Preventive Health Care

Federal Bureau of Prisons

Clinical Practice Guidelines

August 2012

What's New in the Document?

Revisions since the April 2007 version of the BOP Clinical Practice Guidelines for *Preventive Health Care* are outlined below—including those in the current July 2012 guidelines and those that were in the July 2011, December 2010, and April 2009 versions. Except where otherwise noted, these changes are primarily based on updated guidance from the U.S. Preventive Services Task Force (USPSTF).

July 2012 Revisions:

The following changes are new, and are highlighted in yellow throughout the guidelines:

Mammogram screening: Biennial mammogram screening is recommended from age 40 years for women with increased risk for breast cancer, and from ages 50 through 74 years for women with average risk.

Osteoporosis screening: The following intervals are recommended for bone mineral density (BMD) screening in women:

- Normal BMD (T score of 1.00 or higher) or mild osteopenia (T score of 1.01 to -1.49) → screen every 15 years
- Moderate osteopenia (T score of -1.50 to -1.99) on BMD testing → screen every 5 years
- Advanced osteopenia (T score of -2.00 to -2.49) on BMD testing → screen every year

Cervical cancer screening: Recommendations for cervical cancer screening are as follows:

- Women ages 21–65 years → screen every 3 years with cytology (Pap smear), without human papillomavirus (HPV) testing
- Women ages 30–65 years → screen with cytology every 3 years or combination of cytology and HPV testing every 5 years

Tdap vaccine: It is recommended that pregnant women receive a tetanus, diphtheria, and acellular pertussis (Tdap) booster, preferably after 20 weeks of gestation, to protect infants from pertussis via transfer of protective maternal antibodies. It is also recommended that all inmates who have never received the Tdap vaccine be administered a one-time Tdap dose at the baseline visit.

Hepatitits B vaccine: Hepatitis B vaccination is recommended for adults with diabetes who are younger than age 60 years.

Oral cancer screening: It is recommended that clinicians conduct oral cancer screening by directly inspecting and palpating the oral cavity in adults age > 55 who have a history of HPV, sun exposure, alcohol and tobacco use.

July 2011 Revisions:

The following changes are new, and are highlighted in yellow throughout the guidelines:

- **Osteoporosis screening:** Recommendations for screening have been extended to women younger than age 65 whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.
- **MMR vaccine:** It is recommended that a pregnancy test be given at intake to women of child-bearing age who report never having received the MMR vaccine as an adult, prior to administering the vaccine.
- **Tdap vaccine:** There is no longer an upper age limit for the use of the Tdap (Tetanus-Diptheria-Pertussis) vaccine.

December 2010 Revisions:

The following changes were new to the 2010 version of the guidelines:

- **Diabetes screening:** Hemoglobin A1C testing now may be used for both screening and diagnosing diabetes, with a cut point of ≥6.5% being diagnostic for diabetes. The BOP recommendations have been changed to align with the American Diabetes Association's *Standards of Medical Care in Diabetes – 2010*.
- **Hepatitis B screening:** Several different screening strategies have been recommended, depending upon the clinical context and goal for screening, such as pre-vaccination screening and screening to detect chronic HBV. Various serologic markers, alone or in combination, have been proposed for this purpose, including: anti-HBc alone or in combination with HBsAg, and HBsAg alone or in combination with anti-HBs. For the purpose of screening federal inmates for HBV infection, the combination of HBsAg and anti-HBs should be performed. Additional HBV serologic tests may be warranted depending on the inmate's medical history. The BOP recommendations have been changed to align with the latest recommendations from the Centers for Disease Control and Prevention.
- **Folic acid:** All females of child-bearing age should be counseled to consider taking folic acid, which they can purchase as an OTC drug through the commissary.
- **Vision acuity in older adults:** Vision screening in older adults is not effective in identifying common pathologies and is not routinely recommended.

April 2009 Revisions:

The following changes were issued in the 2009 guidelines:

- **HIV screening:** Routinely encourage HIV testing for all sentenced inmates who have not been previously tested in the BOP.
- **Colorectal cancer screening:** BOP and USPSTF recommend fecal occult blood testing (FOBT) for average risk persons, beginning at age 50. It is emphasized that three FOBTs annually are necessary to achieve adequate sensitivity for cancer screening. Routine screening for colorectal cancer screening should cease at age 75. Updated American Cancer Society/American Gastroenterological Association guidelines for screening persons who are at increased risk for colorectal cancer are included in the current document.
- **Diabetes screening:** The USPSTF has concluded that there is only one group of asymptomatic, individuals for whom routine diabetes screening is warranted: those with a blood pressure greater than 135/80 (treated or untreated). Screening should also be performed as clinically warranted, including for hyperlipidemia, cardiovascular disease, peripheral vascular disease, history of gestational diabetes, or history of polycystic ovary disease.
- **Blood pressure screening:** Inmates with borderline blood pressure elevations (systolic 120–139; diastolic 80–90) should be screened annually.
- **Screening for lipid disorders:** Routine screening of average-risk women is no longer recommended.
- **Aspirin for CVD prevention:** Risk-based guidance is provided on whether or not to recommend aspirin, based on the risk of CVD in men and the risk of stroke in women, as compared against the risk of gastrointestinal hemorrhage. For men, calculate the 10-year risk of CVD every 5 years, beginning at age 45. For women, calculate the 10-year risk of stroke every 5 years, beginning at age 55. Links to risk calculators are provided in this document. (Please see the BOP *Management of*

Diabetes Clinical Practice Guidelines for recommendations about treating diabetic inmates with aspirin.)

Risk Level at Which Prevented CVD Events ("Benefit") Exceed GI Harms

Men: 10-year CHD risk	Women: 10-year stroke risk
Age 45–59 years ≥4%	Age 55–59 years ≥3%
Age 60–69 years ≥9%	Age 60–69 years ≥8%
Age 70–79 years ≥12%	Age 70–79 years ≥11%

- **Pneumococcal vaccine** is no longer recommended routinely for Native Americans/Alaskan Natives. Pneumococcal vaccine is now recommended for inmates with asthma, cerebrospinal fluid leaks, or chronic alcoholism, and those who are long-term care residents. For inmates with newly diagnosed HIV-infection, pneumococcal vaccine should be administered as close as possible to the time of diagnosis.
- **Meningococcal vaccine** is recommended for inmates with asplenia, i.e., sickle cell disease.

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Appendices

1. Purpose

The Federal Bureau of Prisons (BOP) clinical practice guidelines for preventive health care outline health maintenance recommendations for federal inmates.

These preventive health guidelines *do not cover* diagnostic testing or medical treatments that might be indicated by a patient's signs and symptoms. These guidelines also *do not preclude* patient-specific screenings based on medical histories and evaluations.

2. Preventive Health Care Overview

Based on the recommendations of the U.S. Preventive Services Task Force (USPSTF), the BOP defines a scope of preventive health care services for inmates that incorporates targeted patient counseling and immunizations, as well as screening for infectious diseases, cancer, and chronic diseases. The BOP preventive health care program deviates from USPSTF recommendations only when the risk characteristics of the BOP inmate population suggest an alternative approach. The BOP preventive health care program includes the following components:

- A health care delivery system that uses a multi-disciplinary team approach, with specific duties assigned to each team member.
- An emphasis on the inmate's responsibility for improving his or her own health status and seeking preventive services.
- Prioritization of inmates who are at high risk for specific health problems.
- Recognition that routine physical examinations are not a recommended component of a preventive health care program.

3. Preventive Health Care Scope of Services

Intake

Newly incarcerated inmates are screened for conditions that warrant prompt intervention: contagious diseases, active substance abuse, chronic diseases, and mental illness. Intake screening and prevention parameters are outlined in *Appendix 1* (*Preventive Health Care – Intake Parameters*) and are governed by current BOP policy.

- **Tuberculosis (TB):**
  - **Symptom screening** for TB disease should be considered a public health priority and should be conducted universally, by a trained health care provider, for all newly incarcerated inmates.
  - **Tuberculin skin testing** should be performed on all inmates within 48 hours of intake, except for those with documentation of a prior positive TST (in millimeters), those who have a credible history of being treated for latent TB infection or active TB disease, or those who report history of a severe reaction to a TST (e.g., swollen, blistering).
  - **Chest radiographs** should be performed for inmates with a positive TST. All HIV-infected inmates should have a CXR performed at intake, in addition to their intake TB symptom screen and TST. Routine screening chest radiographs are also now

recommended for foreign-born inmates who have been in the United States for one year or less and have no documentation of a chest radiograph obtained in the U.S. This screening guideline also applies to inmates who have been out of the U.S. or Canada for six months or more prior to incarceration in the Bureau of Prisons.

In facilities that house inmates with a high incidence of TB, it may be appropriate to conduct routine CXR screening of all inmates entering the prison. Decisions about the use of routine CXR screening should be made in consultation with the Warden and the HSD staff from the Regional and Central Offices.

- **Sexually transmitted disease (STD):** Screening for STDs is based on age, gender, and patient-specific risk factors (see *Appendix 1*).
  - **Female inmates:** Syphilis screening should be conducted universally. Chlamydia screening should be conducted for all women less than age 25, and for other women with identified risk factors.
  - **Male inmates:** Syphilis screening should be provided if the inmate reports risk factors for syphilis. However, Clinical Directors should consider universal syphilis screening for males if the inmate population is drawn from communities where syphilis is hyperendemic, e.g., certain large urban areas.
- **Immunizations:** Immunizations ordinarily are not recommended at the time of intake, except for the measles-mumps-rubella (MMR) vaccine for all women of child-bearing age who report that they have never received the vaccine as an adult. *In such cases, the women should first be tested for pregnancy.*

Prevention Baseline Visit

A prevention baseline visit should be conducted for all sentenced inmates within six months of incarceration. At the discretion of the Clinical Director and Health Services Administrator, the prevention baseline visit may be either incorporated into the intake physical examination or scheduled later as a separate visit.

The primary purpose of the prevention baseline visit is to assess the inmate's risk factors and identify the need for and frequency of recommended preventive health measures, as outlined in *Appendix 2* (*Preventive Health Care Scope of Services*) and *Appendix 3* (*Preventive Health Care Guidelines by Disease State*). **All inmates should be advised of the preventive health measures that are provided by the BOP, as well as their responsibility for seeking these services.** A plan should be developed with the inmate for accessing recommended preventive health services.

The following preventive measures should be provided in accordance with the specific indications outlined in *Appendix 2*:

- Completing a preventive health risk assessment and developing a plan with the inmate for delivery of follow-up preventive health services.
- Immunizing against tetanus-diphtheria-pertussis, pneumococcal pneumonia, hepatitis A, hepatitis B, measles-mumps-rubella, and influenza (as seasonally appropriate).

- HIV testing should be offered to all sentenced inmates, regardless of risk factor history. HIV testing for sentenced inmates with HIV risk factors is considered mandatory per BOP policy.
- Screening for HBV and HCV infections in asymptomatic inmates is based on the presence of risk factors or upon inmate request.

Prevention Periodic Visits

Periodic visits to review the inmate's need for and receipt of preventive health care services are recommended at least at the following intervals:

- **Every three years, for sentenced inmates under age 50** (with the exception of annual tuberculin skin tests, annual influenza vaccinations for certain inmates, and annual audiograms for inmates at occupational risk).
- **Annually, for inmates 50 years of age and older.**

The frequency of monitoring inmates should be patient-specific, and adjusted as clinically necessary to monitor significant changes in a parameter such as weight or blood pressure.

The following screening parameters should be included in periodic preventive health care visits, as outlined in *Appendix 2* (*Preventive Health Care Scope of Services*) and *Appendix 3* (*Preventive Health Care Guidelines by Disease State*):

- Counsel regarding nutrition, exercise, substance abuse, and infectious disease transmission.
- Measure weight and BMI (schedule reevaluation based on trend).
- Measure blood pressure (schedule reevaluation based on trend).
- Screen for latent TB infection with annual tuberculin skin test (unless previously positive).
- Screen for hearing loss with annual audiograms for those at occupational risk.
- Screen for breast, cervical, and colon cancers per established parameters and clinical indications.
- Screen for cardiovascular risk (aspirin need), diabetes, and hypercholesterolemia per criteria.
- Screen for osteoporosis in females 65 years of age and older, and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.
- Screen for oral cancer screening by directly inspecting and palpating the oral cavity in adults who are older than 55 have a history of HPV, sun exposure, alcohol, and tobacco use.
- Screen for abdominal aortic aneurysms in male smokers 65 to 75 years of age.

Universal screening for certain diseases (e.g., glaucoma, ovarian and prostate cancer) is not recommended, due to a lack of evidenced-based data. However, screening for these diseases may be indicated for certain inmates, based on specific risk factors or clinical concerns. Decisions regarding screening for such conditions should be patient-specific.

4. Preventive Health Care Delivery

The delivery of preventive health care services is a shared responsibility between the inmate and the BOP health care team.

- Inmates should be provided information on available preventive services, as outlined on the *Inmate Fact Sheets* (see *Appendices* 4a and 4b), and should be counseled about their responsibility to seek these services.
- All members of the health care team should take part in preventive health care in some capacity, under the collaborative leadership of the Health Services Administrator and the Clinical Director. Specific assignments are determined locally, based on staffing mix, staff skill sets, and logistical factors. *Appendix 5* (*Staff Roles for Preventive Health Care Delivery*) outlines how different categories of staff can be utilized in implementing the preventive health program.
- Additionally, inmate education and preventive services can be delivered, in part, through ancillary means such as group counseling, educational videotapes, and health fairs conducted by volunteers and community-based organizations.

5. Preventive Health Care Program Evaluation

Health Services Administrators, Clinical Directors, and Director of Nursing (at MRCs) should develop local protocol outlining the implementation of their preventive healthcare program. The preventive health care programs should be evaluated through the local IOP programs. Applicable evaluation strategies include, but are not limited to:

- **Assessing process measures** such as the proportion of inmates who were eligible for a certain health screen and were screened, e.g., proportion of eligible, female inmates who are screened for breast cancer within the recommended time frames.
- **Assessing outcome measures such as the proportion of asymptomatic inmates who were screened for a certain condition** and were diagnosed with it, e.g., proportion of those screened with a fasting blood glucose who were diagnosed with diabetes.
- **Conducting case studies of inmates who were priority candidates** for preventive services, i.e., inmates who were at high risk for a certain condition, but were not evaluated for the condition.
- **Conducting case studies of inmates who were diagnosed clinically, rather than by preventive screening,** or who had a negative clinical outcome related to a preventive measure that was not conducted, e.g., an inmate with hypertension who suffered a myocardial infarction and in the process was diagnosed with diabetes (even though the individual should have been a candidate for an earlier diabetes screening).

Appendix 1. Preventive Health Care – Intake Parameters

All Inmates	
Detoxification	Assess need for detoxification at intake health screen.
TB Symptom Screen	At intake, a health care professional should ask all inmates about a history of tuberculosis and presence of the following symptoms: • Blood tinged sputum • Night sweats • Weight loss • Fever • Cough Inmates who have symptoms suggestive of TB disease should receive a thorough medical evaluation, including a TST, a chest radiograph, and, if indicated, a sputum examination. If TB is suspected, they should be immediately told to wear a surgical mask and placed in a low traffic area until they can be isolated in an airborne infection isolation (AII) room.
Tuberculin Skin Test (TST)	Place TST within 48 hours of intake for all inmates *except* those with a credible history of being treated for latent TB infection (TLTBI) or TB disease, or a history of severe reaction to tuberculin. Ignore BCG history. Consider 2-step test for inmates who are foreign-born.
Chest Radiograph (CXR)	Obtain intake screening CXR for HIV-infected inmates. Also obtain screening CXR for foreign-born inmates who have been in the United States for one year or less, and for whom there is no documentation of a chest radiograph obtained in the U.S. This screening guideline also applies to inmates who have been out of the U.S. or Canada for six months or more prior to incarceration in the BOP.
Vision	Visual acuity testing with a Snellen eye chart at the intake physical.
Female Inmates	
Syphilis	RPR for all females.
Chlamydia	Nucleic acid amplification test (NAAT) from urine or cervical swab for females who fall into *any* of the following categories: • Are age 25 and under. • Have HIV infection. • Have a history of syphilis, gonorrhea, or chlamydia.
Cervical Cancer	PAP smear at intake physical.
MMR Vaccine	Measles-mumps-rubella (MMR) vaccine at intake for all child-bearing age women who report never having received MMR as an adult. The women should be tested for pregnancy prior to administering the vaccine.
Male Inmates	
Syphilis*	RPR for all males who fall into *any* of the following categories: • Have had sex with another man. • Are HIV infected. • Have a history of syphilis, gonorrhea, or chlamydia.
***** Consider universal syphilis screening for male inmates from endemic areas.	

Appendix 2. Federal Bureau of Prisons – Preventive Health Care Scope of Services for Sentenced Inmates

This 2-page chart provides an overview of preventive health services to be offered to *sentenced* inmates, based on age, sex, and identified risk factors. This chart does not include intake preventive health measures (see *Appendix 1* for these). An asterisk (*****) in this table indicates that more detail on risk factors and specific screening tests can be obtained from *Appendix 3*. These guidelines do not cover testing indicated by clinical signs and symptoms; nor do they preclude patient-specific screening based on medical history and evaluation.

Screening	Recommended Age Groups												Tests / Schedule/ Risk Factors
	15	20	25	30	35	40	45	50	55	60	65	70	
Prevention Visit	**Every 3 years**							**Every year**					**Prevention baseline visit:** Within 6 months of intake. **Periodic prevention visit: Under age 50**, every 3 years; **Age 50+**, annually. Review risk factors and needed screening tests; provide inmate counseling; obtain blood pressure and weight. If BMI is 30 kg/m^2 or greater, provide nutrition/exercise counseling. Calculate BMI: http://www.cdc.gov/healthyweight/assessing/bmi/index.html
Hepatitis B Viral Infection	**Risk-factor based**												**HBsAg and anti-HBs. Risk-factor based*:** Hepatitis B vaccination recommended for adults with diabetes younger than age 60. Ever injected illegal drugs, received tattoos or body piercings while in jail, history of STD, males who have had sex w/ males, HIV or HCV infection, from high-risk country, on chronic hemodialysis or immunosuppressants, etc.
Hepatitis C Viral Infection	**Risk-factor based**												**Anti-HCV. Risk-factor based*:** Ever injected illegal drugs, received tattoos or body piercings while in jail, HIV or HBV infection, blood transfusion (before 1992), ever on hemodialysis, etc.
HIV Infection	**Offer HIV testing to all sentenced inmates. HIV testing is mandatory for sentenced inmates with HIV risk factors.**												**HIV EIA. Risk factors*:** Injected illegal drugs, unprotected sex w/ multiple partners or w/ persons at risk for HIV, males who have had sex w/ males, history of STD, from sub-Saharan/W. Africa, hemophiliac, received blood products (1977–85), etc.
TB	**Annual tuberculin skin test (TST); chest x-ray (CXR) only for specific groups.**												**Annual TST** unless documented prior TST(+). **CXRs** (see *Appendix 3* for detail): **Baseline CXR only:** If TST (+). **Semi-annual CXR indefinitely:** If HIV (+) and either TST (+) or a close contact to an active TB case (regardless of TST result), and have not completed TLTBI. **Semi-annual CXR x 2 years:** If HIV (-) & TST (+) and either recent TST convertor or close contact of an active TB case and have not completed TLTBI.
Breast Cancer						**High risk: every 2 years**		**Average risk: every 2 years**					**Mammogram. High risk** (see *Appendix 3*)**:** Biennial mammogram screening beginning at age 40. **Avg risk:** Biennial mammogram screening from ages 50 to 74.
Cervical Cancer		**Every 3 years**		**Every 3 years (with HPV testing, extend screening to every 5 years)**									**Pap smear. Age 21-65:** At intake & every 3 years – Pap smear without HPV testing. **Ages 30–65:** At intake & every 5 years if screened with combination of Pap smear and HPV testing.
Colorectal Cancer	**Risk-factor based**							**Annual FOBT (x3)**					**Fecal occult blood test (FOBT), 3 consecutive. Average risk:** Annually, begin at age 50. Three tests are required for adequate sensitivity. Stop routine screening at age 75. **Higher risk:** Follow American Cancer Society recommendations (see *Appendix 3*).

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Appendix 2. Federal Bureau of PrisonsCPreventive Health Care Scope of Services for Sentenced Inmates *(continued from previous page)*

Screening		15	20	25	30	35	40	45	50	55	60	65	70	Tests / Schedule / Risk Factors
Aspirin for CVD Risk Factors	♂							**Calculate 10-year CVD risk every 5 years.**						**Males, ages 45–79:** Calculate 10-year CVD risk every 5 years. Risk calculator: http://www.mcw.edu/calculators/CoronaryHeartDiseaseRisk.htm **Females, ages 55–79:** Calculate 10-year risk of stroke. Risk calculator: http://www.westernstroke.org/index.php?header_name=stroke_tools.gif&main=stroke_tools.php **Recommend aspirin 81 mg daily if risk exceeds the following:*** **Men, if 10-year CVD risk:** Ages 45–59 (≥4%); ages 60–69 (≥9%); ages70–79 (≥12%) **Female, if 10-yr stroke risk:** Ages 55–59 (≥3%); ages 60–69 (≥8%); ages 70–79(≥11%) ➔For patients with diabetes, see BOP *Management of Diabetes* Clinical Practice Guidelines.
	♀									**Calculate 10-year stroke risk q 5 yrs.**				
Diabetes (Type II)		**High risk (BP>135/80): Every 3 years**												**Fasting serum glucose or hemoglobin A1C. High Risk:** Screen every 3 years if blood pressure is >135/80 (treated or untreated).
Hearing		**If occupational risk: Baseline & annual**										**Annual**		**Occupational Risk:** Annual audiogram. **Age 65+:** Ask about hearing annually.
Lipid Disorders	♂	**Risk-factor based**				**Average risk: Every 5 years**								**Avg-risk males:** Beginning at age 35, screen every 5 years (total chol & HDL). **Avg-risk females:** No routine screening. **If DM, CVD, or PVD:** Beginning at age 20, perform lipoprotein analysis annually. **If other risk factors** *(has relative with CVD disease–male under age 50 or female under age 60; or has multiple CVD risk factors, e.g., tobacco & hypertension)***:** Beginning at age 20, screen every 5 years (total chol & HDL).
	♀	**Average risk: No routine screening**												
		Risk-factor based												
Substance Abuse		**Risk-factor based**												**Assessment of substance abuse history** *(including tobacco)***:** Provide substance abuse counseling and referral as needed.
Folic Acid		**Women of child-bearing age**												**Women capable of pregnancy:** Recommend 400–800 µg daily, OTC through commissary.

Vaccine	Vaccine/Indications
Tetanus-Diptheria-Pertussis	**Booster every 10 years:** Administer a one-time Tdap dose instead of the Td dose; thereafter, Td boosters every 10 years. **If incomplete or unknown vaccination history:** Administer 3-dose series, including a one-time dose of Tdap (preferably as the initial dose) and 2 doses of Td. For wound management, see BOP guidelines on *Medical Management of Exposures*. For issues related to pregnancy, see *Appendix 3*.
Influenza	**Age 50 or older or if risk factors:** Administer annually. See *Appendix 3* for list of risk factors.
Pneumococcal	**Age 65 or older:** Administer once.* **Risk-factor based*:** Administer once regardless of age for certain chronic medical conditions such as chronic lung disease (including asthma), chronic CVD, immunocompromising conditions, chemotherapy or long-term systemic corticosteroids, diabetes mellitus, chronic liver diseases, cirrhosis, chronic renal failure or nephrotic syndrome, functional or anatomic asplenia, cochlear implants, CSF leaks, chronic alcoholism, or in long term care. **For certain risk factors:** Repeat in 5 years (see *Appendix 3* for list of risk factors).
Hepatitis A	**Risk-factor based*:** Men who have sex with men, users of injection illegal drugs, liver disease or cirrhosis, recipients of clotting factor concentrates.
Hepatitis B	**Risk-factor based*:** Recommended for adults with diabetes younger than age 60. Other clinical conditions include cirrhosis or liver disease, HIV infection (with HBV risk factors), HCV infection (prioritized for those with evidence of liver disease), injection drug use, men who have sex with men, recent history of an STD, inmate workers at risk for bloodborne pathogen exposure, hemodialysis patients, end-stage renal disease, post-exposure prophylaxis, contacts to inmates with acute hepatitis.
MMR	**If born after 1956, previously vaccinated, but no history of MMR as an adult:** Administer 1 dose (booster). **If born after 1956 and vaccination history is incomplete/unknown:** Administer 2-dose series. ***Women of childbearing age without evidence of immunity are high priority for MMR vaccine, but should first be tested for pregnancy.***

*** See *Appendix 3* for more complete information.**

Abbreviations: ♂=male, ♀=female, **Anti-HCV**=HCV antibody, **BMI**=body mass index, **chol**=cholesterol, **CVD**=cardiovascular disease, **DM**=diabetes mellitus, **EIA**=enzyme immunoassay, **HBV**=hepatitis B virus, **HBsAg**=hepatitis B surface antigen, **HCV**=hepatitis C virus, **NAAT**=nucleic acid amplification test, **PVD**=peripheral vascular disease, **STD**=sexually transmitted disease, **TLTBI**=treatment of latent TB infection

Appendix 3. Preventive Health Care Guidelines by Disease State

Throughout most of this chart, recommendations regarding health screenings and vaccinations are displayed in the third column. These recommendations are based on age, sex, and the risk factors that are listed in the middle column. The first column indicates: the disease or condition, whether the recommendation applies to *all* inmates or only those who are *sentenced* (unless modified in the middle column), and the source of the recommendation.

Source Abbreviations: ***ACS****=American Cancer Society,* ***ACIP****=Advisory Committee on Immunization Practices,* ***ADA****=American Diabetes Association,* ***BOP****=Bureau of Prisons,* ***CDC****=Centers for Disease Control and Prevention,* ***CDC-DQ****=CDC Division of Global Migration and Quarantine,* ***USPSTF****=United States Preventive Services Task Force,* ***AGA*** *= American Gastroenterological Association*

A. Infectious Disease Screening

Disease/Source	Risk Factors Indicating Screening	Screening Test/Guideline
Hepatitis B Viral Infection *Sentenced* BOP, CDC	• ever injected illegal drugs and shared equipment • received tattoos or body piercings while in jail or prison • males who have had sex with another man • history of chlamydia, gonorrhea, or syphilis • HIV infected • HCV infected • from high risk country in Africa, Eastern Europe, Western Pacific, or Asia (except Japan) • history of percutaneous exposure to blood • on chronic hemodialysis and failed to develop antibodies after 2 series of vaccinations (screen monthly) (*all*) • planned immunosuppressant therapy, e.g. chemotherapy, anti-tumor necrosis factor alfa agents, organ transplant recipient • pregnancy (*all*)	**HBsAg and anti-HBs** **At baseline prevention visit:** If HBV risk factors are identified, HBsAg and anti-HBs testing is recommended. If inmate is pregnant, test for HBsAg immediately.
Hepatitis C Viral Infection *Sentenced* BOP, CDC	• ever injected illegal drugs and shared equipment • received tattoos or body piercings while in jail or prison • HIV infected • HBV infected (chronic) • received blood transfusion/organ transplant before 1992 • received clotting factor transfusion prior to 1987 • percutaneous exposure to blood (*all*) • ever on hemodialysis (if currently, screen semiannually)	**Anti-HCV** **At baseline prevention visit:** If HCV risk factors are identified, recommend testing for anti-HCV.
HIV-1 *Sentenced* BOP, Federal Law	**HIV risk factors:** • ever injected illegal drugs and shared equipment • males who have had sex with another man • had unprotected intercourse with a person with known or suspected HIV infection or multiple sexual partners • history of chlamydia, gonorrhea, or syphilis • from a high risk country (in Sub-Saharan or West Africa) • hemophiliac or received blood products (1977–1985) • percutaneous exposure to blood (*all*) • diagnosis of active TB (*all*) • pregnancy (*all*)	**HIV-1 EIA** Routinely encourage HIV testing for all sentenced inmates who have not been previously tested in the BOP. HIV testing of sentenced inmates with HIV risk factors is considered mandatory per BOP policy.

(Appendix 3 continues on next page.)

A. Infectious Disease Screening *(continued)*

Disease/Source	Risk Factors Indicating Screening	Screening Test/Guideline
HIV-2 *Sentenced* CDC	• **from African countries where HIV-2 prevalence is >1%:** Cape Verde, Côte d´Ivoire, Gambia, Guinea-Bissau, Mali, Mauritania, Nigeria, and Sierra Leone • **from other West African countries reporting HIV-2:** Benin, Burkina Faso, Ghana, Guinea, Liberia, Niger, Sao Tome, Senegal, and Togo • **from other African nations reporting HIV-2 at >1%:** Angola & Mozambique • have been sex partners or needle-sharing partners of a person from West Africa or a person known to have HIV-2 infection • received transfusions in West Africa	**HIV-2 EIA** For inmates with these risk factors, also test for HIV-2.
Sexually Transmitted Diseases **(Chlamydia & Syphilis)** *All* BOP, USPSTF	• **All females** ..... • **All females who:** ..... ▸ are age 25 or under *and/or* ▸ have HIV infection *and/or* ▸ have history of syphilis, gonorrhea, or chlamydia • **All males who:** ..... ▸ have had sex with another man *and/or* ▸ have HIV infection *and/or* ▸ history of syphilis, gonorrhea, or chlamydia ***Note:*** *Routine gonorrhea screening is not recommended unless symptoms of gonorrhea are present, or unless syphilis or chlamydia have been diagnosed.*	• **RPR:** At intake physical • **Chlamydia:** At intake physical (NAAT urine or cervical swab) • **RPR:** At intake physical
Tuberculosis *All* CDC, BOP	• **All inmates** ..... • **All inmates except those with:** ..... ▸ history of tx of latent TB infection (TLTBI) or active TB ▸ documented TST positive (in millimeters) ▸ history of severe reaction to tuberculin • **Foreign born** (with above exceptions**)** ..... • **Foreign born** living in U.S. less than 1 year & no history of CXR in U.S.; or **U.S. born and has lived outside of U.S. or Canada for the previous 6 months** ..... • **HIV seropositive** ..... ▸ ***and*** **history of positive TST and has not completed TLTBI, *or* a contact of TB case and refusing TLTBI** (regardless of TST result) .. • **All inmates with baseline negative TST** ..... • **Documented HIV (-) TST converter** refusing TLTBI	• **Intake TB symptom screen** • **Tuberculin skin test (TST)** within 48 hrs of intake • **Consider 2-step TST** • **CXR:** At intake • **CXR:** At intake • **CXR:** Every 6 mos indefinitely • **TST:** Annually • **CXR:** Every 6 mos for 2 yrs

(Appendix 3 continues on next page.)

B. Cancer Screening

Disease/Source	Risk Factors Indicating Screening	Screening Test/Guideline
Breast Cancer *Sentenced* BOP, USPSTF, ACA	• **All females** ..... • **Average-risk females, ages 50–74** ..... • **Risk-factor based, beginning age 40:** ..... ▸ 2 first-degree relatives with breast or ovarian cancer ▸ relative with breast cancer before age 50 ▸ relative with two cancers (breast and ovarian or two independent breast cancers) ▸ female with male relative with breast cancer	• **Clinical breast exam:** Offer annually • **Mammogram:** Every 2 yrs • **Mammogram:** Every 2 yrs
	The USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in *BRCA1* or *BRCA2* genes be referred for genetic counseling and evaluation for *BRCA* testing. Certain women of Jewish heritage may be at increased risk. Both maternal and paternal family histories are important. See USPSTF recommendations, which are available at: http://www.ahrq.gov/clinic/uspstf05/brcagen/brcagenrs.htm#clinical	
Cervical Cancer *Sentenced* BOP, ACS	**All females (who have a cervix):** • **Age 21–65 (Pap smear only)** ..... • **Ages 30–65 (Pap smear & HPV test)**	• At intake physical, then every 3 years • At intake physical, then every 5 years
Ovarian Cancer USPSTF	The United States Preventive Services Task Force *recommends against routine screening for ovarian cancer*, finding that there is no evidence that any screening test (including CA-125, ultrasound, or pelvic examination) reduces mortality from ovarian cancer.	
Oral Cancer USPSTF	The United States Preventive Services Task Force recommends that clinicians conduct oral cancer screening by directly inspecting and palpating the oral cavity in adults who have a history of HPV, sun exposure, alcohol and tobacco use.	
Prostate Cancer USPSTF	The United States Preventive Services Task Force has found *insufficient evidence to recommend for or against routine screening for prostate cancer* by prostate surface antigen or digital rectal exam. Decisions about screening should be made case-by-case, with the inmate. Prostate cancer screening should not be done for men over age 75.	
Colorectal Cancer *Sentenced* USPSTF, ACS, AGA	**Average risk** ..... **Increased risk:** *Follow guidance on next page if …* • history of polyps at prior colonoscopy • history of colorectal cancer • family history • genetic predisposition • inflammatory bowel disease ***(Colorectal Screening Guidelines begin on next page of Appendix 3.)***	**Fecal occult blood test:** Annually beginning at age 50. *Stop routine screening at age 75.* Provide guiac-based test cards to use with 3 consecutive stools and return to clinic. Do not rehydrate specimen. If positive, do colonoscopy. ***Note:*** *It is necessary to test 3 stools each year to achieve adequate sensitivity.*

(Appendix 3 continues on next page.)

B. Cancer Screening *(continued)*

Colorectal Screening Guidelines: Increased Risk and High Risk

Guidelines for Screening and Surveillance for the Early Detection of Colorectal Adenomas and Cancer in Individuals at Increased Risk or High Risk (AGA/ACS, 2008)

Increased Risk: Patients with History of Polyps at Prior Colonoscopy

Risk Category	Age to Begin	Recommendation/Comment
Patients with small rectal hyperplastic polyps	Same as those with average risk	**Colonoscopy or other screening options** at same regular intervals as for those at average risk. Those with hyperplastic polyposis syndrome are at increased risk for adenomatous polyps and cancer, and should have more intensive follow-up.
People with 1 or 2 small (≤1 cm) tubular adenomas with low-grade dysplasia	5–10 years after the polyps are removed	**Colonoscopy:** Time between tests should be based on other factors such as prior colonoscopy findings, family history, and patient and doctor preferences.
People with 3 to 10 adenomas, or a large (≥1 cm) adenoma, or any adenomas with high-grade dysplasia or villous features	3 years after the polyps are removed	**Colonoscopy:** Adenomas must have been completely removed. If colonoscopy is normal or shows only 1 or 2 small tubular adenomas with low-grade dysplasia, future colonoscopies can be done every 5 years.
People with more than 10 adenomas on a single exam	Within 3 years after the polyps are removed	**Colonoscopy:** Consider possibility of genetic syndrome (such as FAP or HNPCC).
Patients with sessile adenomas that are removed in pieces	2–6 months after adenoma removal	**Colonoscopy:** If entire adenoma has been removed, further testing should be based on physician's judgment.

Increased Risk: Patients with Colorectal Cancer

Risk Category	Age to Begin	Recommendation/Comment
People diagnosed with colon or rectal cancer	At time of colorectal surgery, or can be 3–6 months later if person doesn't have cancer spread that can't be removed	**Colonoscopy** to view entire colon and remove all polyps. If the tumor presses on the colon/rectum and prevents colonoscopy, CT colonoscopy (with IV contrast) or DCBE may be done to look at the rest of the colon.
People who have had colon or rectal cancer removed by surgery	Within 1 year after cancer resection (or 1 year after colonoscopy to make sure the rest of the colon/rectum was clear)	**Colonoscopy:** If normal, repeat exam in 3 years. If normal then, repeat exam every 5 years. Time between tests may be shorter if polyps are found or there is reason to suspect HNPCC. After low anterior resection for rectal cancer, exams of the rectum may be done every 3–6 months for the first 2–3 years to look for signs of recurrence.

(Colorectal Screening Guidelines continue on next page of Appendix 3.)

B. Cancer Screening *(Colorectal Screening Guidelines, continued)*

Increased Risk: Patients with a Family History

Risk Category	Age to Begin	Recommendation/Comment
Colorectal cancer or adenomatous polyps in any first-degree relative before age 60, or in 2 or more first-degree relatives at any age (if not a hereditary syndrome)	Age 40, or 10 years before the youngest case in the immediate family, whichever is earlier	**Colonoscopy:** Every 5 years
Colorectal cancer or adenomatous polyps in any first-degree relative aged 60 or higher, or in at least 2 second-degree relatives at any age	Age 40	**Fecal occult blood test:** 3 times annually.

High Risk

Risk Category	Age to Begin	Recommendation/Comment
Familial adenomatous polyposis (FAP) diagnosed by genetic testing, or suspected FAP without genetic testing	Age 10 to 12	**Yearly flexible sigmoidoscopy** to look for signs of FAP. Provide counseling to consider genetic testing if it hasn't been done. If genetic test is positive, removal of colon (colectomy) should be considered.
Hereditary non-polyposis colon cancer (HNPCC), or increased risk of HNPCC based on family history without genetic testing	Age 20 to 25, or 10 years before the youngest case in the immediate family	**Colonoscopy** every 1–2 years; counseling to consider genetic testing if it hasn't been done. Genetic testing should be offered to first-degree relatives of people found by genetic tests to have HNPCC mutations. It should also be offered if 1 of the first 3 of the modified Bethesda criteria[1] is met.
Inflammatory bowel disease: • Chronic ulcerative colitis • Crohn's disease	Cancer risk begins to be significant 8 years after the onset of pancolitis (involvement of entire large intestine), or 12–15 years after the onset of left-sided colitis	**Colonoscopy** every 1–2 years with biopsies for dysplasia. These patients are best referred to a center with experience in the surveillance and management of inflammatory bowel disease.

Abbreviations: **DCBE** = double-contrast barium enema; **FAP** = familial adenomatous polyposis; **HPNCC** = hereditary nonpolyposis colon cancer; **CTC** = computed tomographic colonoscopy

[1] The Bethesda criteria can be found in the American Cancer Society "Can Colorectal Cancer Be Prevented?" available at: http://www.cancer.org/docroot/CRI/content/CRI_2_4_2X_Can_colon_and_rectum_cancer_be_prevented.asp?sitearea=

Reference: American Cancer Society [homepage on the internet]. Detailed guide: colon and rectum cancer. Can colorectal polyps and cancer be found early? Revised 3/5/2008. Available from: http://www.cancer.org/docroot/CRI/content/CRI_2_4_3X_Can_colon_and_rectum_cancer_be_found_early.asp

(General guidelines resume on next page of Appendix 3.)

C. Chronic Diseases/Lifestyle

Disease/Source	Risk Factors Indicating Screening	Screening Test/Guideline
Abdominal Aortic Aneurysm *Sentenced* USPSTF	**At risk:** Men, ages 65–75, with a history of smoking. *Screen for abdominal aortic aneurysm (AAA); surgically repair large AAAs (5.5 cm or more).*	**Abdominal ultrasonography:** Once
Aspirin for CHD & Stroke Risk *Sentenced* USPSTF	**Males ages 45–79:** Calculate CHD risk every 5 years using risk calculator: http://www.mcw.edu/calculators/CoronaryHeartDiseaseRisk.htm **Females ages 55–79:** Calculate risk of stroke every 5 years using stroke calculator: http://www.westernstroke.org/index.php?header_name=stroke_tools.gif&main=stroke_tools.php *If risk of adverse cardiovascular event exceeds risk of gastrointestinal bleed, then recommend that inmate take aspirin 81 mg every day.*** * For patients with diabetes, see the BOP *Management of Diabetes Clinical Practice Guideline*.	
	Risk Level at Which CVD Events Prevented ("Benefit") Exceeds GI Harms: **Men: 10-Year CHD Risk**: Ages 45–59 ≥4%; Ages 60–69 ≥9%; Ages 70–79 ≥12% **Women: 10-Year Stroke Risk**: Ages 55–59 ≥3%; Ages 60–69 ≥8%; Ages 70–79 ≥11%	
Diabetes Mellitus *Sentenced* ADA, BOP, USPSTF	**Risk-factor based:** If blood pressure is >135/80 or if otherwise clinically indicated.	**Fasting serum glucose or hemoglobin A1C:** Every 3 years
	The BOP recommends the use of serum glucose testing or A1C for initial screening and diagnosis. When fasting serum glucose values are borderline high, a fasting plasma glucose should be obtained.	
Hypertension *Sentenced* BOP, USPSTF	**Based on age:** • Under age 50 ..... • Age 50 and over..... • Borderline blood pressure elevations (systolic 120-139; diastolic 80-90)	**Blood pressure:** • At least every 3 yrs • At least annually • At least annually
Lipids *Sentenced* USPSTF	• **If diabetes, CVD or peripheral vascular disease**, *beginning at age 20* ..... • **If risk factors:** First-degree relative with CVD (male before age 50, female before age 60) or tobacco use and hypertension, *beginning at age 20*..... • **Average risk men:** *Beginning at age 35*..... • **Average risk women:**..... *If lipid levels are close to warranting therapy, then shorten intervals between screenings.*	**Fasting lipoproteinanalysis:** • Annually **Total cholesterol & HDL:** • At least every 5 years • Every 5 years • Screening not indicated at any age

(Appendix 3 continues on next page.)

C. Chronic Diseases/Lifestyle *(continued)*

Disease/Source	Risk Factors Indicating Screening	Screening Test/Guideline
Obesity *Sentenced* USPSTF	Calculate Body Mass Index (BMI), utilizing calculator at http://www.cdc.gov/healthyweight/assessing/bmi/index.html • **Under age 50**..... • **Age 50 and older**..... Nutrition/exercise counseling for BMI of 30 or greater.	**Height/ weight/ body mass index** • Every 3 years • Every year
Osteoporosis *Sentenced* USPSTF, Surgeon General Report	• **Women age 65 and older, and younger women** whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors. • **Risk factor based:** Women age 60–64 with body weight less than 70 kilograms and no current use of estrogen. **Repeat BMD screening as clinically indicated.** The following intervals are recommended: • **Normal BMD** (T score of 1.00 or higher) **or mild osteopenia** (T score of 1.01 to -1.49) → screen every 15 years • **Moderate osteopenia** (T score of -1.50 to -1.99) → screen every 5 years • **Advanced osteopenia** (T score of -2.00 to -2.49) → screen every year	**Bone mineral density screening (BMD)** The most commonly recommended test is dual x-ray absorptiometry (DXA).
Folic Acid *Sentenced women* USPSTF	• **Women of child-bearing age:** Supplements containing 400–800 μg of folic acid in the periconceptual period reduce the risk for neural tube defects.	**Counsel inmate** Recommend OTC purchase through commissary.
Substance Abuse BOP	• **All inmates:** At intake assess for substance abuse history and need for detoxification. Provide counseling and referral to BOP substance abuse and smoking cessation programs, as indicated.	**Substance abuse history** at intake

D. Sensory Screening

Disease/Source	Risk Factors Indicating Screening	Screening Test/Guideline
Vision *Sentenced* USPSTF	• **All inmates**	**Snellen** at intake physical **Note:** Vision acuity testing is not effective in identifying common age-related pathologies.
Hearing *Sentenced* USPSTF, BOP	• **Age 65 and older**..... • **Occupational risk (any age)**	• **Ask about hearing** annually • **Audiogram** annually

(Appendix 3 continues on next page.)

E. Immunizations

For more specific information about immunizations and contraindications, see CDC adult immunization recommendations at http://www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm.

For information about pregnant women, refer to the current adult immunization schedule (see link above).

Vaccine/Source	Risk Factor	Guideline
Hepatitis A *Sentenced* CDC, BOP, ACIP	**Risk-factor based:** • Men who have sex with men • Users of injection illegal drugs • Liver disease or cirrhosis • Recipients of clotting factor concentrates *For foreign born inmates, consider pre-screening for hepatitis A immunity prior to vaccination.*	**At baseline prevention visit:** If patient has risk factors for hepatitis A, start two-dose series; administer 2nd dose at least 6 months after 1st dose. The two available single antigen vaccines (Vaqta® and Havrix®) can be used interchangeably. For candidates for both vaccines, the combined hepatitis A and hepatitis B vaccine (Twinrix®) can be used. Administer 3 doses at 0, 1, and 6 months; or alternatively, use a 4-dose schedule, administered on days 0, 7 and 21–30, followed by a booster dose at month 12.
Hepatitis B *Sentenced* BOP, CDC, ACIP, USPSTF	**Risk-factor based:** • Diabetic adults younger than age 60 • Hemodialysis patients • End-stage renal disease (hemodialysis anticipated) • Inmate workers at risk for bloodborne pathogen exposure • HIV infected (with risk factors for acquiring HBV) • HCV infection (prioritized for those with evidence of liver disease) • Cirrhosis or liver disease • Injection drug use • Men who have sex with men • History of syphilis, gonorrhea, or chlamydia in last 6 months • Post-exposure prophylaxis • Contacts to inmates with acute hepatitis *For foreign born inmates, consider pre-screening for hepatitis B immunity prior to vaccination.*	**At baseline prevention visit:** If patient has risk factors for hepatitis B, start 3-dose series. The 2nd dose is given 1–2 months after the 1st dose. The 3rd dose is given 4–6 weeks after the 2nd dose (or thereafter). For candidates for both vaccines, the combined hepatitis A and hepatitis B vaccine (Twinrix®) can be used. Administer 3 doses at 0, 1, and 6 months; or alternatively, use a 4-dose schedule, administered on days 0, 7 and 21–30, followed by a booster dose at month 12.

(Appendix 3 continues on next page.)

E. Immunizations *(continued)*

Vaccine/Source	Risk Factor	Guideline
Influenza *All* ACIP, CDC	• **Age 50 or older** • **Medical risk factors** ► Chronic disorders of the cardiovascular or pulmonary systems, including asthma ► Chronic metabolic diseases, including diabetes mellitus, renal or hepatic dysfunction, hemoglobinopathies ► Immunocompromising conditions, including HIV ► Asplenia, including sickle cell disease ► Any condition that compromises respiratory function, e.g., cognitive dysfunction, spinal cord injury, or seizure disorder ► Pregnancy (during flu season) • **Occupational/Residential risk factors:** ► Inmate health care workers ► Residents of long term care facilities	**Annually.** Inmates age 50 and older, and those who are younger with risk factors should receive annual influenza vaccine.
Measles-Mumps-Rubella (MMR) ACIP, CDC-DQ	• **Women of child-bearing age** (*All*)**.....** • **If born after 1956 and previously vaccinated** *(Sentenced)***.....** • **If incomplete or unknown vaccination history and born after 1956** (*Sentenced*)**.....**	• **At intake:** Administer 1 dose. *Test for pregnancy prior to vaccinating.* • **At prevention baseline visit:** Administer 1 booster dose. • **At prevention baseline visit:** Administer initial dose of two-dose series; then give 2nd dose 4–8 weeks later.
	Notes: (1) HIV infection is not a contraindication to MMR, except for those who are severely immunocompromised, i.e., CD4+ T-cell count <200 cells/mm3. (2) MMR is *contraindicated* during pregnancy.	
Meningococcal *All* ACIP, CDC	**Anatomic or functional asplenia**, including sickle cell disease (*age 55 and under only*)	Administer meningocccal conjugate vaccine (one-time only).

(Appendix 3 continues on next page.)

E. Immunizations *(continued)*

Vaccine/Source	Risk Factor	Guideline
Pneumococcal *Sentenced* ACIP	• **Age 65 and over.....** • **Risk-factor based .....** ► Chronic lung disease (including asthma) ► Chronic cardiovascular diseases ► Diabetes mellitus ► Chronic liver diseases, cirrhosis ► Chronic renal failure or nephrotic syndrome* ► Functional or anatomic asplenia (e.g., sickle cell disease or splenectomy)* ► Immunocompromising conditions (e.g., congenital immunodeficiency, HIV infection, leukemia, lymphoma, multiple myeloma, Hodgkins disease, generalized malignancy, or organ transplantation)* ► Chemotherapy with alkylating agents, antimetabolites, or long-term systemic corticosteroids* ► Cochlear implants ► Cerebrospinal fluid leaks ► Chronic alcoholism ► Long term care residents	• **Administer once*** • **Administer once**, regardless of age. For patients who are age 65 or older, administer a one-time re-vaccination if the person was vaccinated 5 years or more ago, and was less than age 65 when initially vaccinated. * *For inmates with asterisked conditions, give one-time revaccination after 5 years.* ***Notes:*** (1) Administer pneumococcal vaccine as soon as possible after HIV-infection is diagnosed. (2) Routine use of pneumococcal vaccine is no longer recommended for Alaska Native or American Indian persons younger than 65 years unless they have other qualifying medical conditions. (3) Pneumococcal vaccine can be administered to pregnant women with risk factors.
Tetanus-Diphtheria-Pertussis *Sentenced* ACIP, CDC-DQ, USPSTF		To protect against pertussis, a **one-time** Tdap dose should replace a single dose of Td for adults ages 19 and older, who have not received a dose of Tdap previously (either as a booster dose or part of a vaccine series).
	• **If never has had a Tdap vaccine .....**	• **At prevention baseline visit:** Administer a one-time Tdap dose instead of the Td dose. Thereafter, a Td booster should be administered every 10 years.
	• **If incomplete or unknown vaccination history.....**	• **At prevention baseline visit:** Administer a 3-dose tetanus-diphtheria-pertussis series, including a one-time dose of Tdap (preferably as the initial dose) and 2 doses of Td. Administer the first 2 doses at least 4 weeks apart, and the 3rd dose 6–12 months after the 2nd dose. Thereafter, a Td booster should be administered every 10 years.
	Note: *Pregnant women in need of vaccine may receive Td in the 2nd or 3rd trimester. It is recommended that pregnant women receive a tetanus, diphtheria, and acellular pertussis (Tdap) booster, preferably after 20 weeks of gestation, to protect infants from pertussis via transfer of protective maternal antibodies.*	

Appendix 4a. Inmate Fact Sheet – Preventive Health Program for Women

Initial Preventive Health Screening

You will receive the following preventive health screening shortly after you enter federal prison:

TB Skin Test..... To test for exposure to TB, unless your medical record shows a previous positive TB skin test.

Chest X-Ray ..... If you have a positive TB skin test, if you are foreign-born or have recently been outside the U.S., or you have HIV infection.

Chlamydia Test... If you are age 25 or less, have HIV infection, or have a history of sexually transmitted diseases such as syphilis, gonorrhea, or chlamydia.

Syphilis Test ..... At your intake physical exam.

PAP Smear..... To test for cervical cancer or other conditions, at your intake physical exam.

MMR Vaccine ..... To protect against measles, mumps, and rubella; given if you are of child-bearing age, have no record of vaccination, and have first been tested to see if you are pregnant.

Your health care provider may recommend additional health screens (tests) based on your medical history and physical examination.

Routine Preventive Health Screening for Sentenced Inmates

The following preventive health tests are routinely provided for *sentenced* inmates:

Viral Hepatitis ..... If you are at risk for hepatitis B or hepatitis C viral infections, or if you report that you had a prior infection.

HIV..... Recommended for all sentenced inmates.

TB Skin Test..... Every year, unless your record shows a positive test in the past.

Breast Cancer ..... Mammogram every 2 years, beginning at age 50; beginning at age 40, if there is a history of breast cancer in your family. Annual breast exam upon request.

Pap Smear..... Every 3 years, if you are age 21 to 29.

Every 3–5 years (with an HPV test), if you are age 30 or older.

Colon Cancer ..... Testing for blood in your stool every year, beginning at age 50; colonoscopy if you are at higher risk for colon cancer.

Diabetes ..... If your blood pressure is greater than 135/80.

Cholesterol ..... Beginning at age 20, but only if you have risk factors.

In addition, vaccinations are provided as recommended by health authorities. Based on your age and specific needs, other preventive health services may be made available to you. You can also request a *preventive health visit* to review needed services: every three years (if you are under age 50) or every year (if you are age 50 and over).

Take care of yourself while you are in prison!

- Exercise regularly.
- Eat a healthy diet (low fat, more fruits and vegetables).
- Take medications and supplements recommended by your doctor.
- Don't use tobacco or illegal drugs.
- Don't have sexual contact with others while in prison.
- Don't get a tattoo while in prison.
- Don't share personal items (razors, toothbrushes, towels).
- Wash your hands regularly.

Appendix 4b. Inmate Fact Sheet – Preventive Health Program for Men

Initial Preventive Health Screening

You will receive the following preventive health screening shortly after you enter federal prison:

TB Skin Test..... To test for exposure to TB, unless your medical record shows a previous positive TB skin test.

Chest X-Ray ..... If you have a positive TB skin test, if you are foreign-born or have recently been outside the U.S., or if you have HIV infection.

Syphilis Test ..... At your intake physical exam if you have HIV infection, or if you have a history of sexually transmitted diseases such as syphilis, gonorrhea, or chlamydia.

Your health care provider may recommend additional health screens (tests) based on your medical history and physical examination.

Routine Preventive Health Screening for Sentenced Inmates

The following preventive health tests are routinely provided for sentenced inmates:

Viral Hepatitis ..... If you are at risk for hepatitis B or hepatitis C viral infections, or if you report that you had a prior infection.

HIV..... Recommended for all sentenced inmates.

TB Skin Test..... Every year, unless you had a positive test in the past.

Colon Cancer..... Testing for blood in your stool every year, beginning at age 50; colonoscopy if you are at higher risk for colon cancer.

Diabetes..... If your blood pressure is greater than 135/80.

Cholesterol ..... Beginning at age 35, screen every 5 years (sooner if you are at risk).

In addition, vaccinations are provided as recommended by health authorities. Based on your age and specific needs, other preventive health services may be made available to you. You can also request a *preventive health visit* to review needed services: every three years (if you are under age 50) or every year (if you are age 50 and over).

Take care of yourself while you are in prison!

- Exercise regularly.
- Eat a healthy diet (low fat, more fruits and vegetables).
- Take medications as recommended by your doctor.
- Don't use tobacco or illegal drugs.
- Don't have sexual contact with others while in prison.
- Don't get a tattoo while in prison.
- Don't share personal items (razors, toothbrushes, towels).
- Wash your hands regularly.

Appendix 5. Staff Roles for Preventive Health Care Delivery

Primary Care Provider Teams will be responsible for providing preventive health care services in each facility. Roles and responsibilities for specific aspects of preventive health care will vary, based on staffing in each facility and adaptations required to maintain clinic operations. The most efficient and cost-effective way to implement the preventive health care guidelines is to assign appropriate responsibilities to each health care professional team member. All team members should be oriented to the guidelines in this document.

Clerical Staff

Possible tasks include pulling and filing medical records, scheduling appointments, preparing lab slips, and auditing records.

Nursing Staff

Emphasis on preventive health care may involve an expanded role for nurses in each facility, depending on their availability.

Preparation for Preventive Health Visits: In advance of the visit, a thorough chart review should be conducted to determine what tests and evaluations are indicated by the inmate's age, sex, and risk factors. Laboratory tests and evaluations can be ordered prior to the visit (utilizing standing orders), to maximize clinic efficiency.

Preventive Health Visits: Nursing functions can include interviewing inmates, assessing risk factors, recommending and ordering (with standing orders) specific health screens and interventions, instructing inmates about prevention measures, administering immunizations, and providing health education.

Preventive Health Follow-Up: Abnormal results shall be reviewed and referred to the MLP or physician for follow-up.

Mid-Level Practitioners

MLPs are responsible for: ensuring that their patients have been offered preventive services; counseling inmates on serious health conditions that require treatment; following-up on abnormal results; and developing a treatment plan.

Physicians

Physicians are responsible for developing a treatment plan—particularly for complicated patients—and for mentoring and advising MLPs on specific patients.

Clinical Director

The Clinical Director is responsible for serving as a role model and leader in delivering preventive health services; providing standing orders for nurses; providing staff education; developing IOP measures; and working with the Health Services Administrator to ensure that adequate staffing, supplies, and materials are available for successful implementation of the program.

Appendix 6. Selected Preventive Health Care References

U.S. Preventive Services Task Force (USPSTF): Topic Index: A–Z. Available from: http://www.uspreventiveservicestaskforce.org/uspstopics.htm. A PDA program is available, the *Electronic Preventive Services Selector*. To download, go to http://pda.ahrqgov. More detailed publications of the USPSTF are referenced below under the relevant topic.

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