a 770 redesignation request for transfer to a transplant capable institution. A limited evaluation and copy of the subspecialist consultation is sufficient to support the 770 redesignation request. A more thorough medical evaluation for transplant eligibility criteria will be performed with a transplant specialist after transferring to an MRC.

The CD or designee of a transplant capable institution 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, and case management, as described in the Bureau clinical guidance on Organ Transplantation.

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. The Bureau Transplant Advisory Board membership is facilitated by the Utilization Review Section and chaired by the Chief, Health Programs. Members include the Chief, Population & Correctional Health, 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 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.

Requests for corneal transplants are reviewed in accordance with the Program Statement **Healthcare Utilization Management**.

35. 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.

36. SEXUAL ASSAULT PREVENTION AND INTERVENTION

a. **Prevention.** General training requirements for staff will comply with the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program**. As appropriate, medical personnel will refer inmates to mental health providers who have been identified as victims of:

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

b. **Intervention.** When an inmate reports being sexually assaulted, medical personnel will conduct a medical evaluation and 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 staff when requested.

The above medical evaluation is not to be confused with a forensic sexual evaluation, which can only be completed by either a Sexual Assault Nurse Examiner (SANE) or Forensic Nurse Examiner (FNE), or a Sexual Assault Forensic Examination (SAFE) clinician.

To avoid compromising medical evidence on an inmate who reports a recent sexual assault, the inmate will be transported as soon as possible 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. In these circumstances, only life-saving measures and immediate first aid will be rendered prior to transfer. All efforts will be made to avoid contaminating forensic evidence.

Institutions housing high security level inmates or having limited access to local community resources providing specialized services for sexual assault victims, may contract with a rape crisis center with on-call clinical providers (SANE, FNE, or SAFE), who can respond to the institution or nearby hospital and are credentialed to conduct a forensic sexual exam and collect all evidence.

The CD and HSA will ensure:

- There is a plan for referring inmates to nearby hospitals capable of conducting forensic sexual exams, or contractors who can respond to the institution.
- The inmate's rights must be adhered to. An inmate may not be compelled to submit to a forensic exam without explicit informed consent and may consent only to a partial examination.
- Appropriate testing and follow up for infectious disease and pregnancy is offered.
- 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 staff will document and provide treatment, as appropriate.

37. ADVANCE DIRECTIVES, LIVING WILLS, AND DO NOT RESUSCITATE (DNR) ORDERS

The Bureau remains committed to the principle of preserving and extending life. A seriously ill or dying inmate will be provided with care consistent with this goal. Emergency resuscitative measures must always be performed on an inmate who suffers cardiopulmonary arrest inside a general population institution (Care Level 1, 2, 3 institutions). However, when an inmate is at a community hospital/nursing center/skilled nursing facility, pre-existing advance directives, living wills, and/or DNR orders will be honored.

Inmates and health care providers are increasingly confronted with difficult and sensitive decisions regarding health care, including the decision to have extraordinary means of care and life support withheld and care re-directed to comfort in terminal or irreversible illness. Inmates may direct, in advance, to withhold or withdraw certain medical treatments when recovery or cure is not medically possible. 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 expediting of the inmate's death.

The inmate'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.

Inmates may appoint, in advance, proxy decision makers who will make critical health care 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 staff member.

End-of-life care authorized by the CD, or RMD or Medical Director in their absence, will continue regardless of care setting (e.g., 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 will be provided with comfort/palliative care.

a. **Implementation.** To facilitate the creation and implementation of an advance directive, each institution will develop an Institution Supplement describing local implementation procedures. 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 statutes should be attached to the Institution Supplement if available. This includes state laws addressing the non-liability of health care practitioners who implement an advance directive in good faith.
- 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.

When the seriously ill or dying inmate receives care in a community hospital or medical center, and the organization has policy and procedures regarding the involvement of next of kin, the Bureau will adhere to the following:

- The hospital will follow its established bylaws concerning seriously ill or dying inmates (e.g., implement advance directive/living will/initiating DNR orders, discontinuing mechanical life support, etc.), according to the wishes of the inmate or next of kin.
- 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.

b. **Implementation at MRC's and Care Level 3 facilities with specific 24-hour care medical units (e.g., SSU).** 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 the non-liability of health care 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 (i.e., 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 who suffers cardiopulmonary arrest at a general population institution. The CD may consult with the RMD regarding terminally ill inmates housed at facilities not providing inpatient care.
- Include that a validly executed advance directive will only be invoked and honored while the inmate is under a physician's direct care at a community health care facility, Care Level 4 facility (i.e., MRCs), or Care Level 3 facility having an approved long-term care or inpatient mission.

Community health care 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:

- 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 health care 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 their expressed request
  - Wishes of immediate family member(s) if available
  - Decisions and recommendations of other medical staff 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 inmate'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 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 two attending physicians' decision that the inmate is in terminal illness status and further medical treatment is futile. When a DNR order conflict exists between the primary care physicians and the inmate 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.

38. **SERIOUS ILLNESS OR INJURY**

Serious illness or serious injury is hereby defined as a significant change in an inmate's medical condition leading to permanent disability or death as a potential outcome.

Many unexpected hospitalizations in the Bureau meet the definition of "serious illness." HSAs and CDs should exercise clinical judgement in applying this definition to other scenarios to determine when urgent notification to the next of kin is required. The following list of potential scenarios meets this definition but is not all inclusive.

- Unresponsive inmate sent for resuscitation or evaluation (e.g., suspected overdose, suicide attempt, cardiac arrest, serious assault, etc.)
- Myocardial infarction
- Sepsis
- Stroke
- Closed head or spinal cord injuries
- Severe injuries (work related or non-work related) e.g., head trauma, chest wounds, profuse exsanguination
- Severe respiratory compromise
- Emergency Room evaluation leading to emergency surgery

The HSA will develop a Serious Illness and Serious Injury Institution Supplement that describes local procedures. If an inmate becomes seriously ill, sustains a serious injury, or requires major surgery, the Warden or designee will notify the next of kin, 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 Statements **Escapes/Deaths Notifications** and **Pretrial Inmates** for more details.

The Warden, Regional Director, and Medical Director must review and approve the Serious Illness and Serious Injury Institution Supplement.

When a seriously ill or dying inmate is in a community hospital, the Bureau retains authority

regarding administrative decisions (e.g., visitors, movement of the inmate, limits on medical services the Bureau will authorize, etc.); the hospital retains clinical authority for medical decisions (e.g., drug regimen, laboratory tests, x-rays, treatment performance, etc.).

In general, the following procedures will be implemented:

a. **Sharing medical information with the inmate.** Inmates have the right to know all of their medical diagnosis and prognosis. It is the clinician's responsibility to share this information with the inmate.

b. **Sharing medical information with the next of kin.**

- **Inmate is alert and oriented.**
  - The inmate has the right to decide with whom (e.g., friends, family, next of kin) they would like to share their relevant medical information. The inmate may notify these individuals of any changes in their medical condition, such as worsening chronic diseases, new serious illness diagnoses (e.g., cancer, heart disease, infectious diseases, etc.), or changes in medical care level that may necessitate a higher level of care or medical intervention. There are several routes of communication available including visitation, phone calls, video visits, email, and mail.
  - The inmate may elect to request copies of portions or the entire medical record to be sent to the next of kin or other outside entity provided there is a signed release of medical information completed on BP-A0621, Authorization for Release of Medical Records form.
- **Inmate is incapacitated or hospitalized.**
  - When the inmate becomes incapacitated or hospitalized, the HSA will notify the Warden or their designee and the Chaplain by phone or in person within 24 hours of learning about the inmate's serious illness or injury. A written notification will follow and briefly describe the illness or injury and, if possible, provide a prognosis. A copy of the notification will be sent to the Chaplain.
  - Notification of the next of kin is approved by the Warden, the designated staff member should make every effort to contact the inmate's next of kin within 24 hours of Warden approval utilizing form BP-A0408, Acknowledgment of Inmate, Part 3 & 4. If no contact information for next of kin is available, Unit Management will proceed with appropriate next steps in the notification process as outlined in the Program Statement **Escapes/Death Notifications**.

c. **Request for consideration of reduction in sentence (compassionate release).** When inmates are suitable candidates for early release through a 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 staff 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 and 4205(g)** to review and determine if the inmate is eligible for RIS.

d. **Visitation.** When the inmate is seriously ill or injured and hospitalized, coordination and addressing custodial or additional visitation needs, including any limitations placed on visiting, are typically coordinated by Correctional Services and Unit Management staff.

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** for additional guidance regarding visitation.

39. DEATH PROCEDURES

The HSA will develop a Death Procedures Institution Supplement that describes local procedures for legally pronouncing death and notifying the coroner or medical examiner. When an inmate is pronounced dead, the Warden or designee will also notify the U.S. Attorney's Office and, in the case of a pretrial inmate, the committing court. Refer to the Program Statements **Escapes/Deaths Notifications and Pretrial Inmates** for additional information regarding death notifications.

a. Resuscitative Efforts.

- CPR is not indicated if signs of irreversible death are present:
  - Rigor mortis – stiffness of the limbs and body that develops two to four hours after death and may take up to 12 hours to fully develop
  - Dependent lividity – reddish-blue discoloration of the skin resulting from the gravitational pooling of blood in the lower lying parts of the body in the position of death
  - Decapitation – separation of the head from the body
  - Transection – division by cutting across the body
  - Decomposition – decay
- If CPR is initiated and any of the above indications of irreversible death are present as determined by a Bureau RN, APP, or physician, CPR may be stopped. Immediately notify the institution CD or physician and Lieutenant for further action.
- CPR is to be initiated and continued in all other circumstances until Emergency Medical Services (EMS [i.e., community EMT or paramedic]) arrive on scene.
- Upon pronouncement of death by community EMS or a Bureau physician, all resuscitative efforts are to immediately stop.

b. **Pronouncement of death in accordance with state law.** In the Bureau, only a physician is authorized to pronounce death after an in-person physical exam. When an inmate is found pulseless or without signs of life, community EMS must be activated. After resuscitation efforts are attempted and fail, responding EMS personnel are also authorized to pronounce death, after communication with their medical command.

Whether the death occurred onsite, or at an outside hospital or medical center, the CD or designee will write a final EHR administrative note, that will detail a brief inmate medical history, the circumstances leading up to the death, and emergency response. This note is in addition to the final clinical encounter documenting the actual emergency response if it involved health services clinicians.

c. **Notification.** The HSA and CD will be responsible for notifying the Warden and submitting the 24-hour Death Notification. The components of the 24-hour death report are detailed in Program Statement **Health Services Quality Improvement.**

- The Warden or their designee will notify the inmate's next of kin within 24 hours utilizing form BP-A0408, Acknowledgment of Inmate, Part 3 & 4. This responsibility may default to the Institution Duty Officer after the regular workday, as well as on weekends and holidays. If no contact information for next of kin is available, Unit Management will proceed with appropriate next steps in the notification process as outlined in the Program Statement **Escapes/Death Notifications**.
- Notification will be made to the coroner or medical examiner in accordance with the Program Statement **Autopsies**. The HSA or designee will develop standard 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

d. **Autopsies/post-mortem testing.** For information regarding authorization for autopsies and/or post-mortem pathology/toxicology, see Program Statement **Autopsies**. Institutions will be familiar with and adhere to state laws on this topic. Where issues are identified in coordinating these services with local experts (coroners/medical examiners), the institution will seek input from local or regional Bureau counsel to ensure both compliance with state laws and protection of federal interests.

40. INMATE RIGHTS AND RESPONBILITIES

a. **Privacy.** Staff 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, staff, and institution.

The inmate's right to privacy extends to receiving care in their native language to the extent possible. Where a health care provider is not proficient in the inmate's language, a language translation service (e.g., telephonic, computer-based, etc.) should be utilized. Except in rare circumstances when no staff are available to translate, inmates will not be used as interpreters, even with the inmate's consent.

b. **Access to Medical Records.** Inmates may request a copy of their immunization record through procedures outlined in the Program Statement **Health Information Management**.

c. **Chaperones.** Chaperones will be made available during sensitive physical examinations, including anytime a female inmate is in a state of undress as part of a medical evaluation (e.g., breast exam, pelvic exam, etc.). Chaperones will additionally be used for safety when a disruptive inmate is being examined, and/or at a health care provider's request. For sensitive examinations, the sex of the inmate should be taken into consideration when requesting a chaperone. If HSU staff are unable to secure a preferred-sex chaperone, the appointment may be rescheduled if clinically appropriate. For circumstances where rescheduling may cause delay in care, poor outcomes or harm, HSU staff will be mindful of the sex of the inmate, but the examination may proceed with the available chaperone regardless of sex.

d. **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 health care personnel will perform the cavity search.

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

If radiographic examination is determined to be 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. If contraband is confirmed (e.g., balloons of heroin in the GI tract), the physician is to proceed with serial radiographs and any other intervention to minimize the risk of a poor outcome for the inmate.

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

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

When an inmate refuses recommended diagnostic testing, counseling, or treatment, clinicians document the refusal in the EHR, complete a BP-A0358, Medical Treatment Refusal form. At a minimum, refusals should be obtained any time the inmate refuses preventive health care (e.g., screening tests, labs, immunizations, etc.), CCC treatment plans, consultations for inhouse or community specialists, telehealth visits, or medication refusal. The refusal form is signed by the inmate and the witnessing staff and scanned into the EHR. If an inmate refuses care, and the clinician determines 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 from reconsidering their 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 EHR (e.g., delay in accepting recommended treatment for cancer affects the efficacy of the treatment).

If the inmate refuses to sign, two staff 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 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 (e.g., refusal of insulin by an inmate with Type I Diabetes).
- 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 Statement **Psychiatric Evaluation and Treatment**.

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

Diagnostic procedures related to potentially communicable disease may be mandatory for the protection of the inmate, other inmates, and staff. 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.

The inmate'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.

41. **EXPERIMENTATION, PHARMACEUTICAL TESTING, AND CLINICAL TRIALS**

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

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 a subspecialist (e.g., oncologist), the CD, and approved by the Medical Director.

Clinical trials can be the last option an inmate has in receiving treatment for a serious condition. Clinical trials are designed by a team of professionals, including clinical investigators, biostatisticians, and regulatory experts who ensure compliance with ethical standards and regulatory requirements. 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 registered by the National Institutes of Health database and conducted according to the standards for the protection of human subjects. If there are questions about the legitimacy of a clinical trial, contact the Medical Director's office and the Bureau's Research Review Board. Refer to the Program Statement **Research** for additional information.

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

REFERENCES

Program Statements
Autopsies
Compassionate Release/Reduction in Sentence: Procedures for Implementation of 18 U.S.C. §§ 3582 and 4205(g)
Dental Services
Employee Development Manual
Escapes/Deaths Notifications
Female Offender Manual
Food Service Manual
Health Care Credential and Privileging Program
Healthcare Utilization Management
Health Information Management
Health Services Administration
Health Services Quality Improvement
Infection Prevention and Control
Inmate Copayment Program
Inmate Furloughs
Inmate Personal Property
Ion Spectrometry Device Program
Management of Inmates With Disabilities
Medical Designations and Referral Services for Federal Prisoners
Narcotic Identification, Inmate Urine and Alcohol Surveillance and Testing Program
Occupational Safety
Pharmacy Services
Pretrial Inmates
Psychiatric Evaluation and Treatment
Psychology Services Manual
Research
Searches of Housing Units, Inmates, and Inmate Work Areas
Sexually Abusive Behavior Prevention and Intervention Program
Suicide Prevention Program
Treatment and Care of Inmates With Mental Illness
Use of Force, Application of Restraints, and Firearms
Visiting Regulations
Whole Body Imaging

Bureau Forms
BP-A0358 Medical Treatment Refusal
BP-A0408 Acknowledgment of Inmate, Part 3 & 4
BP-A0621 Authorization for Release of Medical Records

BP-A0770 Medical/Surgical and Psychiatric Referral Request

Other Forms

OF-522	Medical Record – Request for Administration of Anesthesia and for Performance of Operations and Other Procedures
OSHA Form 300	Log of Work-Related Injuries and Illnesses

ACA Standards

Performance-Based Standards and Expected Practices for Adult Correctional Institutions (5th Edition): 5-ACI-5C-11M, 5-ACI-6A-01M, 5-ACI-6A-03, 5-ACI-6A-04, 5-ACI-6A-05, 5-ACI-6A-06, 5-ACI-6A-07,5-ACI-6A-08M, 5-ACI-6A-09, 5-ACI-6A-10M, 5-ACI-6A-12M, 5-ACI-6A-18M, 5-ACI-6A-19, 5-ACI-6A-19-1, 5-ACI-6A-21M, 5-ACI-6A-22M, 5-ACI-6A-25M, 5-ACI-6A-27, 5-ACI-6A-31M, 5-ACI-6A-37, 5-ACI-6A-40, 5-ACI-6A-42, 5-ACI-6B-01M, 5-ACI-6B-02M, 5-ACI-6B-03M, 5-ACI-6B-08M, 5-ACI-6C-04M, 5-ACI-6C-05, 5-ACI-4A-01M, 5-AC-6C-08M, 5-ACI-6C-09M, 5-ACI-6D-04, 5-ACI-2A-03

Performance-Based Standards and Expected Practices for Adult Local Detention Facilities (5th Edition): 5-ALDF-2E-02, 5-ALDF-4A-13M, 5-ALDF-4C-01M, 5-ALDF-4C-03, 5-ALDF-4C-04, 5-ALDF-4C-05, 5-ALDF-4C-06, 5-ALDF-4C-08M, 5-ALDF-4C-09, 5-ALDF-4C-13M, 5-ALDF-4C-19M, 5-ALDF-4C-20, 5-ALDF-4C-21, 5-ALDF-4C-23M, 5-ALDF-4C-24M, 5-ALDF-4C-25M, 5-ALDF-4C-26, 5-ALDF-4C-27M, 5-ADLF-4C-28M, 5-ALDF-4C-33, 5-ALDF-4C-34, 5-ALDF-4C-36, 5-ALDF-4D-01M, 5-ALDF-4D-02M, 5-ALDF-4D-03M, 5-ALDF-4D-15M, 5-ALDF-4D-16, 5-ALDF-4D-17M, 5-ALDF-4D-18M

Standards for Administration of Correctional Agencies, 2nd Edition: 2-CO-1F-14, 2-CO-4E-01

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) on the Bureau's intranet site.