Department of Public Safety and Correctional Services
Clinical Services & Incarcerated Individual Health

MEDICAL EVALUATIONS MANUAL
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DEFINITIONS

A. In this Manual, the following terms have the meanings defined.

B. Terms Defined.

(1) "Abnormal laboratory result" means lab results with test values that fall outside the established "reference range" for a healthy population, usually marked high (H) or low (L) on reports.

(2) "Acute care infirmary" means an inpatient care setting where individuals are treated for a brief but severe episode of illness for conditions that are the results of a disease or trauma, and during recovery from surgery or return from community hospitalization.

(3) "Altered protective sensation" means a condition such as peripheral neuropathy that alters the nerve signaling in an individual thereby causing impaired or diminished response to stimuli.

(4) "Area Contract Operations Monitor (ACOM)" means an employee in the Department's Office of Clinical Services who audits health services provided by the healthcare vendor in a correctional facility within a service delivery area.

(5) "Certified wound care provider" means a licensed physician or podiatrist who has received certification in wound care by a body such as the American Board of Wound Management.

(6) "Certified wound care nurse" means a registered nurse who holds a baccalaureate degree or higher and has completed additional education focused on wounds, ostomies, and/or continence care.

(7) "Consultation" means a clinical evaluation, diagnostic review, or specialty assessment provided by a qualified healthcare provider, whether conducted in person or through telehealth, upon referral from a qualified healthcare provider for the purpose of diagnosing, managing, treating, or further evaluating a medical, surgical, mental health, dental, or specialty care condition.

(8) "Correctional facility" has the meaning stated in Correctional Services Article, § 1-101, Annotated Code of Maryland.

(9) "Dehydration" means a state in which the loss of water exceeds the body's intake, leading to a deficit in total body water. It may result in disturbances in electrolyte balance, cellular function, and hemodynamic stability.

(10) Direct Intake.

(a) "Direct intake" means the processing of an incarcerated individual who has been sentenced by a court of law and taken directly to a detention facility for placement into a correctional facility.

(b) "Direct intake" does not include an individual who, subsequent to an appearance in a court of law, is returned to a detention facility without being sentenced by the court.

(11) "Electronic medication administration record (EzMAR)" means the Department's approved electronic system that tracks medication orders, dosage times, and provider instructions, and serves as the official record of medication administration within the electronic patient health record.

(12) "Electronic Patient Health Record (EPHR)" means the Department's system of record for an incarcerated individual's medical, mental health, dental, and related patient records. All patient encounters shall be documented in the EPHR. If the EPHR is unavailable, the healthcare provider shall maintain all records in the hard copy medical record and scan into the EPHR within 72 hours of availability.

(13) "Enterprise Practice Management (EPM)" means the approved system of record for scheduling in the EPHR system.

(14) "Gender" means a sociological construct based on a group of physical, emotional, and psychological characteristics and conceptual elements, such as appearance, expression, and behavior, that identify an individual as a woman, man, or gender nonconforming.

(15) "Gender-affirming care" means healthcare that supports and affirms an individual's gender identity, including but not limited to hormone therapy, gender-affirming surgery, mental health services, and other treatments in accordance with prevailing standards of care.

(16) "Gender expression" means how an individual expresses their gender outwardly.

(17) Gender Identity.

(a) "Gender identity" means the gender-related identity, appearance, expression, or behavior of an individual, regardless of the individual's sex assigned at birth, which may be demonstrated by:

(i) Consistent and uniform assertion of the person's gender identity; or

(ii) Any other evidence that the gender identity is sincerely held as part of the person's core identity.

(b) "Gender identity" has the meaning stated in State Government Article, § 20-101, Annotated Code of Maryland.

(18) "Gender nonconforming" means an individual whose gender expression:

(a) Does not present as exclusively man or woman (e.g., non-binary); or

(b) Is inclusive of more than one gender or with no gender at all (e.g., gender-fluid)

(19) "Healthcare vendor (vendor)" means a vendor contracted by the Department to provide medical, mental health, and dental services to incarcerated individuals.

(20) "Heat risk code" means a code for designating heat risk.

(21) Incarcerated Individual.

(a) "Incarcerated individual" has the meaning stated in Correctional Services Article, § 1-101, Annotated Code of Maryland.

(b) Incarcerated individual" includes the term "inmate" as stated in Correctional Services Article, § 1-101, Annotated Code of Maryland prior to October 1, 2023.

(c) "Incarcerated individual" includes the term "incarcerated person".

(22) Intake Provider.

(a) "Intake provider" means a licensed healthcare provider—such as a physician, nurse practitioner, or physician assistant—assigned to a designated intake area of a correctional facility.

(b) "Intake provider" has the responsibility of corroborating with intake nursing personnel to ensure timely, accurate, and clinically appropriate completion of the Initial Medical and Mental Health Assessment (IMMS) process and supports continuity of care through documentation, referrals, and follow-up planning, including:

(i) Evaluating a patient identified with emergent or urgent healthcare needs;

(ii) Issuing clinical orders;

(iii) Initiating individualized care plans; and

(iv) Determining medial appropriateness for custody.

(23) "Local correctional facility" means a correctional facility that is operated by:

(a) One or more counties; or

(b) A municipal corporation.

(24) "M1 – Chronically Ill – Stable" means a risk stratification for any chronic illness that anticipates hospitalization is not anticipated during the next year.

(25) "M2 – Chronically Ill – Unstable" means a risk stratification for any chronic illness, including Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), and asthmatic patients, that anticipates hospitalization will be required during the next year.

(26) "Medical clearance" means an assessment conducted by a medical or mental health services clinician to establish that an incarcerated individual has no underlying medical or mental health issues that would preclude them from safely participating in work assignments.

(27) "Medication administration record (MAR)" means the Department's approved medication administration record.

(28) "Parole violator" means an individual who has been released under parole supervision and is determined to have violated one or more terms or conditions of that parole, whether through technical violations or new criminal offenses, and is subject to retake, revocation, or other sanctions by the Maryland Parole Commission.

(29) "Patient" means an incarcerated individual who has made a sick call request or is receiving healthcare services from the Department or healthcare vendor.

(30) Prescription Hormone Therapy.

(a) "Prescription hormone therapy" means the medically supervised use of estrogen, testosterone, or other gender-affirming medications prescribed by a licensed healthcare provider to align an individual's physical characteristics with their affirmed gender identity.

(b) "Prescription hormone therapy" includes oral, injectable, transdermal, or implantable formulations, and requires regular clinical monitoring for dosage, safety, efficacy, and potential side effects.

(31) "Prison Rape Elimination Act (PREA)" means a federal law and standards established under the authority of the Prison Rape Elimination act of 2003 (P.L. 108-79) that is intended to:

(a) Identify incarcerated individuals who may be at risk of being the victim of, or perpetrating sexual violence; and

(b) Prevent or reduce the incidence of sexual abuse in correctional facilities.

(32) "PREA Compliance Manager (PCM)" means the individual designated by the facility managing official, in accordance with 28 C.F.R. § 115.11(b), who has sufficient time and authority to coordinate the facility's efforts to comply with PREA standards.

(33) "PREA Coordinator (Coordinator)" means the individual designated by the Department, in accordance with 28 C.F.R. § 115.11(a), who has sufficient time and authority to develop, implement, and oversee agency-wide efforts to comply with PREA standards.

(34) "Private medical, psychiatric, and psychological professional" means any community provider that is not affiliated with the Department or the Department's healthcare vendor either as an employee, locum, or employment agency employee.

(35) "Service delivery area (SDA)" means the service delivery areas identified as Hagerstown, Cumberland, Jessup, Baltimore, and Eastern.

(36) "Serious event incident report (SEIR)" means a formal report of the indent completed by an employee of the healthcare vendor at the time they become aware of an incident.

(37) "Sex" means the designation of an individual as either male or female based on anatomical make-up, including genitalia, chromosomes, and reproductive system.

(38) "Sex assigned at birth" means the sex assigned to an individual at birth generally based on biological attributes.

(39) "Sexual abuse" means the abuse of an incarcerated individual by another incarcerated individual and includes the following acts:

(a) Acts listed under §§ .04B(9)(a)(i) and (ii) of *DPSCS.020.0026 – PREA – Federal Standards Compliance*;

(b) Penetration of the anal or genital opening of another person, however slight, by a hand, finger, object, or other instrument; and

(c) Any other intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or the buttocks of another incarcerated individual, excluding contact incidental to a physical altercation.

(40) "Sexual assault forensic examiner (SAFE)/Sexual assault nurse examiner (SANE)" means a registered nurse who completed additional education and training to provide comprehensive healthcare to a survivor of sexual assault.

(41) "Sexually transmitted infection (STI)" means an infection or disease that is passed from one individual to another through sexual contact.

(42) "Sheltered housing" means an area designated for an incarcerated individual who no longer requires acute care services but may need assistance or support for activities of daily living due to a disability or a progressive chronic illness.

(43) Special Housing.

(a) "Special housing" means a designated non-general population housing assignment for an incarcerated individual with special medical, mental health, disability-related, or environmental needs that require clinical accommodation, enhanced supervision, or non-restrictive housing modifications.

(b) "Special housing" placement is recommended by clinical determination and is made in collaboration with custody personnel to ensure the health, safety, and constitutional rights of the incarcerated individual.

(c) "Special housing" includes:

(i) Isolation Housing – for a patient diagnosed with, or suspected of having, a communicable disease or infection.

(ii) Observation and Treatment Housing – for a patient presenting with:

(a) Abnormal vital signs, respiratory distress, or gastrointestinal distress;

(b) Self-harming behavior or suicidal ideation; or

(c) Withdrawal from alcohol or another substance.

(iii) Modified Non-Restrictive Housing – for a patient who:

(a) Is at risk of sexual abuse;

(b) Has physical limitations preventing safe movement in a standard cell; or

(c) Requires a bottom bunk, durable medical equipment (DME), or an assistive device due to a physical limitation.

(iv) Heat-Stratification Housing – for a patient at risk of heat-related complications due to a medical or mental health condition.

(44) "Substance use disorder (SUD)" means a treatable mental disorder that affects an individual's brain and behavior, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications. Symptoms can be moderate to severe, with addiction being the most severe form of SUD.

(45) "Transgender" (Adj.) means an individual whose gender identity is different from their sex assigned at birth. **Note:** *Using this term as a verb (e.g., transgendered) or noun (e.g., transgenders) is offensive and should be avoided.*

(46) "Wound care clinics" means a specialty care clinic held by the certified wound care provider to assess and treat patients who have a chronic wound or who is at high risk for developing a chronic wound.

CHAPTER 1—INTAKE HEALTH ASSESSMENTS

.01 POLICY.

A. The healthcare vendor shall conduct an Initial Medical and Mental Health Screening (IMMS) for each patient immediately upon entry into a Department correctional facility. This requirement applies to all Department intake facilities, regardless of the time of day or location of arrival, including:

(1) Entry into a designated pretrial intake facility following arrest;

(2) Entry from a court following sentencing;

(3) Transfer from a local correctional facility after sentencing;

(4) Return from the community as a parole violator;

(5) Transfer from a local correctional facility under an agreement for treatment;

(6) Transfer under the Interstate Correctional Compact (ICC);

(7) Receipt as a federal detainee; or

(8) Admission following a hospital inpatient commitment.

B. The healthcare vendor shall:

(1) Conduct the IMMS within 4 hours of the patient's arrival, or as soon as clinically appropriate when immediate access is not possible due to security lockdowns, hospital transport, or other operational limitations; and

(2) Document the reason for any delay and ensure completion as soon as feasible.

C. During the IMMS, the healthcare vendor shall:

(1) Identify and address any emergent or urgent medical, mental health, dental, or disability-related needs;

(2) Isolate any patient who appears to be potentially contagious or presents with a communicable disease, consistent with facility infection-control procedures;

(3) Initiate suicide-risk intervention when the patient appears to be at risk, in accordance with the Department's suicide prevention directive;

(4) Provide immediate intervention for any patient with a history of acute, persistent, or serious psychiatric illness;

(5) Provide immediate intervention for any patient with a history of acute, persistent, or serious developmental disability;

(6) Facilitate intervention for a patient with a physical or mental impairment that substantially limits one or more major life functions, in compliance with the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act; and

(7) Intervene for a patient at risk for alcohol, benzodiazepine, or opioid withdrawal.

D. The healthcare vendor shall document all IMMS findings, interventions, referrals, and patient refusals in the patient's EPHR in accordance with Department record-keeping procedures.

E. The healthcare vendor shall ensure that all clinical personnel conducting the IMMS receive annual training that includes:

(1) Standard operating procedure for completing the IMMS form;

(2) Didactic education in identifying mental health issues, including early signs of psychiatric distress and developmental disabilities; and

(3) Procedures for conducting and documenting a suicide risk assessment.

.02 SECTION A – INITIAL MEDICAL AND MENTAL HEALTH SCREENING (IMMS).

A. Preliminary Medical and Mental Health Intake Screening Process.

(1) Preliminary IMMS Screening by the Intake Nurse.

(a) A registered nurse (RN) or higher-level healthcare provider shall complete the preliminary IMMS process for each patient upon arrival into a Department intake facility before the correctional facility accepts custody of the patient.

(b) An RN or higher-level healthcare provider shall initiate the preliminary IMMS if the patient:

(i) Is conscious;

(ii) Is not actively bleeding; and

(iii) Does not require immediate medical attention.

(c) An RN or higher-level healthcare provider shall continue the preliminary IMMS unless they determine that continued detention or incarcerations is clinically inappropriate because of:

(i) An observed emergent medical condition; or

(ii) The patient is exhibiting bizarre or unusual behaviors suggesting they may be under the influence of alcohol or substance abuse.

(2) Criteria for Declining to Accept Custody.

(a) An RN or higher-level healthcare provider shall decline to accept custody of a patient into the Department's care when the patient requires immediate and obvious medical attention.

(b) Conditions that warrant declining custody include, but are not limited to:

(i) Active illicit substance use or evidence of withdrawal;

(ii) Evidence of gunshot or stab wound;

(iii) Obvious respiratory distress, stridor, or severe wheezing;

(iv) Pregnancy with active labor or a history of recent abdominal trauma;

(v) Obvious head trauma, deformity, or open wound;

(vi) Severely abnormal vital signs, such as:

a. Blood pressure greater than 180 systolic or 120 diastolic, or below 90 systolic or 60 diastolic;

b. Heart rate greater than 120 or below 50; or

c. Pulse ox of lower than 94% on room air; or

(vii) Unconsciousness, semi-consciousness, or altered mental status.

(3) Escalation Procedures.

(a) If the RN or higher-level healthcare provider determines that the patient meets any criteria under §.01A(1)(c) or §.01A(2)(b) of this chapter, or otherwise presents an emergent condition, they shall:

(i) Immediately notify the intake provider to corroborate the patient's conditions and determine whether referral to the emergency department (ED) is required;

(ii) Activate emergency medical services (EMS) when clinically indicated; and

(iii) Simultaneously notify facility custody personnel and the transporting officer.

(b) The intake provider shall:

(i) Immediately assess the patient and determine whether to:

a. Refer the patient to the ED; or

b. Accept the patient into the correctional facility with on-site medical intervention.

(ii) Document the clinical assessment and final disposition on the patient's IMMS form.

(c) If the intake provider refers the patient to the ED, the patient may not be admitted or returned to the correctional facility until written medical clearance is received from the ED.

B. **Continuation of the Initial Medical Mental Health Screening (IMMS) Process.**

(1) IMMS Clinical Procedures.

(a) An RN or higher-level healthcare provider shall:

(i) Resume and complete the IMMS within 4 hours of the patient's admission, acceptance for intake, or transfer from another correctional facility when a prior IMMS was not completed, once the patient is medically appropriate for entry;

(ii) Conduct the IMMS as an individual, face-to-face, and confidential interview;

(iii) Screen the patient for medical and mental health conditions using the IMMS template in the patient's EPHR;

(iv) Document all identified medical and mental health concerns on the IMMS template in the patient's EPHR;

(v) Obtain and upload the patient's electronically signed General Consent/Refusal for Medical Treatment form;

(vi) Obtain intake provider orders, which include testing for:

a. Chlamydia;

b. Hepatitis C Virus (HCV);

c. Human Immunodeficiency Virus (HIV);

d. Purified Protein Derivative (PPD) for tuberculosis;

e. Pregnancy, as clinically indicated;

f. Syphilis serology, followed by a Rapid Plasma Regain (RPR) test with automatic Fluorescent Treponemal Antibody (FTA) confirmation only if the initial syphilis serology screen is positive; and

g. Other clinically indicated laboratory tests or diagnostics;

(vii) Review all medical and mental health records received from law enforcement or the local correctional facility and file them in the patient's EPHR;

(viii) Initiate an emergency medical response and immediately notify the intake provider and custody personnel if the patient becomes medically or physical unstable or unable to safety complete the IMMS process; and

(ix) If the patient refuses any component of the IMMS, document the refusal in the patient's EPHR and notify the intake provider for further clinical evaluation and disposition.

(b) An RN or higher-level healthcare provider shall complete and document the following clinical procedures using the IMMS template in the patient's EPHR:

(i) Measure blood pressure using a standard cuff, or a wrist cuff if restraints cannot be safely removed;

(ii) Perform a finger-stick glucose test if the patient reports, or is suspected to have diabetes;

(iii) Conduct a pregnancy test for incarcerated females and transgender men aged 12 through 59 upon intake;

(iv) Measure pulse oximetry and peak flow rate if respiratory issues are suspected; and

(v) Record the patient's pulse, respiratory rate, and temperature.

(c) To ensure clinical quality and policy compliance, the healthcare vendor shall:

(i) Submit a monthly audit sample of completed IMMS records to the Continuous Quality Improvement (CQI) committee; and

(ii) Evaluate the sample for timeliness, documentation completeness, clinical accuracy, and property EPHR integration.

(2) Sallyport Screening and Referral Log (SSRL).

(a) When it is determined that the patient requires immediate or time-sensitive evaluation or treatment beyond the standard intake timeframe, an RN or higher-level healthcare provider shall document a patient on the SSRL and document the patients as emergent, urgent, or routine.

(b) A team leader employed by the healthcare vendor, such as a charge nurse, assistant director of nursing, site medical director, or psychiatrist, shall:

(i) Review the SSRL on a continuing basis and as often as necessary to confirm that prompt and appropriate care is provided; and

(ii) Document interim clinical checks for any patient awaiting emergent or urgent evaluation at intervals appropriate to the patient's condition, but not less frequently than every 2 hours, until the evaluation is completed.

(c) At least every 2 hours, or more frequently if clinically necessary, the charge nurse or designated healthcare provider shall:

(i) Confirm that each referral listed on the SSRL has been addressed and completed; and

(ii) Submit the updated SSRL to the area contract operations manager (ACOM) for daily review.

(d) If a patient referred emergently is not evaluated within 2 hours or an urgent referral is not evaluated within 12-24 hours of referral, the charge nurse or designated healthcare provider shall:

(i) Immediately escalate the case to the supervising healthcare provider for review and intervention;

(ii) Document the delay, reason for the delay, and planned follow-up in the patient's EPHR; and

(iii) Ensure the patient remains actively flagged on the SSRL until services are delivered.

(e) To ensure compliance, the healthcare vendor shall audit a weekly sample of referral logs to evaluate timelines of care, accuracy of reconciliation, and documentation quality in the patient's EPHR.

(3) Expedited Intervention.

(a) The medical team shall identify each patient who requires expedited intervention based on IMMS findings.

(b) An RN or higher-level healthcare provider shall:

(i) Place an orange wristband on the right wrist of each patient requiring expedited intervention; and

(ii) Prioritize those patients during the intake process according to medical acuity and time of arrival.

(c) An RN or higher-level healthcare provider shall evaluate a patient wearing an orange wristband who has stable medical or mental health conditions based on their acuity level to ensure efficient intake management.

(d) If a patient displays symptoms of alcohol or drug withdrawal, and RN or higher-level healthcare provider shall:

(i) Place a yellow wristband on the patient's left wrist; and

(ii) Monitor, evaluate, and prioritize the patient throughout the intake process.

(e) If a patient requires immediate intervention:

(i) An RN shall promptly direct or escort the patient to a mid-level medical provider or mental health clinician following IMMS disposition.

(ii) The mid-level medical provider or mental health clinician shall:

a. Perform a targeted evaluation addressing the immediate concern; and

b. Provide necessary intervention.

(iii) If a patient exhibits symptoms of withdrawal requiring detoxification management:

a. A female patient shall receive detox in a designated detox bed and retain the yellow wristband until discharged from detox care.

b. A male patient shall be transferred to the designated detox unit at the Baltimore City Booking and Intake Center (BCBIC).

C. **Standard Evaluations, Screenings, and Assessments.**

(1) PREA § 115.15(e) Limits to Cross-Gender Viewing and Searches.

(a) The Department may not search or physically examine a patient for the purpose of determining the patient's genital status.

(b) If the patient's genital status is unknown, only a healthcare practitioner may determine the individual's genital status through:

(i) A private conversation with the individual;

(ii) A review of the individual's medical record; or

(iii) A broader medical examination conducted in private, or otherwise medically necessary.

(2) Recent Pregnancy and Lactation.

(a) The RN or higher-level healthcare provider shall ask the patient about any prior pregnancies.

(b) If the patient has given birth, and RN or higher-level healthcare provider shall:

(i) Ask whether delivery occurred within the past 12 months; and

(ii) Ask whether the patient is breastfeeding or providing expressed breast milk.

(c) If the patient answers "yes", an RN or higher-level healthcare provider shall coordinate appropriate equipment and provide the patient opportunities and privacy to pump every 4 hours.

(d) The healthcare vendor shall collaborate with custody personnel to:

(i) Establish protocols to ensure safe storage and handling of expressed breast milk in the medical dispensary, including refrigeration at or below 40°F (4°C) for no longer than 4 days; and

(ii) Outline procedures for transferring expressed milk to the patient at release or to a designated family member if the patient remains incarcerated.

(3) Chronic or Acute Health Conditions.

(a) An RN or higher-level healthcare provider shall:

(i) Using the IMMS template, obtain a full medical history, including known chronic or acute conditions;

(ii) Determine whether the patient is currently using medications to treat those conditions; and

a. Document any report of:

(iii) A medical, mental health, or dental issue;

a. A substance use disorder; or

b. A substantial physical or mental health impairment that significantly limits one or more activities of daily living.

(b) If the patient reports or is identified as having a chronic or acute health condition, mental health issue, substance use disorder, substantial disability or impairment, or any conditions requiring immediate care, an RN or higher-level healthcare provider shall:

(i) Refer the patient to an appropriate healthcare provider for a focal emergent/urgent evaluation and intervention/treatment; and

(ii) Requests custody personnel to escort the patient to the appropriate healthcare provider immediately upon completion of the IMMS.

(4) Criteria for Emergent Referral.

(a) An RN or higher-level healthcare provider shall immediately refer any patient who exhibits one or more of the following emergent conditions:

(i) Active productive cough, chronic cough, or suspected communicable disease;

(ii) Active vomiting or diarrhea;

(iii) Chest pain, dizziness, shortness of breath, or wheezing despite stable vital signs;

(iv) Chronic, significant weakness in more than one limb or paralysis in at least one limb;

(v) Evidence of intoxication;

(vi) Glossy swollen joints;

(vii) Head injury, even without altered mental status or disorientation;

(viii) Withdrawal symptoms with COWS/CIWA > 10;

(ix) Night sweats;

(x) Obvious bruising;

(xi) Open wound on the torso or extremities;

(xii) Current pregnancy with vaginal bleeding or discharge, abdominal pain, or positive gonorrhea/chlamydia screening;

(xiii) Suicidal ideation, agitation, delusions, or hallucinations;

(xiv) Systolic blood pressure > 170, diastolic blood pressure > 110, and/or heart rate > 100;

(xv) Dialysis with an unknown or past-due treatment date;

(xvi) Substantial physical or functional impairment requiring immediate intervention; or

(xvii) Special treatment needs due to age < 18 or ≥ 60.

(b) Stats Post Emergency Department (ED) Evaluation prior to reception at the intake facility (any reason):

(i) A healthcare provider shall assess the patient within 2 hours of admission and document findings in the emergent/urgent provider template in the patient's EPHR.

(ii) An RN or higher-level healthcare provider shall document interventions, including monitoring orders, unless the patient is referred to the ED for medically indicated services.

(5) Criteria for Urgent Referral.

(a) An RN or higher-level healthcare provider shall provide an urgent referral for any patient with an acute, sub-acute, or stable chronic medical, mental health, or substance use condition managed with active medication that does not meet emergent criteria.

(b) An RN or higher-level healthcare provider shall immediately refer any patient exhibiting one or more of the following urgent conditions:

(i) Fleeting, non-exertional, non-radiating chest pain with normal vital signs;

(ii) Known active psychiatric illness with mild agitation and no hallucinations or active suicidal ideation;

(iii) Moderate abdominal pain with intact bowel sounds;

(iv) Nausea without vomiting;

(v) Subjective asthma symptoms without wheezing and with good air movement on exam;

(vi) Systolic blood pressure 160-169, diastolic blood pressure 100-109, or heart rate < 110 but elevated; or

(vii) Suspected ectoparasite infestation.

(c) A healthcare provider shall assess within 12 – 24 hours of admission and document in the SSLR.

(d) An RN or higher-level healthcare provider shall document all intervention provided in the patient's EPHR.

(6) Medication Management.

(a) An RN or higher-level healthcare provider shall:

(i) Document all reported medications – prescription, over the counter, and illicit – including last dose and time;

(ii) Ask each patient aged 12-59 with the potential to become pregnant, including transgender males who retain reproductive potential, about current contraceptive methods, including oral contraceptives, transdermal patches, vaginal rings, and injectable contraceptives; and

(iii) Ask each patient about current or previous gender-affirming hormone therapy or other prescribed hormone therapy.

(b) Each patient shall be required to turn over any medications brought into a correctional facility to custody personnel for placement in their assigned property envelope.

(c) An RN or higher-level healthcare provider shall dispose of medications in accordance with OCS.130.0008 – Pharmacy and Therapeutics Manual and applicable laws and regulations.

(d) A healthcare provider shall administer medications and order new medications as needed following initial assessment.

(e) An RN or higher-level healthcare provider shall administer patient supplied medications as directed in OCS.130.0008 – Pharmacy and Therapeutics Manual.

(f) An RN or higher-level healthcare provider may administer community prescribed medications only if verified as packaged by a recognized correctional facility, detention center, or verified pharmacy.

(g) If the patient's next dose of medication is due during the current shift, an RN shall:

(i) Contact the intake provider to obtain written orders; or, if unavailable

(ii) Contact the on-call provider immediately for verbal orders.

(7) Emergency Contraception Screening.

(a) An RN or higher-level healthcare provider shall screen each patient aged 12-59 with the potential to become pregnant for eligibility for emergency contraception.

(b) If a patient reports having unprotected sex or being a victim of sexual assault within the last 5 days with a male or transgender woman, an RN shall:

(i) Refer the patient to a mid-level provider immediately if the reported event occurred within the last 5 days; or

(ii) Refer the patient to a mid-level provider no later than 24 hours if the reported event occurred within 4 days prior to arrest.

(8) Immediate Infection Disease Testing.

(a) Within 4 hours of acceptance, an RN or higher-level healthcare provider shall:

(i) Collect urine for chlamydia and gonorrhea testing;

(ii) Draw blood for syphilis testing and, if the initial syphilis screen is positive, obtain RPR with automatic FTA confirmation;

(iii) Perform rapid HIV testing; and

(iv) Perform rapid HCV testing.

(9) Observation and Visual Inspection.

(a) While completing the IMMS, an RN or higher-level healthcare provider shall observe:

(i) Appearance;

(ii) Interactions with personnel;

(iii) Psychiatric symptoms;

(iv) State of consciousness;

(v) Sweating; and

(vi) Tremors.

(b) While completing the IMMS, an RN or higher-level healthcare provider shall inspect for:

(i) Deformities;

(ii) Ease of movement; and

(iii) Need for braces, durable medical equipment, or prostheses.

(c) While completing the IMMS, an RN or higher-level healthcare provider shall examine visible skin for:

(i) Bruises;

(ii) Infestations;

(iii) Indications of drug use;

(iv) Jaundice;

(v) Needle marks;

(vi) Rashes;

(vii) Sores; and

(viii) Ulcerations.

(d) While completing the IMMS, and RN or higher-level healthcare provider shall:

(i) Assess the patient's mouth and teeth; and

(ii) Refer the patient immediately to the dentist for emergent or urgent dental conditions.

(10) Tuberculosis (TB) Screening.

(a) An RN or higher-level healthcare provider shall:

(i) Administer a PPD or IGRA Quantiferon gold within 72 hours of a patient's acceptance;

(ii) Read the administered PPD between 48 and 72 hours after placement;

(iii) Refer each patient with a positive PPD or a positive IGRA Quantiferon gold blood test for further evaluation and chest x-ray; and

(iv) Ensure the PPD or IGRA Quantiferon gold result is available for review during the patient's comprehensive 7-day history and physical examination.

(b) If the PPD is contraindicated, an RN or higher-level healthcare provider shall ensure that blood is drawn for an IGRA Quantiferon gold blood test within 72 hours of intake.

(c) A healthcare provider shall:

(i) Complete a chest x-ray within 5 days of a positive PPD reading or IGRA Quantiferon gold blood test;

(ii) Document the chest x-ray results in the patient's EPHR; and

(iii) Review signs or symptoms of tuberculosis (TB) and evaluate imaging to rule out active disease.

(d) A healthcare provider shall:

(i) Isolate each patient with a positive PPD or IGRA Quantiferon gold blood test who presents symptoms suggestive of active TB until infectious TB is ruled out; or

(ii) Waive isolation for each asymptomatic patient with a prior documented positive TB screening test and no evidence of active TB on current imaging or clinical evaluation.

(iii) Offer appropriate preventive treatment for latent TB infection (LTBI) as recommended by the CDC.

(11) Substance Use Screening.

(a) An RN or higher-level healthcare provider shall conduct substance use screening for each patient assigned a yellow wristband during the IMMS based on observed or reported withdrawal risk.

(b) The RN or higher-level healthcare provider shall:

(i) Establish a baseline COWS (opioids) or CIWA (alcohol);

(ii) Assess patient history of dependence, substance use disorder, or potential for withdrawal, and active symptoms;

(iii) Document the COWS or CIWA score in the patient's IMMS; and

(iv) Refer the patient immediately for clinical intervention of withdrawal or intoxication management as appropriate.

(c) If a patient awaits presentation to a commissioner, an RN or higher-level healthcare provider shall:

(i) Complete a Transfer of Housing form; and

(ii) Notify custody of the need for detox placement.

(d) An RN or higher-level healthcare provider shall:

(i) Provide withdrawal management as directed by OCS.130.0006 – Substance Use Disorder Manual;

(ii) Perform serial COWS or CIWA each shift for at least 48 hours;

(iii) Document serial COWS or CIWA scores in the patient's EPHR;

(iv) Refer each eligible patient to the substance use disorder specialist for methadone maintenance or continuation of buprenorphine; and

(v) Emergently refer any patient with signs or symptoms of opioid, benzodiazepine, or alcohol withdrawal after IMMS screening to the substance use disorder specialist.

(e) The substance use disorder specialist shall enroll each referred patient in the appropriate program within 24 hours of the completed IMMS screening.

(f) Special Considerations for Pregnancy Patients.

(i) An RN or higher-level healthcare provider shall provide an emergent referral to the intake provider for each pregnant patient with a history of substance use disorder who is not currently enrolled in a verifiable Opioid Treatment Program (OTP).

(ii) The intake provider shall:

a. Immediately consult with the substance use disorder specialist and the OB/GYN specialist to establish an individualized care plan;

b. Refer the patient to an off-site ED if appropriate; and

c. Maintain prescribed methadone or buprenorphine if verified as taken in the community.

(12) Mental Health and Suicide Risk Management.

(a) An RN or higher-level healthcare provider shall immediately refer any patient with suspected psychosis, unstable mood, suicidal thoughts or behavior, or severe agitation not attributable to substance use or delirium to the intake provider for clearance.

(b) The intake provider shall:

(i) Evaluate the patient for emergent mental health needs; and

(ii) Refer the patient to a mental health clinician or psychiatric RN for further evaluation.

(c) A mental health clinician or psychiatric RN shall perform a suicide risk evaluation (SRE) within 24 hours of admission from the community; and

(d) The mental health clinician conducting the suicide risk assessment shall:

(i) Follow the Department's applicable mental health policies; and

(ii) Take all clinically and procedurally required actions based on the findings.

(13) Physical or Functional Impairment Assessment.

(a) An RN or higher-level healthcare provider shall immediately refer any patient with a substantial physical or functional impairment requiring immediate care to the intake provider.

(b) The intake provider shall:

(i) Perform a physical and functional assessment;

(ii) Complete a disability assessment in the patient EPHR;

(iii) Order the required durable medical equipment (DME) or other necessary accommodation or supplies through the designated EPHR module;

(iv) Complete a Transfer of Housing form; and

(v) Provide a housing recommendation to custody for appropriate accommodations in compliance with OPS.200.0007 – ADA Accommodation for Incarcerated Individuals.

(14) Durable Medical Equipment (DME) and Medical Supply.

(a) An RN or higher-level healthcare provider shall:

(i) Immediately provide required DME or medical supply when available;

(ii) Obtain a signed Acknowledgment of Receipt form; and

(iii) Upload the completed Acknowledgment of Receipt form to the patient's EPHR.

(b) If the required DME or medical supply is not immediately available, an RN or higher-level healthcare provider shall:

(i) Document unavailability and all efforts to obtain the item in the patient's EPHR; and

(ii) Notify the intake provider of the delay for further clinical consideration.

(c) The intake provider shall:

(i) Take necessary steps to ensure patient safety while awaiting delivery; and

(ii) Consider infirmary admission or other appropriate housing until the required DME or medical supply is received.

(15) Heat Risk Code Assignment.

(a) Each incarcerated individual entering a Department facility as an intake shall be assigned an H1 heat risk code by default until completion of the 7-Day History and Physical Examination.

(b) An RN or higher-level healthcare provider shall:

(i) Document the patient's H1 heat risk code on the IMMS form in the patient's EPHR; and

(ii) Complete and sign Section 1 of *Form 100-0007dR – Transfer of Housing Assignment* by the end of the current shift; and

(iii) Immediately deliver the completed copy of *Form 100-0007dR – Transfer of Housing Assignment* to the shift commander and the traffic unit.

D. Continuity of Care, Medication, and Record Keeping.

(1) Continuity of care ensures that each patient's health information, medications, and active treatment needs are maintained during transition from the community into the Department's custody.

(2) Responsibilities of an RN or higher-level healthcare provider:

(a) An Rn or higher-level healthcare provider shall initiate the Continuity of Care form by competing all sections related to:

(i) Patient demographic information;

(ii) Current medical and mental health conditions; and

(iii) Current medications and substances reported by the patient, including:

a. Prescribed medications;

b. Over-the-counter medications; and

c. Non-prescribed or self-administered treatments.

(b) An RN or higher-level healthcare provider shall obtain a signed and completed Release of Information form to verify:

(i) Current prescriptions and medications;

(ii) Other health information required to support patient care management;

(iii) Information regarding any recent hospitalizations or treatment in progress prior to arrest or incarceration; and

(iv) Patient medical records necessary to ensure continuity of care from the community into the Department.

(c) An RN or higher-level healthcare provider shall document in the patient's EPHR:

(i) All efforts made to obtain information from external healthcare providers; and

(ii) The outcome of each effort, including whether records were received, pending, or unavailable.

(3) Record Validity.

(a) A signed and completed Release of Information form remains valid for 1 year from the date the patient signs it, unless the patient withdrawals consent in writing.

(b) An RN or higher-level healthcare provider shall update the release of information as necessary when additional external information is needed to maintain continuity of care.

(4) Medication Continuity Process.

(a) An RN or higher-level healthcare provider shall maintain all medical and mental health medications by following the Department's established medication continuity process to ensure uninterrupted therapy during intake and transition into Department custody.

(b) During the IMMS, an RN or higher-level healthcare provider shall:

(i) Determine whether to initiate or continue medication therapies that began prior to the patient's arrest or incarceration;

(ii) Collect available information regarding the patient's prescription and non-prescription medications, including:

a. Medication name and dosage;

b. Prescribing provider's name;

c. Name and address of the community clinic;

d. Name and address of the dispensing pharmacy; and

e. Date and time the patient last took the medication; and

(iii) Document all attempts to verify reported medications and outcomes of those attempts in the patient's EPHR within 8 hours of data collection or by the end of the shift, whichever occurs first.

(c) An RN shall:

(i) Complete the patient's assessment history during the IMMS;

(ii) Verify the patient's prescribed medication history using available sources, including:

a. The patient's EPHR;

b. The Chesapeake Regional Information System for Our Patients (CRISP);

c. Datalink or other integrated data system;

d. A local private healthcare provider; and

e. A local pharmacy.

(iii) Obtain information from the patient regarding any medications taken the day of intake and report this to the qualified healthcare provider for further evaluation;

(iv) Observe and document any physical evidence of current medications, including pill bottles, prescription labels, medication packaging, or containers provided by arresting or transporting officers; and

(v) Allow the patient to continue taking currently prescribed medications, pending verification and review by a qualified healthcare provider, when clinically appropriate.

(d) A qualified healthcare provider shall:

(i) Identify and continue the patient's pre-incarceration treatment regimen as reported by the patient, or prescribe a pharmacologically equivalent substitute when continuation is clinically necessary;

(ii) Write medication orders to continue pre-incarceration somatic and mental health medications, when appropriate;

(iii) Identify any medications the patient took on the day of intake, document this information in the encounter note, and enter the corresponding medication order in the patient's EPHR, including the expected start date and time;

(iv) Specify medications that require immediate or first-dose administration within 24 hours of intake when ordering medication; and

(v) Document the clinical decision to prescribe or discontinue any medication and provide the rationale for that decision in the patient's EPHR.

(5) Medication Refusal.

(a) If a patient refuses prescribed medications, an RN shall:

(i) Educate the patient on the purpose, risk, and benefits of the medication;

(ii) Document the refusal in the patient's EPHR and notify a qualified healthcare provider; and

(iii) Obtain and upload a signed Refusal of Treatment form into the patient's EPHR.

(b) Upon notification, a qualified healthcare provider shall:

(i) Educate the patient on the purpose, risk, and benefits of the medication;

(ii) Assess the clinical impact of the refusal; and

(iii) Determine whether continued administration attempts are warranted or if alternative treatments are appropriate.

(6) Stock Medications and Formulary Use.

(a) An RN or higher-level healthcare provider shall administer medications from stock when available and clinically appropriate.

(b) A medical provider shall submit a non-formulary request for any medication that is not available from stock and not listed on the Department's approved formulary.

(c) If the prescribed medication is not likely to be available within a 24 hour period the medical provider shall prescribe an appropriate alternative until the prescribed medication is available.

(7) Contraceptive Continuity.

(a) A qualified healthcare provider shall continue or prescribe contraceptives for any patient who was taking contraception prior to incarceration.

(b) A qualified healthcare provider shall prescribe oral contraceptive pills or a clinically appropriate alternative method (e.g., transdermal patches or vaginal rings) used prior to incarceration, whether for birth control or other medical indications.

(c) A qualified healthcare provider shall administer injectable contraceptives (e.g., Depo-Provera) every 3 months only as indicated and with shared decision making while the patient remains in pretrial custody.

(8) Medication-Assisted Treatment (MAT).

(a) An RN or higher-level healthcare provider shall:

(i) Identify each patient reporting enrollment in a verifiable OTP or buprenorphine treatment prior to incarceration; and

(ii) Immediately notify the substance use disorder specialist to coordinate continued treatment.

(b) A qualified healthcare provider shall:

(i) Continue or initiate MAT using methadone or buprenorphine when clinically appropriate and consistent with OTP coordination;

(ii) Prescribe interim treatment or symptom management pending OTP verification; and

(iii) Document the individualized MAT plan, medication orders, and follow-up care in the patient's EPHR.

(9) Pregnancy-Specific MAT.

(a) An RN or higher-level healthcare provider shall:

(i) Identify each pregnant patient with a history of opioid use disorder or enrollment in a community-based OTP; and

(ii) Immediately refer the pregnant patient to the intake provider.

(b) The intake provider shall:

(i) Maintain the patient on prescribed methadone or buprenorphine when verified or reasonably confirmed;

(ii) Immediately consult the Department's obstetric and substance use disorder specialist to establish an individuated care plan; and

(iii) Refer the patient to an off-site emergency department if neither specialist is available within a clinically appropriate timeframe.

(10) Medication Records and Administration.

(a) The intake provider shall:

(i) Prescribe somatic and mental health medications for up to 10 days based on the patient's clinical needs identified during the IMMS;

(ii) Clearly indicate which medications that require immediate or first-dose administration and when the initial dose of mediation should be administered within 24 hours of intake; and

(iii) Enter all prescribed medications into the patient's EPHR and ensure population into the Electronic Mediation Administration Record (EzMAR).

(b) An RN shall:

(i) Verify all medication orders in the EzMAR against the provider's signed orders in the patient's EPHR before administration;

(ii) Transcribe medication orders onto the paper Medication Administration Record (MAR) when the EzMAR is unavailable or incomplete;

(iii) Document all administered doses in the EzMAR or paper MAR, including date, time, route, and nurse's initials; and

(iv) Follow safe medication-administration practices consistent with Department policy and the RN's scope of practice.

(c) If a patient refused prescribed medication, the RN shall:

(i) Educate the patient on the purpose, benefits, and potential risks of refusing the medication;

(ii) Document the refusal in the EzMAR or paper MAR;

(iii) Document a corresponding nursing note in the patent's EPHR;

(iv) Notify a qualified healthcare provider of the patient's refusal; and

(v) Obtain and upload a signed Refusal of Treatment form into the patient's EPHR.

(d) Upon notification of a medication refusal, a qualified healthcare provider shall:

(i) Educate the patient on the purpose, benefits, and potential risks of refusing the prescribed medication;

(ii) Assess the clinical impact of the refusal; and

(iii) Determine whether continued administration attempts or alternative treatment are warranted.

(e) If a dose of medication is missed or delayed, an RN shall:

(i) Document the reason for the missed or delayed dose in the EzMAR or paper MAR, including the circumstances and any patient-related factors;

(ii) Notify a qualified healthcare provider if the missed or delayed dose may have clinical impact or requires rescheduling; and

(iii) Re-administer the medication when instructed or clinically appropriate; and

(iv) Document the new administration time in the EzMAR or paper MAR, including time, dose, route, and nurse's initials.

(v) Evaluate and document the patient's response to the PRN medication in the patient's EPHR within a clinically appropriate. timeframe.

(f) When administering PRN or as needed medications, an RN shall:

(i) Confirm the PRN order, maximum daily dosage, and allowable frequency in the EzMAR or paper MAR before administration;

(ii) Assess and document the patient's symptoms or condition supporting PRN use;

(iii) Record administration details in the EzMAR, paper MAR, and patient's EPHR; and

(iv) Evaluate and document the patient's response to the PRN medication in the patient's EPHR within a clinically appropriate. timeframe.

(g) When administering a controlled substance, and RN shall:

(i) Follow all DEA regulations and Department policy for controlled-substance handling, storage, and administration;

(ii) Verify each controlled-substance order against the patient's EPHR before administration;

(iii) Count and reconcile controlled-substance inventory at the beginning and end of each shift, with a second RN when required;

(iv) Document each administration in the controlled-substance logbook, EzMAR, and MAR, including patient name, dosage, time, and nurse's initials; and

(v) Immediate report any discrepancy, diversion, or waste to the on-duty supervisor and pharmacy, following internal reporting protocols.

(h) Post-Administration Observation and Monitoring.

(i) An RN shall observe and monitor each patient after administering medications that may produce adverse effects or require follow-up, including but not limited to:

a. Narcotics or opioids;

b. Psychotropic medications;

c. First-time-administered medications; or

d. Insulin or other glucose-lowering agents.

(ii) An RN shall:

a. Document observations and any adverse reactions or side effects in the patient's EPHR; and

b. Immediately notify a qualified healthcare provider when clinically indicated.

(i) During each shift exchange, the outgoing and incoming RN shall:

(i) Review the current medication list and pending medication dose of each patient;

(ii) Confirm and reconcile narcotic and controlled-substance counts;

(iii) Communicate and identify any patient requiring post-medication monitoring, urgent medication orders, or follow-up; and

(iv) Document completion of the shift-change medication handoff in accordance with the Department's nursing protocol.

(11) Indications for Emergent or Urgent Referral to Psychiatry Related Mental Health Mediation Continuation.

(a) The intake provider shall refer a patient to the psychiatry provider when the patient requires continuation of any mental health medication identified during the IMMS.

(b) Immediate Flagging and Log Entry.

(i) The intake provider shall place "**" (two asterisks) beside the patient's name and record the referral on the Emergent/Urgent mental Health Referral Log.

(ii) The intake provider shall promptly call the designated psychiatry provider covering emergent/urgent mental health issues to:

a. Discuss the reason for continuation;

b. Place an order for a mental health medication exception, if recommended by the psychiatry provider; and

c. Record the discussion in the patient's EPHR, including the psychiatry provider's name, date and time of consultation, medication options discussed, and final recommendations.

(c) Post-Consult Tasking and Follow-Up.

(i) After consulting with the psychiatry provider, the intake healthcare provider shall:

a. Submit a mental health referral in the patient's EPHR for follow-up by the healthcare vendor; and

b. Assign the consultation to the psychiatry provider through the EPHR tasking functionality.

(ii) If the EPHR cannot assign the consultation, the intake provider shall copy and email the completed consultation to the psychiatry provider.

(iii) The psychiatry provider shall:

a. Review the referral request;

b. Evaluate the patient;

c. Determine the final disposition regarding mental health medication (continue, substitute a pharmacological equivalent, or discontinue); and

d. Develop and document an individualized follow-up care plan, as needed.

(iv) An RN shall:

a. Transcribe or review medications ordered by a medical or mental health services clinician at intake and administer the first dose within 24 hours of the IMMS, using stock medications whenever possible;

b. Document medication administration – somatic, psychiatric, or single-dose; stock or non-stock – on the EzMAR or, if unavailable, the paper MAR, consistent with OCS.130.0008 – Pharmacy and Therapeutics Manual; and

c. Record use of stock medication on the stock card.

(v) A healthcare provider shall:

a. Assess and manage the patient's ongoing care at intake;

b. Prescribe the mental health medications documented during the IMMS when clinically indicated;

c. Complete a mental health referral request in the patient's EPHR after psychiatry consultation, if necessary;

d. Assign the completed consultation request to the designated mental health services clinician covering emergent/urgent services using EPHR tasking when available;

e. Refer to a psychiatrist for specific medication only when a valid clinical reason has been documented; and

f. If tasking is unavailable, copy and email the completed consultation request to the designated mental health services clinician covering emergent/urgent services.

(vi) If the psychiatric provider determines that no need exists to order the prior mental health medication or recommends a substitute/alternative:

a. The psychiatric provider shall record the rationale in the patient's EPHR; and

b. Schedule the patient to see a mental health services clinician within 24 hours for medication continuation consultation and individualized care planning.

(vii) The healthcare vendor shall:

a. Generate a daily Mental Health Medication Exception Report using the Emergent/Urgent Referral Log to identify each patient for whom mental health medications were not continued at intake;

b. Review the Emergent/Urgent Referral Log daily and, by the end of each shift, confirm with the onsite or on-call mental health services clinician that all flagged patients received appropriate care; and

c. Submit a weekly report by 12:00 p.m. (noon) each Monday to the designated Duvall coordinator or designee, identifying each patient referred to a mental health services clinician and the resolution/status or each case.

(12) Non-Formulary Medical and Mental Health Medications.

(a) The healthcare vendor shall use formulary medications whenever clinically appropriate.

(b) When no clinically appropriate formulary equivalent exists, or formulary agent is contraindicated, the healthcare vendor shall initiate the non-formulary request process without delay.

(c) Within 12 hours of a patient's IMMS, the intake provider shall:

(i) Substitute identified non-formulary medications with clinically appropriate formulary equivalent, when possible;

(ii) Complete a Non-Formulary Request form for each medication that cannot be substituted;

(iii) Submit the completed Non-Formulary Request form by secure fax or email to the regional medical director (RMD), state chief psychiatrist (for mental health medications), and clinical pharmacist for disposition;

(iv) Notify the RMD, state chief psychiatrist (as applicable), and clinical pharmacist by follow-up phone call to confirm receipt and expedite review; and

(v) Enter a corresponding medication order in the patient's EPHR with appropriate start parameters (e.g., "pending non-formulary approval") and document clinical justification in the encounter note.

(d) Disposition and Routing.

(i) Upon approval of non-psychotropic, non-formulary medication the RMD or RMD's designee shall forward the approved request to the pharmacy vendor.

(ii) Upon approval of a psychotropic, non-formulary medication the state chief psychiatrist, or the state chief psychiatrist's designee, shall forward the approved request directly to the pharmacy vendor via secure email.

(e) Pharmacy Vendor Responsibilities.

(i) The pharmacy vendor shall:

a. Process approved, non-formulary requests immediately upon receipt; and

b. Prioritize fulfillment to prevent interruption of therapy.

(ii) The pharmacy vendor shall complete processing of non-formulary requests within the same 12-hour window measured from the patient's completed IMMS evaluation, or as soon as operationally feasible when after-hours constraints apply.

(f) Documentation and Tracking. The intake provider shall document in the patient's EPHR:

(i) The clinical rationale for non-formulary use;

(ii) Submission time and method of the Non-Formulary Request form;

(iii) Name and title of individuals notified by phone;

(iv) Time of each notification made; and

(v) Final disposition and pharmacy transmission details once approved.

(13) Bridging and Escalation.

(a) If approval or supply of a non-formulary medication will delay therapy beyond the 12-hour requirement, the intake provider shall:

(i) Order an interim formulary alternative of pharmacologically appropriate equivalence, when clinically acceptable; or

(ii) Provide a single-dose or limited bridge supply form stock when available and clinically indicated in accordance with OCS.130.0008 – Pharmacy and Therapeutics Manual.

(b) The intake provider shall:

(i) Escalate unresolved delays to the RMD, or state chief psychiatrist for mental health medications, and the clinical pharmacist; and

(ii) Document the escalation and interim plan in the patient's EPHR.

(14) The healthcare vendor shall include non-formulary activity in the monthly CQI audits, reviewing timelines, appropriateness of justification, documentation completeness, and time-to-first dose.

E. **Special Housing Requirements and Accommodations.**

(1) Identification of Special Housing Needs.

(a) During the IMMS, the healthcare vendor shall identify any immediate health or safety issues that may require special housing placement or medical accommodation.

(b) An RN shall:

(i) Immediately refer the patient to an onsite healthcare provider or mental health clinician if IMMS responses indicate a need for special housing or accommodation; and

(ii) Immediately refer the patient to a mental health professional when the IMMS responses or initial PREA risk screening identify:

a. A patient at risk of committing or being a victim of sexual assault;

b. A transgender, gender-nonconforming, or intersex patient; or

c. A patient diagnosed with gender dysphoria.

(2) Referrals for Medical, Infectious, or Disability-Related Concerns.

(a) An RN shall immediately refer the patient to the intake provider if IMMS responses include any of the following:

(i) A positive result for tuberculosis (TB) or other communicable or infectious disease;

(ii) Signs or symptoms of TB or any suspected communicable or infectious disease;

(iii) Indication of substance use disorder or active drug use;

(iv) Known or suspected alcohol, benzodiazepine, or opioid withdrawal requiring rapid assessment for maintenance or initiation of treatment; or

(v) Indication of a medical condition, disability, or physical limitation requiring accommodation under the Americans with Disabilities Act (ADA).

(b) After completing the IMMS, an RN shall:

(i) Evaluate the patient;

(ii) Consult with the intake or on-call healthcare provider; and

(iii) Initiate written orders for:

a. Initiation or continuation of an assistive device;

b. Transfer to ADA housing accommodations;

c. Vital-sign monitoring; or

d. Other clinically necessary services.

(3) Special Housing Categories.

(a) The Department shall maintain 4 types of special housing for a patient with medical, mental health, or disability-related needs, as follows:

(i) Isolation Housing – for a patient diagnosed with, or suspected of having, a communicable disease or infection.

(ii) Observation and Treatment Housing – for a patient presenting with:

a. Abnormal vital signs, respiratory distress, or gastrointestinal distress;

b. Self-harming behavior or suicidal ideation; or

c. Withdrawal from alcohol or another substance.

(iii) Modified Non-Restrictive Housing – for a patient who:

a. Is at risk of sexual abuse;

b. Has physical limitations preventing safe movement in a standard cell; or

c. Requires a bottom bunk, durable medical equipment (DME), or an assistive device due to a physical limitation.

(iv) Heat-Stratification Housing – for a patient at risk of heat-related complications due to a medical or mental health condition.

F. **Facility Transfer and Release Procedures during the IMMS.**

(1) Within 12 hours of receiving custody notification of a patient transfer, and RN at the sending facility shall:

(a) Review the patient's medical record;

(b) Label the medical record envelope "H-1" or "H-2", as appropriate, based on the patient's heat-risk code;

(c) Complete a Transfer of Housing Assignment form; and

(d) Forward the patient's medical record and completed Transfer of Housing form to the receiving facility.

(2) Upon transfer, an RN at the receiving facility shall:

(a) Continue and complete the IMMS process if the patient transfers from another Department correctional facility before IMMS completion; or

(b) Conduct the full IMMS if the patient was admitted from a non-Department correctional facility.

(3) If a patient is released within 24 hours of intake, the healthcare vendor shall:

(a) Follow the procedures outlined in this Manual for continuity of care;

(b) Finalize the Continuity of Care form initiated during the IMMS; and

(c) Provide the patient with information on available community health resources.

.03 REFERENCES AND STANDARDS.

A. National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons (2026).

B. American Correctional Association (ACA), 5th Edition (2019).

.04 HISTORY.

Date Issued	March 1, 1996	DCD 130-100, § 110 Medical Intake Evaluation
Reviewed/Revised	July 15, 2007	Office of Treatment Services Manual, Chapter 1 DCD 130-100 (rescinded)
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.05 SECTION B – 7-DAY INTAKE – HISTORY AND PHYSICAL.

A. 7-Day History and Physical Examination.

(1) A qualified healthcare provider shall complete a comprehensive history and physical evaluation for each newly admitted incarcerated individual to a Department correctional facility as soon as possible, but no later than 7 calendar days after intake, regardless of whether earlier medical intervention is required.

(2) During this evaluation, a qualified healthcare provider shall identify medical, mental health, and dental issues and develop an individualized treatment plan to address ongoing, episodic, and chronic health needs by:

(a) Assessing urgent medical, mental health, or dental needs;

(b) Triaging each patient with known or identifiable chronic health needs;

(c) Isolating each patient who is potentially contagious or diagnosed with a communicable disease;

(d) Evaluate each patient who is at risk for suicide or self-harming behaviors and implementing appropriate intervention plans;

(e) Referring each patient with a history of acute or persistent serious psychiatric illness or developmental disabilities to the appropriate mental health professional;

(f) Assessing each patient who shows signs of withdrawal from controlled substances or those needing a substance use disorder assessment and intervention;

(g) Assessing the risk of heat-related illness or injury by screening for medical or mental health conditions that may be affected by high heat; and

(h) Completing the appropriate PREA Risk Screener for each patient within 7 days of intake.

B. Patient History and Physical Examination.

(1) A qualified healthcare provider shall:

(a) Complete a comprehensive history and physical examination for each newly admitted patient after completion of the IMMS, and as soon as possible and no later than 7 calendar days after intake; and

(b) Document the examination using the Department-approved Intake History and Physical Examination template in the patient's EPHR.

(2) Pre-Examination Requirements.

(a) Before beginning the comprehensive history and physical examination, a qualified healthcare provider shall:

(i) Confirm that the patient has completed and signed the Consent/Refusal of Medical Treatment form;

(ii) Confirm that the patient has completed and signed the Request and Authorization to Release Information form; and

(iii) Verify that the signed Consent/Refusal or Medical Treatment form and the Request and Authorization to Release Information form are properly filed in the patient's EPHR.

(b) If either form is not signed and on file in the EPHR, a qualified healthcare provider shall:

(i) Present the applicable form to the patient in a positive, respectful, and trauma-informed manner;

(ii) Explain the purpose and contents of the form in language the patient can understand, including reading the form aloud; and

(iii) Obtain the patient's signature in the appropriate section of the form before initiating the examination.

(3) Testing Requirements.

(a) The healthcare provider shall collect a test specimen for syphilis, gonorrhea, and chlamydia testing during the 7-Day History and Physical Examination if these tests were not completed during the IMMS.

(b) The healthcare provider shall clearly inform the patient that HIV testing is optional and explain the process for declining the test.

(c) If the patient refuses HIV testing, the healthcare provider shall ensure the patient documents the refusal on the Consent/Refusal of Medical Treatment form and that the form is filed electronically in the patient's EPHR.

(4) Patients Requiring a Comprehensive History and Physical Examination.

(a) The healthcare provider shall conduct a comprehensive history and physical examination tailored to the patient's anatomy, medical history, and healthcare needs for:

(i) Each patient entering a Department correctional facility from the community following arrest, entry from a court following sentencing, transfer from a local correctional facility after sentencing, transfer under the Interstate Correctional Compact, or receipt as a federal detainee;

(ii) Each patient transferred to an inpatient medical or mental health infirmary within 7 days of intake; and

(iii) Each patient who is admitted to an inpatient infirmary from a bedside commitment status in a community hospital.

(b) The healthcare provider shall conduct a comprehensive history and physical examination for every newly incarcerated individual, including "retakes" such as parole or probation violations, regardless of the length of time since prior incarceration.

(5) Review of Prior History and Physical Examination.

(a) When a previous history and physical examination was completed within the past 12 months and is available in the patient's EPHR, the healthcare provider shall:

(i) Review and reference the prior examination;

(ii) Verify whether any changes have occurred in the patient's medical or mental health status since that assessment;

(iii) Document updates or changes for each reviewed section; and

(iv) Incorporate the updated information into the new intake history and physical examination using the Department-approved 7-Day Intake History and Physical Examination template in the patient's EPHR.

(b) The healthcare provider may use the prior history and physical examination to supplement the current evaluation but may not replace the requirement to conduct a new examination at intake.

(6) Identification of Medical Needs.

(a) The healthcare provider shall identify and document all acute, chronic, or special medical needs, including but not limited to:

(i) Abnormal vital signs;

(ii) Acute medical problems;

(iii) Chronic medical conditions;

(iv) Physical disabilities;

(v) Pregnancy or recent pregnancy loss;

(vi) Prescription medications currently prescribed;

(vii) Physical trauma or surgery within the past 12 months;

(viii) Seizure disorder;

(ix) Substance use disorder; and

(x) Tuberculosis infection or disease.

(b) The healthcare vendor shall document all findings in the patient's EPHR.

(7) The healthcare provider shall evaluate the patient undergoing a history and physical examination and document the following information using the 7-Day Intake History and Physical Examination template in the patient's EPHR.

(a) Medical history, including but not limited to, the following:

(i) Allergies;

(ii) Chronic medical conditions;

(iii) Current medications;

(iv) Family history

(v) Social history;

(vi) The use of contraception by a patient, whether for birth control or medical reasons, and date of their last menstrual cycle;

(vii) The use of contraception by a transgender-male who has not undergone full gender-affirming medical treatment, whether for birth control or medical reasons, and date of their last menstrual cycle;

(viii) The use of contraception or hormonal management by an intersex patient, as clinically indicated based on the individual's anatomy and reproductive potential, including documentation of menstrual, hormonal, or reproductive-cycle information;

(ix) Head injuries;

(x) History of sexual, physical, emotional trauma or abuse;

(xi) Hospitalizations;

(xii) Identification of substantial physical impairments;

(xiii) Review of symptoms; and

(xiv) Vaccination history if the patient is younger than 18 years of age.

(b) The physical examination shall include an evaluation of the:

(i) Head;

(ii) Ears;

(iii) Eyes;

(iv) Nose;

(v) Mouth and teeth to determine if there are any apparent dental issues requiring referral and make referral as appropriate;

(vi) Oropharynx;

(vii) Neck;

(viii) Chest, including palpation of breasts for masses (shall be witnessed);

(ix) Heart;

(x) Lungs;

(xi) Abdominal exam, including palpation of the liver for masses;

(xii) Genital examination (shall be chaperoned) appropriate to the patient's specific anatomy and medical history, including:

a. Palpation of the testicles (if present) to check for masses; or

b. A pelvic examination when clinically indicated and with the patient's consent.

(xiii) Digital rectal prostate examination (shall be chaperoned), when clinically indicated (as stated below in diagnostics), including:

a. Stool guaiac testing for each patient aged 45-75 regardless of risk;

b. Individualized screening for each patient aged 76-85 based on screening history and health status; and

c. Consideration based on individual risk factors for transgender women who have retained their prostate;

(xiv) Observation and notation of Tanner stages of sexual characteristics development related to endogenous or exogenous hormonal influence;

(xv) Extremities;

(xvi) Lymphatics;

(xvii) Skin; and

(xviii) Neurological functioning cranial nerves 1-12, reflexes, and deficits.

(8) Refusals.

(a) The healthcare provider shall have the patient sign the Release of Responsibility form in the patient's EPHR if the patient refuses the full physical examination.

(b) If the patient refuses only a portion of the physical examination, the healthcare provider shall document the refusal in the progress note, including the reason for the refusal.

(9) Expedited Examination.

(a) The Department's Chief Medical Officer (CMO) may expedite the timeframe for conducting the 7-Day History and Physical Examination for any patient within a Department correctional facility when clinically or operationally necessary.

(b) The healthcare vendor shall document all expedited examinations with the reason for modification, date competed, and CMO's authorization in the patient's EPHR.

C. **Diagnostic and Preventive Health Screening Tests.**

(10) The healthcare provider shall:

(a) Conduct diagnostic and age-appropriate preventive health screening tests tailored to the patient's anatomy, medical history, and risk factors, consistent with the recommendations of the American Academy of Family Physicians (AAFP) and the Centers for Disease Control and Prevention (CDC);

(b) Conduct STI screening, including syphilis serology. If the syphilis screen returns positive, obtain a confirmatory rapid plasma regain (RPR) test with automatic Fluorescent Treponemal Antibody (FTA) confirmation;

(c) If the healthcare vendor did not conduct a PPD test during the IMMS, the healthcare provider shall draw blood for the necessary lab work, ensuring the results are available during the completed physical examination;

(d) If the healthcare vendor did not test the patient during the IMMS, the healthcare provider shall conduct STI screening, including tests for gonorrhea, chlamydia, and trichomonas via urine testing;

(e) Provide a patient with HIV and HCV education;

(f) Conduct HCV testing;

(g) Offer voluntary HIV testing;

(h) Perform Pap smear with HPV testing for each female, transgender male, and intersex patient aged 21-65 who has a cervix, unless a normal test was preformed and documented within the last 3 years, and perform an annual Pap smear for each patient who is HIV-positive;

(i) Review the pregnancy test results and refer each patient for obstetrical care as needed, in accordance with OCS.130.0004 – Pregnancy Manual. If the pregnancy test results are missing for any reason, repeat the test and document the results in the patient's EPHR. This guidance applies to each individual capable of pregnancy;

(j) Perform clinically indicated mammograms for each female, transgender male, and intersex patient who has breast tissue within the timeframes recommended by the AAFP and the US Preventive Services Task Force (USPSTF);

(k) Perform the Snellen vision test and a near vision test unless these tests have been performed and documented within the past 12 months;

(l) Perform audiometric testing for each patient aged 21 years of age or younger, and refer them for a full audiometric examination if they report a hearing problem or if the audiometric test results are abnormal;

(m) Perform a tuning fork assessment for each patient aged 22 years or older, and refer them for a full audiometric examination if they report a hearing problem or if the results of the tuning fork test are abnormal;

(n) Perform an electrocardiogram (ECG) when medically indicated;

(o) Perform blood chemistry tests and a urinalysis with microscopic examination if medically indicated;

(p) Perform sickle cell screening and other diagnostic studies when medically indicated;

(q) Conduct a chest x-ray if the patient has a past positive result for TB;

(r) Perform a prostate-specific antigen (PSA) test for each high-risk male, transgender female, and intersex patient aged 40 or older who have a prostate, if deemed appropriate through shared decision-making between the examining provider and the patient; and

(s) Perform a prostate-specific antigen (PSA) test for each average-risk male, transgender female, and intersex patient aged 50 or older who have a prostate, if deemed appropriate through shared decision-making between the examining provider and the patient.

(11) Diagnostic Lab Test Results.

(a) The healthcare vendor shall complete all intake lab tests within 48 hours of the order.

(b) The healthcare provider shall:

(i) Review RPR test results within 4 hours of receipt and document the review and actions taken in the patient's EPHR; or

(ii) Review intake diagnostic lab test results within 24 hours of receipt and document the review and actions taken in the patient's EPHR

(12) Identified Disabilities and Treatment plan.

(a) The healthcare vendor shall document a treatment plan for a patient identified with a disability during the 7-day history physical examination and update the patient's problem list in the EPHR.

(b) The healthcare vendor shall:

(i) Describe the identified disability in functional terms only, without disclosing related medical problems;

(ii) Completed a Disabilities Assessment form in the patient's EPHR; and

(iii) Forward a copy of the completed Disabilities Assessment form to the case manager supervisor of the intake facility.

(13) Reproductive Health Needs.

(a) The healthcare provider shall assess each incarcerated female, transgender male, and intersex patient aged 60 years or younger with reproductive anatomy requiring care for reproductive health needs, including but not limited to:

(i) Sexual activity;

(ii) History of contraception use;

(iii) Desire to become pregnant upon release; and

(iv) Potential need for abortion services.

(b) The healthcare provider shall provide appropriate preconception counseling to each incarcerated female, transgender male, and intersex patient who indicate a desire to become pregnant upon release, focusing on planning for a healthy pregnancy, including but not limited to:

(i) Cessation of tobacco, alcohol, and drug use;

(ii) Appropriate screenings and tests; and

(iii) Nutrition and vitamins.

(c) The healthcare provider shall offer each incarcerated female, transgender male, or intersex patient who can become pregnant, a full range of contraceptive methods that can be initiated on-site while in custody or coordinated as part of release planning on the patient's informed choice. Available on-site contraceptive methods include:

(i) Combined oral contraceptive pills;

(ii) Progestin-only oral contraceptive pills;

(iii) Injectable contraception;

(iv) Hormonal and non-hormonal intrauterine devices (IUDs); and

(v) Subdermal contraceptive implants.

(d) The healthcare provider shall:

(i) Offer reproductive health counseling, including contraceptive options and referrals to community-based providers, to any patient who does not wish to initiate contraception while in custody; and

(ii) Provide each patient with written information about local family planning and reproductive health clinics as part of discharge planning.

(e) If a patient expresses interest in an IUD or implant, the healthcare provider shall schedule two separate appointments:

(i) The first appointment is to provide comprehensive counseling on reproductive options, assess medical eligibility, and document patient interest; and

(ii) The second appointment to confirm informed consent and perform device placement if clinically appropriate.

(f) Placement of an IUD or implant shall be performed by:

(i) A qualified gynecological specialist authorized under Maryland law to perform contraceptive services; and

(ii) Using ACOG guidelines for IUD pain management.

(g) If a patient with an IUD or implant, regardless of whether the device was place in custody or in the community, requests removal, the healthcare provider shall refer

the patient to a qualified gynecological specialist for removal without unnecessary delay, consistent with the patient's medical needs and personal autonomy.

(h) If a patient initiates a contraceptive method while in custody, the healthcare provider shall provide written discharge instructions that include the names and locations of community providers offering follow-up care.

(i) If a patient begins oral contraceptive pills in custody, the healthcare provider shall dispense at least a one-month supply of medication at the time of release to support continuity of care.

(14) Abortion Counseling and Referral.

(a) The healthcare vendor may not interfere with the patient's constitutionally protected right to access abortion care.

(b) If a patient expresses a desire to access abortion services, the healthcare provider shall:

(i) Provide non-directive, unbiased counseling; and

(ii) Coordinate access to abortion services upon the patient's request without unnecessary delay.

(15) Treatment Plan/Risk Stratification.

(a) The healthcare vendor shall document treatment plan information on the 7-Day History and Physical Examination form and continue to adjust the individualized treatment plan in the patient's EPHR.

(b) The individualized treatment plan shall include, but not be limited to, the following:

(i) An assessment of active medical problems;

(ii) An enumeration of all medically indicated diagnostic studies and treatments;

(iii) Recommendations for specialty referrals;

(iv) Chronic care clinic assignment as per Department protocol including the placement of the clinical flow (i.e., diabetic flow sheet, etc.) record sheet in the medical record;

(v) Special housing assignment;

(vi) Special nutrition/dietary needs;

(vii) Final heat risk assessment;

(viii) Immunization assessment;

(ix) Medical alert assessment;

(x) Education/Special needs assessment and order referrals, as appropriate;

(xi) Instructions about exercise;

(xii) Adaption to the correctional environment;

(xiii) Risk stratification for chronic illness, as follows:

a. 0 – No Chronic Illness;

b. M1 – Chronically Ill – Stable; or

c. M2 – Chronically Ill – Unstable.

(c) The healthcare provider shall ensure that all identified medical, dental, and mental health problems are documented on the patient's problem list in the EPHR.

(16) Immunizations.

(a) The healthcare provider shall offer to:

(i) Vaccinate each patient with all age-appropriate immunizations;

(ii) Vaccinate each patient with tetanus/diphtheria toxoid when medically indicated; and

(iii) Document vaccination in the patient's EPHR using the appropriate immunization template.

(b) The healthcare provider may:

(i) Offer and schedule the COVID-19 vaccine during the intake process; and

(ii) Offer and schedule the influenza vaccine during the intake process, depending on the season.

(c) The healthcare provider shall:

(i) Assess the immunization needs of each patient under the age of 18;

(ii) Provide age-appropriate vaccination updates with prior authorization from the appropriate parent or guardian; and

(iii) Document the appropriate parent or guardian authorization to update vaccinations in the patient's EPHR.

(17) Medical Restrictions.

(a) The healthcare provider shall determine the:

(i) Appropriate level of medically permissible activity for each patient; and

(ii) Medically necessary housing assignment for each patient.

(b) The healthcare provider shall:

(i) Document the recommendation using the Medical Clearance Program and Work Assignment form in the patient's EPHR; and

(ii) Forward a completed copy of the Medical Clearance Program and Work Assignment form to the case management supervisor of the intake facility.

(18) Medical Alert.

(a) The healthcare provider shall assign a distinct medical alert badge to a patient if any of the following conditions apply:

(i) Alcohol/benzodiazepine or opiate use or abuse;

(ii) Dialysis-dependent renal disease;

(iii) Disabilities;

(iv) External medical devices;

(v) Heart disease;

(vi) Infectious disease;

(vii) Insulin-dependent diabetes;

(viii) Life-threatening allergies;

(ix) Moderate to severe asthma;

(x) Psychiatric illness; and

(xi) Seizure disorder.

(b) The healthcare provider shall:

(i) Assign a medical alert badge to a patient by completing the Medical Identification Request form in the patient's EPHR; and

(ii) Submit a completed copy of the Medical Identification Request form to the facility's identification unit, unless the facility managing official specifies otherwise.

(19) Heat Risk Code Assignment.

(a) The healthcare provider shall assess the patient's heat risk code during the 7-Day Intake – History and Physical.

(b) The healthcare provider shall assign the highest applicable heat risk code based on all known medical conditions and medications. Conditions include:

(i) Medications known to impair thermoregulation or increase dehydration risk are initiated, discontinued, or adjusted;

(ii) The patient's medical condition changes in a manner that may affect heat tolerance;

(iii) The patient experiences symptoms consistent with heat-related illness; or

(iv) Environmental or clinical factors indicate an increased risk of heat-related illness.

(c) The mental health clinician shall assess the patient's heat risk code during the patient's initial mental health evaluation.

(d) The mental health clinician shall assign the highest applicable heat risk code based on all known mental health conditions and medications when:

(i) Psychotropic medications are initiated, discontinued, or adjusted;

(ii) The patient's psychiatric condition changes; or

(iii) Environmental or clinical factors indicate an increased risk of heat-related illness.

(e) The healthcare provider or mental health services clinician assigning a patient's heat risk code, shall:

(i) Document the patient's heat risk code assignment in the patient's EPHR, on the Physical Examination Template within the medical classification field on the CMH homepage of NextGen;

(ii) Complete and sign Section 1 of *Form 100-0007dR – Transfer of Housing Assignment* by the end of the current shift; and

(iii) Immediately deliver the completed copy of *Form 100-0007dR – Transfer of Housing Assignment* to the shift commander and the traffic unit.

(f) If the healthcare provider or mental health services clinician assigns a heat risk code that changes the patient's medical clearance for programming or work assignments, they shall:

(i) Document the patient's heat risk code assignment in the patient's EPHR, on the Physical Examination Template within the medical classification field on the CMH homepage of NextGen;

(ii) Document the patient's medical status and restrictions on *Form OTS 130-100hR – Medical Clearance: Program and Work Assignment*; and

(iii) Immediately deliver a copy of the completed *Form OTS 130-100hR – Medical Clearance: Program and Work Assignment* to the facility case management office.

(20) Education/Special Needs Referral.

(a) The healthcare provider shall document all education provided to the patient related to their disease, condition, or access to care in the patient's EPHR.

(b) The healthcare provide shall refer a patient requiring special needs accommodation using the Department-approved referral form in accordance with DPSCS.200.0007 – Americans with Disabilities Act (ADA) Title II Non-discrimination and Accommodations for Persons with Disabilities.

.06 REFERENCES AND STANDARDS.

A. National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons (2026).

B. American Correctional Association (ACA), 5th Edition (2019).

.07 HISTORY.

Date Issued	March 1, 1996	DCD 130-100, § 110 Medical Intake Evaluation
Reviewed/Revised	July 15, 2007	Office of Treatment Services Manual, Chapter 1—DCD 130-100 (rescinded)
Reviewed/Revised	July, 2008	
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Reviewed/Revised	July 1, 2026	Substantively Updated

CHAPTER 2—PERIODIC MEDICAL EXAMINATIONS

.01 POLICY.

A. The Department shall:

(1) Ensure that a qualified healthcare provider conducts an annual examination for each patient aged 50 or older;

(2) Ensure that a qualified healthcare provider conducts a biennial health examination for each patient younger than 50; and

(3) Provide additional health examinations at intervals determined by a qualified healthcare provider, based on the patient's chronic condition or identified health risk, according to NCCHC and community healthcare guidelines.

B. A qualified healthcare provider shall:

(1) Conduct age- and gender-appropriate preventive health examinations at clinically appropriate intervals and tailored to the patient's anatomy, medical history, and health needs to ensure comprehensive preventive care following guidelines from the American Academy of Family Physicians (AAFP), the U.S. Preventive Services Task Force (USPSTF), and NCCHC;

(2) Assess the patient's functional independence using the Karnofsky scale, particularly during reexaminations of a patient with serious illness, debilitating conditions, or those over 55 years of age; and

(3) Evaluate the patient's need for palliative care during periodic medical examinations, including a review of advanced directives, symptom management, pain management, and psychological support services, with referrals provided as clinically indicated in accordance with NCCHC and community healthcare guidelines.

.02 PROCEDURES.

A. Comprehensive Physical Examination.

(1) The healthcare vendor shall:

(a) Provide a comprehensive physical examination in accordance with NCCHC and nationally recognized guidelines; and

(b) Ensure the examination is documented using the Periodic Examination template in the patient's EPHR.

(2) A qualified healthcare provider shall, at a minimum, perform the following:

(a) General assessment, including measurement of vital signs, height, weight, and body mass index (BMI);

(b) Examination and documentation of umbilical or inguinal hernias;

(c) Examination of the head, ears, eyes, nose, throat, neck, lymphatic system, skin, extremities, breasts, lungs, heart, abdomen, and genitalia;

(d) Pelvic examination and Pap smear for a patient with a cervix, as clinically indicated;

(e) Neurological assessment, including cranial nerve function, motor and sensory evaluation, reflex testing, and coordination assessment;

(f) Pulmonary function assessment, including peak flow measurement and pulse oximetry when indicated;

(g) Point-of-care testing, including random finger stick glucose tester;

(h) Tuberculosis screening and other infectious disease screenings, including hepatitis, HIV, and sexually transmitted infections;

(i) Mental health assessment, including screening for suicidal ideation, psychiatric disorders, and substance use history, with referrals as clinically indicated;

(j) Evaluation of chronic medical conditions, such as diabetes, hypertension, and respiratory disease, to determine ongoing care needs;

(k) Assessment of physical functionality and disability using the Karnofsky scale, for a patient with a serious illness or debilitating condition;

(l) Assessment of the risk of heat-related illness or injury by screening for medical or mental health conditions that may be affected by high temperatures; and

(m) Review of advance care planning, including assessment of palliative care needs, advanced directives, pain management, and psychological support services, with referrals as necessary.

B. **Diagnostic and Age-Appropriate Preventive Health Screenings.**

(1) The healthcare vendor shall:

(a) Provide diagnostic and age-appropriate preventive health screenings tailored to the patient's anatomy, medical history, and risk factors, in accordance with the recommendations of the American Academy of Family Physicians (AAFP) and NCCHC guidelines; and

(b) Ensure all screenings and diagnostic evaluations are documented using the Intake History and Physical Examination Template in the patient's EPHR.

(2) A qualified healthcare provider shall perform the following:

(a) Fasting blood glucose (FBG) and/or HbA1c test for diabetes;

(b) Complete blood count (CBC) to assess overall health and detect potential abnormalities;

(c) Screening for tuberculosis (TB) using PPD per NCCHC guidelines;

(d) Screening for HIV, hepatitis B and C, and sexually transmitted infections (STIs) as clinically indicated;

(e) Electrocardiogram (ECG) with interpretation at age 50 as a baseline study and at any age when medically indicated;

(f) Colorectal cancer screening using a fecal immunochemical test (FIT) or guaiac fecal occult blood test (gFOBT) (three samples);

(g) Assessment for colorectal abnormalities, including a digital rectal examination;

(h) Consideration for colonoscopy per clinical guidelines based on age and risk factors;

(i) Audiometric screening using a tuning fork for each patient aged 22 and older or a bell-tone audiometer for each patient aged 21 and younger;

(j) Snellen vision test to assess visual acuity;

(k) Evaluation for the need of a Prostate-Specific Antigen (PSA) test for each patient aged 40 or older with a prostate, and perform the test if deemed appropriate by the examining provider;

(l) Digital prostate examination for each patient with a prostate, beginning at age 40 or earlier if symptoms indicate a need;

(m) PSA test for each patient aged 50 and older with a prostate during their periodic physical examination;

(n) Point-of-care testing, including urinalysis dipstick to evaluate protein, red and white blood cells, and glucose levels; and

(o) Additional diagnostic tests as clinically indicated.

C. **Cervical Cancer Screening.**

(1) The healthcare vendor shall:

(a) Perform a cervical cancer screening using a liquid-based Pap smear for identifying abnormal cervical cells and testing for high-risk human papillomavirus (HPV) subtypes;

(b) Utilize the liquid-based Pap smear method to enable simultaneous screening for cervical cancer and sexually transmitted infections (STIs), including Chlamydia, Gonorrhea (GC), and HPV; and

(c) Conduct a cervical cancer screening based on age, health status, and individual risk factors, following the clinical guidance of the American College of Obstetricians and Gynecologists (ACOG) and the U.S. Preventive Services Task Force (USPSTF).

(2) A qualified healthcare provider shall follow USPSTF's recommendations as endorsed by ACOG recommendations as outlined below:

(a) **Age under 21:** Do not perform Pap smear screening.

(b) **Age 21-24:** Perform Pap smear alone every 3 years.

(c) **Age 25-29:** Continue Pap smear alone every 3 years and consider HPV testing alone if clinically appropriate.

(d) **Age 30-65:** Prefer Pap smear with HPV co-testing every 5 years. Alternative options include Pap smear alone every 3 years or HPV testing alone every 5 years, if clinically appropriate.

(e) **Age 65 or older:** Discontinue screening if the patient has not had a history of cervical changes and has had 3 consecutive negative Pap tests, or 2 consecutive

negative HPV tests within the last 10 years, with the most recent test within the past 5 years.

(f) **Post-hysterectomy:** Do not perform screening of a patient who has had a total hysterectomy and has no history of cervical cancer or high-grade cervical changes.

(g) The healthcare vendor shall ensure an annual cervical cancer screening for each patient at increased risk, including those who:

(i) Are HIV-positive;

(ii) Are immuno-compromised;

(iii) Have a history of diethylstilbestrol (DES) exposure in utero; or

(iv) Have a history of cervical cancer or cervical changes (CIN 2 or CIN 3).

(h) ACOG and USPSTF guidelines are generally aligned and are summarized below:

Screening Method	ACOG	USPSTF
Pap smear only	Every 3 years (Age 21-29)	Every 3 years (Age 21-29)
HPV testing only	May consider (Age 25-29)	Not recommended alone
Pap + HPV co-testing	Every 5 years (Age 30-65)	Every 5 years (Age 30-65)

(i) The Department adopts the USPSTF recommendations, as endorsed by ACOG, as the base line standard for cervical cancer screening, while permitting more frequent screening if clinically indicated.

(i) Begin Pap smear at age 21;

(ii) Perform Pap smear alone every 3 years through age 29; and

(iii) From age 30 through 65, perform Pap smear with HPV co-testing every 5 years as the preferred method.

(j) Clinical Decision-Making.

(i) The healthcare provider shall engage each patient in shared decision-making regarding screening options, particularly when multiple screening methods are appropriate.

(ii) The healthcare provider shall document all clinical decisions and patient education regarding screening frequency and method in the patient's EPHR.

(k) Documentation. The healthcare provider shall document in the patient's EPHR:

(i) Screening method used;

(ii) Screening interval applied;

(iii) Clinical risk factors assessed;

(iv) Patient counseling and education provided; and

(v) Results and follow-up plan.

D. **Breast Cancer Screening.**

(1) Breast cancer is the most common cancer among women in the United States and the second leading cause of cancer-related death in women. Screening aims to detect cancer at an early state, when treatment is most effective. However, screening may also lead to false positives, unnecessary procedures, or delayed detection in some cases.

(2) The healthcare vendor shall:

(a) Ensure that breast cancer screening services are provided in accordance with nationally recognized guidelines, including those of the U.S. Preventive Services Task Force (USPSTF); and

(b) Ensure screenings are based on the patient's age, risk level, and clinical history.

(3) A healthcare provider shall assess each patient's risk of developing breast cancer using a standardized risk assessment tool. Risk levels are determined as:

(a) **Average risk:** Lifetime risk <15%;

(b) **Moderate risk:** Lifetime risk 15-20%; or

(c) **High risk:** Lifetime risk >20%.

(4) A healthcare provider shall engage each patient in shared decision-making regarding the timing and frequency of breast cancer screening, considering the benefits and potential harms of screening.

(5) The healthcare vendor shall implement the following breast cancer screening practices for patients at **average risk**:

(a) **Under age 40:** Do not recommend screening mammography.

(b) **Age 40-74:** Recommend screening mammography every 2 years.

(c) **Age 75 or older:** Discontinue screening if life expectancy is less than 10 years; otherwise, consider continuation based on the individual health status and patient-provider discussion.

(6) The healthcare vendor shall implement the same screening approach for a **moderate risk** (e.g., one first-degree relative with a history of breast cancer and no high-risk genetic mutation) patient as an average-risk patient unless otherwise indicated.

(7) A high-risk patient includes those with:

(a) An individualal history of breast, ovarian, or fallopian tube cancer;

(b) Known genetic mutations associated with breast cancer (e.g., BRACA1, BRACA2);

(c) A strong family history suggestive of hereditary breast cancer; or

(d) A history of chest radiation between ages 10 and 30.

(8) A healthcare provider shall ensure that each high-risk patient is referred for specialized evaluation and management, which may include:

(a) Annual mammography starting at age 30-40, as clinically appropriate;

(b) Annual breast MRI, in addition to mammography; or

(c) Consideration of risk-reducing strategies, such as prophylactic bilateral mastectomy.

(9) Routine clinical breast examinations and self-breast examinations are not recommended for a patient at average risk, in alignment with USPSTF, ACOG, and AAFP guidance as methods have not been shown to reduce mortality from breast cancer; however, a healthcare provider may offer a clinical breast examination based on clinical judgement or at the patient's request, following education and shared decision-making.

E. **Tuberculosis Screening.**

(1) A qualified healthcare provider shall conduct tuberculosis screening for each patient annually or as clinically indicated, in accordance with OCS.130.0007 – Infection Control manual, NCCHC guidelines, and CDC recommendations.

(2) A qualified healthcare provider shall document screening results using the tuberculosis screening template in the patient's EPHR.

F. **HIV/AIDS Testing.**

(1) The healthcare vendor shall:

(a) Implement an opt-out HIV testing approach by informing each patient that HIV testing will be conducted unless the patient declines, in accordance with Health—General Article, § 18-336.2, Annotated Code of Maryland;

(b) Provide education to each patient regarding HIV transmission, prevention, strategies, treatment options, and viral suppression to support informed decision-making and engagement in care; and

(c) Document in the patient's EPHR that the patient received education and either accepted or declined testing.

(2) The qualified healthcare provider shall:

(a) Assess HIV risk factors during periodic physical examinations;

(b) Offer HIV testing during periodic physical examination and upon request, consistent with Health—General Article, § 18-336.2, Annotated Code of Maryland;

(c) Document the offer of testing in the patient's EPHR; and

(d) Document all screening results and any individualized treatment plan in the patient's EPHR.

(3) If a patient receives a positive HIV test result, the healthcare vendor shall:

(a) Notify the patient of the results in a confidential and clinically appropriate manner consistent with Health—General Article, § 18-338.1, Annotated Code of Maryland;

(b) Initiate an individualized HIV care plan, including counseling regarding disease progression, transmission prevention, and viral suppression;

(c) Ensure timely access to antiretroviral therapy (ART), indicated laboratory monitoring, and specialty consultation in accordance with current clinical guidelines; and

(d) Report confirmed HIV cases to the appropriate local health department in accordance with Health—General Article, § 18-205, Annotated Code of Maryland and COMAR 10.06.01.

(4) The qualified healthcare provider shall:

(a) Offer post-exposure prophylaxis (PEP) when clinically indicated; and

(b) Offer pre-exposure prophylaxis (PrEP) to each eligible HIV-negative patient who is at an ongoing risk of acquisition.

(5) Prior to being released into the community, the healthcare vendor shall:

(a) Adhere to procedures established in the current Memorandum of Understanding (MOU) between the Department and the Baltimore City Health Department to facilitate linkage to HIV care and continuation of antiretroviral therapy (ART);

(b) Coordinate discharge planning for each patient diagnosed with HIV by facilitating linkage to private healthcare providers; and

(c) Provide education and written information regarding medication continuation, follow-up appointments, and community HIV resources.

G. **Hepatitis Testing.**

(1) The healthcare vendor shall:

(a) Implement an opt-out testing approach by informing each patient that the Department will conduct hepatitis B (HBV) and hepatitis C (HCV) testing unless the patient declines;

(b) Provide education to each patient regarding hepatitis transmission, prevention strategies, vaccination availability, and treatment options to support informed decision-making; and

(c) Document in the patient's EPHR that education was provided and whether the patient accepted or declined testing.

(2) The qualified healthcare provider shall:

(a) Assess hepatitis risk factors during periodic physical examinations;

(b) Rescreen each patient for HBV and HCV during periodic physical examinations and upon request;

(c) Offer HBV vaccination to each patient who is non-immune or susceptible, unless contraindicated; and

(d) Document all screening results, vaccination status, immunity status, and the individualized treatment plan in the patient's EPHR.

(3) If a patient receives a positive hepatitis test result, the healthcare vendor shall:

(a) Notify the patient of the results in a clinically appropriate and confidential manner;

(b) Initiate an individualized care plan and provide counseling regarding disease progression, transmission prevention, and treatment options, unless the patient is already receiving appropriate treatment;

(c) Ensure timely access to indicated laboratory evaluation, antiviral therapy, specialty consultation, and ongoing monitoring in accordance with current evidence-based clinical standards; and

(d) Document all clinical findings, counseling, referrals, and treatment decision in the patient's EPHR.

(4) For a patient diagnosed with hepatitis, the healthcare vendor shall:

(a) Initiate discharge planning sufficiently in advance of release to support continuity of care;

(b) Facilitate linkage to private healthcare providers for ongoing treatment and monitoring; and

(c) Provide the patient with education and written information regarding community resources, medication continuation, and follow-up care.

(5) The healthcare vendor shall:

(a) Report all required hepatitis cases to the appropriate local or state health department in accordance with Health—General Article, § 18-201, Annotated Code of Maryland;

(b) Coordinate, as appropriate, with local and state health departments to support surveillance, outbreak response, and prevention initiative within the facility; and

(c) Maintain documentation of required reporting in the patient's EPHR.

H. **Heat Risk Code Reassessment.**

(1) The healthcare provider shall reassess the patient's heat risk code during each periodic physical examination.

(2) During any subsequent encounter, the healthcare provider shall assign the highest applicable heat risk code based on all known medical conditions and medications.

(3) The healthcare provider shall reassign a patient's heat risk code when:

(a) Medications known to impair thermoregulation or increase dehydration risk are initiated, discontinued, or adjusted;

(b) The patient's medical condition changes in a manner that may affect heat tolerance;

(c) The patient experiences symptoms consistent with heat-related illness; or

(d) Environmental or clinical factors indicate an increased risk of heat-related illness.

(4) If the healthcare provider reassigns a patient's heat risk code, the provider shall:

(a) Document the patient's heat risk code assignment in the patient's EPHR, on the Physical Examination Template within the medical classification field on the CMH homepage of NextGen;

(b) Complete and sign Section 1 of *Form 100-0007dR – Transfer of Housing Assignment* by the end of the current shift; and

(c) Immediately deliver the completed copy of *Form 100-0007dR – Transfer of Housing Assignment* to the shift commander and the traffic unit.

(5) If the healthcare provider reassigns a patient's heat risk code that changes the patient's medical clearance for programming or work assignments, the provider shall:

(a) Document the patient's heat risk code assignment in the patient's EPHR, on the Physical Examination Template within the medical classification field on the CMH homepage of NextGen;

(b) Document the patient's medical status and restrictions on *Form OTS 130-100hR – Medical Clearance: Program and Work Assignment*; and

(c) Immediately deliver a copy of the completed *Form OTS 130-100hR – Medical Clearance: Program and Work Assignment* to the facility case management office.

I. PREA Rescreening.

(1) The qualified healthcare provider shall conduct a PREA rescreening as part of the periodic healthcare examination in accordance with OPS.200.0006 – PREA Assessment for Risk of Sexual Victimization and Abusiveness.

(2) The qualified healthcare provider shall:

(a) Conduct a confidential, face-to-face interview with the patient using *OPS 200-6bR MMH PREA Risk Screener and Instructions for a MMH PREA Screening*.

(b) If a patient answers "yes" to questions (enter question numbers) then ask the patient if they would like a follow-up appointment with a mental health professional;

(c) If the patient consents to a follow-up appointment, assist the patient in completing *OPS 200-6bR – Mental Health Follow Up form* to the Department's mental health services; and

(d) Forward original *OPS 200-6bR MMH PREA Risk Screener form* to case management personnel.

J. New Diagnosis.

(1) Documentation of New Diagnosis.

(a) The qualified healthcare provider shall record each new diagnosis identified during a periodic medical evaluation in the patient's EPHR problem list on the date of diagnosis.

(b) The qualified healthcare provider shall update the problem list to reflect the current clinical status of the condition, including resolution and remission. Or chronic management status, as applicable.

(2) Communication of Test Results.

(a) The qualified healthcare provider shall review all diagnostic test results in accordance with established timeliness standards and shall:

(i) Notify the patient of normal test results within 14 business days of receipt and document the notification in the patient's EPHR;

(ii) Discuss abnormal test results face-to-face with the patient within 5 business days of receipt and document the discussion, clinical assessment, and care plan in the patient's EPHR;

(iii) Discuss urgent or critical abnormal test results with the patient immediately, or within a clinically appropriate timeframe consistent with the severity of the finding;

(iv) Initiate all necessary and immediate clinical interventions for urgent or critical findings in accordance with Department policy; and

(v) Document all actions taken in response to abnormal, urgent, or critical results in the patient's EPHR, including any referrals, medication changes, or additional testing ordered.

(3) When a patient receives a new diagnosis, the qualified healthcare provider shall:

(a) Develop an individualized treatment plan that includes:

(i) Clearly defined treatment goals;

(ii) A clinically appropriate follow-up schedule;

(iii) Patient education regarding diagnosis, prognosis, and management plan; and

(iv) Referral to specialty care when clinically indicated.

(b) Document the treatment plan in the patient's EPHR;

(c) Discuss the treatment plan with the patient in a manner appropriate to the patient's level of understanding; and

(d) Monitor the patient's response to treatment and modify the treatment plan as clinically indicated.

K. **Treatment Refusal.**

(1) If a patient refuses any recommended examination, diagnostic testing, treatment, referral, or follow-up care, the qualified healthcare provider shall document the refusal in the patient's EPHR.

(2) Informed Refusal Process.

(a) Before requesting the patient's signature on a Release of Responsibility form, the qualified healthcare provider shall:

(i) Explain the nature of the recommended examination, diagnostic test, treatment, or referral;

(ii) Explain the risks, benefits, and potential consequences of refusal;

(iii) Offer alternative options, when clinically appropriate; and

(iv) Document the discussion in the patient's EPHR.

(b) If the patient continues to refuse care, the qualified healthcare provider shall:

(i) Request that the patient complete and sign the Release of Responsibility form;

(ii) Document the specific service or treatment refused;

(iii) Document the patient's stated reason for refusal, when provided; and

(iv) File the completed Release of Responsibility form in the patient's EPHR.

(c) If the patient refuses to sign the Release of Responsibility form, the qualified healthcare provider shall:

(i) Document the refusal to sign in the patient's EPHR; and

(ii) Obtain a witness signature to attest that the patient was informed of the risk and declined to sign.

(3) The qualified healthcare provider shall continue to offer clinically appropriate care at subsequent encounters and may re-offer previously refused services when medically indicated.

L. **EPHR Documentation.**

(1) The qualified healthcare provider shall document each examination, diagnostic test, clinical assessment, result, and related clinical action in the patient's EPHR on the date the service is rendered or the result if reviewed.

(2) If the EPHR is unavailable due to system outage or technical disruption, the qualified healthcare provider shall:

(a) Document the examination, test, assessment, and clinical findings on an approved paper medical record form;

(b) Maintain the hard copy in a secure manner consistent with confidentiality requirements; and

(c) Scan and upload the documentation into the patient's EPHR within 72 hours of system restoration.

.03 REFERENCES AND STANDARDS

A. National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons (2026).

B. American Correctional Association (ACA), 5th Edition (2019).

.04 HISTORY.

Date Issued	March 1, 1996	DCD 130-100, § 110 Medical Intake Evaluation
Reviewed/Revised	July 15, 2007	Office of Treatment Services Manual, Chapter 1—DCD 130-100 (rescinded)
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Reviewed/Revised	July 1, 2026	Substantively Updated

CHAPTER 3—TELEMEDICINE AND TELEPSYCHIATRY

.01 POLICY.

A. The Department shall ensure that the contracted healthcare vendor provides telemedicine and telepsychiatry services to deliver timely, clinically appropriate care and maintain continuity of care for patients with acute and chronic medical or mental health conditions.

B. The healthcare vendor shall provide telemedicine services for medical care and telepsychiatry services for psychiatric care.

C. When a qualified healthcare provider determines that specialty medical care is clinically indicated, the healthcare vendor shall submit the request thorough the healthcare vendor's utilization management process and review and approve medically necessary telemedicine services without unreasonable delay.

D. The healthcare vendor shall provide telemedicine and telepsychiatry services in accordance with applicable clinical standards, the same standard of care required for in-person clinical encounters, patient confidentiality requirements, and Department policy.

.02 SECTION A – GENERAL TELEHEALTH PROCEDURES.

A. Technology, Equipment, and Security.

(1) The healthcare vendor shall provide and maintain Department-approved telecommunication systems and equipment used for telehealth services.

(2) Each remote provider shall:

(a) Use secure, real-time, two-way interactive audio-video technology;

(b) Conduct telehealth sessions through secure communication systems or dedicated secure lines;

(c) Implement encryption technology to protect the confidentiality and integrity of transmitted data; and

(d) Follow authentication procedures to verify the identity of both the sender and receiver before initiating a telehealth session.

(3) The healthcare vendor shall:

(a) Provide provider access through the Department's approved enterprise license or telehealth platform;

(b) Assign each provider a unique username and password;

(c) Prohibit the sharing of login credentials; and

(d) Maintain and monitor audit logs of provider system access.

(4) Telehealth services shall comply with:

(a) The HIPAA privacy rule;

(b) The HIPAA security rule; and

(c) State and federal patient confidentiality laws.

(5) Recording of telehealth sessions is prohibited.

B. **Provider Credentialing Requirements.**

(1) The remote provider shall:

(a) Maintain an active, unrestricted license to practice in the State of Maryland; and

(b) Practice within the scope of that license.

(2) The healthcare vendor shall:

(a) Verify licensure, credentials, and professional standing prior to authorizing a provider to deliver telehealth services; and

(b) Verify licensure in accordance with credentialing requirements.

(3) The remote provider shall complete initial and annual training on:

(a) The Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules;

(b) Department telehealth security protocols; and

(c) Proper use of telehealth systems and equipment.

(4) The healthcare vendor shall conduct a biannual competency assessment of each remote provider that includes:

(a) Proficiency in telehealth equipment use;

(b) Compliance with documentation standards; and

(c) Adherence to telehealth clinical protocols.

(5) The healthcare vendor shall maintain documentation of licensure verification, training completion, and competency assessments in accordance with Department credentialing requirements.

C. **Telehealth Examination and Provider Roles.**

(1) Trained healthcare personnel who are physically present with the patient during a telehealth encounter (telepresenter) shall:

(a) Verify the patient's identify prior to initiating the encounter;

(b) Provide the remote provider with access to relevant portions of the patient's medical record;

(c) Obtain and report vital signs and other clinical data as requested by the remote provider;

(d) Operate Department-approved medical peripherals and telehealth equipment as directed; and

(e) Document all procedures performed and clinical information obtained during the encounter in the patient's EPHR and, when applicable, in consultation notes.

(2) The remote provider or specialty consultant who conducts a telehealth encounter shall:

(a) Review the patient's available medical records and clinical information provided during the encounter;

(b) Conduct the clinical evaluation consistent with the applicable standard of care;

(c) Document findings, clinical impressions, recommendations, and services provided in the patient's EPHR or in consultation documentation submitted for inclusion in the patient's EPHR; and

(d) Clearly communicate the treatment plan, follow-up recommendations, and any required in-person evaluation to on-site healthcare personnel (telepresenter).

D. **Telehealth Session Procedures.**

(1) During normal working hours, the qualified healthcare provider who initiates a telehealth consultation shall:

(a) Attend the telehealth appointment;

(b) Assist the remote provider or specialty consultant with additional assessment or physical examination as requested; and

(c) Coordinate and document follow-up care in the patient's EPHR.

(2) If urgent or emergent care is required outside normal working hours, the RN shall:

(a) Contact the on-call provider to arrange an urgent or emergent telehealth consultation;

(b) Attend the telehealth appointment;

(c) Assist the remote provider or specialty provider with additional assessment or physical examination as requested; and

(d) Coordinate follow-up care in consultation with the on-call provider and document all actions in the patient's EPHR.

(3) If the patient's condition requires immediate in-person or hospital-level care, the RN or on-site medical personnel shall activate emergency response procedures in accordance with Chapter 4 of this Manual.

E. **Technical Failure and Security Breach Procedures.**

(1) If a technical failure prevents completion of a telehealth consultation, the on-site healthcare provider shall:

(a) Attempt to re-establish connection within 15 minutes;

(b) Notify the facility's Information Technology and Communications Department (ITCD) and the remote provider if the issue persists;

(c) Determine whether the consultation can safely continue using an alternative approved modality;

(d) Reschedule the appointment if the issue cannot be resolved the same day; and

(e) Document the interruption, actions taken, and rescheduling plan in the patient's EPHR.

(2) If a security breach or unauthorized access to telehealth equipment or systems is suspected or detected, the healthcare vendor shall:

(a) Immediately restrict access to the affected system;

(b) Immediately notify the Department's Chief Medical Officer (CMO) or designee and the Department's Information Technology and Communications Division (ITCD);

(c) Preserve relevant system log and audit data; and

(d) Initiate a HIPAA breach risk assessment and notification process in accordance with federal and Department policy requirements.

F. **Quality Assurance and Compliance Monitoring.**

(1) Monthly Telehealth Compliance Reporting.

(a) The statewide UM report coordinator, or designee shall generate a monthly telehealth compliance report by region.

(b) The monthly report shall include:

(i) The total number of primary care telehealth encounters;

(ii) The total number of specialty care telehealth consultations;

(iii) The number of primary care telehealth encounters by facility;

(iv) The number of specialty care telehealth consultations by facility; and

(v) Any additional telehealth performance data requested by the Department.

(2) Tracking Incomplete Telehealth Appointments.

(a) The healthcare vendor's UM department shall track and document all telehealth appointments that are not completed, categorized by specialty and facility.

(b) Documented reasons for incomplete or missed telehealth appointments shall include:

(i) Equipment failure;

(ii) Patient refusal;

(iii) Specialty provider cancelation;

(iv) Custody-related issue;

(v) Patient release from custody; or

(vi) Patient death.

(3) Corrective Action and Performance Review.

(a) The healthcare vendor shall review telehealth compliance data monthly to identify trends, delays, or systemic barriers.

(b) The healthcare vendor shall:

(i) Implement corrective action when patterns of delayed, canceled, or incomplete telehealth appointments are identified; and

(ii) Report significant compliance concerns to the Department in accordance with contract reporting requirements.

G. **Annual Evaluation and Continuous Quality Improvement (CQI) Review.**

(1) The healthcare vendor shall conduct an annual evaluation of telehealth services as part of the CQI process.

(2) The annual evaluation shall assess:

(a) Clinical effectiveness;

(b) Timeliness of care;

(c) Patient access to services;

(d) Compliance with documentation and security requirements;

(e) Trends in incomplete or delayed telehealth encounters; and

(f) Any additional telehealth performance data requested by the Department.

(3) The healthcare vendor shall present the annual telehealth evaluation findings at the statewide CQI forum to:

(a) Review performance outcomes;

(b) Identify systemic barriers or operational deficiencies; and

(c) Develop a corrective action plan when indicated.

(4) The healthcare vendor shall document all CQI findings and corrective actions in accordance with Department reporting requirements.

.03 SECTION B – TELEMEDICINE SERVICES.

A. Primary Care Telemedicine Services.

(1) Primary care telemedicine services allow a qualified healthcare provider to evaluate, diagnose, treat, and manage routine, non-emergent, or chronic healthcare needs when an in-person encounter is not clinically required.

(2) Primary care telehealth services may include:

(a) Continuity of care visits;

(b) Chronic disease management;

(c) Diagnostic result review;

(d) Medication management; and

(e) Non-emergent sick call encounters.

B. Specialty Care Telemedicine Services.

(1) Specialty care telemedicine services consist of consultations that allow a qualified specialty care provider to evaluate, diagnose, treat, or provide follow-up care for a patient's specialty healthcare need when clinical judgement determines that an in-person encounter is not required.

(2) Specialty telehealth consultations may include:

(a) Cardiology;

(b) Endocrinology;

(c) Gastroenterology;

(d) Nephrology;

(e) Neurology;

(f) Oncology;

(g) Orthopedics; or

(h) Other specialties approved through the UM process.

C. **Specialty Telehealth Authorization.**

(1) The healthcare vendor shall maintain a Specialty Care Telemedicine Consolation Log to ensure timely tracking, review, authorization, and coordination of all specialty care telemedicine requests and encounters.

(2) The Specialty Care Telehealth Consultation Log shall include:

(a) The patient's first and last name;

(b) The patient's SID number;

(c) The date and time the specialty care telehealth consultation request was submitted;

(d) The date and time the request was reviewed;

(e) The current status and disposition of the request; and

(f) Authorization number associated with the consultation, when approved.

(3) The healthcare vendor shall update each entry in real time to accurately reflect the current status of the consultation request.

(4) The site medical director shall:

(a) Review the Specialty Care Telehealth Consultation Log daily;

(b) Compile pending specialty care telehealth consultation requests; and

(c) Forward requests to the regional medical director for review.

(5) The regional medical director shall:

(a) Review specialty care telehealth consultation requests for clinical appropriateness; and

(b) Forward requests to the utilization management (UM) medical director for final review and authorization

(6) The UM medical director shall:

(a) Approve medically necessary specialty care telehealth services and assign a specific authorization code for approved consultations; or

(b) Issue an Alternate Treatment Plan (ATP), when appropriate, in accordance with the healthcare vendor's UM management process.

(7) Pre-Appointment Requirements.

(a) After approval and prior to scheduling the telehealth consultation, the qualified healthcare provider or designee shall:

(i) Review OTS 130-600-6 Informed Consent for Telemedicine Consultation form with the patient;

(ii) Explain the risks, benefits, and limitations of telehealth services; and

(iii) Obtain the patient's signature on OTS 130-600-6 Informed Consents for Telehealth Consultation form.

(b) If the patient refused to sign the consent form, the qualified healthcare provider or designee shall:

(i) Document the refusal in the patient's EPHR; and

(ii) Offer the patient the option of an in-person consultation when clinically appropriate.

D. **Scheduling and Prioritization of Specialty-Care Telemedicine Consultations.**

(1) The healthcare vendor shall schedule specialty-care telehealth consultations for each patient whose consultation request has received authorization through the utilization management process.

(2) The site medical director at each facility shall prioritize specialty-care telehealth referrals based on clinical necessity, acuity, and risk of adverse outcome.

(3) The site medical director, or the director's designee, shall notify the regional medical director (RMD) of any urgent or time-sensitive case that requires expedited scheduling.

(4) The healthcare vendor shall schedule urgent specialty-care telehealth consultations without unreasonable delay in accordance with established clinical timeframes.

.04 SECTION C – TELEPSYCHIATRY SERVICES.

A. **Oversight.**

(1) The healthcare vendor or contracted provider shall comply with telepsychiatry policy and procedure when providing telepsychiatry services within the Department.

(2) The Director of Mental Health Services and the healthcare vendor's psychiatric medical director shall oversee the Department's telepsychiatry program.

(3) Telepsychiatry services shall comply with applicable state laws and regulations, national clinical practice guidelines, and the standards of the American Correctional Association (ACA) and National Commission on Correctional Health Care (NCCHC).

B. **Definition and Scope of Telepsychiatry.**

(1) A psychiatrist or psychiatric-mental health nurse practitioner (PMHNP) shall provide telepsychiatry services within the scope of the provider's professional license using secure, real-time, two-way interactive audio-video communication technology.

(2) Telepsychiatry services may not consist solely of:

(a) Telephone conversations;

(b) Electronic mail messages;

(c) Facsimile transmissions; or

(d) Provider-to-provider consultations that do not include direct patient interactions.

(3) A psychiatrist or PMHNP may use telepsychiatry for:

(a) Initial psychiatric evaluations (IPE);

(b) Pharmacological management;

(c) Psychiatric consultations;

(d) Routine follow-up interviews; and

(e) Collaboration with on-sire healthcare personnel.

(4) A psychiatrist or PMHNP may not use telepsychiatry to:

(a) Evaluate a patient housed in an inpatient mental health unit;

(b) Evaluate a patient admitted to a medical infirmary;

(c) Evaluate a patient placed in a crisis observation cell; or

(d) Conduct new medication evaluations during intake.

C. **Telepsychiatry Patient Preparation, Clinical Supervision, and Documentation.**

(1) Before a telepsychiatry encounter, the telepsychiatry coordinator shall prepare the patient by informing the patient of:

(a) The purpose of the encounter;

(b) The telepsychiatry process;

(c) The telepsychiatry equipment that will be used during the encounter;

(d) The name and medical specialty of the telepsychiatry provider; and

(e) The individuals who will be present at both locations during the telepsychiatry encounter.

(2) The telepsychiatry coordinator shall remain present with the patient during the scheduled telepsychiatry appointment unless clinical circumstances require otherwise.

(3) Each telepsychiatry session shall be conducted in a manner consistent with in-person psychiatric clinical encounters and applicable professional standards of care.

(4) The psychiatric provider shall document the following information in the patient's EPHR:

(a) The patient's physical location during the telepsychiatry session;

(b) Diagnosis and differential diagnosis, when applicable;

(c) A summary of clinical findings;

(d) The treatment plan; and

(e) Medication orders or changes.

D. **Psychiatric Crisis During Telepsychiatry.**

(1) If a patient exhibits psychiatric distress or crisis symptoms during a telepsychiatry session, the telepsychiatry coordinator shall:

(a) Coordinate with custody personnel when immediate security intervention is required;

(b) Terminate the telepsychiatry session when necessary to protect the patient's immediate safety; and

(c) Refer the patient to on-site mental health personnel for immediate evaluation and intervention.

(2) If a psychiatry crisis occurs during a telepsychiatry encounter, the telepsychiatry provider shall:

(a) Notify the regional chief psychiatrist, crisis psychiatrist, or on-call psychiatrist for urgent consultation when clinically indicated; and

(b) Document the psychiatric crisis, clinical assessment, and intervention in the patient's EPHR.

E. **Telepsychiatry Audit.**

(1) The healthcare vendor, in collaboration with the Department's Information Technology and Communications Division (ITCD) shall conduct an annual telepsychiatry technology audit to verify:

(a) HIPAA encryption compliance;

(b) Connectivity and bandwidth requirements; and

(c) Security patch compliance.

.05 REFERENCES AND STANDARDS

A. National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons (2026).

B. American Correctional Association (ACA), 5th Edition (2019).

C. OPS.130.0013—DPSCS Tele-Medicine Manual.

D. HIPAA 45 CFR Part 164.530(b).

.06 HISTORY

Date Issued	August 12, 2012	
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CHAPTER 4—EMERGENCIES

.01 POLICY.

A. The Department shall ensure that emergency healthcare is provided to patients by the healthcare vendor through community emergency medical services in accordance with established procedures for community standards and the Department's approved Utilization Management (UM) Procedures and Protocol Manual.

B. The healthcare vendor shall:

(1) Establish written criteria for identifying emergencies and prioritizing emergency conditions using clinically accepted triage protocols;

(2) Ensure 24/7 access to emergency medical care, either on-site or through immediate transport to an external provider;

(3) Ensure that a qualified healthcare provider and psychiatric provider is on-call 24 hours a day, with coverage documented on a monthly roster that is distributed in advance and posted for all personnel and facility personnel.

(4) Ensure effective coordination between medical personnel and security personnel during emergencies to maintain safety and facilitate the timely delivery of care;

(5) Require each individual involved in emergency care to maintain current certification in Basic Life Support (BLS) and, when appropriate, Advanced Life Support (ACLS); and

(6) Require documentation of all emergency encounters in the patient's EPHR and Quarterly Serious Incident/Risk Management Report to ensure continuity of care and support clinical oversight.

C. Licensed healthcare personnel contracted by the Department shall complete training in the use, deployment, and maintenance of Automated External Defibrillators (AEDs) as part of Basic Life Support (BLS) requirements to ensure a rapid and effective response to cardiac emergencies involving incarcerated individuals, employees, and visitors.

.02 PROCEDURES.

A. Community Emergency Medical Services – Access and Awareness.

(1) The healthcare vendor shall maintain access to community emergency medical services (EMS), including but not limited to:

(a) Community hospitals;

(b) Emergency departments;

(c) Poison control centers;

(d) Regional burn centers; and

(e) Regional trauma centers;

(2) The healthcare vendor shall:

(a) Post emergency response listing containing addresses, telephone numbers, and 24/7 contact information in medical areas designated by a regional medical director and administrative areas designated by the facility's managing official;

(b) Maintain emergency equipment such as automated external defibrillators (AEDs), oxygen tanks, and first aid supplies in designated areas, inspect and restock equipment monthly, and immediately correct any deficiencies; and

(c) Require all medical personnel and administrative medical personnel who complete annual in-service training to maintain current certification in Basic Life Support (BLS), first aid, and emergency response procedures.

(3) The regional medical director shall:

(a) Coordinate 911 emergency services with local emergency healthcare providers responsible for ambulance "911" response operations; and

(b) Conduct quarterly reviews of emergency healthcare services to ensure compliance with policy and identify areas for improvement.

B. Emergency Procedures.

(1) A healthcare vendor employee who observes or becomes aware of a patient exhibiting signs or symptoms of an unusual presentation shall immediately respond, assess the patient, and make a clinical determination regarding the patient's condition and the

need for emergency medical intervention, regardless of the institutional location of the patient or whether a medical emergency has been reported.

(2) The healthcare vendor shall follow the approved UM Procedure and Protocol Manual for emergency notifications, including:

(a) Immediate transport of a patient requiring emergency medical treatment after assessment by an RN or higher-level healthcare provider; and

(b) Promptly reporting delays or issues with 911 responses to the healthcare services administrator, regional medical director, Agency Contract Operations Manager (ACOM), and Department's Chief Medical Officer (CMO).

(3) The healthcare vendor shall:

(a) Immediately respond to all emergencies upon notification by anyone reporting the event;

(b) Provide immediate emergency response and treatment to patients, personnel, and visitors by:

(i) Administering first aid and BLS to an incarcerated individual experiencing a medical emergency;

(ii) Triaging and managing an individual member or visitor experiencing a medical emergency, regardless of institutional location until transfer to an infirmary or community emergency services arrive; and

(iii) Encouraging an individual member or visitor with a non-emergent condition to seek prompt care from their primary care or urgent care provider;

(c) Send any patient who receives cardiopulmonary resuscitation (CPR) or Narcan intervention (nasal or injectable) to a community hospital for further evaluation;

(d) Except as provided in § .02B(2)(c) of this chapter, send any patient who receives emergency services to the emergency department, unless a qualified healthcare provider conducts a face-to-face evaluation and determines that 24-hour observation in a medical infirmary is clinically appropriate prior to returning the patient to their assigned housing unit;

(e) Observe all patients returning from a community hospital or emergency department in a medical infirmary for a minimum of 24 hours, and continue observation until the patient is deemed medically cleared for discharge, unless a

qualified healthcare provider conducts a face-to-face evaluation and determines that immediate return to assigned housing is appropriate; and

(f) Ensure that, regardless of the facility from which a patient is sent, the patient returns to a facility with an operational infirmary for appropriate post-emergency observation and care.

C. **Higher-level Healthcare Provider—Not on Site.**

(1) If a healthcare provider is not on-site, the RN shall:

(a) Consult with the on-call provider to obtain any necessary interventions and to secure clearance for the patient's return to the housing unit;

(b) Schedule an on-site follow-up appointment with an on-site provider to occur within 48 hours; and

(c) Ensure that any written consultation report received is documented in the patient's EPHR and forward to the facility healthcare provider for review and signature within 48 hours of receive, if the report was not available at the time of the patient's return to the facility.

D. **Training and Certification.**

(1) The healthcare vendor shall:

(a) Ensure that healthcare providers, nursing personnel, dental personnel, mental health personnel, administrators, and support personnel working in a correctional facility:

(i) Are certified in BLS; and

(ii) Maintain current BLS certification;

(b) Ensure that healthcare providers, nursing personnel, dental personnel, mental health personnel, administrators, and support personnel working in a correctional facility:

(i) Are certified in the administration of nasal Narcan during new employee orientation and prior to providing services; and

(ii) Receive certification that includes hand-on competence testing to ensure preparedness for effective emergency response.

(c) Ensure that healthcare providers, nursing personnel, dental personnel, mental health personnel, administrators, and support personnel working in a correctional facility:

(i) Receive initial AED training within 30 days of hire;

(ii) Complete a self-directed learning module every 6 months to reinforce AED operational knowledge and awareness of any updates to equipment or protocols; and

(iii) Complete AED training as part of CPR recertification, including an annual, documented, hands-on AED skills refresher to maintain clinical readiness.

(2) The healthcare services administrator shall:

(a) Conduct quarterly audits of training records to ensure compliance with certification and recertification requirements;

(b) Update training curriculum as necessary;

(c) Ensure healthcare personnel in all correctional facilities complete CPR and AED training with documented competency specific to healthcare providers; and

(d) Ensure that at least annually, designated healthcare personnel receive in-service training on emergency medical care, including:

(i) First aid;

(ii) Review of the usage and location of stock emergency medications, supplies, and equipment;

(iii) Recertification for CPR, AED, BLS, and nasal Narcan administration; and

(iv) Interdisciplinary emergency response exercises involving custody, healthcare, and administrative personnel.

(e) Ensure that emergency equipment, including AEDs and first aid kits are placed in accessible locations throughout the facility and inspected monthly to ensure readiness;

(f) Maintain documentation of CPR, BLS, AED, and Narcan training and certification in the healthcare vendor's on-site administrative office; and

(g) Review and update training or certification documentation annually within credentialing and training folders in the Department's document management system.

E. **Emergency Equipment, Supplies, and Personnel Readiness.**

(3) The regional medical director, in collaboration with the pharmacy contractor's clinical pharmacist shall establish and update the list of approved emergency medications, supplies, and equipment that dispensaries and infirmaries must maintain.

(4) The healthcare vendor assigned to a dispensary or infirmary shall maintain an AED and ensure a designated vendor employee:

(a) Check the functionality of the AED and other emergency response equipment every shift;

(b) Documents the results of functionality check as part of the crash cart checklist and emergency equipment log; and

(c) Submits a monthly AED utilization report for inclusion in the Continuous Quality Improvement (CQI) monthly meeting agenda.

(5) The healthcare vendor assigned to a dispensary or infirmary area shall maintain emergency crash carts stocked with approved medical supplies listed on the *Emergency Cart Supply List*.

(6) The healthcare vendor shall:

(a) Ensure crash carts remain sealed without compromising emergency access;

(b) Inspect the tamper seal for breakage and validate functionality during every shift using the crash cart checklist;

(c) Restock used or expired medications and supplies during the same shift they are identified or used; and

(d) Conduct a weekly inspection to verify the availability and validity of supplies and medication in accordance with the crash cart's inventory list.

(7) The healthcare vendor assigned to a dispensary or infirmary area shall maintain emergency equipment—including portable oxygen tanks, portable suction machines, and associated supplies—and ensure that designated vendor employees check these items for readiness during every shift.

(8) The regional medical director, in collaboration with each facility managing official shall:

(a) Maintain compact and manually transportable first aid kits in secure and accessible locations as directed by OCS.130.0008 – Pharmacy Services Manual.

(b) Ensure the designated individual employed by the healthcare vendor reviews the inventory of facility first aid kits monthly to confirm all supplies are individually wrapped and dry;

(c) Ensure the designated individual employed by the healthcare vendor replaces and documents outdated inventory and missing medications; and

(d) Verify the inventory in authorized Department motor vehicles monthly in coordination with designated custody personnel.

F. **AED Operation, Troubleshooting, and Maintenance.**

(1) AED operation, troubleshooting, and maintenance shall include:

(a) Operation and deployment in an emergency;

(b) Troubleshooting common AED issues;

(c) Battery replacement and performing battery checks; and

(d) Routine AED maintenance procedures.

(2) The healthcare vendor shall:

(a) Maintain AEDs in designated clinical areas within the infirmary and the dispensary area;

(b) Ensure AEDs are stored properly and remain readily available with other emergency equipment;

(c) Maintain AEDs in good working condition; and

(d) Document a progress note in the patient's EPHR to reflect the use of the AED during an emergency situation, including the clinical indication of its use.

(3) The RN on each shift at each location where an AED is kept shall:

(a) Complete the Safety Inspection Log and document the following information:

(i) Condition of carrying case;

(ii) Battery check status indicator; and

(iii) Confirmation of appropriate equipment in the carrying case;

(b) Correct any discrepancy noted during the inspection during the shift in which the inspection occurred by:

(i) Recording the discrepancy on the Safety Inspection Log;

(ii) Replenishing the supply that was missing, depleted, or expired;

(iii) Documenting the date and time the discrepancy was corrected on the Safety Inspection Log; and

(iv) Reporting the discrepancy to the director of nursing or designated nurse manager accordingly; and

(c) Ensure a back-up AED battery is always available on site.

(d) The healthcare vendor shall submit a monthly state-wide report on AED utilization to the Department's ACOM and Chief Medical Officer.

G. **Naloxone hydrochloride (Narcan).**

(1) Supplies.

(a) The healthcare vendor shall maintain the approved quantity of nasal Narcan supplies on-site.

(b) The healthcare vendor shall follow the approved procedures for the secure storage and accountability of nasal Narcan by the pharmacy vendor.

(2) Usage.

(a) The healthcare vendor shall track Narcan usage by documenting:

(i) The patient's first and last name;

(ii) The patient's SID number;

(iii) The date of the incident;

(iv) The time of the incident;

(v) The correctional facility in which the incident occurred;

(vi) The type and quantity of Narcan used;

(vii) The patient's response; and

(viii) The patients disposition.

(b) The healthcare vendor shall:

(i) Document each use of Narcan in the patient's EPHR;

(ii) Provide a monthly summary report of Narcan use to the ACOM during the monthly regional CQI meeting; and

(iii) Submit a quarterly report of Narcan use for both suspected and confirmed overdose to the Department's CMO as part of the quarterly and annual risk management reports.

(c) The dental contractor shall:

(i) Provide a monthly summary report for the use of Narcan as part of the monthly CQI meeting report; and

(ii) Submit a monthly summary with CQI meeting report into the Department's document management system.

H. **Emergency Department Reviews.**

(1) The facility healthcare provider shall:

(a) Assess the patient's physical and mental status within 24 hours upon return to the facility from an outpatient consultation to determine clinical stability and the need for further intervention;

(b) Review the treatment plan, necessary diagnostic studies, evaluation and treatment recommendations with the patient during the follow-up; and

(c) Determine clearance for the patient's return to the housing unit.

(2) If a healthcare provider is not on-site, the RN shall:

(a) Consult with the on-call provider to obtain any necessary interventions and to secure clearance for the patient's return to the housing unit.

(b) Schedule an on-site follow-up appointment with the facility healthcare provider to occur within 48 hours; and

(c) Ensure that any written consultation report received is documented in the patient's EPHR and forwarded to the facility healthcare provider for review and signature within 48 hours of receipt.

(d) The RN or facility healthcare provider shall document the following in the patient's EPHR before the end of the shift:

(i) The emergency services provided;

(ii) Date and time of the ambulance's arrival;

(iii) The patient's condition prior to transport; and

(iv) The receiving hospital.

(e) The RN or facility healthcare provider shall make every reasonable effort to obtain a copy of the patient's medical and discharge summary from the treating hospital.

(3) The site medical director shall review each ER run for appropriateness and include this review in the monthly and quarterly CQI meeting.

(4) The regional medical director shall conduct a weekly regional ED review with the site medical teams to assess the appropriateness of each ED send-out for educational purposes and to review preventable ED send-outs.

(5) The healthcare vendor shall:

(a) Provide the regional ACOM and Department's Chief Medical Officer with a daily and monthly ED run report for all regions, including:

(i) Patient's first and last name;

(ii) Patient's SID number;

(iii) Date of the incident;

(iv) Time of the incident;

(v) A brief description of the incident explaining the rationale for the ED run;

(vi) A review of the medical record upon the patient's return;

(vii) The hospital diagnosis and International Classification of Disease (ICD) code;

(viii) A heat stratification update;

(ix) The infirmary to which the patient returned; and

(x) The final disposition and follow-up care.

(b) Generate a quarterly report of all emergencies in a Quarterly Serious Incident/Risk Management Report and submit the report to the Department's document management system; and

(c) Provide the ER Review and Utilization report in the agenda for the monthly regional CQI meeting, the quarterly regional multi-vendor meeting, and the state-wide, multi-vendor CQI meeting.

I. Emergency Response and Disaster Drill Training.

(1) Department medical employees, healthcare vendor employees, and custody employees shall participate in monthly interdisciplinary emergency and disaster drill training.

(2) The healthcare vendor, in coordination with the facility managing official, shall conduct quarterly emergency response training to respond to health-related situations within a four-minute response time.

(3) The health services administrator shall:

(a) Conduct quarterly audits of training records and emergency response procedures to ensure compliance;

(b) Conduct emergency drills at least semi-annually in each Department correctional facility and maintain documentation of each drill in the Department's document management system;

(c) Review and update the training curriculum as necessary;

(d) Maintain documented evidence of initial training, certification, and required refresher training in both the employee's on-site file and credentialing/training folder in the Department's document management system; and

(e) Ensure the healthcare vendor conducts credentialing and training file audits in accordance with the Department's approved audit calendar.

.03 REFERENCES AND STANDARDS.

A. National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons (2026).

B. American Correctional Association (ACA), 5th Edition (2019).

.04 HISTORY

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CHAPTER 5—CONSULTATIONS

.01 POLICY.

A. The Department shall ensure that each patient's timely access to medical, surgical, mental health, and dental consultations.

B. The healthcare vendor shall conduct all consultations in accordance with the Department-approved Utilization Management (UM) Protocol and Procedures Manual.

C. The UM process may not create unreasonable delays or barriers to medically necessary care.

D. Urgent and life-threatening conditions shall receive expedited review to support immediate access to appropriate services.

.02 PROCEDURES.

A. Consultation Requests.

(1) The healthcare provider shall:

(a) Enter a written order in the patient's EPHR and complete a consultation request for medical evaluation;

(b) Document the medical indication for the consultation in the patient's EPHR, classify the request as on-site or off-site, and categorize it as emergent, urgent, or routine based on clinical need;

(c) Consider emergent consultations as pre-authorized and schedule as clinically indicated but no later than 24 hours, or follow emergency response procedures under Chapter 4, § .02 if conditions require an emergency department visit; and

(d) Discuss routine consultation requests with the regional medical director (RMD) prior to submission in the patient EPHR.

(2) In the case of a pulmonary consultation for suspected obstructive sleep apnea, the healthcare provider shall:

(a) Administer the Epworth Sleepiness Scale OTS.130-701 to evaluate the need for sleep apnea/hypopnea study;

(b) Obtain the patient's signature on the completed OTS.130.701 form; and

(c) Upload the completed OTS.130-701 form into the patient's EPHR.

(3) The UM process shall include a pre-certification review program applicable to all referrals (e.g., medical, dental, or mental health) for extraordinary care, to include, but not be limited to:

(a) Imaging studies (e.g., MRI, CT, ultrasound);

(b) Non-emergency inpatient hospitalizations;

(c) Outpatient diagnostic and therapeutic procedures;

(d) Specialty consultations;

(e) Surgical procedures;

(f) 23-hour observation or admission requests; and

(g) Telehealth specialty consultations.

B. **Utilization Management Review.**

(1) The Utilization Management (UM) team shall consider all requests for consultations in accordance with the UM Policy and Procedures Manual.

(2) The UM team shall consist of a qualified clinician or UM nurse 24 hours per day, seven days per week to provide pre-certification and pre-admission approvals for services that cannot be managed within business hours.

(3) The RMD shall participate in the UM collegial review and appeals process in accordance with the procedures outlined in the Department approved UM Policy and Procedures Manual.

(4) The healthcare vendor shall:

(a) Track all consultation requests by region using the Consultation Log; and

(b) Submit a weekly consultation request summary report to the ACOM.

(5) When a site medical provider submits a consultation request, the UM team shall:

(a) Render a decision to authorize the consultation or recommend and alternate treatment plan (ATP) within 24 hours of receipt for urgent consultations and within 5 business days for routine consultations;

(b) Enter the authorization or ATP recommendation into the patient's EPHR on the same day the decision is made; and

(c) Task the approved authorization or ATP recommendation to the appropriate physician or medical provider for review and consideration.

(6) When the UM team recommends an ATP, the site medical provider shall, within 1 business day of receipt:

(a) Accept the ATP recommendation; or

(b) Appeal the ATP recommendation to the RMD.

C. **Appeal Request.**

(1) The site medical provider shall:

(a) Initiate the appeal through direct phone communication with the RMD and UM Director to support timely clinical resolution; and

(b) Document all ATP decisions, appeals, and final determinations in the patient's EPHR.

(2) If a difference of clinical opinion remains unresolved, the matter shall be addressed during the weekly patient care conference between the UM Director, RMD, and Statewide Medical Director (SMD).

(3) If the consultation request remains unresolved following the weekly patient care conference, the site medical provider shall refer the matter to the Department's CMO.

(4) The Department's CMO shall hold final authority to render a clinical decision.

D. **Scheduling Approved Consultations.**

(1) The designated scheduler shall:

(a) Schedule the approved consultation as soon as possible, but no later than 3 business days after authorization;

(b) Document all scheduling attempts and confirmed appointments in the patient's EPHR;

(c) Enter confirmed appointments in the EPHR scheduling tool; and

(d) Enter the following information in the Consultation Log:

i. The date the healthcare provider submitted the consultation request;

ii. The date the consultation was approved or ATP was received;

iii. The consultation location (e.g., on-site or off-site);

iv. The consultation acuity level (e.g., emergency, urgent, or routine);

v. The scheduled appointment date and all scheduling attempts;

vi. The service completion date;

vii. The service category (e.g., cardiology, urology, general surgery);

viii. Rescheduled date for a missed appointment;

ix. Appointment disposition (e.g., completed or not completed); and

x. The plan of action for unresolved consultations.

(2) If a scheduling difficulty occurs, the healthcare vendor shall refer the matter to the facility's Health Services Administrator (HSA) and SMD for resolution no later than the next business day.

(3) The healthcare vendor's regional administration and RMD shall review the case if the consultation process exceeds 8 weeks from the date of the original request.

E. **Missed Appointments.**

(1) The healthcare vendor shall complete and submit a missed appointments listing to the ACOM within 24 hours of a missed appointment due to a scheduling issue, transportation issue, or failure to complete required preoperative tests or precautions.

(2) The healthcare vendor shall:

(a) Submit the completed Consultation Log to the ACOM and Department CQI Director monthly; and

(b) Incorporate missed UM appointments, UM approvals, and ATP recommendations into the monthly facility and statewide CQI agenda.

F. **Post-Consultation Assessment and Follow-Up.**

(1) The healthcare vendor shall ensure a patient follow-up assessment with an on-site healthcare provider within 48 hours of a consultation that was scheduled as emergency/urgent, or within 5 days of a consultation that was scheduled as routine.

(2) The healthcare vendor shall:

(a) Review and summarize the specialty consultant's recommendations in the patient's EPHR;

(b) Write the appropriate orders for any medically indicated diagnostic studies, evaluations, or treatment in the patient's EPHR, or document in the treatment plan why the recommendation will not be followed;

(c) Educate the patient on the intended treatment plan; and

(d) Schedule the patient for an on-site follow-up within 30 days to monitor clinical response to the new treatment plan, or document why a follow-up is not necessary.

G. **Medical Hold for Urgent Consultations and Major Surgery.**

(1) The ordering provider shall ensure that any patient requiring an urgent consultation or major surgery is not transferred to another Department correctional facility without notifying the healthcare vendor and implementing the following procedures:

(a) Clearly indicate "urgent" on the off-site consultation request for all urgent consultations;

(b) Enter a written physician order placing the patient on medical hold;

(c) Complete the Transfer of Housing Assignment form;

(d) Provide completed copy of the Transfer of Housing form to the traffic unit;

(e) On the Transfer of Housing Assignment form, mark the following restriction, "Restricted: Medical hold evaluation in process. The patient should not be transferred.".

(2) Once the consultation or surgical evaluation is complete, the healthcare provider shall use the same Transfer of Housing Assignment form to impose the restriction to formally lift the restriction.

.03 REFERENCES AND STANDARDS.

A. National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons (2026).

B. American Correctional Association (ACA), 5th Edition (2019).

.04 HISTORY.

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CHAPTER 6—DISABILITIES, LEP, AND SPECIAL MEDICAL NEEDS

.01 POLICY.

The healthcare vendor shall act in accordance with the policies in accordance with §.07 of DPSCS.200.0007 – Americans with Disabilities Title II Non-Discrimination and Accommodations for Persons with Disabilities; and DPSCS.020.0032—Limited English Proficiency (LEP) Policy.

A. The qualified healthcare provider shall:

(1) Upon request, referral, or during a routine medical examination evaluate the patient to determine if the patient is disabled and ascertain if the disability substantially limits the patient's ability to engage in a major life activity;

(2) Provide a written recommendation to custody and case management personnel regarding the need for reasonable accommodation by the qualified individual with a disability; and

(3) Communicate instructions for reasonable accommodation directly to a shift commander of a pretrial or correctional facility, or designee, whenever immediate action is required to protect the health or safety of the qualified individual with a disability.

B. The healthcare vendor shall:

(1) Identify and document each patient's special medical or physical needs that require medical equipment or supplies to ensure safety and well-being during intake, clinical encounters, and discharge planning;

(2) Provide clinically indicated medical equipment, and assistive devices within the vendor's scope of responsibility;

(3) Ensure continuity of care for each patient's special medical needs or disability from intake through incarceration discharge;

(4) Coordinate with custody personnel to determine whether operational accommodation or security-related support are necessary;

(5) Develop appropriate treatment and discharge plans to address each patient's special medical needs or disability;

(6) Recommend that each patient with special medical needs or a disability receive appropriate housing and disability accommodations in compliance with federal and state regulations, including the American with Disabilities Act (ADA); and

(7) Access and recommend accommodation for each patient with the following conditions:

(a) Physical impairments;

(b) Communicable diseases requiring isolation or social distancing;

(c) Dependence on medical devices, such as machines for sleep apnea;

(d) Dialysis catheters requiring specialized care;

(e) Vision or hearing impairments, or chronic illness requiring medical accommodation;

(f) Terminal illness**;**

(g) Karnofsky performance status of 50 or below;

(h) Developmental disabilities; and

(i) Neurocognitive impairments.

C. The healthcare vendor shall refer any patient identified with mental health special needs to the Office of Mental Health Services for further evaluation and care coordination.

D. The healthcare vendor shall provide translation and interpretation services for patients who have limited English proficiency and sign language interpretation services for patients who are hearing impaired.

.02 PROCEDURES.

Note: The procedures referred to in § .02A and B of this chapter are conducted as part of Chapter 1, §.02 – IMMS and §.03 – 7-Day History Physical Examination of this Manual.

A. Initial Evaluation.

(1) The RN or higher-level healthcare provider shall;

(a) Conduct an initial medical and mental health screening as part of the IMMS within 4 hours of the individual's entry into the facility;

(b) Refer each patient who screens positive for a special medical need or disability to the appropriate healthcare provider immediately upon identification;

(c) Refer each patient who screens positive for a mental health special need to the Office of Mental Health Services immediately upon identification;

(d) Execute provider orders as written by the referred healthcare provider;

(e) Provide all ordered durable medical equipment (DME) and medical supplies to the patient within 24 hours of the healthcare provider's order;

(f) Obtain a signed Acknowledgement of Receipt form from the patient for provided DME or medical supplies; and

(g) Document the delivery of DME and medical supplies in the patient's EPHR.

(2) The healthcare provider shall:

(a) Ensure each patient referred by the RN or higher-level healthcare provider during an initial evaluation is assessed within 24 hours of the positive screen, or sooner if the patient's condition warrants emergency evaluation;

(b) Conduct an intake history and physical examination on all new and direct intakes within 7 days of their entry into a Department correctional facility;

(c) Document the individualized treatment plan in the patient's EPHR for each patient with special medical needs or a disability;

(d) Document all identified medical and dental problems on the problem list in the patient's EPHR;

(e) Document the individualized treatment plan in the patient's EPHR; and

(f) Complete the Disabilities Assessment form in the patient's EPHR, describing the patient's special medical need or disability in functional terms only, without disclosing any underlying medical diagnoses.

(3) The healthcare provider shall:

(a) Print and forward the completed Disabilities Assessment form to the patient's assigned facility case manager;

(b) Determine the patient's medically permissible activity level and recommend necessary housing assignment, which may include:

(i) Special consideration for sight and sound separation of juveniles from adults;

(ii) Bottom bunk assignment; or

(iii) Single-cell assignment to ensure privacy during certain daily activities;

(c) Document the clinically appropriate rationale for:

(i) Requesting the patient be assigned to a specialized housing unit;

(ii) Recommending specific accommodation; and

(iii) Determining the duration of requested specialized housing or the need to discontinue a patient from specialized housing;

(d) Assess and make recommendations for the patient's access to:

(i) Clothing;

(ii) Mattress and bedding;

(iii) Commissary;

(iv) Telephone use;

(v) Meals; and

(vi) Other privileges; and

(e) Document all prescribed medication in the electronic medication administration record (EzMAR) or in the hard copy MAR when the EzMAR is unavailable.

(4) The healthcare provider, in coordination with nursing personnel, shall develop a comprehensive treatment plan for each patient on a case-by-case basis which includes:

(a) The specific type of DME required;

(b) The specific type of medical supply needed; and

(c) The frequency of delivery for the ordered DME or medical supply.

(5) The healthcare vendor shall:

(a) Develop an approved process that outlines how the identified DME or medical supplies will be provided to the patient, in accordance with the established treatment plan; and

(b) Obtain a signed Receipt of Issued Equipment/Supply form for each item of DME or medical supply issued to the patient.

B. **Comprehensive Treatment Plan.**

(1) A qualified healthcare provider shall develop a comprehensive treatment plan that includes:

(a) Assessment of active healthcare problems;

(b) Assignment to appropriate services or specialized housing, including:

(i) Chronic care clinic;

(ii) Disability accommodations; or

(iii) Recommendations for specialized housing, infirmary, or designated cells;

(c) Enumeration of all diagnostic studies and treatments;

(d) Recommendations for housing conditions for juveniles that ensure sight and sound separation from adults;

(e) Memory care planning for patients with moderate to severe memory loss;

(f) Recommendations for specialty services or DME, including;

(i) Specialty referrals;

(ii) Required DME; and

(iii) Specialized medications;

(g) Review of the individualized care plan to ensure alignment with psychiatric needs;

(h) Provision of social and psychological services;

(i) Identification of special dietary considerations, such as:

(i) Increased caloric needs for juveniles;

(ii) Renal dialysis dietary management;

(iii) Diabetes management; or

(iv) Pregnancy nutrition; and

(v) Recommendations for specialty consultations, as clinically appropriate.

(2) The qualified healthcare provider shall:

(a) Document the comprehensive treatment plan in the patient's EPHR; and

(b) Review each comprehensive treatment plan every 90 days, or sooner if clinically indicated, to reflect changes in the patient's physical or mental health condition.

C. **Personal DME or Medical Supply.**

(1) If the healthcare provider determines a patient requires DME or any special or customized medical supplies or equipment that if ordered by the healthcare vendor would cause delays in treatment, the patient may retain their personal medical equipment or supplies from the community provided it is cleared by custody personnel for safety and security.

(2) If the patient does not possess the required personal medical equipment or if it fails to meet clinical or security standards, the healthcare vendor shall supply a medically approved alternative.

D. **Reevaluation.**

(1) The qualified healthcare provider shall reevaluate each patient with a diagnosed special medical or mental health need or a disability during every chronic care encounter as part of the patient's periodic medical examination, to determine the need to renew special accommodation orders.

(2) During reevaluation, the qualified healthcare provider shall:

(a) Update the patient's individualized treatment plan in the EPHR;

(b) Continue or discontinue each medical order as indicated;

(c) Complete a new Disability Assessment form in the patient's EPHR annually; and

(d) Forward a copy of the completed Disability Assessment form to the patient's assigned facility case manager.

E. **Work Assignments.**

(1) The qualified healthcare provider shall:

(a) Evaluate each patient with special medical needs or a disability for work assignments that are consistent with the patient's functional abilities and clinical limitations;

(b) Document the work clearance recommendation on the Medical Clearance: Program and Work Assessment form in the patient's EPHR; and

(c) Forward a completed copy of the Medical Clearance: Program and Work Assessment form to the patient's assigned facility case manager.

(2) The healthcare provider shall review and update the patient's work clearance recommendation at regular clinical intervals or upon any significant change in the patient's medical condition.

F. **On-Site Housing.**

(1) The healthcare vendor shall monitor each patient with special medical or mental health needs or a disability who is housed in a specialized housing unit or designated cell.

(2) If a patient's medical or mental health condition worsens or becomes unstable, the qualified healthcare provider shall:

(a) Issue an order for admission to the infirmary;

(b) Make appropriate referral to the Office of Mental Health Services; and

(c) Update the patient's individualized treatment plan and problem list in the EPHR for:

(i) Each admission to the infirmary or another specialized housing unit;

(ii) Each return from a hospital or emergency department visit; or

(iii) Any new findings from a medical encounter that affects the patient's condition or care.

(3) The RN or higher-level healthcare provider shall assess the patient's ongoing suitability for housing in a specialized housing unit or designated cell and determine the appropriate housing recommendation based upon clinical disposition.

(4) The qualified healthcare provider shall reassess and make an updated recommendation for the patient's access to items listed under § .02A(3)(d), of this chapter.

G. **Continuity of Care.**

(1) The healthcare vendor shall include appropriate discharge planning for each patient who is:

(a) Discharged from the infirmary or other specialized housing;

(b) Enrolled in chronic care;

(c) Transferred to another jurisdiction; or

(d) Released into the community.

(2) If a patient is transferred within the Department, the qualified healthcare provider from the sending facility shall:

(a) Complete a Transfer and Receiving Screening form. The form shall include:

(i) A scheduled follow-up appointment;

(ii) A list of current medications and allergies;

(iii) A written assessment of the patient's active medical and mental health problems;

(iv) Any identified activity restrictions and housing needs;

(v) Current treatments and any pending consultations; and

(vi) Any other clinically appropriate assessment information; and

(b) Upload the completed Transfer and Receiving Screening form to the patient's EPHR.

(3) If a patient is transferred within the Department, an RN or higher-level healthcare provider from the receiving facility shall:

(a) Review the provided Transfer and Receiving Screening form upon the patient's arrival; and

(b) Ensure continuity of care with appropriate accommodations.

H. **Accommodation for Persons with Disabilities.**

(1) The healthcare vendor shall;

(a) Follow procedures established in DPSCS.200.0007;

(b) Send an email alert using the email address DLBaltimoreADAAlertsDPSCS@maryland.gov to notify case management, custody, traffic, and other relevant departments of any patient requiring ADA accommodation in a DPDS facility;

(c) Complete a Transfer of Housing form;

(d) Forward the completed Transfer of Housing form to the facility traffic unit and case management; and

(e) Scan completed Transfer of Housing form into the patient's EPHR within 72 hours.

(2) The healthcare vendor shall maintain a record of the email alert in the patient's EPHR.

I. **Mental Health Special Needs Referral.**

(1) A qualified healthcare provider shall:

(a) Complete an initial evaluation as directed under § .02A of this chapter;

(b) Complete a reevaluation as directed under § .02D of this chapter; and

(c) Make appropriate referrals to the office of Mental Health Services for each patient suspected to have mental health special needs or a disability.

(2) A psychiatrist or mental health clinician shall provide appropriate assessment and follow-up care for each referral.

.03 REFERENCES AND STANDARDS.

A. National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons (2026).

B. American Correctional Association (ACA), 5th Edition (2019).

C. DPSCS.200.0007 – ADA Title II Nondiscrimination of Incarcerated Individuals.

D. DPDS.200.0002 – Accommodations for Persons with Disabilities.

.04 HISTORY.

Date Issued	August 12, 2012	
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Reviewed/Revised	July 1, 2026	Substantively Revised

CHAPTER 7—TRANSGENDER, GENDER-NONCONFORMING, AND INTERSEX HEALTHCARE

.01 POLICY.

A. The Department shall provide appropriate medical treatment that recognizes the unique healthcare needs of each transgender or intersex individual while respecting the individual's autonomy, dignity, and identity. When clinically indicated, full medical treatment shall be provided, which includes, but is not limited to:

(1) Continuity of care;

(2) Gender-affirming surgery;

(3) Hormone therapy; and

(4) Mental health support.

B. Authority and Standards.

(1) The Department shall determine eligibility for gender-affirming medical treatment in accordance with the Maryland Trans Health Equity Act (THEA), Maryland CH0863 – Legally Protected Health Care – Gender Affirming Treatment, the World Professional Association for Transgender Health Standards of Care, Version 8 (WPATH SOC-8), and the guidelines of the National Commission on Correctional Health Care (NCCHC).

(2) The Department shall ensure its healthcare vendor provides care consistent with the prevailing standards of the World Professional Association for Transgender Health (WPATH SOC-8), as adopted by the NCCHC, for the medical and mental health treatment of transgender, gender non-confirming, and intersex individuals.

C. Gender-Affirming Treatment. When clinically indicated, the healthcare vendor shall:

(1) Provide hormone therapy as part of gender-affirming treatment;

(2) Provide access to gender-affirming surgeries based on clinical indications;

(3) Provide gender-affirming mental health services tailored to the patient's needs, which may include:

(a) Counseling;

(b) Therapy; and

(c) Support groups;

(4) For a new diagnosis of gender dysphoria, conduct a comprehensive evaluation to assess the patient's health needs and initiate gender-affirming treatment; and

(5) Ensure the patient is fully informed of available treatment options, risks, and benefits, including long-term considerations, and allow the patient to make decisions consistent with the patient's own values and preferences.

D. Continuity of Care.

(1) When clinically indicated, the healthcare vendor shall:

(a) Continue gender-affirming treatment that the patient received prior to incarceration; and

(b) Provide the patient with the same or equivalent medications, therapies, or treatments received prior to incarceration, with documented clinical rationale.

E. Mental Health Support. When clinically indicated, the healthcare vendor shall:

(1) Provide mental health care that affirms and responds to the patient's gender identity and address stressors and trauma unique to the patient; and

(2) Provide recommendations supporting the patient's access to gender-affirming clothing, hygiene products, and other items through the facility commissary when such items are clinically supportive of the patient's mental health or gender affirmation.

F. Access to Gender-Affirming Commissary Items.

(1) Gender-affirming commissary items shall be available to transgender, gender-nonconforming, and intersex patients without requiring a medical recommendation.

(2) A medical or mental health services clinician may issue a recommendation to support or document clinical need, but such a recommendation may not serve as a prerequisite for access.

(3) Gender-affirming commissary items may not be denied or restricted based on personal beliefs, or non-clinical factors

G. Informed Consent Model for Gender-Affirming Treatment. When clinically indicated, the healthcare vendor shall:

(1) Provide the patient with information about the risks and benefits of hormone therapy;

(2) Provide the patient with sufficient information to make an informed decision about whether to initiate hormone therapy; and

(3) Inform the patient who elects to initiate hormone therapy that, based on follow-up evaluations, the healthcare provider may make additional clinical treatment determinations to ensure the patient receives appropriate medical care.

.02 PROCEDURES.

A. **Special Considerations for Individualized Case Planning.**

(1) The Department shall:

(a) Ensure that healthcare for transgender, gender-nonconforming, or intersex patients is delivered through individualized case planning consistent with prevailing standards of care;

(b) Ensure ongoing training for Department healthcare personnel and contractual medical and mental health services clinicians to support continued access to appropriate treatment for transgender, gender-nonconforming, or intersex patients;

(c) Maintain oversight while the healthcare vendor provides direct clinical services; and

(d) Monitor and evaluate the healthcare vendor's compliance with individualized case planning requirements.

(2) When clinically indicated, the healthcare vendor shall:

(a) Provide transgender, gender-nonconforming, or intersex patients with access to healthcare providers who are trained in and knowledgeable about health needs specific to transgender, gender-nonconforming, or intersex patients, including through the use to telehealth consultation as necessary;

(b) Facilitate timely access to an external specialist or consultant when necessary; and

(c) Collaborate with external facilities and specialist to provide patients who are transgender, gender-nonconforming, or intersex with access to medically necessary procedures and post-operative care, including gender-affirming surgeries and advanced medical interventions.

B. **Preventive and Diagnostic Health Screenings.**

(1) The Department shall:

(a) Ensure that preventive and diagnostic health screenings for patients are conducted in accordance with nationally recognized clinical guidelines and incorporated into individualized case planning;

(b) Ensure that preventive and diagnostic health screenings for patients who are transgender are conducted in accordance with transgender-specific clinical standards, including WPATH SOC-8, as adopted by NCCHC, and THEA when applicable to gender-affirming care; and

(c) Maintain oversight to confirm that healthcare providers follow the recommendations of the American Academy of Family Physicians (AAFP) and the Centers for Disease Control and Prevention (DCD) during the 7-Day History and Physical Examination, periodic physical examinations, and routine follow-up evaluations.

(2) The healthcare vendor shall:

(a) Perform and document diagnostic and age-appropriate preventive health screening tests in accordance with prevailing clinical guidelines;

(b) Include testing of hormone levels such as testosterone, estradiol, serum prolactin, and other appropriate laboratory studies when clinically indicated and consistent with the patient's comprehensive care plan;

(c) In deciding whether to test hormone levels, take into account the patient's goals, health needs, and clinical history; and

(d) Avoid routine hormone testing for all transgender, gender-nonconforming, or intersex patients unless specific clinical reason exists or the testing is required as part of the patient's ongoing comprehensive care plan, such as monitoring treatment effects or assessing readiness for hormone therapy.

(3) If a conflict arises between general preventive health guidelines and transgender-specific clinical standards when evaluating or treating a transgender, gender-nonconforming, or intersex patient, the healthcare vendor shall:

(a) Apply the standard that best aligns with individualized, patient-centered gender-affirming care consistent with WPATH SOC-8, as adopted by the NCCHC and THEA; and

(b) Document clinical rationale for the selected standard in the patient's EPHR.

C. **Individualized Treatment Plans.**

(1) The Department shall:

(a) Ensure that individualized treatment plans are developed and maintained for patients who are transgender, gender non-conforming, an intersex that is consistent with prevailing clinical standards and Department directives;

(b) Maintain oversight to confirm that all treatment plans and housing recommendations comply with applicable Department policies; and

(c) When clinically appropriate, recommend the use of modified non-restrictive housing to mitigate safety risks and ensure that transgender, gender non-conforming, or intersex patients have access to necessary healthcare services;

(2) The healthcare vendor shall:

(a) Develop treatment plans and healthcare recommendations on a case-by-case basis, considering the patient's medical history, prior physical examination, laboratory results, available medical records, and other relevant information;

(b) Ensure that all housing-related clinical recommendations give serious consideration to the patient's own views regarding safety and may not rely on automatic placements in restrictive or isolated housing consistent with PREA standards §§ 115.42(e) and 115.43(a);

(c) Recommend housing classifications for patients who have completed gender-affirming surgery; and

(d) Coordinate with healthcare personnel, facility administration, and custody personnel to recommend housing, safety measures, and placement decisions that are consistent with PREA standards and the patient's individualized clinical needs.

D. **Screening and Evaluation.**

(1) Discontinuation of hormone therapy against the patient's wishes may not occur unless the healthcare vendor documents a clinically significant risk of harm, contraindication, or other medical necessity based on an individualized medical evaluation.

(2) The healthcare vendor may not:

(a) Discontinue hormone therapy solely because the patient's reported hormone regimen cannot be verified; or

(b) Make treatment decisions regarding hormone therapy based solely on the presence or absence of a gender dysphoria diagnosis.

(3) Hormone Therapy.

(a) The Department shall ensure continuity of care for transgender, gender non-conforming, and intersex patients at intake and throughout incarceration.

(b) If a patient is actively undergoing verified prescription hormone therapy at the time of incarceration, the healthcare vendor shall continue hormone therapy, hormone blockers, or an equivalent treatment in consultation with the patient, without interruption.

(c) If, after making reasonable efforts to obtain verification, the patient's reported hormone regimen cannot be confirmed, the healthcare vendor shall:

(i) Conduct a medical evaluation to minimize disruption in therapy;

(ii) Determine an appropriate interim treatment plan consistent with § D(4) of this chapter; and

(iii) Complete a physician-to-physician consultation with the Department's designated external provider with expertise in gender-affirming care to assist in determining the ongoing hormone regimen.

(d) If the provider-to-provider consultation results in a recommendation to modify the interim treatment plan, the healthcare provider shall document the clinical basis for any change in accordance with § D(4) of this chapter.

(e) If a patient is actively undergoing hormone therapy at the time of incarceration – whether verified or unverified – the healthcare vendor shall consider the patient's medical risks, contraindications, or urgent medical needs when determining continuation of prior hormone medication, dosage, and schedule.

(f) If discontinuation of hormone therapy occurs against the patient's wishes, the healthcare vendor shall ensure that a qualified mental health services clinician evaluates the patient and conducts a self-harm assessment.

(g) If a patient is not undergoing hormone therapy at the time of incarceration but requests to begin therapy, the healthcare vendor shall:

(i) Use a shared decision-making approach that integrates evidence-based medicine, clinical expertise, and patient values;

(ii) Ensure the patient's full understanding of options, risks, benefits, and long-term considerations; and

(iii) Conduct all necessary medical and mental health screenings to identify contraindications to hormone therapy.

(h) A qualified mental health services clinician shall:

(i) Assess the patient's mental health history and current psychological state;

(ii) Determine whether psychological conditions may impact informed consent or post-surgical recovery;

(iii) Refer the patient to an external mental health specialist with expertise in gender-affirming care when appropriate; and

(iv) Provide ongoing follow-up care to monitor mental health needs in coordination with medical treatment.

(4) Shared Decision-Making and Treatment Modification.

(a) The healthcare vendor shall use a shared decision-making approach in all hormone therapy-related decisions, including initiation, continuation, modification, or discontinuation of treatment.

(b) The healthcare vendor shall incorporate evidence-based practices, clinical expertise, and the patient's stated goals and values.

(c) When clinically significant risks, contraindications, or urgent medical needs require modification or temporary discontinuation of hormone therapy, the healthcare vendor may adjust the treatment plan. When any modification, reduction, interruption, or discontinuation of hormone therapy occurs, the healthcare vendor shall:

(i) Make decisions based on documented clinical determination consistent with WPATH SOC-8, as adopted by NCCHC, THEA, and established medical standards;

(ii) Include a written clinical rationale that identifies the specific clinical risks necessitating the change;

(iii) Communicate the decision with the patient, including an explanation of the clinical reasoning and anticipated duration of the modification; and

(iv) Provide timely follow-up evaluation to assess whether the modification remains clinically necessary.

E. **Gender-Affirming Surgery.**

(1) Screening and Referral.

(a) The Department shall ensure that referral of a patient requesting gender-affirming surgery to a designated external specialist with expertise in gender-affirming surgery and mental health expertise.

(b) The Department may not consider hormone therapy as a mandatory prerequisite for gender-affirming surgery except as determined by the surgical specialist.

(c) The healthcare vendor shall:

(i) Accept requests for gender-affirming surgery at the time of intake, during routine health assessments, or at any later point in incarceration;

(ii) Conduct an initial evaluation of the patient's physical health, history of gender dysphoria, and prior gender-affirming treatments;

(iii) Apply an individualized risk-benefit analysis consistent with accepted standards;

(iv) Refer the patient to an external healthcare specialist with expertise in gender-affirming surgery for further evaluation; and

(v) Provide ongoing follow-up care to monitor medical needs, ensure continuity, and coordinate steps for surgery as recommended by the external healthcare specialist.

(2) Mental Health Evaluation. A qualified mental health services clinician shall:

(a) Assess the patient's mental health history and current psychological state;

(b) Determine whether psychological conditions may impact informed consent or post-surgical recovery;

(c) Refer the patient to an external mental health specialist with expertise in gender-affirming care when appropriate; and

(d) Provide ongoing follow-up care to monitor mental health needs in coordination with medical treatment.

(3) Pre-Surgical Evaluation.

(a) The healthcare vendor shall coordinate a pre-surgical evaluation involving the referring healthcare provider, the surgical specialist, and necessary support personnel.

(b) The referring healthcare provider shall:

(i) Complete a pre-surgical medical evaluation, including health assessment, review of hormone therapy, and stabilization of any conditions;

(ii) Communicate identified risks, concerns, or special considerations to the surgical specialist;

(iii) Provide full medical history, laboratory results, and treatment records;

(iv) Arrange pre-operative counseling on expectations, post-surgical care, and recovery planning;

(v) Collaborate with mental health services clinicians to ensure psychosocial support is in place; and

(vi) Coordinate with facility administration to ensure timely access to required procedures and appropriate follow-up care.

(4) Post-Surgical Care and Follow-Up.

(a) The healthcare vendor shall ensure the patient:

(i) Receives comprehensive postoperative care, including infection monitoring, wound healing, pain management, and complication management;

(ii) Is assigned to medical housing for as long as clinically necessary, with accommodations for mobility and hygiene;

(iii) Attends follow-up appointments with the surgical team at clinically appropriate intervals;

(iv) Receives uninterrupted hormone therapy, adjusted as needed for surgical changes;

(v) Receives education on self-care, complication warning signs, and recovery expectations; and

(vi) Has coordination between healthcare personnel, facility administration, and custody personnel to ensure housing and safety are consistent with PREA standards.

(b) A psychologist shall provide:

(i) Short-term counseling for immediate post-surgical mental health needs; and

(ii) Long-term psychological follow-up for patients requiring extended support.

F. **Mental Health Screenings and Evaluations.**

(1) The Department shall:

(a) Ensure that a mental health services clinician conduct screenings and evaluations sensitive to the unique needs of transgender, gender-nonconforming, or intersex individuals; and

(b) Ensure confidentiality and informed constant in all mental health interactions.

(2) The healthcare vendor shall:

(a) Conduct comprehensive mental health screenings at intake, at regular clinical intervals, and during significant medical or placement changes;

(b) Conduct screenings and evaluations in a manner that protects patient confidentiality;

(c) Develop individualized crisis response plans that prioritize non-punitive interventions, de-escalation strategies, and protective measures related to gender identity and trauma;

(d) Inform each patient of available mental health services and crisis intervention;

(e) Monitor for suicidal ideation and self-harm risk, especially during transition periods or after stressful events; and

(f) Provide ongoing monitoring and support, including:

(i) Follow-up assessment as part of a long-term mental health plan;

(ii) Access to individual or group therapy using a gender-affirmative approach to address identity, dysphoria, trauma, and coping with incarceration stressors; and

(iii) Trauma-informed care using sensitive language and supportive approaches.

.03 REFERENCES AND STANDARDS.

A. Maryland Statutes and Executive Orders.

(1) Maryland Trans Health Equity Act (THEA), CH253. 2023 Md. Laws (H.B. 283).

(2) Maryland Executive Order No. 01.01.2023.08 (June 5, 2023).

B. Federal Standards.

(1) Prison Rape Elimination Act (PREA), 25 C.F.R Part 115.

(2) Estelle v. Gamble, 429 U.S. 97 (1976).

C. National Clinical and Correctional Standards.

(1) World Professional Association for Transgender Health (WPATH), Standard of Care for the Health of Transgender and Gender Diverse People, Version 8.

(2) National Commission on Correctional Health Care (NCCHC), Position Statement on Transgender and Gender Diverse Health Care in a Correctional Setting (2020).

(3) National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons (2026).

(4) American Correctional Association (ACA), 5th Edition (2019).

D. Professional Guidelines.

(1) American Academy of Family Physicians (AAFP), Recommendations for Preventive Services.

(2) Centers for Disease Control and Prevention (DCD), Guidelines for Preventive Health Screenings and Clinical Care.

.04 HISTORY.

Date Issued	July 1, 2026	New Chapter Added

CHAPTER 8—TRANSFER SCREENING

.01 POLICY.

A. The healthcare vendor shall conduct a transfer screening to maintain continuity of care and ensure uninterrupted access to prescribed medication for each patient.

B. The healthcare vendor shall provide a health screening within 24 hours of a patient:

(1) Transferring between Department correctional facilities;

(2) Transferring from another state's department of correction into a Department correctional facility;

(3) Transferring from a local correctional facility into a Department correctional facility;

(4) Following an infirmary discharge to the general population; or

(5) Returning to a Department correctional facility from a hospital admission.

C. Transfer screenings shall include, but is not limited to:

(1) A review of current medical conditions;

(2) An assessment of medication needs;

(3) A review of pending referrals;

(4) An evaluation for special accommodation; and

(5) The completion of *OPS 200-6bR – PREA Medical and Mental Health Screening* directed in § .06B(C) of OPS.200.0006 – Screening for Risk of Sexual Victimization and Abusiveness.

D. The healthcare vendor shall document the results of each transfer screening in the patient's EPHR within 24 hours of completion to ensure accountability and audit compliance.

.02 PROCEDURES.

A. Intrasystem Transfer.

(1) When a patient is transferred between Department correctional facilities, the healthcare vendor at both the sending and receiving facilities shall:

(a) Review the patient's medical record;

(b) Complete the Health Services Transfer Screening template in the patient's EPHR;

(c) Confirm that any necessary follow-up or pending appointments are scheduled by the receiving facility; and

(d) Confirm that pending chronic care, sick call, specialty consultations, clinician order, and any continuity of care concerns are addressed by the receiving facility.

(2) The healthcare vendor at the sending facility shall:

(a) Immediately notify the receiving facility of the patient's transfer;

(b) Review the patient's medical records prior to transfer;

(c) Complete the Health Services Screening template in the patient's EPHR;

(d) Place a healthcare alert in the patient's EPHR for any medical or mental health needs requiring urgent attention, and immediately notify the receiving facility via telephone to ensure timely intervention;

(e) Ensure the patient's medications and any hard copy medical records are packaged and delivered to custody for transport with the patient; and

(f) Confirm via telephone with the receiving facility, transfer screening information to include:

(i) The number of patients being transferred; and

(ii) Any significant patient needs;

(3) The healthcare vendor at the receiving facility shall:

(a) Review the patient's medical records within 4 hours of arrival;

(b) Verify and reconcile medications upon arrival to ensure continuity of care;

(c) Continue or discontinue medications as clinically indicated, with no interruption prior to the next scheduled dose;

(d) Review all health alerts upon arrival and take appropriate clinical action;

(e) Document the medical review using the Health Services Transfer Screening template in the patient's EPHR;

(f) Ensure chronic care follow-up encounters are scheduled:

(i) Within 30 days of arrival for patients with a chronic disease diagnosis; or

(ii) Within 7 days of arrival for patients designated as high-risk;

(g) Ensure all previously scheduled and missed appointments related to the transfer are rescheduled, including:

(i) Sick call (the patient is not required to submit a new sick call request for a missed appointment due to a transfer);

(ii) Chronic care;

(iii) Periodic physical examination; and

(iv) Specialty clinics.

(h) Refer the patient to:

(i) A mental health services clinician, if clinically indicated;

(ii) Infection control personnel, for any necessary follow-up; or

(iii) The dental department, for current dental needs;

(i) Complete *OPS 200-6bR – PREA Medical and Mental Health Screening* as directed in § .06B(c) of OPS.200.0006 – Screening for Risk of Sexual Victimization and Abusiveness; and

(j) Ensure all actions related to the transfer are documented in real time or within 24 hours in the patient's EPHR.

B. **Intersystem Transfer.**

(1) When a patient is transferred from a local correctional facility or as an interstate transfer with a medical summary and medication, the healthcare vendor at the receiving facility shall follow standard transfer procedures stated under § .02A of this chapter.

(2) When a patient is transferred from a local correctional facility or as an interstate transfer without a medical summary or medications, the receiving facility's charge nurse or designee shall immediately contact the appropriate counterpart at the sending facility to obtain the following:

(a) A current list of medications;

(b) Relevant medical information about the patient; and

(c) Information regarding the patient's special medical and mental health needs, including:

(i) Ambulatory status;

(ii) Dietary restrictions;

(iii) Hearing or vision impairments; and

(iv) Existing DME or medical supply.

(3) The charge nurse or designee shall document all communication efforts to obtain medication, equipment, and medical records in the patient's EPHR within 24 hours of the patient's arrival.

(4) Arrival and Immediate Care Responsibilities.

(a) The charge nurse or designee shall:

(i) Initiate contact with the sending facility immediately upon the patient's arrival;

(ii) Obtain all necessary medical information within 24 hours; and

(iii) Document all communication attempts and received information in the patient's EPHR.

(b) If the patient's medications are unavailable upon arrival, a qualified healthcare provider shall:

(i) Assess the patient clinically;

(ii) Issue interim medication orders as needed to prevent treatment delays; and

(iii) Document interim medication orders in the patient's EPHR at the time of issuance.

(c) A qualified healthcare provider shall complete *OPS 200-6bR – PREA Medical and Mental Health Screening* as directed in § .06B(c) of OPS.200.0006 – Screening for Risk of Sexual Victimization and Abusiveness.

C. **Medical Evaluation and Clearance for Returning Patients.**

(1) This section applies to patients returning to a Department correctional facility from:

(a) An inpatient hospital or healthcare facility;

(b) The temporary housing in another jurisdiction; or

(c) An emergency department visit.

(2) Custody personnel shall transport the returning patient to the regional infirmary for evaluation and medical clearance prior to returning the patient to their assigned Department correctional facility.

(3) A qualified healthcare provider shall:

(a) Evaluate the patient within 1 hour of arrival at the infirmary and determine the appropriate clinical disposition;

(b) Document the completed assessment and disposition in the patient's EPHR within 1 hour of completing the evaluation; and

(c) Complete *OPS 200-6bR – PREA Medical and Mental Health Screening* as directed in § .06B(c) of OPS.200.0006 – Screening for Risk of Sexual Victimization and Abusiveness.

(4) If a qualified healthcare provider is unavailable, an RN shall:

(a) Evaluate the patient within 1 hour of arrival to the infirmary;

(b) Contact the on-call healthcare provider for disposition and housing recommendation;

(c) Document the complete assessment and provider-directed disposition in the patient's EPHR within 1 hour of completing the evaluation; and

(d) Complete *OPS 200-6bR – PREA Medical and Mental Health Screening* as directed in § .06B(c) of OPS.200.0006 – Screening for Risk of Sexual Victimization and Abusiveness.

D. **Temporary Transfer.**

(1) When a patient is temporarily transferred from a Department correctional facility to another jurisdiction for more than 1 day, the healthcare vendor shall:

(a) Provide facility case management personnel with a completed Continuity of Care form prior to the patient's transfer;

(b) Ensure the form includes all essential clinical information necessary to maintain continuity of care during the patient's absence from the Department; and

(c) Upload a completed copy of the Continuity of Care form to the patient's EPHR for documentation and audit purposes.

.03 REFERENCES AND STANDARDS

A. National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons (2026).

B. American Correctional Association (ACA), 5th Edition (2019).

.04 HISTORY.

Date Issued	August 12, 2012	
Reviewed/Revised	March 30, 2017	
Reviewed/Revised	April 12, 2017	
Reviewed/Revised		

CHAPTER 9—OPTICAL HEALTH

.01 POLICY.

A. The Department shall provide standardized procedures for early periodic screening diagnosis, treatment, and follow-up of vision and eye-related conditions for incarcerated individuals.

B. The Department shall utilize digital retinal imaging as a diagnostic and disease-monitoring tool to support early detection of glaucoma and other ocular diseases and to monitor and document disease progression over time.

.02 PROCEDURES.

A. Early Screening and Routine Vision Care.

(1) A qualified healthcare provider shall conduct an initial vision screening during the IMMS, including assessment of near and distance visual acuity using the Snellen chart or other clinically appropriate methods.

(2) A qualified healthcare provider shall perform a vision screening at each periodic medical examination and during chronic care clinic evaluations when clinically indicated and consistent with Department policy.

(3) A qualified healthcare provider shall refer each patient found to have a visual acuity of 20/50 or worse in either eye by Snellen examination or other clinically appropriate methods of optometric evaluation.

(4) A self-referral for vision examination may be submitted by the incarcerated individual on a completed OPS.130-3aR – Sick Call Request/Encounter form or otherwise submitted in writing with all the information required by OPS.130-3aR – Sick Call Request/Encounter form.

(5) A self-referral for vision examination may not occur more frequently than once every 24 months unless the incarcerated individual reports symptoms associated with visual difficulty.

(6) A self-referral submitted more frequently than once every 24 months shall be reviewed by a healthcare provider to determine medical necessity prior to referral to optometry or ophthalmology.

B. **Optometric Evaluation.**

(1) The optometric/ophthalmologic contractor shall conduct all optometric and ophthalmologic evaluations for non-emergency care within 8 weeks from the date of referral, unless a shorter timeframe is clinically indicated or required by the Department.

(2) An optometrist shall examine each patient under 50 years of age at least every 24 months, except as otherwise specified in this chapter.

(3) An optometrist shall examine each patient 50 years of age or older at least every 12 months.

(4) An optometrist shall examine each patient of any age with a suspected or confirmed diagnosis of diabetes, severe vascular hypertensive disorders, lipid disorders, or other ocular pathology at least every 12 months.

(5) When special clinical needs, traumatic injury, disease, or disorder impacting vision are identified, an optometrist may evaluate the patient more frequently than the minimum intervals specified and refer the patient to ophthalmology based on demonstrated clinical needs.

C. **Diagnostic Screening and Retinal Imaging.**

(1) When screening for glaucoma, an optometrist may not rely solely on the measurements of intraocular pressure (IOP), as a substantial number of patients with glaucomatous visual field changes may have normal IOP.

(2) If a tonometry screening identifies abnormal IOP, including pressure above or below the normal range, the optometrist shall refer the patient for ophthalmologic evaluation.

(3) If the patient's IOP exceeds 21mm/Hg, the optometrist shall obtain digital retinal imaging prior to referring the patient to ophthalmology, unless clinically contraindicated.

(4) If the patient has suspected or confirmed diagnosis of diabetes, diabetic retinopathy, glaucoma, hypertensive, retinopathy, or other documented ocular pathology, the optometric/ophthalmologic contractor shall conduct an annual digital retinal imaging and dilated eye examination to monitor the patient's disease progression and guide treatment.

(5) Consistent with the American Academy of Ophthalmology (AAO) recommendations, an optometrist or ophthalmologist skilled in optic nerve assessment shall conduct a

comprehensive eye examination at clinically appropriate intervals based on the patient's age, risk factors, and disease status.

D. **Referral, Scheduling, and Utilization Management (UM).**

(1) An optometrist shall:

(a) Generate each referral or consultation to ophthalmology in the patient's EPHR; and

(b) Assign the referral or consultation to the patient's primary care physician.

(2) The primary care physician shall prepare the patient's referral or consultation for presentation at collegial review and UM approval as required under Chapter 5, §.02A of this Manual.

(3) The optometrist shall provide all routine ophthalmology consultations to the scheduler to ensure scheduling is completed.

(4) The scheduler shall schedule each retinal imaging and ophthalmology consultation through a centralized scheduling process.

(5) The scheduler shall base scheduling decisions on:

(a) The patient's age;

(b) The patient's medical risk profile;

(c) The patient's documented diagnosis; and

(d) Other clinical determination of risk by optometry or ophthalmology.

(6) The scheduler shall:

(a) Track each scheduled retinal imaging and ophthalmology consultation of patients identified as at risk; and

(b) Ensure appropriate ophthalmologic follow-up actions are scheduled.

(7) The optometric/ophthalmologic contractor shall ensure ophthalmologic evaluations occur within the authorized service completion timeframe established through UM.

E. **Ophthalmologic Evaluation and Treatment.**

(1) An ophthalmologist shall review all digital retinal images within 4 weeks of completion.

(2) An ophthalmologist shall document evaluation findings, clinical assessment, and treatment plan in the patient's EPHR.

(3) The optometric/ophthalmologic contractor, in coordination with the healthcare vendor, shall treat and manage glaucoma, cataracts, and other ocular diseases impacting a patient's vision by utilizing optometric and ophthalmologic specialist in accordance with Department-approved clinical protocols and national recognized ophthalmologic guidelines.

F. **Vision Correction and Optical Devices.**

(1) If an optometric or ophthalmologic examination confirms visual acuity of 20/50 or less in either eye, an optometrist or licensed optician shall:

(a) Immediately order a corrective prescription after the eye exam is completed; and

(b) Provide corrective lenses to the patient within 7 to 14 business days.

(2) An optometrist or licensed optician shall ensure proper fitting and issuance of prescribed eyeglasses within timeframes consistent with acceptable medical practice.

(3) The optometric/ophthalmologic contractor shall provide eyeglasses at its expense as part of the vision testing program.

(4) The optometric/ophthalmologic contractor may not issue eyeglasses more frequently than every 48 months, unless medical necessity requires earlier replacement.

(5) When a patient experiences a significant change in prescription within a 48-month period, the optometric/ophthalmologic contractor shall provide new prescription lenses only and fit them into the patient's existing frames when possible.

(6) If new lenses cannot be fitted into the patient's existing frames, the optometric/ophthalmologic contractor shall provide a complete set of replacement eyeglasses.

(7) When a patient loses or breaks their eyeglasses, the optometric/ophthalmologic contractor shall order replacement eyeglasses upon the patient's request.

(8) The Department shall reimburse the optometric/ophthalmologic contractor for replacement eyeglasses.

(9) The Department may seek reimbursement from the patient in accordance with the Department financial procedures.

(10) Eyeglasses may be distributed by on-site nursing personnel in the absence of an optometrist or licensed optician.

(11) An optometrist or licensed optician, or on-site nursing personnel shall obtain the patient's signature on the receipt form upon issuance.

(12) The optometric/ophthalmologic contractor may not prescribe contact lenses for cosmetic purposes.

(13) When contact lenses are medically indicated to treat a diagnosed ocular condition, the optometric/ophthalmologic contractor shall provide contact lenses and all required maintenance supplies at its expense.

(14) The patient may purchase additional contact lens solutions through commissary.

(15) An optometrist or licensed optician shall ensure proper fitting and issuance of prescribed contact lenses within timeframes consistent with acceptable medical practice.

G. **Emergent Ophthalmologic Care.**

(1) The healthcare vendor shall:

(a) Immediately evaluate a patient presenting with an eye emergency, acute or transient vision loss, infection, pain, or trauma;

(b) Follow procedures for emergency care as outlined in OCS.130.0003 – Medical Evaluations Manual; and

(c) Refer the patient to an ophthalmologist for follow-up assessment.

(2) Emergency referrals shall include, when applicable:

(a) A description of the patient's injury or presenting condition;

(b) Visual acuity findings;

(c) Visual field assessment; and

(d) Slit lamp examination findings.

H. **Clinical Records, Data, and Reporting.**

(1) All clinical data related to eye and vision services are the property of the Department and may not be duplicated, published, or presented without express written authorization from the Department's CMO.

(2) Digital retinal images shall be stored in a Department-designated network location and within the patient's EPHR if capability exists.

(3) Providers shall acknowledge notification of image availability through the alert function in the patient's EPHR.

(4) The optometric/ophthalmologic contractor shall submit clinical data regarding optical health in the form and format specified by the Department's CMO, including monthly submissions with quarterly and annual summaries.

(5) The optometric/ophthalmologic contractor shall maintain and publish data on glaucoma, diabetic retinopathy, and digital retinal imaging to the Department's designated document management system by the 10th day of each month.

.03 REFERENCES AND STANDARDS.

A. National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons (2026).

B. American Correctional Association (ACA), 5th Edition (2019).

.04 HISTORY.

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CHAPTER 10—LABORATORY AND RADIOLOGY SERVICES

.01 POLICY.

A. The Department shall ensure that each patient receives laboratory and radiology services in a timely and clinically appropriate manner under the direction of licensed healthcare provider.

B. The healthcare vendor shall conduct laboratory and radiology services in accordance with this Manual.

C. The health care vendor shall conduct laboratory and radiology services 7 days a week.

D. The healthcare vendor is responsible for all costs associated with laboratory and diagnostic services, including, specimen collection, transportation, testing, reporting, and data collection, unless otherwise specified by contract.

E. All laboratory and radiology results shall be reviewed, acted upon as clinically indicated, and documented in the patient's EPHR within the timeframes established in this chapter.

.02 PROCEDURES.

A. Ordering and Tasking Diagnostic Services.

(1) The ordering healthcare provider shall:

(a) Enter an order for laboratory or radiologic testing into the patient's EPHR; and

(b) Task the order to the appropriate licensed or certified medical personnel.

(2) Only licensed or certified healthcare personnel acting within the scope of their professional licensure shall perform laboratory or radiology procedures.

B. Laboratory Specimen Collection and Handling.

(1) Tasked medical personnel shall:

(a) Verify the order is complete;

(b) Collect specimens in accordance with professional standards; and

(c) Label specimens with:

(i) The patient's first and last name;

(ii) The patient's date of birth;

(iii) The patient's SID#;

(iv) The date and time of specimen collection; and

(v) Name of the correctional facility;

(d) Attach a complete Laboratory Request form to the specimen; and

(e) Place the collected specimen in the designated collection area for shipment to the appropriate laboratory.

(2) A charge nurse or designee shall:

(a) Review the task list at the beginning of each shift and every 2 hours during the shift; and

(b) Ensure each laboratory order is completed by the tasked medical personnel within 24 hours of the date and time the order was issued.

C. **Radiology Services.**

(1) The ordering healthcare provider shall:

(a) Initiate the Department's emergency protocols to complete emergent radiology services;

(b) Refer urgent imaging services to the on-call radiology service within 24 hours; or

(c) Refer routine imaging services to an X-ray technician during the next scheduled radiology service.

(2) Routine imaging shall be completed:

(a) Within 48 hours of order placement; or

(b) By close of business on the next business day if ordered on a weekend or State holiday.

(3) The healthcare vendor shall schedule radiology services to meet the 48 hours imaging requirements under § .02C(2) of this chapter.

(4) A charge nurse or designee shall:

(a) Review the task list at the beginning of each shift; and

(b) Ensure each radiology order is completed by the tasked medical personnel within the timeframes listed under § .02C(1) of this chapter.

D. **STAT Orders for Laboratory Specimen or Radiology Test.**

(1) The ordering healthcare provider shall:

(a) Enter a STAT order in the patient's EPHR; and

(b) Task the STAT order to the appropriate licensed or certified medical personnel.

(2) The tasked medical personnel shall execute STAT orders within 30 minutes of entry of the order.

(3) Upon receipt of STAT results but no later than 2 hours, the ordering healthcare provider shall:

(a) Review and acknowledge the receipt of the STAT results in the patient's EPHR;

(b) Take all necessary and immediate clinical action to address results indicating an emergent or life-threatening condition;

(c) Conduct a patient evaluation if indicated; and

(d) Update the treatment plan in the patient's EPHR.

(4) Verbal or telephone orders shall be signed by the ordering healthcare provider within 24 hours of the next business day.

E. **Provider Review and Clinical Action.**

(1) The ordering provider shall:

(a) Ensure diagnostic results are reviewed and acknowledged within 24 hours of receipt of results unless explicitly directed otherwise under this section; and

(b) Document diagnostic results in the patient's EPHR.

(2) The radiologist shall:

(a) Communicate via fax or email all results to the facility; and

(b) Telephone positive results within 2 hours of results to the ordering provider or on-call provider.

(3) Within 30 minutes of receipt of critical laboratory results, the RN receiving notification from the lab shall notify the ordering provider or on-call provider.

(4) Within 24 hours of abnormal laboratory results becoming available, the ordering provider or covering provider shall acknowledge the received results.

(5) Upon receipt of the results listed under § .02E(1)-(4), the ordering healthcare provider or covering provider shall:

(a) Take all necessary and immediate clinical action to address results indicating an emergent or life-threatening condition.

(b) Review and electronically sign diagnostic results within the following timeframes:

(i) Within 24 hours of receipt of all diagnostic and imaging results;

(ii) Within 30 minutes of receipt of critical laboratory results;

(iii) Within 2 hours of receipt of a positive radiology report; or

(iv) Within 24 hours of identified abnormal laboratory results.

(c) Document all actions taken or "no action necessary" in the patient's EPHR; and

(d) Enter treatment orders as clinically indicated.

(6) The RN or designee shall:

(a) Execute tasked treatment orders; and

(b) Document completion of tasked orders in the patient's EPHR.

(7) If the EPHR is unavailable, the ordering provider or on-call provider shall:

(a) Review and sign hard-copy results within required timeframes; and

(b) Ensure signed results are scanned into the patient's EPHR within 72 hours of EPHR availability.

(8) The RN shall:

(a) Receive each radiology report as described under § .02E(2) of this chapter;

(b) Review each radiology report;

(c) Notify the ordering healthcare provider of received radiology report; and

(d) Send received radiology report to the medical records department.

(9) The assigned medical records employees shall:

(a) Scan radiology reports into the Department's document management system no later than 24 hours of receipt of the report; or

(b) If the document management system is unavailable, ensure radiology reports are scanned into the Department's document management system within 72 hours of availability.

F. **Patient Notification and Follow-Up Action.**

(1) When the report is received, the healthcare provider shall schedule the patient for a follow-up, non-sick call visit to receive their radiology report results.

(2) At the follow-up, non-sick call visit:

(a) The RN shall discuss normal diagnostic results with the patient, face-to-face within 14 calendar days.

(b) The ordering provider shall discuss abnormal diagnostic results in an in-person meeting with the patient within 5 calendar days.

(3) In the absence of the ordering provider, the healthcare provider shall designate a responsible healthcare provider to:

(a) Review diagnostic results daily; and

(b) Act on abnormal and critical findings as required in § .02E(5)(b) of this chapter.

(4) After a missed diagnostic appointment, the ordering provider shall:

(a) Document the missed diagnostic appointment in the patient's EPHR;

(b) Document the reason for the missed diagnostic appointment in the patient's EPHR, if available; and

(c) Reschedule the patient for the next available clinic.

(5) After 2 consecutive missed diagnostic appointments, the ordering provider shall:

(a) Counsel the patient and provide education regarding the importance of the missed diagnostic appointment; and

(b) Engage in shared decision-making with the patient to determine whether the requested testing is still necessary.

(6) If the patient refuses to complete a necessary diagnostic test, the ordering provider shall obtain the patient's signature on a Refusal of Treatment form in the patient's EPHR.

G. **Laboratory Tracking and Audit.**

(1) The healthcare vendor shall:

(a) Maintain a monthly laboratory tracking report documenting:

(i) The date testing was ordered;

(ii) The date the specimen was collected;

(iii) The date the results were received;

(iv) The date the results were reviewed, and action was taken or not taken; and

(v) The date the patient was notified.

(2) The healthcare vendor shall:

(a) Conduct a monthly audit of all correctional facilities' compliance with monthly laboratory tracking;

(b) Submit proof of audit completion to the Department's ACOM by the 10th day of each month; and

(c) Update the monthly laboratory tracking audit into the Department's electronic document tracking system.

(3) The healthcare vendor shall take immediate corrective action for identified compliance issues found in the monthly laboratory tracking audit.

H. **Clinical Laboratory Improvement Amendments (CLIA) Certification.**

(1) The healthcare vendor shall:

(a) Obtain and maintain CLIA certification or waiver from the Centers for Medicare & Medicaid Services (CMS); and

(b) Comply with all applicable federal regulations, including inspections, quality control measures, and proficiency testing.

.03 REFERENCES AND STANDARDS.

A. National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons (2026).

B. American Correctional Association (ACA), 5th Edition (2019).

.04 HISTORY.

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CHAPTER 11—PROFESSIONAL EXAMINATION BY PRIVATE MEDICAL, PSYCHIATRIC, OR PSYCHOLOGICAL PROVIDERS

.01 POLICY.

A. The Department may permit a private medical, psychiatric, or psychological professional to examine a patient if the examination pertains to an issue or event unrelated to the Department's and healthcare vendor's mandated healthcare responsibilities.

B. The Department shall permit one medical evaluation conducted at no cost to the patient by a licensed physician who is independent from the Department in accordance with Correctional Services Article, § 7-309, Annotated Code of Maryland.

C. The healthcare vendor shall remain responsible for delivering comprehensive healthcare services to each patient housed within a Department correctional facility in accordance with Department policy and healthcare vendor's contracted responsibilities.

D. A patient may request to be examined by a private healthcare provider at the patient's own expense, provided that all applicable security, clinical, and administrative requirements are satisfied in advance.

E. Except as provided in this chapter regarding independent medical evacuation under Correctional Services Article, § 7-309, the Department may not assume financial responsibility for any private medical or mental health services rendered.

.02 PROCEDURES.

A. Private Examinations at the Patient's Expense.

(1) The Department shall:

(a) Permit a private examination only after receiving sufficient written documentation justifying the request that includes the purpose and scope of the evaluation;

(b) Verify that the provider holds a current and valid license to practice in the State of Maryland;

(c) Ensure the private healthcare provider complies with all Department security clearance requirements prior to entry into the correctional facility;

(d) Limit the examination to evaluation and diagnosis only; and

(e) Ensure that any private examination for purposes beyond evaluation or diagnosis is conducted only under court order of if required by law and after consultation with the Office of the Attorney General.

(2) The healthcare vendor shall:

(a) Coordinate the scheduling of the examination; and

(b) Facilitate the examination and coordinate with facility administration to ensure appropriate clinical space is available.

(3) The patient shall bear full expense of the private examination.

B. **Medical Parole – Independent Medical Evaluation.**

(1) An incarcerated individual under consideration for medical parole may request one independent medical evaluation conducted at no cost to the incarcerated individual pursuant to COMAR 12.08.04.03.

(2) Upon receipt of a request, the Department shall coordinate with the incarcerated individual or the incarcerated individual's designated representative to facilitate the independent medical evaluation.

(3) The incarcerated individual or the incarcerated individual's designated representative may:

(a) Select a licensed physician to conduct a medical evaluation; or

(b) Request the Department to provide a list of community resources to assist the incarcerated individual in finding a licensed physician to conduct an independent medical evaluation.

(4) When an independent licensed physician is identified, the healthcare vendor shall obtain a signed release of medical information from the incarcerated individual authorizing the physician to receive a copy of the individual's medical records.

(5) The regional medical director (RMD) for the assigned correctional facility shall:

(a) Coordinate scheduling of the independent medical evaluation as soon as practicable;

(b) Provide a copy of the individual's medical records at no cost;

(c) Notify the facility's managing official of the scheduled evaluation date; and

(d) Provide appropriate clinical space and reasonable accommodation.

(6) The independent medical evaluation shall:

(a) Be conducted at no cost to the incarcerated individual; and

(b) Be conducted as an in-person examination.

(7) An independent medical evaluation conducted under this section is limited to assessment of medical parole eligibility set forth in COMAR 12.08.04.02 (TBD) and does not authorize the independent medical provider to prescribe medications, order diagnostic testing, or initiate treatment within the facility.

C. **Private healthcare providers – Entry and Reporting Requirements.**

(1) Any private medical, psychiatric, or psychological professional shall, prior to entering a Department correctional facility:

(a) Submit proof of current and valid licensure to practice in the State of Maryland to the Office of Clinical Services for verification;

(b) Provide a written request detailing the purpose and scope of the evaluation signed by the requesting party; and

(c) Undergo facility security clearance and comply with all Department security protocols.

(2) A private medical, psychiatric, or psychological professional who has entered a Department correctional facility to provide evaluation or healthcare services shall submit a written summary of findings to the facility's medical unit within 24 hours of completing the examination.

D. **Private healthcare providers - Scope of Authority.**

(1) A private healthcare provider may not prescribe medications, order diagnostic testing, or initiate treatment within the facility unless specifically authorized by the Office of Clinical Services or ordered by a court.

(2) All medical management decisions shall remain under the authority of the Department's Office of Clinical Services and the contracted healthcare vendor.

.03 REFERENCES AND STANDARDS.

A. National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons (2026).

B. American Correctional Association (ACA), 5th Edition (2019).

.04 HISTORY.

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CHAPTER 12—ORAL HEALTHCARE

.01 POLICY.

A. The Department shall provide oral healthcare services consistent with national recognized correctional healthcare standards and prioritize clinically appropriate treatment based on:

(1) The severity of oral disease;

(2) The patient's overall medical status; and

(3) The patient's projected length of incarceration.

B. The Department shall ensure that each incarcerated individual has access to the full scope of oral healthcare services offered by the Department, including:

(1) Dental screenings and assessments;

(2) Sick call services for evaluation and management of urgent dental concerns;

(3) Routine dental care; and

(4) Emergency dental care.

.02 PROCEDURES.

A. Dental Contractor Requirements.

(1) The dental contractor shall provide each patient with clear written or verbal instructions on how to access dental services, to include sick call requests, routine care, and emergency procedures.

(2) The dental contractor shall:

(a) Assign each patient to a designated oral health classification based on:

(i) Clinical findings;

(ii) Urgency of care; and

(iii) Identified treatment needs; and

(b) Ensure that diagnostic information, treatment plans, and outstanding referrals accompany the patient's dental record when the patient is transferred to another correctional facility; and

(c) Inform each patient of the individual's current oral health status following evaluation or treatment;

B. **Oral health Classifications.**

(1) The dental contractor shall assign each patient to an oral health classification based on clinical findings, urgency of care, and treatment needs.

(2) If a patient is marked at Class I or Class II, they may not be marked as a lower class until they complete the Class I or Class II treatment plan completely.

(3) Class I Patients – Emergent or Urgent Dental Needs.

(a) Class I patients receive scheduling priority over all other classifications.

(b) Class I patients require emergent or urgent dental treatment for conditions including but not limited to:

(i) Acute infections or cellulitis;

(ii) Facial swelling;

(iii) Fractured facial jaw bones;

(iv) Fractured tooth (teeth) with vital pulp exposure;

(v) Severe or intractable pain unresponsive to over-the-counter analgesics;

(vi) Suspected neoplasm of the oral cavity; or

(vii) Traumatic injury to oral soft tissue.

(c) Access to care for Class I patients may begin through:

(i) A sick call request;

(ii) A referral to dental by the healthcare vendor; or

(iii) A diagnosis or finding identified during a prior dental encounter.

(d) The dental contractor shall ensure that each Class I patient receives evaluation and treatment within 24 hours of referral, sick call submission, or telephone triage when the dentist is not physically present in the correctional facility.

(4) Class II Patients – Routine Dental Needs with Clinical Significance.

(a) Class II patients are assigned to this classification when seeking routine dental care that is clinically significant but does not constitute an emergency.

(b) Class II patients receive the second highest scheduling priority after Class I patients.

(c) Class II patients require treatment for conditions including, but not limited to:

(i) Asymptomatic pulpal or apical infections;

(ii) Extensive or advanced dental caries;

(iii) Dental status that affects adequate nutrition, such as missing or nonfunctional dentition; or

(iv) Severe periodontal disease.

(5) Class III Patients – Non-Urgent Dental Needs.

(a) Class III patients receive the third-highest scheduling priority for dental services.

(b) Class III patients present with dental conditions including, but not limited to:

(i) Caries not affecting the pulp;

(ii) Moderate periodontal disease; or

(iii) Multiple missing teeth without urgent nutritional or functional impact.

(6) Class IV Patients – Preventive Care Only.

(a) Class IV patients require no dental treatment other than routine preventive services.

(b) Class IV patients shall continue to receive preventive care according to clinical guidelines.

(c) The dental contractor shall reclassify Class IV patients and provide treatment if their clinical status changes.

C. **Oral Healthcare Delivery Criteria.**

(1) The healthcare vendor shall conduct an oral healthcare screening as part of the patient's 7-Day Intake History and Physical Examination to identify acute dental needs and initiate referrals to the dental contractor.

(2) The dental contractor shall conduct a comprehensive oral healthcare examination within 90 calendar days of the patient's admission to any Department intake facility, unless a documented comprehensive oral examination has been completed within the past 12 months.

(3) If a patient returns to the Department's custody within 12 months of having a full admission dental examination, a new comprehensive examination is not required, but the dental contractor shall:

(a) Ensure that the patient is evaluated by a licensed dentist within 90 days for a clinical check-in to assess changes in oral health; and

(b) Document the clinical check-in in the patient's EPHR.

(4) If a patient is transferred to another Department correctional facility, the dental contractor shall conduct a chart review within 30 calendar days to continue or update the patient's current treatment plan.

(5) 90-Day Admission Dental Examination.

(a) A licensed dentist shall conduct all admission dental examinations.

(b) A licensed dentist shall perform the admission dental examination in accordance with the American Dental Association Comprehensive Exam standards, as adopted by the NCCHC, including:

(i) Periodontal evaluation, including radiographs – minimum bitewing X-rays, with additional imaging as clinically indicated;

(ii) Temporomandibular joint assessment;

(iii) Oral cancer screening;

(iv) Ordering of a diagnostic laboratory kit within 5 business days for any positive or suspicious findings identified during the oral cancer screening;

(v) Completion of all documentation in the patient's EPHR as the initial comprehensive oral examination using the appropriate template;

(vi) Assignment of the patient to the appropriate oral health classification based on clinical findings; and

(vii) Provision of care in accordance with established priority guidelines.

(c) The dental contractor shall record all findings, diagnostic information, and treatment recommendations in the patient's EPHR upon completion of the examination.

(d) If the oral cancer screening identified a positive or suspicious finding, the dental contractor shall order the appropriate diagnostic laboratory kit within 5 business days of the examination.

D. **Emergency Dental Care.**

(1) The healthcare vendor, in collaboration with the dental contractor, shall:

(a) Provide 24-hour emergency care for Class I patients;

(b) Provide hospital-based emergency care when clinically indicated; and

(c) Ensure access to telephone triage by a licensed on-call dentist for after-hours urgent dental concerns.

(2) The healthcare vendor shall refer any patient who returns from hospital-based emergency care to the dental contractor for appropriate follow-up evaluation and treatment.

(3) After-hours Emergency Dental Coverage.

(a) The dental contractor may not be responsible for providing on-site emergency dental services outside normal business hours.

(b) The healthcare vendor, in consultation with the on-call dentist, shall provide emergency dental coverage outside normal business hours, including weekends and State holidays.

(c) The dental contractor shall cooperate with the healthcare vendor to ensure continuity of care, including timely follow-up of any emergency dental cases identified or treated after hours, regardless of which provider delivered initial care.

E. **Preventive and Routine Oral Healthcare.**

(1) The dental contractor shall provide each patient with preventive and routine oral healthcare services conducted annually.

(2) The dental contractor shall provide oral self-care and preventive education to each patient during all routine oral care encounters.

(3) The dental contractor shall deliver care that supports and maintains healthy oral status, defined as:

(a) Caries-free dentition;

(b) Periodontal stability; and

(c) Adequate preservation of teeth to support effective mastication.

(4) The dental contractor shall provide routine treatment for Class II, Class III, and Class IV patients, including, but not limited to:

(a) Amalgam and composite restoration;

(b) Diagnostic tests;

(c) Oral examinations;

(d) Extractions;

(e) Full and partial dentures;

(f) Limited endodontic treatment in accordance with § .02I and §.02J of this chapter;

(g) Periodontal scaling and root planning;

(h) Pre-prosthetic surgery; and

(i) Dental radiographs.

(5) Scheduling Oral Healthcare Access.

(a) The dental contractor shall provide priority scheduling for routine dental treatment to patients whose remaining sentence exceeds 12 months.

(b) The dental contractor shall provide routine oral healthcare to medically compromised patients, regardless of sentence length, to prevent oral disease from complicating overall health.

(c) The dental contractor shall complete a face-to-face dental triage for all routine sick call requests and medical referrals within 1 business day of receipt from the healthcare vendor.

(d) The healthcare vendor, in collaboration with the dental contractor, shall complete a face-to-face dental triage for all emergency and urgent sick call requests and medical referrals in accordance with § .02D of this chapter.

(e) The dental contractor shall tailor the frequency and scope of routine oral healthcare to each patient's responsiveness to treatment, demonstrated oral hygiene practices, and interest in maintaining oral health.

F. **Referrals and Off-Site Care.**

(1) The dental contractor shall refer a patient to the healthcare vendor when medical conditions, diagnostic needs, or complex dental conditions fall outside the scope of oral healthcare services authorized under the Department's dental contract.

(2) Referrals under the section shall include:

(a) Medical conditions that require evaluation of clearance before dental treatment;

(b) Dental conditions requiring advance procedures beyond the scope of dental services; and

(c) Diagnostic imaging or testing not available within the dental clinic setting, including computed tomography (CT) scans or magnetic resonance imaging (MRI).

(3) Cost and Responsibility.

(a) Responsibility of the cost of off-site care, including periodontal services, oral and maxillofacial surgery, prosthodontics, emergency treatment, and hospitalization, rests with the healthcare vendor.

(b) If the dental contractor refers a patient for off-site care without obtaining prior approval from the healthcare vendor's Utilization Management (UM) team or the UM designee, the dental contractor shall assume responsibility for all associated costs.

(4) The dental contractor shall establish and maintain an internal referral tracking system to monitor all specialty and off-site dental referrals initiated by dental personnel.

(5) The dental contractor shall:

(a) Submit urgent referrals to the healthcare vendor within 24 hours of the clinical determination; and

(b) Submit referrals for routine specialty care within 48 hours of making the clinical determination.

(6) The dental contractor shall:

(a) Document the clinical basis for the referral in the patient's EPHR;

(b) Coordinate the referral through the healthcare vendor in accordance with Department policy and established referral procedures; and

(c) Provide relevant dental records, diagnostic findings, and treatment plans necessary to support continuity of care.

(7) Post Off-Site Follow-Up Care.

(a) Upon a patient's return to a Department correctional facility from off-site care, the dental contractor and healthcare vendor shall conduct a joint post-discharge follow-up examination within the timeframe designated by the off-site care provider.

(b) The on-call dentist may conduct the post-discharge follow-up examination remotely when the examination occurs outside of normal business hours or at a facility without an on-site dentist.

(c) The dental contractor shall provide follow-up care within the correctional facility by a licensed dentist or oral surgeon when clinically appropriate and within the provider's scope of practice, regardless of where the initial dental services were provided.

(d) Follow-up care includes, but is not limited to:

(i) Post-operative evaluation;

(ii) Suture removal;

(iii) Assessment of healing; and

(iv) Management of complications arising from prior treatment.

(e) The dental contractor shall refer the patient to the healthcare vendor for coordination of off-site follow-up services only when:

(i) The service delivery region lacks the necessary equipment, resources, or clinical capability to provide the required follow-up care; or

(ii) When an off-site provider specifically requests off-site follow-up care.

(f) The dental contractor shall document all such referrals and obtain approval in accordance with the Department procedures prior to scheduling off-site follow-up care.

G. **Continuity of Care Planning.**

(1) The healthcare vendor shall ensure that each patient being released from Department custody while undergoing active dental prosthetic treatment receives a dental continuity of care plan prior to release.

(2) Discharge planning includes, as clinically indicated:

(a) Providing the patient's dental records and clinical history to the next dental provider;

(b) Ensuring the patient receives any required dental prescriptions;

(c) Ensuring that a plan is in place for delivery or completion of dentures or other dental appliances; and

(d) Coordinating the transfer of any pending laboratory work, molds, impressions, or related materials to the receiving community provider to facilitate completion of treatment.

(3) The healthcare vendor shall designate a release planning coordinator at the start of the contract to coordinate dental continuity of care planning.

(4) The release planning coordinator shall collaborate with the healthcare vendor's reentry director, and Department case management and social work services to ensure compliance with all Department policies governing patient release planning.

(5) Failure to comply with the requirements of this subsection may result in liquidated damages in accordance with the Department's dental services contract.

H. Dental Consultation Services.

(1) The dental contractor shall provide dental consultation services for each patient when referred by the healthcare vendor.

(2) Dental consultation services may include:

(a) Evaluation;

(b) Clinical recommendations; and

(c) Treatment guidance related to dental conditions affecting patient health or ongoing medical treatment.

(3) The dental contractor shall provide consultations:

(a) In person during normal business hours when requested by the Department or the healthcare vendor; or

(b) Remotely through the on-call dentist when consultation is required outside of normal business hours.

(4) The dental contractor shall document all consultation findings, recommendations, and related communications in the patient's EPHR.

I. Dental Laboratory Services and Testing.

(5) The dental contractor shall provide all dental laboratory services necessary to support the delivery of oral healthcare services in accordance with the Department's dental contract.

(6) Dental laboratory services include, but are not limited to, the fabrication, adjustment, repair, and delivery of dental prosthetics.

(7) Dental prosthetics and related laboratory services include:

(a) Full dentures;

(b) Partial dentures;

(c) Denture repairs and relines;

(d) Wax tray-ins and tooth setups;

(e) Bite rims and custom trays;

(f) Acrylic processing and finishing;

(g) Biopsy kits; and

(h) Shade matching and prosthetic tooth selection, when clinically indicated.

(8) The dental contractor shall coordinate all dental laboratory services necessary to support patient treatment plans and ensure timely completion of prosthetics appliances and related laboratory work.

(9) Dental Laboratory Standards.

(a) All dental laboratory work shall be performed by a licensed dental laboratory in accordance with the prescribing dentist's instructions and all applicable clinical and regulatory standards.

(b) The dental contractor shall ensure timely turnaround, quality control, and proper documentation of all dental laboratory services.

(c) The dental contractor shall document all laboratory orders, prosthetic fabrication details, adjustments, and final delivery of appliances in the patient's EPHR.

(10) Dental Laboratory Testing.

(a) The dental contractor shall be responsible for all costs associated with blood draws, laboratory testing, and the delivery of laboratory results ordered by dental personnel.

(b) The healthcare vendor shall:

(i) Ensure that all laboratory testing requested by the dental contractor is performed as directed in Chapter 10 – Laboratory and Radiology Services of this Manual; and

(ii) Ensure that laboratory results are provided to the dental contractor in a timely manner for review and documentation in the patient's EPHR.

(c) If a dental laboratory test result is abnormal, the dental contractor may not perform the related dental procedure until the abnormal result has been reviewed and discussed with the healthcare vendor.

(d) The dental contractor shall ensure that all abnormal laboratory results are promptly flagged and communicated to the healthcare vendor upon receipt.

(e) The healthcare vendor shall:

(i) Review the abnormal test result with the patient as directed in Chapter 10 – Laboratory and Radiology Services, § .02F of this Manual; and

(ii) Document review and patient interaction in the patient's EPHR.

J. **Excluded Oral Healthcare Procedures.**

(1) The dental contractor may not provide elective or cosmetic dental services, including but not limited to:

(a) Tooth bonding performed solely for cosmetic enhancement;

(b) Cosmetic restoration;

(c) Veneers; or

(d) Teeth whitening procedures.

(2) Elective cosmetic dental services are considered non-essential in the correctional healthcare setting and are excluded from the scope of care under the Department's dental contract.

K. **Limitations of Care.**

(1) The healthcare vendor shall recognize the following exception to limitations of care:

(a) The scope of treatment in the oral healthcare program is intended to be limited to those services provided in the general practice of dentistry and as outlined in this program description.

(b) All exceptions to this limitation of care shall be approved by the dental regional director and dental contract administrators before initiating care.

(c) The Department's Chief Medical Officer has the authority to provide a final disposition if conflicts arise and to direct the dental contractor to provide referrals or additional care to patients on a case-by-case basis.

(1) The dental contractor may not be required to provide restorative or cosmetic dental services beyond those medically necessary to maintain basic oral function and health.

(2) Endodontic treatment may not be routinely provided and is subjected to the following clinical limitations:

(a) Limited to anterior or bicuspid teeth that are structurally and periodontally sound and considered essential to preserving the patient's overall oral health; and

(b) Limited to removal of supra- and sub-gingival calculus, with treatment supported by patient self-care, particularly in Class II and Class III periodontal cases.

(3) The dental contractor shall provide prosthetic treatment for a patient who does not possess dentures at the time of incarceration, consistent with the following criteria:

(a) Denture relines;

(b) Chair-side or laboratory denture relines, when clinically indicated; and

(4) The dental contractor may not perform denture relines more frequently than once every 2 years, regardless of any release and subsequent incarceration.

(5) Partial Dentures. The dental contractor shall provide partial dentures when necessary to establish minimal functional occlusion, defined as:

(a) At least 4 posterior teeth in each arch in positive, stable occlusion; and

(b) Functional guidance, including bilateral cuspid lift, cuspid/bicuspid group function, or an adequate number of opposing incisors to permit effective inclusion of food.

(6) Cosmetic partials or flippers that replace one or two anterior teeth may be provided only when:

(a) The patient presents with maxillary edentulous anterior space of 24 mm or greater, or a mandibular edentulous anterior space of 21 mm or greater; and

(b) The patient requires partial denture therapy to support functional mastication, excluding third molars from the count of functional teeth.

L. **Accessory Treatment.**

(1) Accessory treatment services may not be authorized.

(2) Accessory treatment services include:

(a) Orthodontic tooth movement;

(b) Fixed prosthetics;

(c) Dental implants;

(d) Edentulous ridge augmentations;

(e) Orthographic surgery;

(f) Temporomandibular Joint (TMJ) appliances or surgery;

(g) Mouth guards, athletic guards, and orthotics; or

(h) Any elective procedure requiring outside hospitalization or treatment by a dental specialist.

M. **Infection Control.**

(1) The dental contractor shall manage an infection control program in compliance with the Center for Disease Control and Prevention (CDC) guidelines and Occupational Safety and Health Administration (OSHA) regulations.

(2) The infection control program shall include:

(a) Concurrent surveillance of patients and employees for infectious conditions relevant to dental care delivery.

(b) Implementation of preventive infection control techniques, including:

(i) Standard precautions;

(ii) Transmission-based precautions when indicated; and

(iii) Appropriate use of personal protective equipment;

(c) Procedures for the identification, treatment, documentation, and reporting of suspected or confirmed infections in accordance with:

(i) Federal, State, and local laws and regulations; and

(ii) Department policies and clinical guidelines; and

(d) Ongoing personnel training and compliance monitoring related to infection prevention and control in the dental setting.

N. **Sharps and Biohazardous Waste Disposal.**

(1) The dental contractor shall be responsible for the collection and handling of all biohazardous waste generated through the operation of dental services performed by the dental contractor or its subcontractors.

(2) Biohazardous waste includes, but is not limited to:

(a) Waste associated with dental radiography;

(b) Dental amalgam and filling materials;

(c) Sharps; and

(d) Other regulated medical waste.

(3) The dental contractor shall coordinate with the healthcare vendor to ensure that all biohazardous waste generated by dental operations are properly removed and disposed of in compliance with applicable federal, State, and local laws and regulations.

(4) The dental contractor shall ensure that sharps containers and regulated biohazardous waste containers are properly maintained and secured within dental treatment areas in accordance with infection control standards and Department policy.

(5) The healthcare vendor shall provide general waste disposal services at dental clinic locations within correctional facilities at no cost to the dental contractor.

O. **Dental Instrument and Accountability.**

(1) The dental contractor shall conduct a formal daily inventory count of all dental instruments at the beginning and end of each business day.

(2) The dental contractor shall conduct formal weekly inventory count at the start of business each Monday and at the close of business each Friday.

(3) The dental contractor shall document all daily and weekly inventory counts in the Department's SharePoint site.

(4) The dental contractor shall maintain electronic instrument inventory logs for each correctional facility on the Department's SharePoint site.

(5) If a discrepancy in the dental instrument count is identified, the dental contractor shall immediately secure the dental treatment area and notify security personnel.

(6) The dental contractor shall immediately report the incident in accordance with the Department's serious incident reporting procedures and the Maryland Commission on Correctional Standards.

P. **Anesthetics and Medications.**

(7) Dental Anesthetics.

(a) The dental contractor shall be responsible for the cost, procurement, storage, and administration of all local and topical anesthetics necessary for the provision of dental care.

(b) The dental contractor shall ensure the secure on-site storage of dental anesthetics in accordance with Department policy and applicable regulatory requirements.

(8) Dental Medications and Stock Medications.

(a) The dental contractor shall submit all dental medication orders to the pharmacy contractor.

(b) The pharmacy contractor shall dispense prescribed dental medications.

(c) The healthcare vendor shall receive and administer medications in accordance with OCS.130.0008 – Pharmacy Services Manual.

(d) The dental contractor shall coordinate with the pharmacy contractor to maintain an on-site supply of commonly used dental stock medications, including antibiotics and analgesics.

(e) The dental contractor shall:

(i) Maintain accurate electronic inventory records;

(ii) Ensure secure storage of stock medications;

(iii) Administer only the initial dose of stock medication when clinically indicated; and

(iv) Document administration and inventory actively in the patient's EPHR.

Q. **Quality Assurance.**

(1) The dental contractor shall evaluate the quality of oral healthcare services using the Department's approved oral health quality assurance program.

(2) The dental contractor shall:

(a) Submit monthly quality assurance reports to the Department's designee and ACOM; and

(b) Upload the monthly quality assurance report in the Department's approved document management system as required by the contract.

(3) The dental contractor shall document all patient care interactions in the oral healthcare events in the patient's EPHR, including:

(a) 90-day admission evaluation;

(b) Progress notes;

(c) Treatment plans;

(d) Radiographs;

(e) Dental charting;

(f) Medication records;

(g) Referral and consultation notes;

(h) Appointment logs/scheduling;

(i) Consent forms;

(j) Refusal forms; and

(k) Emergency encounter records.

(4) The dental contractor shall obtain consent and authorization for dental treatment from each patient in accordance with Department policy.

.03 REFERENCES AND STANDARDS.

A. National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons (2026).

B. American Correctional Association (ACA), 5th Edition (2019).

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CHAPTER 13—CLEARANCE FOR INCARCERATED INDIVIDUALS TO WORK

.01 POLICY.

A. An incarcerated individual may not be assigned to a work assignment listed on *Form OTS.130-100hR – Medical Clearance Program to Work* unless a qualified healthcare provider or mental health professional determines that the individual is medially cleared for the assignment.

B. An incarcerated individual assigned to a food service work detail shall be medically evaluated in accordance with:

(1) OCS.130.0007 – Infection Control Manual; and

(2) COMAR 10.06.01.06E.

.02 PROCEDURES.

A. Medical Clearance for Work Assignments.

(1) A qualified healthcare provider shall complete *Form OTS.130-100hR – Medical Clearance Program to Work* as part of the patient's 7-day physical and evaluation or as referred by facility case management.

(2) Medical clearance includes:

(a) Clinical assessment;

(b) Review of the patient's complete medical record;

(c) Verification of immunization status, when applicable; and

(d) Confirmation of completion of required infection control and prevention training.

(3) When a work assignment involves potential exposure to blood, bodily fluids, environmental contaminants, or other infectious hazards, a qualified healthcare provider shall:

(a) Evaluate the patient's infection disease status in accordance with OCS.130.0007 – Infection Control Manual and applicable occupational health policies; and

(b) Determine whether any restriction, modification, or disqualification is required.

(4) The healthcare vendor's infection control team, in collaboration with the facility's Environmental Compliance and Safety Officer (ECSO) or other designated employee, shall ensure completion of infection control and prevention training prior to the patient beginning a work assignment.

B. **Mental Health Clearance.**

(1) If the qualified healthcare provider determines that a mental health evaluation is necessary to determine suitability for a work assignment, the healthcare provider shall refer the patient to a mental health services clinician.

(2) The mental health services clinician shall:

(a) Complete the mental health assessment within 5 business days of referral; and

(b) Document the assessment findings in the patient's EPHR.

(3) The mental health services clinician shall approve or deny placement in any work assignment involving the mental health condition of an incarcerated individual that may create a safety risk to the individual or others.

C. **Ongoing Evaluation and Monitoring.**

(1) The custody supervisor overseeing the incarcerated individual's work assignment shall notify the medical unit when a medical or mental health condition arises that may affect the incarcerated individual's work clearance.

(2) Upon notification, the qualified healthcare provider shall:

(a) Re-evaluate the incarcerated individual; and

(b) Modify, restrict, or revoke clearance to work as clinically indicated.

(3) The qualified healthcare provider shall conduct additional evaluation when concerns arise related to:

(a) Infectious disease status;

(b) Communicable conditions; or

(c) Occupational health risks.

D. **Food Service Work Restrictions.**

(1) An incarcerated individual with a suspected or confirmed foodborne illness, gastrointestinal illness, or communicable disease that poses a risk to food safety may not be cleared for food services work.

(2) The qualified healthcare provider shall immediately revoke the work clearance of an individual from food service duties when symptoms or laboratory findings indicate a condition that poses a risk to food safety.

(3) Disqualifying conditions include those listed under COMAR 10.06.01.06E.

E. **Immunization Requirements for Exposure-Risk Assignments.**

(1) If an incarcerated individual is assigned to a work detail involving potential infectious disease exposure, the qualified healthcare provider shall:

(a) Offer the required immunizations to the incarcerated individual, unless medically contraindicated; and

(b) Document the incarcerated individual's immunization status in the individual's EPHR.

(2) If the incarcerated individual declines immunizations, the qualified healthcare provider shall:

(a) Obtain the incarcerated individual's signature on *Form OPS 130-5bR – Release of Responsibility*; and

(b) Determine whether work restrictions or disqualifications are required.

F. **Removal and Return to Work.**

(1) The qualified healthcare provider or mental health clinician shall immediately revoke the work clearance of an individual from a work assignment when a medical or mental health condition:

(a) Affects clearance for the work assignment; or

(b) Poses a safety risk to the individual or other.

(2) The qualified healthcare provider or mental health clinician shall:

(a) Provide or coordinate appropriate treatment;

(b) Determine when the incarcerated individual is clinically appropriate to return to work; and

(c) Document all decisions in the incarcerated individual's EPHR.

(3) The qualified healthcare provider or mental health clinician shall base return-to-work decisions on:

(a) Resolution of symptoms;

(b) Completion of treatment; and

(c) Applicable criteria in OCS.130.0007 – Infection Control Manual.

G. **Documentation and Clearance Determination.**

(1) The qualified healthcare provider or mental health clinician shall:

(a) Complete *Form OTS.130-100hR – Medical Clearance program to Work*;

(b) Upload the completed *Form OTS.130-100hR – Medical Clearance program to Work* into the incarcerated individual's EPHR; and

(c) Forward a copy of the completed *Form OTS.130-100hR – Medical Clearance program to Work* to the facility case management office.

(2) If work clearance is denied or revoked, the qualified healthcare provider or mental health clinician shall:

(a) Document the reason for the denial on *Form OTS.130-100hR – Medical Clearance program to Work;*

(b) Upload the completed *Form OTS.130-100hR – Medical Clearance program to Work* into the incarcerated individual's EPHR;

(c) Forward a copy of the completed *Form OTS.130-100hR – Medical Clearance program to Work* to the facility case management office.

(d) Notify the incarcerated individual of the denial; and

(e) Schedule medical follow-up evaluation as clinically indicated.

H. **Final Clinical Authority.**

(1) The site medical director, or the director's designee, shall make the determination regarding medical clearance when:

(a) Clinical complexity exists;

(b) Infectious disease concerns are present; or

(c) Occupational health risks require elevated review.

(2) The site medical director, or the director's designee, shall base their determination regarding medical clearance on:

(a) Review of the incarcerated individual's complete medical history;

(b) Clinical findings;

(c) Occupational exposure risk;

(d) Infection control considerations; and

(e) Immunization status, when applicable.

(3) The Department's CMO shall have final clinical authority regarding medical clearance.

.03 REFERENCES AND STANDARDS.

A. National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons (2026).

B. American Correctional Association (ACA), 5th Edition (2019).

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CHAPTER 14—SEXUAL ASSAULT FORENSIC EXAMINATION

.01 POLICY.

A. The healthcare vendor shall manage the care of an incarcerated individual who reports a sexual abuse while in Department custody in accordance with the Prison Rape Elimination Act (PREA) guidelines.

B. The healthcare vendor shall:

(1) Conduct an initial medical evaluation upon report of the sexual assault;

(2) Provide emergent medical intervention to address injuries or trauma sustained during the assault; and

(3) Ensure forensic specimen collection occurs only at a community hospital, where a qualified independent provider or forensic nurse conducts the examination.

.02 PROCEDURES.

A. **Initial Medical Response Following a Report of Sexual Abuse.**

(1) If a healthcare vendor employee or mental health professional employed by the Department becomes aware of or receives a report of sexual abuse involving an incarcerated individual, they shall immediately initiate the following actions:

(a) Notify custody personnel without disclosing any medical or clinical details;

(b) Notify the designated healthcare provider at the facility;

(c) Notify the facility's PREA compliance manager;

(d) Notify the Department's PREA coordinator;

(e) Notify the healthcare vendor's regional administrator;

(f) Notify the appropriate external authorities in accordance with PREA national standards 28 CFR § 115.61(a-e); and

(g) Document all notifications in the patient's EPHR.

(2) Upon receiving a report of sexual abuse, the healthcare vendor or mental health professional employed by the Department shall request custody to escort the

incarcerated individual to the facility's medical area for an examination and to address emergent healthcare needs.

(3) A qualified healthcare provider shall:

(a) Identify and triage injures or conditions requiring emergency intervention;

(b) Provide necessary medical treatment to stabilize the patient;

(c) Follow PREA regulations and forensic examination protocols; and

(d) Ensure the chain of evidence is preserved for legal and investigative purposes.

(4) To preserve forensic integrity, the healthcare vendor may not wash, clean, or otherwise remove blood, semen, body fluids, clothing, or any other potential forensic evidence from the patient.

(5) If a juvenile reports an allegation of sexual abuse, the healthcare vendor employee shall take immediate action as required in DPSCS.020.0026 – Prison Rape Elimination Act – Federal Standards Compliance.

B. **Forensic Examination.**

(1) Upon receiving a report of sexual abuse, the qualified healthcare provider shall:

(a) Contact the designated SAFE/SANE community hospital to coordinate care and clinical overview of the reported PREA incident, including:

(i) Pertinent medical or mental health information; and

(ii) Documented disabilities;

(b) Arrange for the immediate transportation of the patient to the designated SAFE/SANE community hospital for forensic examination as determined by the SAFE/SANE examiner;

(c) Make notifications to the following individuals:

(i) The facility's PREA compliance manager;

(ii) The Department's PREA coordinator;

(iii) The healthcare vendor's regional administrator; and

(iv) The facility managing official or designee;

(d) Refer the patient to mental health services for supportive care and follow-up;

(e) Ensure all documented disabilities are recorded in the patient's EPHR;

(f) Ensure all referrals and communication are documented in the patient's EPHR; and

(g) Complete a Serious Event Incident Report (SEIR).

(2) A qualified mental health professional shall:

(a) Conduct a mental health evaluation within 24 hours of the reported incident;

(b) Assess the patient's clinical needs and risk, including indicators of trauma, emotional distress, or self-harm potential; and

(c) Document the evaluation, including disposition and required follow-up in the patient's EPHR.

C. **Transport for SAFE/SANE Assessment.**

(1) If the SAFE/SANE community-based hospital determines a forensic examination is necessary, the dispensary RN shall:

(a) Notify the shift commander or designee of the required emergency department transportation of the patient to a community hospital for a forensic medical examination and collection of forensic evidence;

(b) Send a copy of the patient's medical history and initial examination findings for review by the medical professionals in the emergency department;

(c) Notify the facility's PREA compliance manager within 1 hour of transfer to report that:

(i) The patient has been evaluated and medically stabilized; and

(ii) The patient has been transported to the hospital for forensic examination; and

(d) Initiate a referral to mental health services for post-assault follow-up care immediately upon the patient's return to the correctional facility.

(2) Upon return to the correctional facility, the qualified healthcare provider shall:

(a) Review all notes generated from the receiving hospital and enter appropriate care orders into the patient's EPHR within 4 hours of return; and

(b) Conduct a medical follow-up evaluation within 24 hours of the patient's return from the hospital, which includes:

(i) Any additional diagnostic testing as clinically indicated; and

(ii) Administration of any required treatment, such prophylaxis or vaccinations; and

(c) Complete provider review, clinical action, and necessary follow-up action required under Chapter 10, § .02E for:

(i) Sexually transmitted infections (STIs);

(ii) Pregnancy;

(iii) Hepatitis B virus (HBV);

(iv) Hepatitis C virus (HCV); or

(v) Rapid plasma regain (RPR) test for syphilis within 5 business days of receiving the results.

(3) The healthcare vendor shall:

(a) Ensure the completion of all PREA-related post-abuse follow-up clinical activities for medical and mental health care, regardless of whether an off-site emergency department visit is required. These activities include testing and prophylactic treatment for sexually transmitted infections (STIs) and pregnancy, if applicable;

(b) Obtain informed consent prior to providing medical treatment; and

(c) Maintain patient confidentiality in accordance with HIPAA and PREA regulations.

D. **Reproductive Health Services.**

(1) The healthcare vendor shall immediately inform an individual capable of pregnancy with information regarding access to emergency contraception. Within 72 hours of sexual abuse, and upon request from the individual, the healthcare vendor shall provide access to emergency contraception.

(2) If the patient becomes pregnant because of the sexual assault, the healthcare vendor shall:

(a) Provide timely and comprehensive information regarding access to all pregnancy-related medical services, including abortion; and

(b) Make appropriate referrals to mental health and social work services.

E. **Repeated and Recurrent Allegations of Sexual Abuse.**

(1) If a patient repeatedly alleges to be the victim of sexual abuse the chief medical officer and the director of mental health services may, in coordination with the facility's managing official or designee, and facility PREA compliance manager, convene a multidisciplinary team to review the patient's case.

(2) Prior to convening, the multidisciplinary team shall ensure that all allegations of sexual abuse have been investigated in accordance with *DPSCS.020.0026 – Prison Rape Elimination Act Audit Manual*.

(3) The multidisciplinary team shall assess the circumstances surrounding the repeated allegations which may include:

(a) The credibility of the allegations based upon the findings of the investigation;

(b) The patient's clinical and mental health needs; and

(c) Review and, if appropriate, recommend an update to the patient's PREA risk code to ensure the individual's safety and well-being.

(4) The multidisciplinary team shall:

(a) Develop a case-specific plan of action; and

(b) Document findings, recommendations, and the final disposition in the patient's EPHR.

F. **Healthcare Follow-Up Assessment.**

(1) The healthcare vendor shall:

(a) Provide an alleged perpetrator STI testing within 5 days of the alleged assault or abuse;

(b) Provide an alleged perpetrator a mental health evaluation by a mental health clinician within 30 days of the alleged assault or abuse; and

(c) Provide the victim and alleged perpetrator follow-up STI testing within 60 days of initial STI testing.

(2) If the victim or alleged perpetrator refuses the offered testing, the healthcare vendor shall obtain the individual's signature on Form OTS 130-600-5 – Consent or Refusal of Medical Treatment.

(3) The healthcare vendor shall provide all PREA related healthcare services to both the victim and the alleged perpetrator without financial costs and regardless of whether the victim identifies the alleged abuser or cooperates with any investigation arising out of the incident.

G. **PREA Reporting and Training.**

(1) The healthcare vendor shall:

(a) Establish and implement a process to report and respond to a PREA-related incident through the PREA reporting hotline;

(b) Notify the correctional facility's ACOM, the Office of Clinical Services, Office of Mental Health Services, and facility social work personnel upon receiving a report of sexual abuse;

(c) Document the report using the healthcare vendor's serious event incident report supplement form; and

(d) Enter an encounter note acknowledging the report the incident and supporting information in the patient's EPHR.

(2) PREA Training.

(a) The healthcare vendor shall ensure that all full- and part-time healthcare vendor employees are trained in:

(i) Detecting and assessing signs of sexual abuse and sexual harassment;

(ii) Preserving physical evidence of sexual abuse;

(iii) Responding effectively and professionally to victim of sexual abuse and sexual harassment; and

(iv) Reporting allegations or suspicions of sexual abuse and sexual harassment.

(b) Medical and mental health practitioners shall receive specialized training mandated for employees under PREA § 115.31 or for contractors and volunteers under PREA § 115.32.

(c) The healthcare vendor shall:

(i) Ensure all vendor employees who provide direct care to an incarcerated individual are provided PREA training during the new employee orientation process prior to delivering healthcare services; and

(ii) Document completion of training in the employee's credentialing folder within the document management system and maintain hard copy credentials on site for review.

(d) The healthcare vendor shall:

(i) Ensure all employees receive annual PREA refresher training; and

(ii) Document completion of training in the employee's credentialing folder.

H. **PREA Audits.**

(1) The healthcare vendor shall:

(a) Conduct an annual audit consistent with the Department's audit calendar to ensure compliance with PREA training requirements; and

(b) Provide the audit results to the CQI manager for presentation during the monthly CQI meetings.

(2) The healthcare vendor shall:

(a) Conduct a monthly PREA compliance audit using the Department's approved audit tool; and

(b) Submit audit results, trending reports and corrective action plans for non-compliant areas, by region and facility, to the regional ACOM and Department's CQI manager.

(3) The healthcare vendor shall:

(a) Present PREA findings, trending reports, and corrective action plans during the monthly medical advisory council meetings; and

(b) Submit PREA related audit results, findings, reports, and corrective action plans as required by the contract within the Department's document management system.

.03 REFERENCES AND STANDARDS.

A. National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons (2026).

B. American Correctional Association (ACA), 5th Edition (2019).

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CHAPTER 15—PRESSURE INJURIES AND WOUND CARE

.01 POLICY.

A. The healthcare vendor shall implement preventive and clinical interventions to maintain skin integrity and reduce the risk of pressure injuries for each patient with impaired mobility or any medical condition that increases the risk of skin breakdown, regardless of housing location.

B. The healthcare vendor shall ensure the timely identification, assessment, staging, treatment, and ongoing monitoring of pressure injuries and wounds in accordance with accepted clinical standards of care.

C. A certified wound care clinician or certified wound care nurse shall assess and stage each pressure injury and wound to ensure treatment is provided in accordance with prescribed clinical protocol based on the wound's stage and clinical presentation.

.02 SECTION A – RISK ASSESSMENT AND MONITORING FOR PRESSURE INJURY OR WOUND.

A. Risk Assessment and Monitoring for Pressure Injury or Wound Development.

(1) The healthcare vendor shall routinely assess each patient who is confined to a bed, uses a wheelchair, has limited mobility, or expresses an altered protective sensation for the risk of pressure injury or wound development.

(2) The healthcare vendor shall develop a nursing care plan for each patient identified as at risk for impaired skin integrity. The nursing care plan shall identify mobility limitations and address the nursing diagnosis of "risk for impaired skin integrity" or "impaired skin integrity."

B. Infirmary and Wound Care Monitoring.

(1) An infirmary RN shall:

(a) Perform a daily skin and wound assessment, or as ordered by a healthcare provider, for each patient housed in the acute care infirmary; and

(b) Document the assessment using the wound care flow sheet in the patient's EPHR.

(2) A certified wound care clinician or certified wound care nurse shall:

(a) Conduct a weekly assessment during the wound care clinic for each patient diagnosed with impaired mobility who resides in sheltered housing or general population to evaluate the patient for early signs of skin breakdown;

(b) Assess pressure points during wound evaluations for each patient who uses a wheelchair;

(c) Apply preventive strategies as clinically indicated;

(d) Measure and document each wound in the patient's EPHR at least once per week; and

(e) Document findings in the patient's EPHR and develop or update the nursing care plan when indicated.

C. **Pressure Injury and Prevention Measures.**

(1) The healthcare vendor shall implement the following preventive measures for each patient with impaired mobility:

(a) Reposition the patient every 2 hours;

(b) Minimize external pressure by maintaining clean, dry bed linens that are taut and wrinkle-free;

(c) Limit the use of excess pads or waterproof materials beneath the patient;

(d) Reduce moisture caused by incontinence or other sources; and

(e) Employ pressure-reliving devices in beds and wheelchairs when clinically appropriate, including cushions and heel off-loading devices.

(2) The healthcare vendor shall reduce shear and friction for each patient with impaired mobility by:

(a) Maintaining the head of the bed at less than 30 degrees unless clinically contraindicated;

(b) Supporting the patient's feet and legs when the head of the bed is elevated;

(c) Supporting the patient's feet when the bed is flat if the patient is at risk for pressure injury development;

(d) Flattening the bed prior to repositioning the patient; and

(e) Using lifting devices such as draw sheets, transport boards, or mechanical lifts during patient movement;

(3) Ensure the patient receives adequate hydration and nutrition; and

(4) Identify and manage underlying medical conditions that contribute to impaired skin integrity.

B. Additional Preventive Measures for Patients with Diabetes.

(1) For each patient diagnosed with diabetes, the healthcare vendor shall:

(a) Perform a foot examination at least monthly to identify early signs of skin breakdown;

(b) Refer concerning findings to the healthcare provider;

(c) Recommend the patient wears appropriate footwear; and

(d) Refer the patient to a healthcare provider for medical footwear when clinically indicated.

(2) The healthcare vendor shall provide monthly education on diabetes and diabetic foot care using educational materials from the Center for Disease Control and Prevention (CDC) and the American Diabetes Association (ADA), and other medical sources as appropriate.

.03 SECTION B – IDENTIFICATION, STAGING, AND TREATMENT OF PRESSURE INJURIES AND WOUNDS.

A. **Procedures.**

(1) A certified wound care clinician or certified wound care nurse shall:

(a) Stage each pressure injury or wound based on its appearance, thickness, size, depth, drainage, and involvement or surrounding tissue;

(b) Document the pressure injury or wound characteristics in the patient's EPHR; and

(c) Initiate treatment based on the pressure injury stage and clinical presentation.

B. **Stage 1 Pressure Injury.**

(2) A stage 1 pressure injury presents as non-blanchable erythema over a bony prominence. Blanching may not be visible for a patient with a darker skin tone. Additional indicators may include discoloration, warmth, edema, induration, or firmness.

(3) Under the direction of a certified wound care clinician or certified wound care nurse, the RN shall:

(a) Assess the patient's skin daily for changes in status and document findings in the patient's EPHR;

(b) Gently cleanse the affected area with mild soap and water, rinse, and pat dry;

(c) If the patient's skin is very dry, apply a moisturizing cream;

(d) If the patient's skin does not appear dry, apply a skin barrier when pressure, friction, shear, or moisture cannot be fully eliminated;

(e) If the patient is incontinent, apply a moisture barrier and/or ointment every 8 hours after each incontinent episode; and

(f) Document pressure injury measurements, treatment interventions, and clinical progress in the patient's EPHR.

(4) The RN shall apply dressings as ordered by a clinician. Dressings may include transparent film, oxygen permeable, Op-Site Hydrocolloid, or Hydrogel.

(5) The RN shall:

(a) Date, time, and initial the dressing at the time of application to ensure timely replacement of dressings; and

(b) Record the date and time the dressing application, observation of wound progress, and wound reaction to treatment in the patient's EPHR.

(6) The RN shall make a referral to the certified wound care clinician, certified wound care nurse, or physician for staging and additional direction on the type of dressing or care to be provided.

(7) The RN shall document all findings in the patient's EPRH and provide an oral update to the provider following patient care.

C. **Stage 2 Pressure Injury.**

(1) A stage 2 pressure injury involves partial-thickness skin loss affecting the epidermis and/or dermis and may appear as a blister, abrasion or shallow ulcer.

(2) Under the direction of a certified wound care clinician or certified wound care nurse, the RN shall:

(a) Assess the wound daily for changes in status (i.e., infection, drainage, granulation, or necrotic tissue) and document findings in the patient's EPHR; and

(b) Cleanse the site as clinically appropriate.

(3) The RN shall apply dressings as ordered by a certified wound care clinician or as indicated if soiled or displaced. Dressings may include transparent film, hydrogel sheet or hydrogel disc that is non-occlusive, or foam and calcium alginate.

(4) The RN shall:

(a) Date, time, and initial the dressing at the time of application to ensure timely replacement of dressings; and

(b) Record the date and time of dressing application, observation of wound progress, and wound reaction to treatment in the patient's EPHR.

(5) The RN shall make a referral to the certified wound care clinician, certified wound care nurse, or physician for staging and additional direction on the type of dressing or care to be provided.

(6) The RN shall document all findings in the patient's EPHR and provide an oral update to the provider following patient care.

D. **Stage 3 and Stage 4 Pressure Injuries.**

(1) Stage 3 and stage 4 pressure injuries represent full-thickness tissue loss and may involve damage to muscle, tendon, ligament, joint capsule, or bone. A stage 3 and stage 4 pressure injury may present as a deep crater or tunnel into surrounding subcutaneous tissue.

(2) A stage 3 pressure injury is full thickness skin loss involving damage to necrosis of subcutaneous tissue, which may extend down to, but not through, underlying fascia. The pressure injury presents clinically as a crater with or without undermining adjacent tissue.

(3) A stage 4 pressure injury is a full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, tendon, ligaments, joint capsule, or bone. Undermining and sinus tracts may also be associated with stage 4 pressure injuries.

(4) Under direction of a certified wound care clinician or certified wound care nurse, the RN shall assess the wound daily for signs of infection, drainage, granulation tissue, or necrotic tissue and document findings in the patient's EPHR.

(5) The RN shall apply treatment and dressing as ordered by a certified wound care clinician. Dressings may include impregnated gauze covered with telfa-like dressing, packing with foam or calcium alginate, and use of specialized wound care therapies.

(6) The RN shall:

(a) Date, time, and initial the dressing at the time of application to ensure timely replacement of dressings; and

(b) Record the date and time of dressing application, observation of wound progress, and wound reaction to treatment in the patient's EPHR.

(7) The RN shall make a referral to the certified wound care clinician, certified wound care nurse, or physician for staging and additional direction on the type of dressing or care to be provided.

(8) The RN shall document all findings in the patient's EPHR and provide an oral update to the provider following patient care.

E. **Surgical and Trauma Related Wounds.**

(1) Under the direction of a certified wound care clinician or certified wound care nurse, the RN shall:

(a) Treat all surgical wounds and acute wounds resulting from trauma according to the certified healthcare provider's orders;

(b) Monitor the wound for signs and symptoms of infection or a lack of responsiveness to treatment; and

(c) Refer the patient to the certified wound healthcare provider for a same-day clinical evaluation and further intervention if a wound shows signs of infection or if a wound does not demonstrate measurable improvement within 7 days.

(2) The certified wound healthcare provider shall complete a same-day clinical evaluation of all referred patients if a wound shows signs of infection or if a wound does not demonstrate measurable improvement within 7 days of initial order.

F. **Wound Care Clinics.**

(1) A certified wound care clinician or certified wound care nurse shall:

(a) Conduct wound care clinics at least once monthly for outpatients to each serve delivery area; and

(b) Conduct wound care clinics at least weekly in each infirmary.

(2) The healthcare vendor shall:

(a) Enroll each patient who uses a wheelchair, has a chronic wound, or is at high risk for developing a chronic wound into the wound care clinic; and

(b) Ensure the patient receives wound care at least monthly or more frequently as medically indicated.

(3) The healthcare vendor shall provide all medical supplies and specialty care equipment necessary to promote wound healing. This includes, but is not limited to, specialty beds and therapeutic mattresses.

(4) The healthcare vendor shall provide the patient with education on pressure injury and wound prevention, and the appropriate use, maintenance, and daily safety checks of all issued medical supplies and specialty care equipment.

(5) The Department's CMO may authorize the use of specific wound care products on a case-by-case basis based on the patient's clinical need.

(6) The healthcare vendor shall document all pressure injury and wound-related observations, treatment, and outcomes in the patient's EPHR.

(7) The healthcare vendor shall record all wounds treated during the month on the Department's monthly wound care report and submit the completed report monthly to the Department's document management system, Department's director of nursing, ACOM and Department's infection control nurse manager with the monthly infection control report.

.04 REFERENCES AND STANDARDS.

A. National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons (2026).

B. American Correctional Association (ACA), 5th Edition (2019).

.05 HISTORY.

Date Issued	October 15, 2007	
Reviewed/Revised	September 17, 2009	
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