PREVENTIVE HEALTH CARE SCREENING

Federal Bureau of Prisons

Clinical Guidance

July 2022

WHAT'S NEW IN THIS DOCUMENT

This new 2022 version of the BOP Clinical Guidance for *Preventive Health Care Screening* contains the following revisions to the version issued in June 2018.

- *This newest BOP guidance on Preventive Health Care Screening is based on the most current recommendations and guidelines available at the time of publication. Please check the resources, listed in Appendix 8, for any subsequent updates published by the USPSTF and other groups.*

- **COGNITIVE IMPAIRMENT:** Added section for cognitive impairment screening for all sentenced inmate patients aged 50 and older.
- **COLORECTAL CANCER SCREENING:** Annual screening for inmate patients aged 45-75 at average risk.
- **CARDIOVASCULAR RISK:** Aspirin treatment may be considered for the primary prevention of ASCVD for adults 40-70 years of age.
- **CARDIOVASCULAR RISK:** Aspirin treatment should not be administered for primary prevention of ASCVD among adults greater than 70 years of age.
- **LUNG CANCER SCREENING:** Added recommendations for lung cancer screening.

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1. PURPOSE

The BOP Clinical Guidance for *Preventive Health Care Screening* outlines health maintenance recommendations for federal inmate patients.

- *These preventive health guidelines do not cover diagnostic testing or medical treatments that might be indicated by an inmate patient's signs and symptoms.*
- *These guidelines also do not preclude inmate patient-specific screenings based on medical histories and evaluations and should not supplant clinical judgment or the needs of individual inmate patients.*
- *Information on preventive dental care (to include oral cancer screenings) is in the BOP Clinical Guidance on Preventive Dentistry: Oral Disease Risk Management Protocols.*

2. PREVENTIVE HEALTH CARE: OVERVIEW

Based on the recommendations of the U.S. Preventive Services Task Force (USPSTF), this BOP Clinical Guidance defines a scope of preventive health care services for inmate patients that incorporates targeted patient counseling and immunizations, as well as screening for infectious diseases, cancer, cognitive impairment, and chronic diseases. In certain cases, the BOP preventive health care program deviates from USPSTF recommendations, e.g., when the risk characteristics of the BOP inmate patient population suggest an alternative approach. Recommendations from other clinical authorities may differ from the USPSTF and may at times be appropriate to follow, especially if they are evidence-based.

The BOP preventive health care program includes the following components:

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

3. PREVENTIVE HEALTH CARE: TIMING AND SCOPE OF SERVICES

There is a lack of evidence to support any one strategy for accomplishing preventive health interventions. BOP policies establish requirements for intake screening and periodic screening for certain contagious diseases. In addition, the BOP recommends a prevention baseline visit plus periodic prevention visits as one means of providing preventive health care services efficiently. Other means of providing preventive services involves incorporating the prevention periodic visit into an annual chronic care visit or another time when an inmate patient is already scheduled, e.g., during annual TB screening.

INTAKE

Newly incarcerated inmate patients are screened for conditions that warrant prompt intervention which may include contagious diseases, active substance abuse, chronic diseases, and mental illness.

- *Intake screening prevention parameters are outlined in Appendix 1 and are governed by BOP policies, including the Dental Services, Infectious Disease Management, Patient Care and Psychiatric Services Program Statements. Screening recommendations may also be found in BOP Clinical Guidance for Withdrawal for Inmate patients with Substance Use Disorders, Tuberculosis (TB), Human Immunodeficiency Virus (HIV) Management and Hepatitis C Virus (HCV) Infection. Immunization guidance is provided in the BOP Clinical Guidance for Immunization.*

PREVENTION BASELINE VISIT

A prevention baseline visit is recommended for all sentenced inmate patients within six months of incarceration. At the discretion of the Clinical Director or Health Services Administrator, the prevention baseline visit may be accomplished during the intake physical examination or initial chronic care visit—or scheduled later as a separate preventive health visit.

- *All inmate patients should be advised of the preventive health measures that are provided by the BOP, as well as their own responsibility for seeking these services. A plan should be developed with the inmate patient for accessing recommended preventive health services.*

The primary purpose of the prevention baseline visit is to assess the inmate patient's risk factors and identify the need for and frequency of recommended preventive health interventions summarized in the below appendices:

- *Appendix 2, Preventive Health Care Guidelines by Disease State*
- *Appendix 6 and Appendix 7 Preventive Health Summaries for Males and Females.*

The prevention baseline visit also includes:

- **SCREENING FOR IMMUNIZATIONS** based on the current CDC Adult Combined Immunization Schedule and necessary immunizations administered based on BOP Immunization Protocols. Refer to *BOP Clinical Guidance for Immunization* for additional information.
- **RISK ASSESSMENT** including completion of a preventive health risk assessment utilizing forms located within the BOP electronic health record.
- **PLANNING FOR FOLLOW-UP** by developing a plan with the inmate patient for delivery of follow-up preventive health services.

PREVENTION PERIODIC VISITS AND SCREENING INTERVALS

FREQUENCY

Periodic prevention visits are an effective way to provide preventive health care services for all inmate patients, but especially for those who are not seen routinely for other medical needs such as chronic care conditions. The frequency of periodic prevention visits needs to be individualized —based on policy requirements, risk profiles, recommended screening intervals, and results of screening tests. Based in part on the screening intervals described below, the BOP encourages prevention visits every 3 to 5 years for average-risk inmate patients under age 50 and annually for inmate patients 50 years and older.

Annual tuberculosis screening, influenza vaccinations, and audiograms for occupational risk are commonly provided through separate clinics.

Optimal screening intervals have not been established for many conditions, and published guidelines and recommendations may differ among professional organizations. However, the following screening intervals for average-risk inmate patients are reasonable and generally consistent with those guidelines, as well as with BOP policy for certain interventions. Shorter intervals between screenings may be appropriate for individuals at higher risk or based on results of screening test results.

- **ANNUALLY**
  - Screening of all inmate patients for tuberculosis
  - Influenza vaccinations for all inmate patients
  - Audiograms for inmate patients at occupational risk
  - Colorectal cancer screening for inmate patients aged 45–75
  - Consider blood pressure screening for hypertension in at-risk populations (age ≥40, Black, overweight, or obese)
  - Lung cancer screening for inmate patients with history of smoking (see recommendation) age 50 -80
- **EVERY 2 YEARS**
  - Breast cancer screening for female inmate patients aged 50-74
- **EVERY 3 TO 5 YEARS**
  - Cardiovascular risk assessment using the pooled cohort calculator aged 40–75
  - Blood pressure screening for hypertension, starting at age 18
  - Cholesterol levels for hyperlipidemia, as part of the cardiovascular risk assessment
  - Fasting glucose or glycohemoglobin (A1C) for diabetes mellitus type 2 in overweight or obese inmate patients aged 35–70, screen all inmate patients aged 45 and older regardless of risk factors
  - Weight and body mass index screening for overweight and obesity starting at age 18
  - Cervical cancer screening for female inmate patients aged 21–65

SERVICES AND SCREENING PARAMETERS

The following services and screening parameters should be included in periodic preventive health care visits.

➔ *For more information, see Appendix 1 and Appendix 2,*

- USPSTF recommends behavioral counseling for alcohol misuse. Although not specifically addressed by USPSTF, periodic counseling on substance misuse and related infectious disease transmission is appropriate for the incarcerated population.
- Measurement of weight, height, and BMI (schedule re-evaluation based on trend.)
  - ➔ *If BMI is >30 kg/m^2, counsel about diet and exercise, and offer intensive, multicomponent behavioral interventions.*
- Measurement of blood pressure (schedule re-evaluation based on trend).
- Screening for LTBI with annual TST (unless previously positive by TST or IGRA, or documented history of TB).
- Screening for hearing loss with annual audiograms for those at occupational risk.

- Screening for breast, cervical, and colon cancers per established parameters and clinical indications.
  - *If HIV+, see "Pap Smears" in Section 3 of BOP Clinical Guidance for HIV.*
- Screening for cardiovascular risk (need for aspirin or statin), including screening for diabetes and hypercholesterolemia per established criteria.
- Screening for osteoporosis in females 65 years of age and older, and in younger women whose fracture risk is greater than or equal to that of a 65-year-old white woman with no additional risk factors. Subsequent screening frequency is determined by results of the initial DEXA.
- Screening for abdominal aortic aneurysms in males who have ever smoked, 65–75 years of age (one time).

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

4. PREVENTIVE HEALTH CARE: TEAM RESPONSIBILITY

Consistent with the Institute of Medicine's recommendations for improving the quality of health care, the BOP encourages the delivery of preventive health care services through patient-centered teams, with responsibility shared between the inmate patient and the BOP health care team.

- 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 outlines how different categories of staff can take part in implementing the preventive health program.*
- Inmate patients should be provided information on available preventive services and should be counseled about their responsibility to seek these services.
  - *See the Inmate Patient Fact Sheets in Appendix 3 and Appendix 4.*
- Some education and preventive services can be delivered to inmate patients via group counseling, educational DVDs, and health fairs conducted by volunteers and community organizations.

5. PREVENTIVE HEALTH CARE: PROGRAM EVALUATION

Health Services Administrators, Clinical Directors, and the Director of Nursing at Medical Referral Centers (MRCs) should develop a process outlining the implementation of the local preventive health care program. The preventive health care program should be evaluated through the local Improving Organizational Performance (IOP) program.

Applicable evaluation strategies include, but are not limited to:

- **ASSESSING PROCESS MEASURES** such as the proportion of inmate patients who were eligible for a certain health screening who were screened, e.g., the proportion of eligible female inmate patients who are screened for breast cancer within the recommended time frames.

- **ASSESSING OUTCOME MEASURES** such as the proportion of asymptomatic inmate patients screened for a certain condition who were diagnosed with that condition, e.g., the proportion of those screened with a fasting blood glucose test who were diagnosed with diabetes.
- **CONDUCTING CASE STUDIES OF INMATE PATIENTS WHO WERE PRIORITY CANDIDATES FOR PREVENTIVE SERVICES** for a particular condition (i.e., inmate patients who were at high risk for that condition) but were not evaluated for the condition.
- **CONDUCTING CASE STUDIES OF INMATE PATIENTS WHO WERE DIAGNOSED CLINICALLY** rather than by preventive screening, or who had a negative clinical outcome related to a preventive measure not being conducted. For example, an inmate patient with hypertension may have 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 INMATE PATIENTS	
Withdrawal	Assess need for withdrawal management.
Tuberculosis (TB) Symptom Screen	**A health care professional should ask all inmate patients about a history of TB and the presence of the following symptoms:** • Blood-tinged sputum • Night sweats • Weight loss • Fever • Cough **Inmate patients who have symptoms suggestive of TB disease** should receive a thorough medical evaluation, including a TST, a CXR, and, if indicated, a sputum examination. If TB is suspected, the inmate patient should be immediately told to wear a surgical mask and placed in a low-traffic area until he or she can be isolated in an airborne infection isolation room (AIIR).
Tuberculin Skin Test (TST)	**A baseline TST will be obtained within two calendar days on all new intakes to the BOP**, regardless of TST results from local jails or an inmate patient's history of a prior positive TST, ***with the following exceptions***: • The inmate patient has documentation of a prior positive TST while incarcerated within BOP. • The inmate patient has a history (either by self-report or clinically documented) of a severe reaction to a TST (e.g., a swollen, blistering, vesiculated reaction), which is considered a positive TST reaction. • The inmate patient provides a credible history of treatment for LTBI (i.e., can describe the medication taken, and when, where, and how long it was taken). • If an inmate patient is in holdover status with a short length of stay anticipated and has documentation of a negative TST in the last year while incarcerated, then that TST is considered valid for screening purposes. ➔ *It is critically important that holdover inmate patients receive a TB symptom screen at intake.* • There is a unique reason not to repeat a TST (as approved by the Regional Medical Director) such as repeated admissions from local detention facilities over a short period. • **Foreign-Born Inmate patients:** Consider performing a two-step TST for foreign-born inmate patients who have not been tested in the previous 12 months. A self-report of being tested within the last year is a sufficient reason not to perform a two-step test.
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ALL INMATE PATIENTS (CONTINUED)	
Chest Radiograph (CXR) – only in certain cases	**The following categories of inmate patients should have a CXR★ at intake:** • Inmate patients reporting TB symptoms (especially a cough for 2–3 weeks), *regardless of TST results.* • TST-positive inmate patients (within 14 days of identifying the positive TST). • All HIV-infected inmate patients. ★ *Inmate patients with symptoms should have both a posterior-anterior (PA) and a lateral CXR. For asymptomatic inmate patients, a PA view is sufficient.*
HIV	• **Opt-out voluntary testing** is offered to all inmate patients, regardless of sentencing status. • **HIV testing for inmate patients with HIV risk factors** is considered mandatory per BOP Clinical Guidance for HIV Management (see *Appendix 2* for list of risk factors).
HCV	**Opt-out HCV testing is offered to all inmate patients.** Obtain anti-HCV. If anti-HCV is positive order HCV RNA to confirm chronic HCV infection.
FEMALE INMATE PATIENTS	
Syphilis	**RPR** (rapid plasma reagin) for all females at increased risk for syphilis infection: • HIV infection. • Pregnant (risk for maternal-fetal transmission). • Others on a case-by-case basis (personal or sex partner history of sexually transmitted infections, commercial sex workers / exchanging sex for drugs or money, a history of multiple sex partners, non-Asian, non–Caucasian ethnicity, etc.).
Chlamydia/ Gonorrhea	**Nucleic acid amplification tests (NAAT) from urine or cervical swab for females who fall into *any* of the following categories:** • Age 24 or under. • Age 25 or older with risk factors. • Have had more than one sex partner. • Have HIV infection. • Have a history of syphilis, gonorrhea, or chlamydia. • Have a sex partner who has other sex partners or a history of a sexually transmitted infection.
Cervical Cancer	**Pap smear at intake physical.** ➔ *If HIV+, see "Pap Smears" BOP Clinical Guidance for HIV Management*
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MALE INMATE PATIENTS	
Syphilis	• **RPR** (rapid plasma reagin) for all males who are at increased risk for infection. • Have had sex with another man. • Are HIV-infected. • Others on a case-by-case basis (personal or sex partner history of sexually transmitted infections, commercial sex workers / exchanging sex for drugs or money, a history of multiple sex partners, non-Asian, non–Caucasian ethnicity, etc.).

APPENDIX 1. PREVENTIVE HEALTH CARE—INTAKE PARAMETERS, Page 3 of 3

APPENDIX 2. PREVENTIVE HEALTH CARE GUIDELINES BY DISEASE STATE

- Throughout most of this chart, recommendations regarding health screenings are displayed in the ***third column***. This column also indicates when screening should take place, e.g., at intake, at baseline, annually, etc. Baseline screening can be incorporated into the intake visit. These recommendations are based on age, sex, and the clinical indications and risk factors listed in the ***middle column***.
- The ***first column*** indicates: the disease or condition, whether the recommendation applies to *ALL* inmate patients 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,* ***AGA****=American Gastroenterological 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*

A. RECOMMENDATIONS FOR INFECTIOUS DISEASE SCREENING		
DISEASE	**CLINICAL INDICATIONS & RISK FACTORS**	**SCREENING TESTS & GUIDELINES**
Hepatitis B Viral Infection (HBV) ***ALL INMATE PATIENTS WITH RISK FACTORS*** BOP, CDC	**CLINICAL INDICATIONS:** • Pregnancy. • Chronic hemodialysis and failed to develop antibodies after 2 series of vaccinations—**SCREEN MONTHLY**. • Asymptomatic inmate patients with elevated ALT of unknown etiology. • Signs or symptoms of acute or chronic hepatitis. • Planned immunosuppressant therapy, e.g., chemotherapy, anti-tumor necrosis factor alfa agents, or therapy for organ transplant recipients. • History of percutaneous exposure to blood. **RISK FACTORS:** • Ever injected illegal drugs and shared equipment. • 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).	**AT BASELINE VISIT, OR AS INDICATED FOR ONGOING HIGH-RISK BEHAVIOR:** • If HBV risk factors are identified: HBsAg, anti-HBs, and HBcAb testing is recommended. ➔ *If inmate patient is pregnant, test only for HBsAg. Testing is recommended at first prenatal visit.*
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A. RECOMMENDATIONS FOR INFECTIOUS DISEASE SCREENING (CONTINUED)		
DISEASE	**CLINICAL INDICATIONS & RISK FACTORS**	**SCREENING TESTS & GUIDELINES**
Hepatitis C Viral Infection (HCV) ***ALL INMATE PATIENTS*** BOP, CDC	**CLINICAL INDICATIONS:** • Reported history of HCV infection without prior medical records. • Chronic hemodialysis. Obtain ALT monthly and anti-HCV semiannually. • Elevated ALT levels of unknown etiology. • Evidence of extrahepatic manifestations of HCV: mixed cryoglobulinemia, membranoproliferative glomerulonephritis, porphyria cutanea tarda, or vasculitis. **RISK FACTORS:** • Ever injected illegal drugs and shared equipment. • 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 INMATE PATIENTS*). • Born to a mother who had HCV infection at the time of delivery. • Born between 1945 and 1965. • Ever on hemodialysis. (If inmate patient is currently on hemodialysis, screen for HCV semiannually.)	**AT BASELINE VISIT, OR AS INDICATED FOR ONGOING HIGH-RISK BEHAVIOR:** • Opt-out HCV testing is offered to all inmate patients. • Obtain Anti-HCV; obtain HCV RNA if ANTI-HCV is positive.
APPENDIX 2. PREVENTIVE HEALTH CARE GUIDELINES BY DISEASE STATE, Page 2 of 9		

A. RECOMMENDATIONS FOR INFECTIOUS DISEASE SCREENING (CONTINUED)		
DISEASE	**CLINICAL INDICATIONS & RISK FACTORS**	**SCREENING TESTS & GUIDELINES**
HIV ***ALL INMATE PATIENTS*** BOP, Code of Federal Regulations	**CLINICAL INDICATIONS:** • Unexplained signs and symptoms compatible with acute HIV infection. The most common symptoms of acute retroviral syndrome include: fever, lymphadenopathy, sore throat, rash, myalgia/ arthralgia, diarrhea, weight loss, headache. Prolonged duration of symptoms and the presence of mucocutaneous ulcers are suggestive of the diagnosis. • Signs and symptoms of HIV-related conditions. • Pregnancy. • Recent exposures to HIV. • Active tuberculosis. **MANDATORY TESTING FOR THESE HIV RISK FACTORS:** • Injected illegal drugs and shared equipment. • (For males) Had sex with another man. • Had unprotected intercourse with a person with a known or suspected HIV infection. • History of gonorrhea or syphilis. • Had unprotected intercourse with more than one sex partner. • From a high-risk country (sub-Saharan Africa or West Africa). • Received blood products between 1977 and May 1985. • Hemophilia. • Percutaneous exposure to blood. • Positive tuberculin skin test.	**AT INTAKE/BASELINE VISITS:** • Opt-out voluntary HIV testing is offered to all inmate patients, regardless of sentencing status. • HIV testing of inmate patients with HIV risk factors is considered **MANDATORY** per BOP policy. **CDC RECOMMENDATION:** • The CDC recommends use of an HIV-1/2 antigen/ antibody combination immunoassay (fourth-generation) algorithm as the best method to accurately detect and diagnose an individual with early (< 6 months) or acute HIV infection. • In the absence of fourth-generation assays, laboratories will utilize a sensitive IgM assay (third-generation) with Western Blot.
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A. RECOMMENDATIONS FOR INFECTIOUS DISEASE SCREENING (CONTINUED)		
DISEASE	**CLINICAL INDICATIONS & RISK FACTORS**	**SCREENING TESTS & GUIDELINES**
Sexually Transmitted Infections (syphilis, chlamydia, and gonorrhea) ***ALL INMATE PATIENTS*** BOP, USPSTF	• All females who: ▸ Are age 24 or under ***AND/OR*** ***(CHLAMYDIA/GONORRHEA TESTING ONLY)*** ▸ Have multiple sex partners ***AND/OR*** ▸ Have HIV infection ***AND/OR*** ▸ Engage in high-risk sexual behavior	**AT INTAKE VISIT:** • **RPR** • **NAAT urine; urethra, vagina, or endocervical swab** for chlamydia/ gonorrhea
	• All males who: ▸ Have had sex with another man ***AND/OR*** ▸ Have HIV infection ***AND/OR*** ▸ Engage in high-risk sexual behavior	• RPR
Tuberculosis ***ALL INMATE PATIENTS*** CDC, BOP	➜ *See Appendix 1 for information on TB symptom screening and baseline TSTs.*	
	• All inmate patients ***EXCEPT*** those with documentation of a prior positive TST ***OR*** history of active TB disease.	• **TST:** At intake, then annually
	• Inmate patients with TST conversion.	• **CXR:** Within 14 days of identifying positive TST if asymptomatic. • **If symptomatic for TB, institute respiratory precautions, obtain CXR and isolate promptly**
	• Inmate patients with HIV infection ***AND*** TST > 5mm ***AND*** a CD4+ T cell count < 200 cells/mm^3 who refuse treatment for LTBI.	• **CXR:** Every 6 months indefinitely with clinical evaluation for signs & symptoms of TB
	• Documented HIV(-) TST convertor ***OR*** close contacts who refuse treatment for LTBI.	• **CXR:** Every 6 months for 2 years. After 2 years, CXR is repeated if clinical evaluation is positive for signs & symptoms of TB.

B. CANCER SCREENING		
DISEASE	**RISK FACTORS INDICATING NEED FOR SCREENING**	**SCREENING TESTS & GUIDELINES**
Breast Cancer ***SENTENCED INMATE PATIENTS*** BOP, USPSTF	• Average-risk females, age 50–74.	• **Mammogram:** Every 2 years
	• Females with a first-degree relative with a history of breast cancer may benefit from screening beginning age 40.	• **Mammogram:** Every 2 years
	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 Breast Cancer resources in Appendix 8 under Cancer Screening.*	
Cervical Cancer ***SENTENCED INMATE PATIENTS*** BOP, ACS, USPSTF	***All females (who have a cervix):****	
	• Age 21–65	• **Pap smear:** At intake, then every 3 years
	• Age 30–65 (option for extended interval)	• **Pap smear & HPV test:** At intake, then every 5 years (as an alternative to pap smear every 3 years)
	• Any age if HIV+	• **Pap smear:** At intake, then annually
	* *Abnormal results may indicate need for increased frequency of screening.* ➔ *For special considerations with HIV+ women, see discussion of "Pap Smears" in BOP Clinical Guidance for HIV Management.*	
Lung Cancer USPSTF	• The USPSTF recommends annual lung cancer screening with low-dose computed tomography (LD-CT) in adults 50 to 80 years of age who have a 20 pack-year smoking history and currently smoke or have quit smoking within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	
Prostate Cancer USPSTF	• The USPSTF recommends selective PSA testing in average-risk men age 55 to 69, based on patient preferences, and informed by relevant clinical information and professional judgment. The frequency of screening is not clearly established. Testing frequencies suggested by professional organizations range from annual, to every two to four years, to variable depending on PSA levels. • Prostate cancer screening should not be done for men older than age 70 or with a life expectancy less than 10 years.	

B. CANCER SCREENING (CONTINUED)		
DISEASE	**RISK FACTORS INDICATING NEED FOR SCREENING**	**SCREENING TESTS & GUIDELINES**
Colorectal Cancer ***SENTENCED INMATE PATIENTS*** USPSTF, ACS, AGA	• **Average risk**	• **Fecal occult blood test (FOBT) *or* Fecal Immunochemical Test (FIT):** ▸ Annually, beginning at age 45. Stop routine screening at age 75. ▸ **Either of two self-collected stool-based options are recommended:** **(1)** Guaiac-based **FOBT** test cards to use for 3 consecutive stools. (Testing of 3 consecutive stools is necessary for adequate sensitivity.) Do not rehydrate specimen; dietary restrictions apply. **(2) FIT** (not FIT-DNA) for one sample collected annually. No dietary restrictions. Return specimen(s) to health services within 7 days of collection. ▸ If either is positive, do colonoscopy.
	• **If at increased risk, including any of the following:** ▸ History of polyps at prior colonoscopy ▸ History of colorectal cancer ▸ Family history ▸ Genetic predisposition ▸ Inflammatory bowel disease	• Follow the *American Cancer Society Recommendations for Colorectal Cancer Early Detection*
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C. CHRONIC DISEASES/LIFESTYLE		
CONDITION/SOURCE	**RISK FACTORS INDICATING NEED FOR SCREENING**	**SCREENING TESTS & GUIDELINES**
Abdominal Aortic Aneurysm (AAA) ***Sentenced inmate patients*** USPSTF	**At risk:** Men, age 65–75, with a history of smoking. ➔ *Screen for abdominal aortic aneurysm (AAA).*	• **Abdominal Ultrasonography:** Once • **Periodic surveillance** is recommended for asymptomatic AAAs <5.5 cm diameter. • In general, **referral** is recommended for symptomatic AAAs of any diameter or asymptomatic AAAs ≥ 5.5 cm.
Assess Need for Aspirin and/or Statin Therapy for CVD & Stroke Risk ***SENTENCED INMATE PATIENTS*** ACC/AHA, USPSTF	**Calculate 10-year CVD/stroke risk every 5 years, based on ACC/AHA pooled cohort risk calculator.** ***Aspirin Therapy*** • Low-dose aspirin (75-100 mg orally daily) might be considered for the primary prevention of ASCVD among select adults 40 to 70 years of age who are at higher risk ASCVD risk but not at increased bleeding risk (class of recommendation [COR] IIb, level of evidence [LOE] A). • Low-dose aspirin 75-100 mg orally daily) should not be administered on a routine basis for the primary prevention of ASCVD among adults >70 years of age (COR III [harm], LOEB-R). • Low-dose aspirin 75-100 mg orally daily) should not be administered for the primary prevention of ASCVD among adults of any age who are at increased risk of bleeding (COR III [harm], LOE C-LD) • For adults aged 40 to 59 years: Estimate CVD risk using a CVD risk estimator. • In patients whose estimated CVD risk is 10% or greater, use shared decision-making, taking into account potential benefits and harms of aspirin use, as well as patients' values and preferences, to inform the decision about initiating aspirin. • For patients initiating aspirin use, it would be reasonable to use a dose of 81 mg/day. • For adults 60 years or older: Do not initiate aspirin for primary prevention of CVD. ***Statin Therapy*** • Patients 40 to 75 years with CVD risk factors should be considered for primary prevention statin therapy based on current evidence and when CVD/stroke risk is ≥7.5%.	

C. CHRONIC DISEASES/LIFESTYLE (CONTINUED)		
DISEASE/SOURCE	**RISK FACTORS INDICATING SCREENING**	**SCREENING TESTS & GUIDELINES**
Cognitive Impairment in Older Adults ***Sentenced inmate patients*** USPSTF	**Age 50 years or older, without recognized signs or symptoms of cognitive impairment**	• **Screening with MiniCog http://www.mini-cog.com**
Diabetes Mellitus (Type 2) ***SENTENCED INMATE PATIENTS*** ADA, BOP, USPSTF	**Age 35 to 70 and overweight or obese:**★ **Screen all age 45 and older regardless of risk factors.** ★ See discussion of screening for diabetes in *BOP Clinical Guidance for Diabetes.*	• **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.*	
Folic Acid ***SENTENCED INMATE PATIENTS*** USPSTF	• **Women of childbearing age:** Supplements containing 400–800 μg of folic acid in the periconceptual period to reduce the risk for neural tube defects.	• **Counsel inmate patient:** Recommend OTC purchase through commissary for non-pregnant inmate patients.
Hypertension ***SENTENCED INMATE PATIENTS*** BOP, USPSTF	• **Ages 18 to 39** • **Age 40 and older, or with risk factors** (risk factors include borderline blood pressure elevations, overweight or obese, or African-American)	**Blood pressure screening at baseline and:** • Every 3 to 5 years • Consider annual screening
	➔ *For up-to-date information, please refer to the BOP Clinical Guidance for Hypertension.*	
Lipids ***SENTENCED INMATE PATIENTS*** USPSTF, *ACC/AHA*	• **If diabetes, CVD, or PVD, beginning at age 20..**	**Fasting lipoprotein analysis:** • Annually
	• **Average risk ages 21 to 39** Given the lack of data on the efficacy of screening for or treatment of dyslipidemia in adults aged 21–39 years, the USPSTF encourages clinicians to use their clinical judgment for patients in this age group.	**Total cholesterol & HDL:**★ • Clinician judgement
	• **Average risk age ≥40 year**	• Every 5 years
	★ *If lipid levels are close to warranting therapy, then shorten intervals between screenings. Lipid lowering therapy should be considered as outlined in an acceptable national guideline. ACC/AHA and USPSTF prevention guidelines are acceptable references.*	

C. CHRONIC DISEASES/LIFESTYLE (CONTINUED)		
DISEASE/SOURCE	**RISK FACTORS INDICATING SCREENING**	**SCREENING TESTS & GUIDELINES**
Obesity ***SENTENCED INMATE PATIENTS*** USPSTF	• **All sentenced inmate patients**	**Height/weight/BMI:**★ • At baseline & each preventive health care visit
	Provide nutrition/exercise counseling for inmate patients with BMI of 30 or greater. Consider referring patients to a local BOP weight reduction clinic.	
Osteoporosis ***SENTENCED INMATE PATIENTS*** USPSTF, Surgeon General Report	• **Women age 65 and older** • **Younger women** whose fracture risk is equal to or greater than that of a 65-year-old white woman with no additional risk factors • **Risk-factor based:** Women age 60–64 with body weight less than 70 kilograms and no current use of estrogen	**Bone mineral density screening (BMD):**★ • The most commonly recommended test is dual x-ray absorptiometry (DXA).
	★ *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	
Substance Use Disorders ***ALL INMATE PATIENTS*** BOP	• **All inmate patients:** Based on assessment, provide counseling and referral to BOP substance use disorder and smoking cessation programs.	**At intake visit:** • Assess for substance use disorders history and need for withdrawal management and/or treatment.
D. SENSORY SCREENING		
Hearing ***SENTENCED INMATE PATIENTS*** USPSTF, BOP	• **Age 65 and older**	• Ask about hearing annually
	• **Occupational risk (any age)**	• Audiogram at baseline and annually
Vision ***ALL INMATE PATIENTS*** USPSTF	• **All inmate patients**..... ➔ *USPSTF indicates that there is insufficient evidence for use of routine visual acuity testing for identifying common age-related pathologies.*	**At intake physical:** • Snellen acuity test

APPENDIX 2. PREVENTIVE HEALTH CARE GUIDELINES BY DISEASE STATE, Page 9 of 9

APPENDIX 3. INMATE PATIENT FACT SHEET—PREVENTIVE HEALTH FOR MEN

INITIAL PREVENTIVE HEALTH SCREENING	
You will receive the following preventive health screenings (tests), as clinically indicated, shortly after you enter federal prison:	
Tuberculosis (TB) Skin Test	To test for exposure to TB, unless your medical record shows a previous positive TB skin test.
Hepatitis B	You will be asked about risk factors for hepatitis B and tested if you report any.
Hepatitis C	Recommended for all inmate patients.
HIV	Recommended for all inmate patients; mandatory for inmate patients with risk factors.
Chest X-Ray	If you have a positive TB skin test or TB symptoms or if you have HIV.
Syphilis Test	If you have HIV, or if you have a history of sexually transmitted diseases such as syphilis, gonorrhea, or chlamydia, or other risk factors.
Immunizations	You will be screened to see if your vaccinations for preventable diseases, for which you are at risk, are up to date, and you will be offered any needed immunizations.
Note: *Your health care provider may recommend additional health screens based on your medical history and physical examination.*	
ROUTINE PREVENTIVE HEALTH SCREENING FOR SENTENCED INMATE PATIENTS	
The following preventive health tests are routinely provided for sentenced inmate patients:	
TB Skin Test	Every year unless your record shows a positive test in the past.
Colon Cancer	Testing for blood in your stool every year, beginning at age 45; colonoscopy if you are at higher risk for colon cancer.
Lung Cancer	Screening with low-dose computed tomography (LD-CT) in adults aged 50-80 with a 20 pack-year history of smoking (see recommendation).
Diabetes	Beginning at age 35, then periodically depending on results; earlier if you have risk factors.
Cholesterol	Based on clinical risk factors.
Cognitive Impairment	Starting at age 50.
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:*** Frequency depends on age, medical condition, and risk factors.	
APPENDIX 3. INMATE PATIENT FACT SHEET – PREVENTIVE HEALTH FOR MEN, Page 1 of 2	

INMATE PATIENT FACT SHEET—PREVENTIVE HEALTH FOR MEN (CONTINUED)

TAKE CARE OF YOURSELF WHILE YOU ARE IN PRISON!

- **Wash your hands regularly.**
- **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).

APPENDIX 3. INMATE PATIENT FACT SHEET – PREVENTIVE HEALTH FOR MEN, Page 2 of 2

APPENDIX 4. INMATE PATIENT FACT SHEET—PREVENTIVE HEALTH FOR WOMEN

INITIAL PREVENTIVE HEALTH SCREENING	
You will receive the following preventive health screenings (tests), as clinically indicated, shortly after you enter federal prison:	
Tuberculosis (TB) Skin Test	To test for exposure to TB, unless your medical record shows a previous positive TB skin test.
Hepatitis B	You will be asked about risk factors for hepatitis B and tested if you report any.
Hepatitis C	Recommended for all inmate patients.
HIV	Recommended for all inmate patients; mandatory for inmate patients with risk factors.
Chest X-Ray	If you have a positive TB skin test or TB symptoms or if you have HIV.
Gonorrhea/ Chlamydia Test	If you are age 24 or younger, or any age with increased risk including HIV, multiple sex partners, or a history of sexually transmitted diseases such as syphilis, gonorrhea, or chlamydia.
Syphilis Test	At your intake physical exam, if you have risk factors including HIV infection and high risk sexual activity.
Pap Smear	At your intake physical exam, to test for cervical cancer or other conditions.
Immunizations	You will be screened to see if your vaccinations for preventable diseases, for which you are at risk, are up to date, and you will be offered any needed immunizations.
Note: *Your health care provider may recommend additional health screens based on your medical history and physical examination.*	
ROUTINE PREVENTIVE HEALTH SCREENING FOR SENTENCED INMATE PATIENTS	
The following preventive health tests are routinely provided for sentenced inmate patients:	
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 through age 74; or 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 21–65. Every 3–5 years (with a test for human papillomavirus, or HPV), if you are ages 30–65.
Colon Cancer	Testing for blood in your stool every year, beginning at age 45; colonoscopy if you are at higher risk for colon cancer.
Lung Cancer	Screening with low-dose computed tomography (LD-CT) in adults aged 50-80 with a 20 pack-year history of smoking (see recommendation).
Diabetes	Beginning at age 35, then periodically depending on results; earlier if you have risk factors.
Cholesterol	Based on clinical risk factors.
Cognitive Impairment	Starting at age 50.
APPENDIX 4. INMATE PATIENT FACT SHEET – PREVENTIVE HEALTH FOR WOMEN, Page 1 of 2	

INMATE PATIENT FACT SHEET—PREVENTIVE HEALTH FOR WOMEN (CONTINUED)

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: Frequency depends on age, medical condition, and risk factors.

TAKE CARE OF YOURSELF WHILE YOU ARE IN PRISON!

- **Wash your hands regularly.**
- **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).**

APPENDIX 4. INMATE PATIENT FACT SHEET – PREVENTIVE HEALTH FOR WOMEN, Page 2 of 2

APPENDIX 5. STAFF ROLES FOR PREVENTIVE HEALTH CARE DELIVERY

The BOP encourages delivery of preventive health care services through patient-centered teams, with responsibility shared between the inmate patient and the BOP health care team. Each health services unit is also encouraged to develop innovative ways of providing these services based on the unique characteristics of the facility, mission, staffing, etc. 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 guidance 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 patient'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 inmate patients, assessing risk factors, recommending and ordering (with standing orders) specific health screens and interventions, instructing inmate patients about prevention measures, administering immunizations, and providing health education.

Preventive Health Follow-Up: Abnormal results will be reviewed and referred to the APP or physician for follow-up (see below).

PHARMACY STAFF

Most Pharmacy staff are certified to administer immunizations. Pharmacists with collaborative practice agreements should ensure that the chronic care patients they follow have been offered preventative services, including appropriate laboratory testing and follow-up, patient education, and immunizations. Abnormal results outside the scope of the pharmacist's practice will be referred to a physician for follow-up.

ADVANCE PRACTICE PROVIDERS (APP)

APPs are responsible for ensuring that their patients have been offered preventive services, counseling inmate patients on serious health conditions that require treatment, following up on abnormal results, and developing a treatment plan.

STAFF ROLES FOR PREVENTIVE HEALTH CARE DELIVERY (CONTINUED)
PHYSICIANS
Physicians are responsible for ensuring that their patients have been offered preventive services, counseling inmate patients on serious health conditions that require treatment, following up on abnormal results, developing treatment plans (particularly for complicated patients), and mentoring and advising APPs 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. When providing direct patient care, Clinical Directors are responsible for ensuring that their patients have been offered preventive services, counseling inmate patients on serious health conditions that require treatment, following up on abnormal results, developing treatment plans (particularly for complicated patients), and mentoring and advising APPs on specific patients.
APPENDIX 5. STAFF ROLES FOR PREVENTIVE HEALTH CARE DELIVERY, PAGE 2 of 2

APPENDIX 6. PREVENTIVE HEALTH SUMMARY – MALES

CATEGORY	CURRENT BOP GUIDELINES
Prevention Visits	***Baseline visit:*** At the intake physical examination, 14-day chronic care visit, or within 6 months of intake. ***Periodic visit:*** Individualized, based on policy requirements, risk profiles, and results of screening tests**.** ***If BMI >30 kg/m²*:** Counsel about diet and exercise.
Immunizations	***Screen for needed immunizations*** with the BOP Clinical Guidance for Immunization.
Tuberculin Skin Test (TST)	***TST annually*** unless inmate patient has documented prior TST (+/mm) or documented history of TB.
Chest X-Ray (CXR)	***Baseline CXR:*** Only if TST (+), TB symptoms, or HIV-infected. ***Semiannual CXR:*** Indefinitely if HIV (+) and CD4 <200. Obtain semiannually for 2 years if either a TST convertor or a close contact to an active TB case and refuses LTBI treatment.
Colon Cancer	***Average risk*:** Annually, for ages 45–75 years: FOBT x 3 or FIT x 1. ***High risk*:** Periodic colonoscopy; determination per risk factors.
Lung Cancer	***Low-dose Computed Tomography- Annually age 50-80 with 20 pack-year smoking history (see recommendation).***
Diabetes	Beginning at age 35, then periodically depending on results; earlier if risk factors are present.
Hypertension	• **Ages 18 to 39** • **Age 40 and older, or with risk factors** (risk factors include borderline blood pressure elevations, overweight or obese, or Black)
Cholesterol	Age range, test type, and test frequency are not clearly established for cholesterol screening. ***A reasonable strategy for average risk persons*** involves obtaining a fasting lipid profile every 3 to 5 years, starting at age 40, in conjunction with the cardiovascular risk assessment**.**
CVD Risk	***Calculate 10-year CVD/stroke risk every 5 years and consider aspirin/statin therapy.*** ***Aspirin and statin therapy*** should generally be considered for prevention of heart attack and stroke or for patients with evidence of cardiovascular disease. ➔ Recommending that a patient use aspirin for primary prevention of CVD/stroke should be based on a clinical assessment that also considers the potential increase in major bleeding. ➔ Patients should be considered for statin therapy based on current evidence and the relative CVD/stroke risk. ACC/AHA and USPSTF prevention guidelines are acceptable references.

APPENDIX 6. PREVENTIVE HEALTH SUMMARY - MALES, PAGE 1 of 2

APPENDIX 6. PREVENTIVE HEALTH SUMMARY – MALES (CONTINUED)	
CATEGORY	**CURRENT BOP GUIDELINES**
Abdominal Aortic Aneurysm (AAA)	***At risk*:** Ages 65–75, with a history of smoking. Perform abdominal ultrasonography once. Periodic surveillance for asymptomatic AAAs < 5.5 cm diameter. Referral for symptomatic AAAs of any diameter or asymptomatic AAAs ≥ 5.5 cm. Surgically repair large AAAs (5.5 cm or more).
Hearing Test	***Occupational risk*:** Annual audiogram.
Substance Abuse	***All inmate patients:*** History of substance abuse at intake. Assess for detoxification; assess for need for referral for counseling.
Cognitive Screening	***Starting at age 50***
Syphilis (RPR)	***Screen:*** Inmate patients with risk factors.
HIV (EIA)	***Opt-out voluntary testing*** for all inmate patients. ***Mandatory testing*** for inmate patients with risk factors.
HBV (HBsAg, anti-HBs, and anti-HBc)	***Screen:*** If has risk factors for hepatitis B.
HCV (Anti-HCV)	***Opt-out voluntary testing*** for inmate patients. Obtain HCV RNA if anti-HCV is positive.
APPENDIX 6. PREVENTIVE HEALTH SUMMARY - MALES, PAGE 2 of 2	

APPENDIX 7. PREVENTIVE HEALTH SUMMARY – FEMALES

CATEGORY	CURRENT BOP GUIDELINES
Prevention Visits	***Baseline visit:*** At the intake physical examination, 14-day chronic care visit, or within 6 months of intake. ***Periodic visit:*** Individualized, based on policy requirements, risk profiles, and results of screening tests**.** ***If BMI >30 kg/m^2*****:** Counsel about diet and exercise.
Immunizations	Screen for needed immunizations using the *BOP Clinical Guidance for Immunization*.
Tuberculin Skin Test (TST)	TST annually unless inmate has documented prior TST (+/mm) or documented history of TB.
Chest X-Ray (CXR)	***Baseline CXR:*** Only if TST (+), TB symptoms, or HIV-infected. ***Semiannual CXR:*** Indefinitely if HIV+ and CD4 <200. Obtain semiannually for 2 years if either a TST convertor or a close contact to an active TB case and refuses LTBI treatment.
Mammogram	***Average risk*****:** Biennial, ages 50–74. ***High risk*****:** Biennial, beginning at age 40.
Pap Smear/HPV	***Pap smear*****:** Intake, then every 3 years for ages 21–65. If HIV+, see *BOP Clinical Guidance for HIV Management*. ***OR*** ***Pap smear & HPV*****:** Intake, then every 5 years for ages 30–65.
Colon Cancer	***Average risk*****:** Annually, for ages 45–75 years: FOBT x 3 or FIT x 1. ***High risk*****:** Periodic colonoscopy; determination per risk factors.
Lung Cancer	***Low-dose Computed Tomography- Annually age 50-80 with 20 pack-year smoking history (see recommendation).***
Diabetes	Beginning at age 35, then periodically depending on results; earlier if risk factors are present.
Hypertension	• **Ages 18 to 39** • **Age 40 and older, or with risk factors** (risk factors include borderline blood pressure elevations, overweight or obese, or African-American)
Cholesterol	Age range, test type, and test frequency are not clearly established for cholesterol screening. ***A reasonable strategy for average risk persons*** involves obtaining a fasting lipid profile every 3 to 5 years starting at age 40 in conjunction with the cardiovascular risk assessment.
APPENDIX 7. PREVENTIVE HEALTH SUMMARY - FEMALES, PAGE 1 of 2	

APPENDIX 7. PREVENTIVE HEALTH SUMMARY – FEMALES (CONTINUED)	
CATEGORY	**CURRENT BOP GUIDELINES**
CVD Risk	***Calculate 10-year CVD/stroke risk every 5 years and consider aspirin/statin therapy.*** ***Aspirin and statin therapy*** should generally be considered for prevention of heart attack and stroke or for patients with evidence of cardiovascular disease. ➔ Recommending that a patient use aspirin for primary prevention of CVD/stroke should be based on a clinical assessment that also considers the potential increase in major bleeding. ➔ Patients should be considered for statin therapy based on current evidence and the relative CVD/stroke risk. ACC/AHA and USPSTF prevention guidelines are acceptable references.
Osteoporosis	***Ages ≥65 & younger women age 60–64 & weight <70 kg:*** BMD screening via DXA. Normal T score ➔ every 15 years Moderate osteopenia ➔ every 5 years Advanced osteopenia ➔ every year
Hearing Test	***Occupational risk:*** Annual audiogram.
Substance Abuse	***All inmates*:** History of substance abuse at intake. Assess for detoxification; assess for need for referral for counseling.
Cognitive Screening	***Starting at age 50***
Gonorrhea/Chlamydia (NAAT)	***Screen:*** If age 24 or younger; had multiple sex partners; is HIV+; or has a history of syphilis, gonorrhea, or chlamydia.
Syphilis (RPR)	***Screen:*** Inmates with risk factors.
HIV (EIA)	***Opt-out voluntary testing*** for all inmates. ***Mandatory testing*** for inmates with risk factors.
HBV (HBsAg, Anti-HBs, and Anti-HBc)	***Screen:*** If has risk factors for hepatitis B. ***If inmate is pregnant,*** test for HBsAg at first prenatal visit.
HCV (Anti-HCV)	***Opt-out voluntary testing*** for all inmates. Obtain HCV RNA if anti-HCV is positive.
APPENDIX 7. PREVENTIVE HEALTH SUMMARY - FEMALES, PAGE 2 of 2	

APPENDIX 8. SELECTED PREVENTIVE HEALTH CARE RESOURCES

Published Recommendations. U.S. Preventive Services Task Force (USPSTF) website: *https://www.uspreventiveservicestaskforce.org/BrowseRec/Index*.

Topics on the website are listed alphabetically and can also be filtered by type (screening, counseling, preventive medication, etc.) and age group. Selected USPSTF publications are referenced below under the relevant topics but may have been updated since publication of this BOP guidance. **Please check the USPSTF website for their most recent recommendations.**

A. PHYSICAL EXAMINATIONS – HISTORIC REFERENCE

American Medical Association. Medical evaluations of healthy persons. *JAMA*. 1983;249(12):1626–1633.

B. BEHAVIORAL COUNSELING

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USPSTF. Healthful diet and physical activity for cardiovascular disease prevention in adults without known risk factors: behavioral counseling. 2017.*

USPSTF. Tobacco smoking cessation in adults, including pregnant women: behavioral and pharmacotherapy interventions. 2015 (update in progress).*

C. INFECTIOUS DISEASE SCREENING

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CDC. Prevention and control of infections with hepatitis viruses in correctional settings. *MMWR*. 2003;52(RR01):1–33. Available at: *http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5201a1.htm*.

Federal Bureau of Prisons. Clinical guidance for hepatitis B. 2011. **

Federal Bureau of Prisons. Clinical guidance for hepatitis C. 2021.**

USPSTF. Hepatitis B in Pregnant Women: screening. 2019.*

USPSTF. Hepatitis B virus infection: screening. 2020.*

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* *See USPSTF website at https://www.uspreventiveservicestaskforce.org/BrowseRec/Index*.

** *See BOP website: http://www.bop.gov/resources/health_care_mngmt.jsp*

HIV:

CDC. HIV/AIDS. CDC website: *http://www.cdc.gov/hiv/*.

CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR*. 2006;55(RR14):1–17. Available at*:* *http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm*.

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NIH. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. NIH AIDSinfo website: *http://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-treatment-guidelines/0*

SEXUALLY TRANSMITTED INFECTIONS:

CDC. 2015 Sexually transmitted diseases treatment guidelines. CDC website: *http://www.cdc.gov/std/treatment/*.

USPSTF. Chlamydia and gonorrhea: screening. 2021.*

USPSTF. Syphilis infection in nonpregnant adults and adolescents: screening. 2016.*

USPSTF. Syphilis infection in pregnancy: screening. 2018.*

TUBERCULOSIS:

American Thoracic Society and CDC. Treatment of tuberculosis. MMWR. 2003;52(RR11):1–77. Available at: *http://www.cdc.gov/MMWR/preview/MMWRhtml/rr5211a1.htm*.

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Federal Bureau of Prisons. Clinical guidance for Tuberculosis. 2020.**

D. CANCER SCREENING

American Cancer Society. American Cancer Society guidelines for the early detection of cancer. American Cancer Society website: *http://www.cancer.org/docroot/ped/content/ped_2_3x_acs_cancer_detection_guidelines_36.asp*.

BREAST CANCER:

American Cancer Society. Can breast cancer be found early? American Cancer Society website: *http://www.cancer.org/docroot/CRI/content/CRI_2_4_3X_Can_breast_cancer_be_found_early_5.asp*.

USPSTF. BRCA-related cancer: risk assessment, genetic counseling, and genetic testing. 2019.*

USPSTF. Breast cancer: screening. 2016.*

CERVICAL CANCER:

USPSTF. Cervical cancer: screening. 2018.*

COLORECTAL CANCER:

American Cancer Society. Can colorectal polyps and cancer be found early? American Cancer Society website: *http://www.cancer.org/docroot/CRI/content/CRI_2_4_3X_Can_colon_and_rectum_cancer_be_found_early.asp?sitearea*.

American Cancer Society. Guideline for colorectal screening. American Cancer Society website: *https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html*

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LUNG CANCER:

USPSTF: Lung cancer: screening. 2021.*

ORAL CANCER:

American Cancer Society. Oral cavity and oropharyngeal cancer. American Cancer Society website: *http://www.cancer.org/cancer/oralcavityandoropharyngealcancer/detailedguide/*.

Rethman MP, Carpenter W, Cohen EE, et al. Evidence-based clinical recommendations regarding screening for oral squamous cell carcinomas. ***J Am Dent Assoc***. 2010;141(5):509–520. Available at: *http://jada.ada.org/article/S0002-8177%2814%2961524-5/fulltext*

USPSTF. Oral cancer: screening. 2013.*

OVARIAN CANCER:

USPSTF. BRCA-related cancer: risk assessment, genetic counseling, and genetic testing. 2019.*

USPSTF. Ovarian cancer: screening. 2018.*

PROSTATE CANCER:

USPSTF. Prostate cancer: screening. 2018.*

E. CHRONIC DISEASE SCREENING AND PREVENTION

ABDOMINAL AORTIC ANEURYSM:

USPSTF. Abdominal aortic aneurysm: screening. 2019.*

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* *See USPSTF website at https://www.uspreventiveservicestaskforce.org/BrowseRec/Index*.

** *See BOP website: http://www.bop.gov/resources/health_care_mngmt.jsp*