CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Preventive Services Care Guide

Presented in four parts:

May 2023

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

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Preventive Services
Part 1: Immunizations

IMMUNIZATIONS	CCHCS VACCINE RECOMMENDATIONS Please see detailed guidance for vaccination recommendations for pregnant and immunocompromised persons or other special populations			RESOURCE GUIDANCE
VACCINE TYPE	**WHO TO VACCINATE?**	**WHICH VACCINE?**	**HOW OFTEN? WHEN?**	**CARE GUIDES AND OTHER RESOURCES**
Influenza Vaccine	≥18 < 65 years	• Quadrivalent Inactivated (IIV4) egg-based • Quadrivalent Inactivated, cell-cultured	• Annually	https://www.cdc.gov/vaccines/hcp/aciprecs/vaccspecific/flu.html
	Age ≥ 65 years	• Quadrivalent Inactivated Adjuvanted (aIIV4) • Quadrivalent Inactivated High Dose	• Annually	https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html
COVID-19	All adults	Primary series and booster schedules vary by vaccine type/manufacturer: • mRNA vaccine (Moderna & Pfizer-BioNTech) • Protein subunit vaccine (Novavax) • Adenovirus vector vaccine (Janssen, unavailable at CDCR)	• Follow current CDC recommendations — offer boosters as recommended	https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html
Tetanus, diphtheria, pertussis (Tdap) or Td.	All adults	• Tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) • Tetanus and diphtheria toxoids (Td)	• 1 dose of Tdap, then Td or Tdap every 10 years • 1 dose Tdap each pregnancy followed by Td every 10 years	https://www.cdc.gov/vaccines/hcp/acip-recs/vacc specific/dtap.html
Measles, mumps, rubella (MMR)	All adults	• M-M-R (Measles-Mumps-Rubella Virus Vaccine (Live)	• 1 dose MMR If history of MMR vaccination but found to not have immunity* • 2 doses at least 28 days apart if no history of receiving MMR previously • During measles or mumps outbreak 1 or more doses of MMR may be given to adults at high risk per public health authorities recommendations *routine MMR serology testing not recommended	https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mmr.html Bureau of Prisons Immunization Guidance (bop.gov)

IMMUNIZATIONS	CCHCS VACCINE RECOMMENDATIONS Please see detailed guidance for vaccination recommendations for pregnant and immunocompromised persons or other special populations			RESOURCE GUIDANCE
VACCINE TYPE	**WHO TO VACCINATE?**	**WHICH VACCINE?**	**HOW OFTEN? WHEN?**	**CARE GUIDES AND OTHER RESOURCES**
Varicella (VAR)	All adults w/out laboratory evidence of immunity [Testing opt-out at Reception Center (RC)]	VARIVAX Varicella Virus Vaccine to immunocompetent adults	• 2-dose VAR series 4–8 weeks apart • 1 dose If previously received 1 dose of varicella-containing vaccine at least 4 weeks after first dose	https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/varicella.html
Zoster recombinant (RZV)	Age ≥ 50 years Also recommended for persons age ≥ 19 with immunocompromising conditions or about to become immunocompromised	Shingrix [Recombinant zoster vaccine (RZV)]	• 2-dose series RZV (Shingrix) 2–6 months apart regard-less of previous her- pes zoster or history of zoster vaccine live [Zoster vaccine live (ZVL), Zostavax] vaccination	https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/shingles.html
HPV vaccine	Adults 18-26 years	Gardasil 9	• 2 or 3 doses depending on the age at initial vaccination or condition	https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hpv.html
	Adults 27- 45 years: vaccine can be offered based on shared decision making		• 3 doses if age 15 at initial dose	
Hepatitis A (HAV)	All adults at risk for HAV infection; All adults at risk for severe adverse outcomes of HAV infection	Havrix Twinrix	• Havrix: 2 dose series at 6–12 months apart • Twinrix: 3 doses (Details on page 13)	https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepa.html Primary care of adults with HIV - UpToDate

IMMUNIZATIONS	CCHCS VACCINE RECOMMENDATIONS Please see detailed guidance for vaccination recommendations for pregnant and immunocompromised persons or other special populations			RESOURCE GUIDANCE
VACCINE TYPE	**WHO TO VACCINATE?**	**WHICH VACCINE?**	**HOW OFTEN? WHEN?**	**CARE GUIDES AND OTHER RESOURCES**
Hepatitis B (HBV)	Offer to all incarcerated adults	Heplisav-B® Twinrix	• Heplisav-B® 2-dose series at 0, 1 months • Twinrix: 3 doses (Details on page 14)	https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html
Pneumococcal	All adults ≥ 65 years and High risk adults 19-64 years	Prevnar 20 (PCV20) Pneumovax 23 (PPSV23)	(Details on page 15)	https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/pneumo.html
The following immunizations are given in special circumstances only – see detail pages				
Haemophilus Influenza type B	High risk patients	Hiberix ActHIB (Both non-formulary)	(Details on page 16)	https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hib.html
Meningococcal	High risk patients	• MenB Vaccine: MenB-4C (Bexsero), MenB-FHbp (Trumenba) • MenACWY Vaccine: MenACWY-D (Menveo, MenQuadFi)	(Details on page 17)	https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html

INFLUENZA VACCINE

WHO TO GIVE

- All incarcerated adults without contraindications should receive one dose of influenza vaccine appropriate for age and health status during each flu season.

HOW OFTEN AND WHEN

- Age 18-64 years: 1 dose of egg-based or egg-free (ovalbumin-free) Quadrivalent Inactivated vaccine.
- Age ≥ 65 years: One dose of High-Dose (HD-IIV4) or Adjuvanted Quadrivalent Inactivated vaccine.

WHAT TO GIVE

VACCINE TYPES:

- For patients' age 18-64 years, Quadrivalent Inactivated vaccines include egg-based Influenza Vaccine (Afluria) and non-egg-based Influenza Vaccine (Flucelvax) will be administered.
- For patients age 65 years and older, Quadrivalent Inactivated High-Dose (Fluzone HD) and Quadrivalent Inactivated Adjuvanted (Fluad) will be administered.

[**Note:** Live influenza vaccines are not administered in CDCR]

CONTRAINDICATIONS AND ALERTS

- Refer to Public Health for questions and vaccine alerts and Refer to Annual Influenza Vaccination Campaign for Patient's' memorandum for more information.

Contraindications/Alerts

- **GUILLAIN-BARRÉ SYNDROME (GBS):** History of Guillain-Barré syndrome within 6 weeks after previous dose of influenza vaccine. Generally, these patients should NOT be vaccinated unless vaccination benefits outweigh the risks for those at higher risk for severe complications from influenza.
- **PERSONS WITH EGG ALLERGY:** may receive any licensed, recommended influenza vaccine appropriate for their age and health status. Please see Flu Vaccine and People with Egg Allergies | CDC
- **PREVIOUS SEVERE ALLERGIC REACTIONS to any component of the vaccine or** to any influenza vaccine is a contraindication. Please see their individual packages for details.

PREGNANCY

- Pregnant women should receive the inactivated vaccine (IM injection).

COVID-19 VACCINE

WHO TO GIVE

- All adults

HOW OFTEN AND WHEN

CDC guidelines

- Intervals vary for different types of vaccines. See table below. Note: Information is frequently updated. Check current CDC COVID Vaccine Update

WHAT VACCINE? Immunization Schedule for Persons Aged 18 Years and Older (Adapted from COVID-19 Immunization)

- Whenever possible, COVID-19 vaccines should be administered at least 2 weeks before initiation or resumption of immunosuppressive therapies.

Primary Series	
1st Dose	**2nd Dose**
Pfizer-BioNTech	**Pfizer-BioNTech**
	3–8 weeks after 1st dose*

UPDATED (BIVALENT) BOOSTER
3rd Dose
Pfizer-BioNTech or Moderna
At least 2 months after 2nd primary series dose or last booster

Primary Series	
1st Dose	**2nd Dose**
Moderna	**Moderna**
	4–8 weeks after 1st dose*

UPDATED (BIVALENT) BOOSTER
3rd Dose
Pfizer-BioNTech or Moderna
UPDATED (BIVALENT) BOOSTER At least 2 months after 2nd primary series dose or last booster

Primary Series	
1st Dose	**2nd Dose**
Novavax	**Novavax**
	3–8 weeks after 1st dose*

UPDATED (BIVALENT) BOOSTER
3rd Dose
Pfizer-BioNTech or Moderna
UPDATED (BIVALENT) BOOSTER At least 2 months after 2nd primary series dose A monovalent Novavax booster is available in limited situations More details: Novavax booster

Note: CDCR no longer uses Janssen vaccine

* From CDC: Stay Up to Date with COVID-19 Vaccines Including Boosters | CDC and COVID-19: Vaccines - UpToDate

CONTRAINDICATIONS AND ALERTS

Persons with history of multisystem inflammatory syndrome (MIS-C and MIS-A) from SARS-CoV-2 infection should consult a primary care physician for vaccination guidance.

TETANUS, DIPHTHERIA, PERTUSSIS VACCINE

WHO TO GIVE

- All adults

HOW OFTEN AND WHEN

- All adults (Regardless of the interval since their last tetanus or diphtheria toxoid–containing vaccine) should receive one dose of Tdap,then Td or Tdap every 10 years.
- One dose of Tdap each pregnancy followed by Td every 10 years.
- Adults should receive a booster dose of either Tdap or Td (a different vaccine that protects against tetanus and diphtheria but not pertussis) every 10 years, or after 5 years in the case of all wounds except clean or minor wound. Refer to Tetanus-diphtheria toxoid vaccination in adults - UpToDate for more details.

WHAT VACCINE?

Tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap).

- Tetanus and diphtheria toxoids (Td).

CONTRAINDICATIONS AND ALERTS

- Severe systemic reactions, such as anaphylaxis, generalized urticaria, angioedema, and neurologic complications have been reported following Td administration, but a causal relationship between the neurologic complications and vaccine administration have not been established.
- Patients who develop an arthus-like reaction tend to have high serum antitoxin levels and should be instructed to avoid booster doses more often than every 10 years.
- Tdap Only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause, within 7 days of administration of previous dose of DTP, DTaP or Tdap should receive Td in place of Tdap for any future administrations.

PREGNANCY

- Tdap is indicated for each pregnancy, preferably during gestational weeks 27-36. However, during a pertussis epidemic or if indicated for wound management, Tdap can be given at any stage of pregnancy. Once given early in pregnancy, it should not be repeated later in pregnancy.

MEASLES, MUMPS, RUBELLA (MMR) VACCINE

WHO TO GIVE

All adults (Born in 1957 or later with no evidence of immunity to measles, mumps, or rubella

- CDC evidence of immunity: Born before 1957, documentation of receipt of MMR vaccine, laboratory evidence of immunity or disease (diagnosis of disease without laboratory confirmation is not evidence of immunity).
- Special populations:

No previous immunity to Measles, Mumps and Rubella	MMR Vaccine doses
Non-pregnant women of childbearing age	• 1 dose
HIV infection with CD4 ≥15%, count ≥200 cells/mm^3 for at least 6 months	• 2-dose series at 4 weeks apart
People in congregate settings such as **incarcerated persons**, students in postsecondary educational institutions and household or close, personal contacts of immune compromised	• 2-dose series at 4 weeks apart if previously did not receive any doses of MMR. • 1 dose if previously received 1 dose MMR

WHAT VACCINE?

- M-M-R (Measles-Mumps-Rubella Virus Vaccine (Live Vaccine)

CONTRAINDICATIONS TO THE MMR

- **Pregnancy**
- HIV infection with CD4 percentage <15% or CD4 count <200 cells/mm^3.
- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.
- Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised).
- Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent.
- During a measles or mumps outbreak, public health authorities might recommend additional doses of MMR vaccine for people at increased risk. (Measles, mumps, and rubella immunization in adults - UpToDate).
- Routine MMR Vaccination Recommendations: For Providers | CDC.

SHINGLES VACCINE

WHO TO GIVE

- Adults 50 years and older.
- Adults 19-49 years old, if they have or will have weakened immune systems because of disease or therapy.
- For all of the above, give regardless of whether they had shingles, received Zostavax, or received the varicella (chickenpox) vaccine in the past.

HOW OFTEN AND WHEN

- 2-dose series RZV (Shingrix) is a recombinant vaccine with the second dose administered 2 to 6 months after the first.

WHAT VACCINE?

- SHINGRIX is a Recombinant zoster vaccine (RZV) an FDA-approved vaccine for the prevention of shingles (herpes zoster) in adults 50 years of age and older.
- SHINGRIX is **not** used to prevent chickenpox.

CONTRAINDICATIONS AND ALERTS

- History of a severe allergic reaction to any component of the vaccine or after a dose of Shingrix.
- Currently have shingles.
- **Women who are pregnant should wait to get Shingrix in the postpartum period.**
- An increased risk of Guillain-Barré syndrome (severe muscle weakness) was observed after vaccination with SHINGRIX.

VARICELLA VACCINE

WHO TO GIVE

- All adults who do not have laboratory evidence of immunity.
- CDCR incarcerated persons are offered serology testing at the Reception Center due to the importance of knowing immunity status for all residents during outbreaks.

HOW OFTEN AND WHEN? RULES?

- If no doses were documented or none is known, give a 2-dose VAR series, separated by 4–8 weeks.
- If one previous dose was given, give a one-time dose, at least 4 weeks after first dose. For people with HIV infection and CD4 $\geq$ 15%, or count ≥ 200 cells/mm^3 give 2 doses 3 months apart.

WHAT VACCINE?

- VARIVAX® is a vaccine indicated for active immunization for the prevention of varicella in adults who are nonimmune to varicella.

CONTRAINDICATIONS AND ALERTS

- **Pregnancy: Do not administer VARIVAX to females who are pregnant. Pregnancy should be avoided for 3 months following vaccination with VARIVAX.**
- HIV infection with CD4 <15%, count <200 cells/mm^3.
- History of severe allergic reaction to any component of the vaccine (including neomycin and gelatin) or to a previous dose ofvaricella vaccine.
- Immunosuppression.
- Moderate or severe febrile illness.
- Active untreated tuberculosis.
- Recent (within the past 11 months) receipt of antibody-containing blood product. For recommended intervals, see vaccine package insert and/or recommendations in Advisory Committee on Immunization Practices (ACIP) General Best Guidance for Immunization (cdc.gov) Table 3-5 and 3-6.
- Salicylates should be avoided for at least six weeks after varicella vaccine.

HUMAN PAPILLOMAVIRUS (HPV) VACCINE

WHO TO GIVE

- Adults, both women and men, aged 16 to 26 years.
- Adults, both women and men aged 27 through 45 years: Considerations for shared clinical decision-making regarding human papillomavirus (HPV) vaccination. Ideally, HPV vaccination should be given in early adolescence because vaccination is most effective before exposure to HPV through sexual activity. For adults aged 27 through 45 years who are not adequately vaccinated, clinicians can consider discussing HPV vaccination with persons who are most likely to benefit.

HOW OFTEN AND WHEN? RULES?

- 3 doses if first dose is age 15 years or older
    - 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon).

WHAT VACCINE?

- Gardasil 9 is the only HPV vaccine used in the United States since 2016.

INFORMATION ON VACCINE

- Gardasil 9 prevents infection with types 6, 11, 16, 18, 31, 33, 45, 52, and 58. HPV types 6 and 11 cause 90% of genital warts. HPV types 16 and 18, two high-risk HPVs, cause about 70% of cervical cancers and an even higher percentage of some of the other HPV-caused cancers.
- HPV vaccines are highly effective in preventing cervical infection with the types of HPV they target when given before first exposure to the virus—that is, before individuals begin to engage in sexual activity.

PREGNANCY

- HPV vaccine is **not recommended for use during pregnancy**. People known to be pregnant should delay initiation of the vaccination series until after the pregnancy. However, pregnancy testing before vaccination is not needed.

HEPATITIS A (HAV) VACCINE

WHO TO GIVE

Per CDC, for incarcerated adults, begin/complete hepatitis A vaccine series for:

- All adults at risk for HAV infection [e.g., MSM (Men who have sex with men), PWID (Persons who inject drugs), experiencing homelessness]
- All adults at risk for severe adverse outcomes of HAV infection including persons with:
  - HBV, HCV, cirrhosis
  - fatty liver disease
  - alcoholic liver disease
  - autoimmune hepatitis
  - alanine aminotransferase [ALT] or aspartate aminotransferase [AST] level greater than twice the upper limit of normal
  - HIV infection

HOW OFTEN AND WHEN? RULES?

- **HAVRIX** is a vaccine indicated for active immunization against disease caused by HAV. HAVRIX is approved for use in all adults.
  2-dose series 6-12 months apart. Primary immunization should be administered at least 2 weeks prior to expected exposure to HAV.

- **TWINRIX** is a vaccine indicated for active immunization against disease caused by HAV and infection by all known subtypes of hepatitis B virus. Twinrix at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months]. A 4-dose rapid schedule is also available for adults 19 years and older.

WHAT VACCINE?

- Havrix
- Twinrix

FOLLOW UP/ CONTRAINDICATIONS /ALERTS

Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component including neomycin

Public Health may also recommend HAV vaccination:

- In persons during a community HAV outbreak propagated by person-to-person transmission.
- As post-exposure prophylaxis.

PREGNANCY

- Pregnant women **should** be vaccinated with HAV vaccine if they are at risk for infection or severe outcome from infection during pregnancy.
- Twinrix: Pregnancy is <u>not</u> a contraindication to vaccination.

HEPATITIS B (HBV) VACCINE

WHO TO GIVE

Per CDC, offer to all incarcerated adults

- All persons aged ≥ 19 years (note this reflects the updated ACIP recommendation for persons aged ≥ 60 years, with incarceration as a risk factor; see ACIP recommendation February 2023 for details)

HOW OFTEN AND WHEN? RULES?

- Heplisav-B®: 2 doses at 0 and 1 months.
- Twinrix: 3-dose series (at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months]); Accelerated: 0, 7, and 21 to 30 days, and 12 months

WHAT VACCINE?

- Heplisav-B
- Twinrix
- For patients on hemodialysis, consult nephrologist for choice of vaccine

CONTRAINDICATIONS AND ALERTS

- Severe allergic reaction (e.g., anaphylaxis) after a previous dose of any hepatitis A-containing or hepatitis B-containing vaccine, or to any component of TWINRIX, including yeast and neomycin, is a contraindication to administration of TWINRIX.

PREGNANCY

- Heplisav-B is not recommended in pregnancy due to lack of safety data in these women.
- Twinrix: Pregnancy is not a contraindication to vaccination.

PNEUMOCOCCAL VACCINE

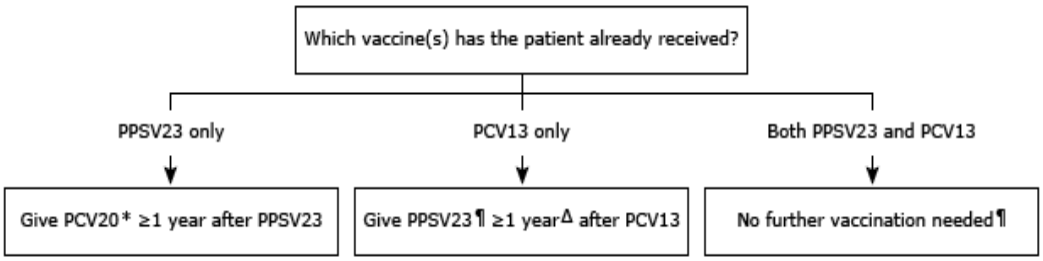
WHO TO GIVE

- Adults age ≥65 years
- Adults <65 years who have high risk conditions including:

  Adults with alcoholism, chronic heart/liver/lung disease, chronic renal failure, cigarette smoking, cochlear implant, congenital or acquired asplenia, CSF leak, diabetes mellitus, generalized malignancy, HIV, Hodgkin disease, immunodeficiency, iatrogenic immunosuppression, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, solid organ transplants, or sickle cell disease or other hemoglobinopathies.

HOW OFTEN AND WHEN? RULES?

- If no history of pneumococcal vaccine or unknown vaccination history: administer one dose of PCV20.
- If previously received PPSV23 (Pneumovax 23) but never a pneumococcal conjugate vaccine (PCV13, PCV15, or PCV20) then give1 dose of PCV 20 at least one year later.
- Patients who have previously received PCV13 but not all the recommended doses of PPSV23 (Pneumovax 23) should continue their schedule according to the current recommendation by CDC.



PCV15 recommendations are Not Included as PCV15 is Not available in CCHCS formulary.

Δ In high-risk individuals (e.g., immunocompromising conditions, cochlear implant, or cerebrospinal fluid leak), a shorter interval of ≥8 weeks may be used to maximize protection more quickly; and may need revaccination with PPSV23 if receiving PPSV23 before the age of 65.

Please see CDC Pneumococcal Vaccine Timing for more details on recommendations for specific patient populations.

This diagram is adapted from Pneumococcal vaccination in adults - UpToDate. Some experts suggested **selected individuals may need revaccination with PPSV23; refer to the text in UpToDate for more details.**

Note: Following the 2022 changes to adult pneumococcal vaccination recommendations, PCV13 is no longer recommended for vaccination at age 19 years and older.

WHAT VACCINE?

Two main vaccine types:

- Pneumococcal conjugate vaccines PCV20 (Prevnar)
- Pneumococcal polysaccharide vaccine (PPSV23)

CONTRAINDICATIONS AND ALERTS

Vaccination is contraindicated for patients who have a history of severe allergic reactions (e.g., anaphylaxis) to either pneumococcal vaccine or any of its components (e.g., diphtheria toxoid for PCV). Consult provider if patient has any severe, life-threatening allergies.

- PCV13: No recommendations.
- Pneumococcal Conjugate (PCV15 and PCV20) (ACIP has not published pregnancy recommendations).

PREGNANCY

- Pneumococcal Polysaccharide (PPSV23): The safety of pneumococcal polysaccharide vaccine during the first trimester of pregnancy has not been evaluated, although no adverse consequences have been reported among newborns whose mothers were inadvertentley vaccinated during pregnancy.

HIB (HAEMOPHILUS INFLUENZAE TYPE B) VACCINE

WHO TO GIVE

- No documented history of vaccine:
  - Adults with anatomical/functional asplenia
  - Adults undergoing elective splenectomy
- For recipient of Hematopoietic stem cell transplant (HSCT), regardless of vaccination history.

HOW OFTEN AND WHEN? RULES?

- Anatomical or functional asplenia (including sickle cell disease): 1 dose
- For patients undergoing elective splenectomy: 1 dose, at least 14 days before elective splenectomy.
- For recipient of HSCT, 3-dose series 4 weeks apart starting 6–12 months after successful transplant.

WHAT VACCINE?

- Hiberix, non-formulary
- ActHIB, non-formulary
- There is no clear preference on which vaccine to order; providers may consider several factors such as availability of the vaccine at local facility, previous vaccine received if applicable, and technical ease of administration, etc. Please refer to the individual vaccine package for details.

CONTRAINDICATIONS AND ALERTS

- Hypersensitivity to *Haemophilus* b polysaccharide, tetanus toxoid-containing vaccine, or any component of the formulation.

PREGNANCY AND BREASTFEEDING

- During pregnancy, Hiberix should be administered only if ordered by obstetrician specialist; it is unknown if it could harm a fetus. Consult with a specialist before breastfeeding.

MENINGOCOCCAL VACCINE

WHO TO GIVE

Meningococcal serogroup B Vaccine (MenB Vaccine)

- Adults with anatomical or functional asplenia (including sickle cell disease).
- Adults with persistent complement component deficiency.
- Adults using complement inhibitor (e.g., eculizumab, ravulizumab).

Meningococcal serogroup ACWY Vaccine (MenACWY Vaccine)

- Adults with any of the RISK FACTORS listed above for MenB.
- Adults living with HIV infection who have no documented history of vaccination.
- In the case of a Meningococcal outbreak, contact the Public Health Warmline for recommendations on vaccination and other measures. Public Health Branch - Home (sharepoint.com)

HOW OFTEN AND WHEN? RULES?

MenB Vaccine:

- MenB-4C (Bexsero) 2 doses at 0 & 4 weeks later. One booster dose 1 year after primary series and one booster dose every 2-3 years if risk remains.
- MenB-FHbp (Trumenba) 3 doses at 0, 1–2, 6 months. One booster dose 1 year after primary series and one booster every 2-3 years if risk remains.

MenACWY Vaccine:

- 2-dose series at 0 and 2 months. Booster every 5 years if risk remains.

WHAT VACCINE?

- MenB Vaccine: there are two products in U.S and they are not interchangeable. Use same product for all doses in series.
  - MenB-4C (Bexsero), non-formulary
  - MenB-FHbp (Trumenba), non-formulary
- MenACWY Vaccine :
  - Menveo, on formulary
  - MenQuadfi, on formulary, preferred as it does not require reconstitution.

CONTRAINDICATIONS AND ALERTS

- There is no clear preference on which MenB vaccine to order; providers may consider several factors such as availability of the vaccine in local facility, time needed for finishing the vaccination series, patient age, previous vaccine received if applicable, and technical ease of administration, etc. Please refer to the individual vaccine package for details.
- Vaccination is contraindicated for patients who have a history of severe allergic reactions (e.g., anaphylaxis) to either the meningococcal vaccine or any of its components. For the detailed precautions, refer to Meningococcal vaccination in children and adults - UpToDate.
- **CDC recommends that vaccination with MenB vaccines should be deferred in pregnant and lactating women unless the woman is at increased risk and the benefits of vaccination are considered to outweigh the potential risks.**

PREGNANCY

Meningococcal ACWY (MenACWY)

- MenACWY is safe to receive during pregnancy.

INFECTIOUS DISEASE	INFECTIOUS DISEASE SCREENING RECOMMENDATIONS			RESOURCE GUIDANCE
INFECTIOUS DISEASE SCREENING	**WHO TO SCREEN**	**HOW OFTEN? WHEN?**	**HOW TO SCREEN**	**CARE GUIDES AND OTHER RESOURCES**
Tuberculosis (TB)	All incarcerated persons	**At Intake:** On arrival at Reception Center (RC)	All patients are screened for TB. "Screening Evaluation Report CDCR 7331" is completed in the Electronic Health Record System (EHRS) and an IGRA blood test is offered at the RC with the following exceptions: • History of an IGRA test interpreted as positive. • TST with millimeter (mm) reading interpreted as positive any time in the past. • TST less than 5 mm in the past 30 calendar days; with a high-risk condition. • TST less than 10 mm in the past 30 calendar days without a high-risk condition. • Patients with signs or symptoms of TB receive a workup to include a medical evaluation and, if clinically indicated, a chest x-ray (CXR), sputum smears, and cultures for Acid-Fast Bacilli (AFB). • Asymptomatic patients known to be HIV infected shall also receive a CXR within 72 hours of arrival at a RC unless their records contain documentation of a normal or stable CXR within the preceding 30 days.	Tuberculosis SurveillanceCare Guide HCDOM 3.8.7 Tuberculosis Surveillance Program TB Screening Evaluation questionnaire for symptom screen available in form browser. CDCR Hub - CDCR 7331 - Tuberculin Screening-Evaluation Report - All Documents (sharepoint.com)
		During Incarceration: • Annual screening/ evaluation (and education/counseling, if applicable) of all patients during their birth month,or as soon after as possible. • All patients returning from Out to Court, inter facility transfer, from county/city jails, and short stay patients are screened immediately on arrival and evaluated as necessary.		

INFECTIOUS DISEASE	INFECTIOUS DISEASE SCREENING RECOMMENDATIONS			RESOURCE GUIDANCE
INFECTIOUS DISEASE SCREENING	**WHO TO SCREEN**	**HOW OFTEN? WHEN?**	**INFECTIOUS DISEASE SCREENING**	**CARE GUIDES AND OTHER RESOURCES**
COVID-19	All incarcerated persons in congregate settings are at increased risk.	Refer to CDCR's Memos, Guidelines & Messaging - COVID-19 Information (ca.gov)	Varies- see Interim Guidance	CDCR - COVID-19 Current Requirements Seasonal Influenza Vaccination Resources forHealth Professionals
Varicella	All incarcerated persons	**At Intake:** All persons on arrival at RC **During Incarceration:** Perform one time if not completed at RC	Serology (VZV IgG) recommended for immunity testing: **Lab order:** **Varicella Immunoglobulin G (IgG)antibodies.**	HCDOM 3.1.8 Reception Center
Human Immunodeficiency Virus (HIV)	All incarcerated persons **High risk groups:** Persons reporting ongoing risk factors (e.g., PWID*+/HCV, MSM†, tattooing) • Persons with signs/symptoms of risk factors (e.g. STIs) • Persons potentially exposed to HIV (such as persons who exchange sex for money or drugs; sex partners who are HIV-infected, bisexual, or inject drugs) • Pregnant persons • Transgender women	**At Intake:** All persons on arrival at RC **During Incarceration:** Testing is offered to all persons, especially to those in high risk groups Consider testing annually or more often as clinically indicated, for persons with ongoing risk factors, HCV reinfection and STI	**Lab order:** **HIV 1/2 Antigen/Antibody 4th Generation with Reflexes.** Test is for screening and diagnosis of HIV-1/HIV-2 infection, including acute HIV-1 infection. This test differentiates HIV-1 from HIV-2 infection	HIV Care Guide

* Hepatitis B virus, ** Hepatitis C virus, *+ Persons who inject drugs, †Men having sex w/ men, °Persons living with HIV

INFECTIOUS DISEASE	INFECTIOUS DISEASE SCREENING RECOMMENDATIONS			RESOURCE GUIDANCE
INFECTIOUS DISEASE SCREENING	**WHO TO SCREEN**	**HOW OFTEN? WHEN?**	**INFECTIOUS DISEASE SCREENING**	**CARE GUIDES AND OTHER RESOURCES**
Hepatitis B (HBV)	All incarcerated persons **High-Risk groups:** • Persons reporting ongoing risk factors (e.g., PWID/HCV, MSM, tattooing) • Persons potentially exposed to HBV (such as persons with multiple sexual partners, sex partners who are HBV-infected, and persons on hemodialysis) • Pregnant persons • Persons serving long-term sentences	**At Intake:** All persons on arrival at RC **During Incarceration:** • Testing is offered to all persons, especially to those in high risk groups • Consider testing annually or more often as clinically indicated, for persons with ongoing risk factors, HCV reinfection and STI	**Lab orders include (all 3 tests):** • Hepatitis B Surface Antigen (HBsAg) • Hepatitis B Surface Antibody (HBsAb) and • Hepatitis B Core Antibody (HBcAb) Please note that immunocompromised persons need to have their HBsAb checked periodically after immunization for proof of immunity and the need for re-vaccination.	Hepatitis B Care Guide

INFECTIOUS DISEASE	INFECTIOUS DISEASE SCREENING RECOMMENDATIONS			RESOURCE GUIDANCE
INFECTIOUS DISEASE SCREENING	**WHO TO SCREEN**	**HOW OFTEN? WHEN?**	**INFECTIOUS DISEASE SCREENING**	**WHO TO SCREEN**
Hepatitis C (HCV)	All incarcerated persons **High Risk groups:** • Persons reporting ongoing risk factors (e.g., PWID*+, tattooing) • Persons potentially exposed to HCV (such as MSM+ who have HIV or are on pre-exposure prophylaxis to prevent HIV, long-term sexual partners of individuals with HCV, persons on hemodialysis) • Pregnant persons	**At Intake:** All persons on arrival at RC **During Incarceration:** Testing is offered to all persons, especially those who want screening, those in high risk groups, and those with clinical finding of liver disease Test annually or more often as clinically indicated, for persons with ongoing risk factors, such as relapse of IV drug use, or new tattoos.	**Lab order:** Hepatitis C Virus: antibody with reflex to HCV viral load offered to all patients.	Hepatitis C Care Guide
Syphilis	All incarcerated persons (Continued risk in persons engaging in condomless sex)	**At Intake:** All persons on arrival at RC **During Incarceration:** Patients with signs/symptoms/complaints related to STIs are referred to their primary care provider for a clinically indicated examination, testing, treatment, and counseling. Pregnancy: All pregnant persons are tested at their first prenatal visit.	**Lab order:** Rapid plasma reagin (RPR)	Sexually Transmitted Infections Care Guide

INFECTIOUS DISEASE	INFECTIOUS DISEASE SCREENING RECOMMENDATIONS			RESOURCE GUIDANCE
INFECTIOUS DISEASE SCREENING	**WHO TO SCREEN**	**HOW OFTEN? WHEN?**	**INFECTIOUS DISEASE SCREENING**	**WHO TO SCREEN**
Gonorrhea, Chlamydia and Trichomonas	All incarcerated persons (Continued risk in persons engaging in condomless sex)	**At Intake:** Gonorrhea, Chlamydia, and Trichomonas: All women ≤ 44 years. Gonorrhea & Chlamydia: All men ≤ 44 years **During Incarceration:** Patients with signs/symptoms/complaints related to STIs are referred to their primary care provider for clinically indicated examination, testing, treatment, and counseling. All pregnant persons are screened	**Lab order:** Chlamydia/N. Gonorrhea T. vaginalis (urine test) In high risk patients, consider "3-site testing" see page 30 3-site testing for gonorrhea and chlamydia (urethra, throat and anus)	Sexually Transmitted Infections Care Guide
Coccidioidomycosis (prior infection)	All incarcerated persons	**At Intake:** All persons on arrival at RC located in high risk Cocci areas. Not offered in women's prisons.	Perform skin test	Coccidioidomycosis (Valley Fever) Care Guide

TUBERCULOSIS (TB) [1, 2, 3]

WHO TO SCREEN?

- All persons

HOW OFTEN AND WHEN?

At intake:
Screening questionnaire "Screening Evaluation Report CDCR 7331" is completed in the EHRS and an IGRA bloodtest is offered at the RC.

HOW TO SCREEN?

At intake, upon arrival, all persons are screened using the TB Screening Evaluation Report CDCR 7331 and IGRA-QFT-G – QuantiFERON-TB Gold is offered.

IGRA is Not Needed at intake if the patient has:

- History of an IGRA test interpreted as positive.
- TST with mm reading interpreted as positive at any time in the past.
- TST less than 5 mm in the past 30 calendar days; with a high-risk condition.
- TST less than 10 mm in past 30 calendar days; without a high-risk condition.
- Patients with signs or symptoms of active TB disease receive a workup to include a medical evaluation and, if clinically indicated, a CXR, sputum smears, and cultures for Acid-Fast Bacilli (AFB).
- Additionally, asymptomatic patients known to be HIV infected shall also receive a CXR within 72 hours of arrival at a RC unless their records contain documentation of a normal or stable CXR within the preceding 30 days.

During Incarceration (TB Screening Evaluation Report CDCR 7331)

- Annual screening/evaluation (and education/counseling, if applicable) of all patients during their birth month or as soon after as possible.
- Additionally, all patients returning from Out to Court, transferred from one institution to another or from county/city jails, and short stay patients are screened immediately on arrival and evaluated as necessary.

TB Screening Evaluation Report CDCR 7331)

- Symptom screen using TB Screening Evaluation Report CDCR 7331 (TB symptoms grid (Yes/No response to following symptoms screening questions): Do you have (Yes/No)? Fever, chills, night sweats, loss of appetite, weight loss, cough equal to/greater than 2 weeks, productive cough, coughing blood, fatigue.

Pregnant Persons

- All pregnant persons shall be screened for signs and symptoms of TB disease, and, if the TST is negative, the TST shall be repeated 6 to 12 weeks postpartum.
- When indicated, a CXR shall be delayed if at all possible (if there are no TB signs or symptoms) until the second trimester, and proper precautions will be taken to shield the abdomen from the effects of radiation.
- When indicated in pregnancy, the CXR shall be repeated after delivery for consideration of treatment for latent TB infection. (During pregnancy and the first six weeks postpartum, the risk of progression from TB infection to TB disease is high and these patients shall be monitored closely for symptoms of TB disease.)

FOLLOW-UP

- If the symptom screen is positive [e.g. prolonged cough] (i.e., ≥2 weeks), hemoptysis (i.e., bloody sputum), or fever, night sweats, weight loss, etc., order QFT-G – QuantiFERON-TB Gold (lab order) and a CXR (Note: QFT-G – QuantiFERON-TB Gold can return a false negative result in active TB).
- Refer patients with positive QFT-G – QuantiFERON-TB Gold or positive screening symptoms to a primary care provider for CXR and additional evaluation.

WHO TO SCREEN?

COVID-19 [4]

- All persons in a congregate setting are at increased risk, but unvaccinated persons and immunocompromised are at highest risk.

HOW OFTEN AND WHEN?

- Movement Matrix
  - See COVID-19 and Seasonal Influenza: Interim Guidance for Health Care and Public Health Providers

HOW TO SCREEN?

- Varies
  - See COVID-19 and Seasonal Influenza: Interim Guidance for Health Care and Public Health Providers

FOLLOW-UP

- Follow current COVID-19 guidance if positive.

VARICELLA [5]

WHO TO SCREEN?

- Screen all patients for Varicella-Zoster Virus Antibody titer (Immunity Screen) at RC[2]
    - A positive titer of ≥1:4 (Antibody Detected) is an evidence for immunity against VZV infection.

HOW OFTEN AND WHEN?

At Intake:

- All persons on arrival at a RC.

During Incarceration:

- Perform one time if not completed at the RC.

HOW TO SCREEN?

Lab order:

- Order Varicella-Zoster Virus Antibody (Immunity Screen). Test code: 14505

FOLLOW-UP

- If test results show varicella titer of <1:4 (Antibody Not Detected) patients has susceptibility to VZV infection.
- Refer to primary care team for follow-up for varicella vaccination.

HUMAN IMMUNODEFICIENCY VIRUS (HIV)[6]

WHO TO SCREEN?

All persons except persons living with HIV at a RC[2]

- **High risk groups:**
  - Persons reporting ongoing risk factors (e.g., PWID/HCV, MSM[†], tattooing).
  - Persons with signs/symptoms of risk factors (e.g., STIs).
  - Persons potentially exposed to HIV (such as persons who exchange sex for money or drugs; sex partners who are HIV-infected, bisexual, or inject drugs).
  - Pregnant persons
  - Transgender women

HOW OFTEN AND WHEN?

At Intake:

- All persons on arrival at RC.

During Incarceration:

- Testing is offered to all persons, especially to those in high risk groups
- Consider testing annually or more often as clinically indicated, for persons with ongoing risk factors, HCV reinfection and STI

HOW TO SCREEN?

Lab order:

- **HIV 1/2 Antigen/Antibody 4th generation with Reflexes**.** Test is for screening and diagnosis of HIV-1/HIV-2 infection, including acute HIV-1 infection.
- This test differentiates HIV-1 from HIV-2 infection.

FOLLOW-UP

- Refer patients with **Reactive test** results to primary care physician.

*** This test is used to help diagnose HIV-1 and HIV-2 infection, including acute infection, and to differentiate HIV-1 from HIV-2. It is consistent with the HIV diagnostic algorithm proposed by the Centers for Disease Control and Prevention [2]. It can be used in adults, including pregnant women, and in children at least 2 years old*

HEPATITIS B VIRUS (HBV) [2, 7]

WHO TO SCREEN?

All incarcerated persons

- **High risk groups:**
  - Persons reporting ongoing risk factors (e.g., PWID/HCV, MSM, tattooing)
  - Persons potentially exposed to HBV (persons with multiple sexual partners, sex partners who are HBV-infected, persons on hemodialysis)
  - Pregnant persons
  - Persons serving long-term sentences (e.g. 30 to 45 years)

HOW OFTEN AND WHEN?

At Intake:

- All persons on arrival at RC.

During Incarceration:

- Testing is offered to all persons, especially to those in high risk groups
- Consider testing annually or more often as clinically indicated, for persons with ongoing risk factors, HCV reinfection and STI

HOW TO SCREEN?

Lab orders include (all 3 tests):

- Hepatitis B Surface Antigen (HBsAg).
- Hepatitis B Surface Antibody (HBsAb).
- Hepatitis B Core Antibody (HBcAb).

FOLLOW-UP

Test results showing:

- Hepatitis B Surface Antibody, Quantitative*(HBsAb)
  - **Positive** > 10 mIU/mL (Can represent previous infection or vaccination)
- Hepatitis B Surface Antibody, Qualitative (HBsAb)
  - **Negative**- NOT immune to HBV refer for HBV vaccination.
- Hepatitis B Surface Antigen with Reflex Confirmation:
  - **Positive** refer to primary care provider - represents acute or chronic HBV.
- If patient has active HBV, see HBV Care Guide and screen for Hepatitis A and Hepatitis C, if not already done.
- Please note that immunocompromised persons need to have their HBsAb checked periodically after immunization for proof of immunity and the need for re-vaccination.

***Evidence of immunity:** Hepatitis B Surface Antibody Immunity, Quantitative - This assay is used to determine immune status for Hepatitis B, as > 10 mIU/mL is considered immune to infection with HBV, per CDC Guidelines.

HEPATISIS C VIRUS (HCV)[2, 8]

WHO TO SCREEN?

All incarcerated persons

- **High risk groups:**
  - Persons reporting ongoing risk factors (e.g., PWID, tattooing)
  - Persons potentially exposed to HCV (such as MSM who have HIV or are on pre-exposure prophylaxis to prevent HIV, long-term sexual partners of individuals with HCV, persons on hemodialysis), see details on UpToDate: Screening and diagnosis of chronic HCV infection
  - Pregnant persons; refer to Prenatal care: Incarcerated females - UpToDate for screening of other communicable diseases.

HOW OFTEN AND WHEN?

At Intake:

- All persons on arrival at a RC.

During Incarceration:

- Testing is offered to all persons, especially those who want screening, those in high-risk groups, and those with clinical findings of liver disease.
- Test annually or more often as clinically indicated, for persons with ongoing risk factors, such as relapse of IV drug use, or new tattoos.

HOW TO SCREEN?

Lab order:

- HCV antibody with reflex to HCV viral load offered to all patients. Alternative Name (s): HCV with Reflex, HCV Anti-body, Anti HCV] - (Test Code: 8472).
- If HCV Antibody is positive, lab will do HCV RNA Quantitative (HCV Viral Load) - if that is detected, patient has chronic HCV.
- For patients with resolved or treated HCV, recheck HCV viral load annually for new/reinfection.

FOLLOW-UP

- Refer patients with detectable HCV viral RNA (>300 IU/mL) to PCP to consider treatment and immunization for HBV and HAV.
- For more details, please refer to Hepatitis C Care Guide

SYPHILIS [10]

WHO TO SCREEN?

- All incarcerated persons at the RC.
- Persons reporting ongoing risk factors (e.g., HIV, HCV, PWID, MSM, or with signs/symptoms of risk factors (e.g., STIs) that might suggest condomless sexual practice.

HOW OFTEN AND WHEN?

At Intake:

- All persons on arrival at RC.

During Incarceration:

- Patients with signs/symptoms/complaints related to STIs are referred to their primary care provider for a clinically indicated exam, testing, treatment, and counseling.
- Pregnancy: All pregnant persons are tested at their first prenatal visit.

HOW TO SCREEN?

Lab order:

- Rapid plasma reagin (RPR).
- For all RPR-positive patients, order treponema pallidum particle agglutination (TPPA) to detect antibodies that are specific for syphilis.

FOLLOW-UP

- For patients with positive RPR results: Refer to PCP.
- Once a patient is diagnosed with syphilis and is receiving treatment, the patient should be **monitored by RPR titers** to assess response to therapy (RPR at 6, 12, and 24 months post treatment for late-latent syphilis).

GONORRHEA, CHLAMYDIA [10]

WHO TO SCREEN?

- All persons ≤ 44 years at reception center.
- Persons of any age engaging in condomless sex.
- Persons with signs/symptoms of STI's.

HOW OFTEN AND WHEN?

At Intake:

- Gonorrhea, Chlamydia: All men and women ≤ 44 years.
- Trichomonas: All women ≤ 44 years.

During Incarceration:

- Patients with signs/symptoms/complaints related to STIs are referred to their primary care provider for a clinically indicated examination, testing, treatment, and counseling.
- All pregnant persons are screened.

HOW TO SCREEN?

- **Women**: Order Chlamydia/ Gonorrhea /Trichomonas urine test (Test Code: 36341) or via self/collected vaginal swab.
- **Men:** Chlamydia/ Gonorrhoeae RNA, urine test (Test Code: 36341).
- If the patient identifies receptive anal/rectal or oral intercourse/contact, then swabs of the anus and mouth should be obtained for gonorrhea and chlamydia in addition to the urine screen.

3-site testing for gonorrhea and chlamydia:

- Urethra—by collecting a urine sample.
- Throat—by collecting a pharyngeal sample.
- Anus—by collecting a rectal sample.

FOLLOW-UP

- For patients with positive test results, refer to PCP for treatment.
- Consider follow-up test of cure (TOC) repeat testing 4 weeks after completing therapy.

TRICHOMONAS VAGINALIS [10]

WHO TO SCREEN?

- All women aged ≤ 44 years at the RC.
- Women of any age engaging in condomless sex.
- Women with signs/symptoms of STI.

HOW OFTEN AND WHEN?

- Once at the reception center.
- Consider additional testing based on symptoms.

HOW TO SCREEN?

- Order Chlamydia/N. Gonorrhea /T. Vaginalis urine test.

FOLLOW-UP

- Patient with test results Trichomonas: **Detected:** refer to PCP for treatment.

COCCIDIOIDOMYCOSIS [11, 12, 13] (PRIOR INFECTION)

WHO TO SCREEN?

- All incarcerated persons.

HOW OFTEN AND WHEN?

At Intake:

- All person on arrival at a RC located in high risk Cocci areas. Not offered in women's prisons.

HOW TO SCREEN?

Skin testing administered by RN. **(Intradermal injection of a coccidioidal antigen preparation)**

- The induration of the skin is measured at about 48 hours after the injection.
- An induration equal and greater to 5 mm is considered **positive.**

FOLLOW-UP

- Skin testing results may be used for populating inmates in certain prisons to prevent Valley Fever among inmates.

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CANCER SCREENING	CANCER SCREENING RECOMMENDATIONS			RESOURCE GUIDANCE
CANCER SCREENING	**WHO TO SCREEN**	**HOW OFTEN? WHEN?**	**HOW TO SCREEN**	**CARE GUIDES AND OTHER RESOURCES**
Colorectal Cancer	45-75 years	Annually	FIT testing (Test code: 11290) is the preferred method; however, other screening methods can be considered in select individuals or situations.	Recommendation: Colorectal Cancer: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
Cervical Cancer	Persons with cervix 21-65 years	Every 3 years, co-testing with cytology and HPV testing. (See page 34 for reason of recommendation)	Cytology and hrHPV Quest SMART Code 90933	Cervical Cancer Screening Access, Outcomes, and Prevalence of Dysplasia in Correctional Facilities: A Systematic Review - PMC (nih.gov) ACS Cervical Cancer Screening USPSTF Cervical Cancer Screening CCHCS' clinical data
Breast Cancer	Women 50 - 74 years Transgender women age > 50 years and have used at least 5 years of feminizing hormone.	Every two years	Screening Mammogram	USPSTF Breast Cancer Screening CCHCS Care Guide: Transgender
Lung Cancer	Persons 50 – 80 years who have a 20 packs per year of smoking history and currently smoke or have quit within the past 15 years.	Annually	Low Dose Chest CT	Recommendation: Lung Cancer: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)

CANCER SCREENING	CANCER SCREENING RECOMMENDATIONS			RESOURCE GUIDANCE
CANCER SCREENING	**WHO TO SCREEN**	**HOW OFTEN? WHEN?**	**CANCER SCREENING**	**CARE GUIDES AND OTHER RESOURCES**
Liver Cancer/ Hepatocellular Carcinoma (HCC)	Patients with cirrhosis of any etiology. Note that patients with HCV who had pre-treatment fibrosis staging as having cirrhosis, need to have continued HCC screening after HCV treatment, even if the cirrhotic stage resolved on Fibroscan after treatment. Patients with chronic HBV without cirrhosis, with any of the following risks: • Asian men > 40 years of age/Asian women > 50 years of age • Africans and African Americans (can develop HCC at younger age) • FHx (i.e., 1st degree relative) of HCC • Patients with HDV co-infection For patients on liver transplant list before arrival at CDCR, for non-HCC causes, offer continued screening for HCC.	Every 6 months	Abdominal Ultrasound Focused on the Liver (with or without Alpha-Fetoprotein)	Diagnosis, Staging, and Management of Hepatocellular Carcinoma: 2018 Practice Guidance by the American Association for the Study of Liver Diseases (aasld.org) CCHCS Care Guide: Hepatitis C

COLORECTAL CANCER SCREENING [1,2]

WHO TO SCREEN?

- All average risk patients age 45 to 75 years age.

HOW OFTEN AND WHEN?

- Annually

HOW TO SCREEN?

- FIT Test (Fecal Globin by Immunochemistry (InSure®).
  - Specimen: Stool-Fecal.
  - EHRS/lab order: [Test Code 11290]

FIT testing annually is the preferred method; however, other screening methods can be considered in select individuals or situations

FOLLOW-UP

- Refer patients with positive FIT test to primary care provider for colonoscopy.

CERVICAL CANCER SCREENING [3,4,5]

WHO TO SCREEN?

- All persons with a cervix between ages 21 to 65 years.

HOW OFTEN AND WHEN?

Due to the higher prevalence of cervical dysplasia and cancer found in incarcerated women compared to non-institutionalized women, identified in various studies and CCHCS' clinical data, as well as our intention to simplify our procedures, the following recommendation is made:

Age: 21 to 65 years: Co-testing with cytology and HPV testing, every 3 years

HOW TO SCREEN?

Age: 21 to 65 years: Specimen: Cervical cytology /Pap smear/ Pap sample collected in 1 ThinPrep® pap vial (ThinPrep Pap and HPV mRNA E6/E7) **(**Quest smart code: 90933)

FOLLOW-UP

- Refer patients with abnormal test results to a primary care provider.

BREAST CANCER SCREENING [6,7]

WHO TO SCREEN?

- Average risk women age 50-74 years
- Transgender women age > 50 years and have used at least 5 years of feminizing hormone

How Often and When

- Every 2 years (if previous test was normal/BIRADS category 1 and 2).

HOW TO SCREEN?

- EHRS Imaging order: [Screening mammography, bilateral (2-view study of each breast)].

FOLLOW-UP

- Refer persons with abnormal mammogram (BIRADS category 3-5) to primary care provider.

LUNG CANCER SCREENING [8]

WHO TO SCREEN?

- Patients age 50 to 80 years
  - Asymptomatic (no previous lung cancer diagnosis/no signs or symptoms of lung cancer).
  - Who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years.

HOW OFTEN AND WHEN?

- Annually (if previous test was normal).

HOW TO SCREEN

- EHRS/Imaging Order: Computed tomography, thorax, and low dose for lung cancer screening, without contrast material.

FOLLOW-UP

- Refer patients with abnormal test results to primary care provider.
- Discontinue screening once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

LIVER CANCER / HEPATOCELLULAR CARCINOMA (HCC) SCREENING [9]

WHO TO SCREEN?

- Patients with cirrhosis of any etiology.
  - Note that patients with HCV who had pre-treatment fibrosis staging as having cirrhosis, need to have continued HCC screening after HCV treatment, even if the cirrhotic stage resolved on Fibroscan after treatment.
- Patients with chronic HBV and without cirrhosis, with any of the following risks:
  - Asian men > 40 years of age/ Asian women > 50 years of age.
  - Africans and African Americans (can develop HCC at younger age).
  - Family history of HCC (i.e., 1st degree relative) of HCC.
  - Patients with HDV co-infection.
- For patients on liver transplant list before arrival at CDCR, for non-HCC causes, offer continued screening for HCC.

HOW OFTEN AND WHEN?

- Every 6 months if the previous test was normal.

HOW TO SCREEN?

- Abdominal ultrasound focused on the liver.
- Some specialists add Alpha-fetoprotein testing in addition to US.

FOLLOW-UP

- Refer patients with abnormal test results to primary care provider.

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SCREENING	SCREENING RECOMMENDATIONS			RESOURCE GUIDANCE
SCREENING/ COUNSELING	**WHO TO SCREEN?**	**HOW OFTEN? WHEN?**	**HOW TO SCREEN?**	**CARE GUIDE AND OTHER RESOURCES**
Abdominal aortic aneurysm (AAA) screening	Men 65-75 years who have ever smoked	One time	Order abdominal ultrasound/screen for AAA. Order in EHRS/imaging.	Abdominal Aortic Aneurysm: Screening
Advanced Directives / POLST	All adults (for advance care planning)	Ask about Advanced Directive (AD) periodically for update as clinically indicated. When patient has advanced serious illnesses, significant frailty, or other life-threatening conditions ask about POLST.	Review EHRS for existingAD/POLST. If existing, ask if any update is needed. If no AD or POLST, provide information to patient and refer to PCP to complete with the patient. EHRS-Adhoc POLST.	POLST Form
Cardiovascular Risk and Statin Use in Primary Prevention of ASCVD	Adults 18-75 years of age, without clinical ASCVD.	Every 3-5 years for adults 18-39 years Annually for adults 40 - 75 years	Calculate 10-year risk of ASCVD using EBM Calc Medical Calculator in EHRS	ASCVD Risk Estimator
Cognitive Impairment	Adults > 50 years DDP 2 patients Patients with Parkinson's Disease	Annually and as needed with change in health status.	Complete Mini-Cog; Patients with Mini-Cog score of ≤ 2 should have LOC assessment using "Level of Care Assessment Placement Tool". (LOCAT)	Standardized Mini-Cog© Instrument CCHCS Cognitive Impairment / DementiaCare Guide
Diabetes Mellitus	Screen overweight or obese patients (BMI ≥ 25 kg/m^2 or ≥ 23 kg/m^2 in Asian Americans) with 1 or more of the risk factors* Patients with prediabetes, history of gestational diabetes (GDM) All other patients age ≥ 35 years	Annually for patients with prediabetes. For all other patients, if results are normal, testing should be repeated at a minimum of 3-year intervals, more frequent if clinically indicated. (See page 46 for details)	Order fasting blood glucose or hemoglobin A1c (HbA1c) level under lab order in EHRS.	Recommendation: Prediabetes and Type 2 Diabetes: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org) ADA DM Diagnosis

*: first degree relative with diabetes, high-risk race/ethnicity (African American, Latino, Native American, Asian American, Pacific Islander), history of CVD, Hypertension, HDL cholesterol <35 mg/dL and/or triglyceride level > 250 mg/dL, history of PCOS
ASCVD: atherosclerotic cardiovascular disease

SCREENING	SCREENING RECOMMENDATIONS			RESOURCE GUIDANCE
SCREENING/ COUNSELING	**WHO TO SCREEN?**	**HOW OFTEN? WHEN?**	**HOW TO SCREEN?**	**CARE GUIDES AND OTHER RESOURCES**
Hypertension	All adults	Annually (Generally done at most health care visits)	Measure blood pressure, sitting after 5 minutes rest Record in EHRS/vital signs field.	CCHCS Hypertension Care Guide
Obesity	All adults	Annually and as needed when clinically indicated.	Record height in (m) and weight (Kg) measurements and BMI (body mass index). Is calculated and recorded in EHRS vital sign field.	The National Institute of Health (NIH) provides BMI Calculator and Body Mass Index Table
Osteoporosis	Women ≥ 65 years Postmenopausal women < 65 years with at least one risk factor (FHx hip fx, smoking, excessive alcohol consumption or low body weight) should have osteoporosis risk assessed with tool to determine screening need. 10-Year Fracture Risk Calculator	May repeat bone mineral density measurement as clinically indicated. (See page 49 for details)	Order Bone density scan/DXA scan under imaging in EHRS.	Osteoporosis to Prevent Fractures: Screening
QT interval	All adults chronically on medications known to prolong the QT interval.	Annually and as needed, if clinically indicated. (See page 53 for details)	Enter order for electrocardiogram (ECG) in EHRS and Enter order for follow-up RN/LVN/MA for ECG	Healthcare Services Dashboard (QT prolongation measure is part of Diagnostic Monitoring measure)

DXA: Dual-energy X-ray Absorptiometry

SCREENING	SCREENING RECOMMENDATIONS			RESOURCE GUIDANCE
SCREENING/ COUNSELING	**WHO TO SCREEN?**	**HOW OFTEN? WHEN?**	**HOW TO SCREEN?**	**CARE GUIDES AND OTHER RESOURCES**
Sexual History/ Counseling for sexually transmitted infection prevention	All adults Especially patients in high-risk groups such as men who have sex with men (MSM) and people living with HIV (PLWHIV)	Annually or as clinically indicated in higher risk patients	Record sexual history in EHRS Ad hoc form underSTI Screening/Education	Chlamydia and Gonorrhea: Screening CCHCS Care Guide: Sexually Transmitted Infections
Substance Use Disorder	All adults	Annually, and more frequently as clinically indicated in high risk groups (e.g., HIV and Hepatitis C and Hepatitis B)	NIDA (National Institute on Drug Abuse) Quick Screens questionnaire EHRS Ad hoc form	Unhealthy Drug Use:Screening CCHCS Substance Use Disorder Care Guide
Tobacco use	All adults	Annually and periodic visits as clinically indicated	Record smoking/other tobacco use history in tobacco history field under the Social History tab in EHRS	Tobacco Smoking Cessation in Adults,Including Pregnant Persons: Interventions

ABDOMINAL AORTIC ANEURYSM SCREENING[1]

WHO TO SCREEN?

- Men age 65 to 75 years who have ever smoked.

HOW OFTEN AND WHEN? RULES

- Record smoking history at annual and periodic visits.

- If a man age 65-75 years has ever smoked:
  - Refer for AAA screening, one time.

HOW TO SCREEN?

- EHRS/ imaging order: Abdominal ultrasound for abdominal aortic aneurysm screening.

FOLLOW-UP

- Patients with abnormal test results should be referred to the primary care provider.

ADVANCE DIRECTIVES AND POLST[2] (PHYSICIAN'S ORDERS FOR LIFE SUSTAINING TREATMENT)

WHO TO SCREEN?

- All adults (for advance care planning)

HOW OFTEN AND WHEN? RULES

- Ask everyone about Advance Directives (AD) and update it periodically as clinically indicated.
- When a patient has advanced serious illnesses, significant frailty, or other life-threatening condition ask about POLST.
- Ask about presence of AD/POLST when patient's health condition changes and offer ability to update as needed.

HOW TO SCREEN?

Review EHRS for existing AD/POLST.

- If existing, ask if any update is needed.
- All patients can/should have an AD, which allows them to list Health Care Agent who can function as surrogate decision-maker if they lose medical decision-making capacity. The AD also allows them to specify end of life preferences (Full-treatment or Comfort Care, etc.) and allows them to indicate if they want to donate organs.
    - The Advanced Directive (Form 7421) is a paper form that is completed and signed by the patient and two witnesses and then scanned into EHRS
- A POLST is appropriate for patients with advanced serious illnesses, significant frailty, or other life-threatening condition, especially those who may die within the next 12 months.
    - The POLST is also a paper Document (Form 7465) that is completed by the patient and provider and signed by both then is transcribed into the EHRS-Adhoc POLST by the provider. [Note: an Attempt Resuscitation or DNR order must also be entered in the EHRS]

FOLLOW-UP

All patients listed below should be referred to a primary care physician for completion of POLST at interval/periodic and annual health care visit

- Life-threatening illness and is likely to die within the next 12 months.
- Frequent hospital admissions (e.g., more than one admission for same condition within several months).
- Complex care requirements (e.g., functional dependency; complex home support for ventilator/antibiotics/feedings).
- Admission prompted by difficult-to-control physical or psychological symptoms (e.g., moderate to severe symptom intensity for more than 24 to 48 hours).
- Decline in function, feeding intolerance, or unintended decline in weight (e.g., failure to thrive).
- Older patient, cognitively impaired (with involvement of surrogate or initiation of PC2604 process, as appropriate).
- Metastatic or locally advanced incurable cancer.
- Advanced organ disease.
- Out-of-hospital cardiac arrest.
- Admission to a higher level of medical care (e.g. CTC).

CARDIOVASCULAR RISK (ATHEROSCLEROTIC CARDIOVASCULAR DISEASE, ASCVD, 10-YEAR RISK) AND STATIN USE IN PRIMARY PREVENTION OF ASCVD [3,4,5,6]

WHO TO SCREEN?

- Adults 18-75 years of age, without clinical ASCVD, suspected to have dyslipidemia due to personal and family history and physical exam (Patients with clinical ASCVD are followed by primary care providers).
  See CCHCS Dyslipidemia Care Guide for list of history and physical exam findings.

HOW OFTEN AND WHEN? RULES

- Every 3-5 years for adults 18-39 years of age.
- Annually for adults 40-75 years of age.

HOW TO SCREEN?

- Assess risk factors (smoking history, hypertension, LDL level, diabetes).
- Use EBM Calc Medical Calculators in EHRS to calculate 10-year ASCVD risk.

FOLLOW-UP

- Refer all patients with low-density lipoprotein cholesterol (LDL-C) ≥ 190 mg/dL to primary care providers.
- Refer adults aged 40 to 75 years with no history of ASCVD, 1 or more ASCVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking), and a calculated 10-year ASCVD event risk of 10% or greater to primary care provider for consideration of statin therapy for the prevention of ASCVD events and mortality.

COGNITIVE IMPAIRMENT[7,8]

WHO TO SCREEN?

- All adults age ≥ 50 years.
- All adults DDP 2 designation in CDCR.
- Adults with diagnosis of Parkinson's.

HOW OFTEN AND WHEN?

- Annually.
- As needed with change in health status.

HOW TO SCREEN?

- Complete Mini cognitive test (Mini-Cog). [/https://mini-cog.com/].
    - All patients with Mini Cog score ≤2 should have LOC assessment using "Level of Care Assessment Placement Tool" EHRS Ad hoc form in UM folder.

FOLLOW-UP

Refer patients to primary care provider:

- Mini-Cog score of ≤ 2 indicates higher likelihood of clinically important cognitive impairment.
- All patients with Mini Cog score ≤2 should have LOC assessment "Level of Care Assessment Placement Tool" EHRS Ad hoc form in UM folder (refer to UM nurse to complete the form).

DIABETES [9,10,11]

WHO TO SCREEN?

- Adults any age with overweight or obesity (BMI ≥ 25 kg/m2 or ≥ 23 kg/m2 in Asian Americans) with one or more of the risk factors (first degree relative with diabetes, high-risk race/ethnicity (African American, Latino, Native American, Asian American, Pacific Islander), history of CVD, hypertension, HDL cholesterol <35 mg/dL and/or triglyceride level > 250 mg/dL, history of PCOS)
- Adults with prediabetes (A1c ≥5.7%, IGT, or IFG)
- Adults with history of gestational diabetes (GDM)
- All others age ≥ 35 years

HOW OFTEN AND WHEN? RULES

- Patients with prediabetes should be tested yearly.
- Patients with history of GDM should have lifelong testing at least every 3 years.
- For all other patients: If tests are normal, repeat screening recommended at a minimum of **3-year intervals**, sooner with symptoms or change in risk (i.e., weight gain).

HOW TO SCREEN?

- EHRS/lab order: Fasting blood glucose or hemoglobin A1c (HbA1c) level on all the above patients, at annual/periodic health care visit.

FOLLOW-UP

- Refer all patient with prediabetes (HbA1c 5.7%-6.4%) and diabetes (HbA1c ≥ 6.5%) to primary care provider.

BMI: body mass index; CVD: cardiovascular disease; HDL: high-density lipoprotein; PCOS: polycystic ovarian syndrome; A1C: glycated hemoglobin; IGT: impaired glucose tolerance; IFG: impaired fasting glucose.

HYPERTENSION [12,13]

WHO TO SCREEN?

- All adults with and without known history of hypertension.

HOW OFTEN AND WHEN? RULES

- Annually
- Generally done at most healthcare visits

HOW TO SCREEN?

- Use manual or automated sphygmomanometer for blood pressure measurement
- Blood pressure measurements should be taken at the brachial artery (upper arm) with a validated and accurate device in a seated position after 5 minutes of rest

FOLLOW-UP

- Patients with history of hypertension will be followed by providers.
- For patients without history of hypertension, if they have an elevated BP (generally systolic ≥120 and diastolic ≥80) should have repeated measurements. For BP of 120-129/80, refer to diet/exercise education. For BP higher than 130/80, refer to providers.
- Generally, the threshold used to define hypertension vs normal blood pressure by various organizations ranges from 130/80 mm Hg or greater to 140/90 mm Hg or greater. For the purposes of this recommendation, the USPSTF reviewed evidence from studies that included any threshold used to define hypertension. Hypertension (also referred to as “sustained hypertension”) is when a person has repeatedly high blood pressure measurements over time and in various settings.

OBESITY[14,15]

WHO TO SCREEN?

- All adults

HOW OFTEN AND WHEN? RULES

- Annual and periodic visit

HOW TO SCREEN?

- Record height and weight. Record height in (m) and weight (Kg) measurements.
- BMI is calculated and recorded in EHRS vital sign field.
- The National Institutes of Health (NIH) provides a BMI calculator at http://ww1.nhlbisupport.com/and a table at https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmi_tbl.htm.

FOLLOW-UP

- Provide educational materials on diet and exercise for patients with BMI of 25 or greater.
- Provide nutrition/exercise counseling for patients with BMI of 30 or greater.

OSTEOPOROSIS [16,17,18,19]

WHO TO SCREEN?

- Women ≥ 65 years.
- Postmenopausal women < 65 years with at least 1 risk factor (FHx hip fx, smoking, excessive alcohol consumption or low body weight) should have osteoporosis risk assessed with tool https://americanbonehealth.org/calculator/.

HOW OFTEN AND WHEN? RULES

Repeat bone mineral density (BMD) measurement as clinically indicated. The following intervals are recommended based on the previous results:

- Normal BMD (T score of 1.00 or higher) or mild osteopenia (T score of 1.01 to -1.49): screen every 15 years.
- Moderate osteopenia (T score of -1.50 to -1.99): screen every 5 years.
- Advanced osteopenia (T score of -2.00 to -2.49): screen every 2 years.

HOW TO SCREEN?

- EHRS/imaging order: Central dual-energy x-ray absorptiometry (DXA) to measure BMD at the hip and lumbar spine.

FOLLOW-UP

- Refer all patients with abnormal test results to a primary care provider.
  - T-score of -1.0 or above = normal bone density
  - T-score between -1.0 and -2.5 = low bone density, or osteopenia
  - T-score of -2.5 or lower = osteoporosis

QT INTERVAL[20,21]

WHO TO SCREEN?

- All adults who are on antipsychotics, clozapine, mood stabilizers, antidepressants, and medications linked to QT prolongation. Due to the comorbidities of patients in CCHCS, these medications are commonly prescribed in our system. Patients are most at risk if taking more than one medication that can prolong the QT interval.
- There are many drugs that can potentially prolong QT intervals. Some common drugs include certain antipsychotics, antibiotics such as erythromycin, certain anti-arrhythmics, and methadone. Drugs can also have interactions resulting in additive risk for QT interval prolongation. Please refer to UpToDate for a more expanded list of commonly cited medications.

HOW OFTEN AND WHEN? RULES.

- Obtain baseline ECG on all patients before starting antipsychotic medications and methadone.
- Obtain follow-up ECG 30 days after starting psychotropic medication or methadone.

HOW TO SCREEN?

- EKG order in EHRS.
    - Must also submit “Follow-up RN/LVN/MA” order in EHRS for the ECG to be performed.

FOLLOW-UP

- The normal range for the rate-corrected QT interval (QTc):
    - Adult male: < 460 ms is normal; 460-469 ms is borderline; ≥ 470 ms is prolonged.
    - Adult female: < 460 ms is normal; 460-479 ms is borderline; ≥ 480 ms is prolonged.
- Refer all patients with abnormal ECG findings to primary care providers.

SEXUALLY TRANSMITTED INFECTIONS PREVENTION [22, 23]

WHO TO SCREEN

- All adults: (USPSTF states "all sexually active adults who are at increased risk for sexually transmitted infections (STIs)" In the incarcerated setting, all patients are considered at increased risk.
- Patients at additional risk who may need additional interval screening include:
  - Men who have sex with men
  - Having multiple sex partners and/or
  - Have HIV infection and/or
  - Engage in high-risk sexual behavior

HOW OFTEN AND WHEN? RULES.

- Annually
- Can do more frequently in high-risk groups as listed above

HOW TO SCREEN?

- Sexual History Screening tool based on the CDC "5 P's" (Partners, Sexual Practices, Past STIs, Pregnancy history and plans, andProtection from STIs)
  - Tool found in EHRS-link to Adhoc/Provider Documentation/STI Screening/Education.

FOLLOW-UP

- Refer patient with positive responses to primary care provider for STI screening and counseling.

SUBSTANCE USE DISORDERS [24,25]

WHO TO SCREEN?

- All adults

High risk groups are:

- Male sex
- Mental health condition (personality or mood disorder)
- Nicotine or alcohol dependence
- History of physical or sexual abuse, parental neglect, or other adversity in childhood
- Drug or alcohol addiction in a first-degree relative
- Those who are more likely to misuse prescription drugs (history of drug use for mental illness, pain, and greater access to prescription drugs)
- History of substance use during pregnancy
- History of Hepatitis C or any other SUD (substance use disorder) related complication (e.g. skin abscess, endocarditis, epidural abscess, etc.)
- **Excluded** are adults with known substance use disorder who are currently undergoing or have been referred for drug use treatment.

HOW OFTEN AND WHEN? RULES

- Annually
- Consider more frequently in high risk groups as listed above and patients with SUD related conditions such as HIV, HCV and HBV.

HOW TO SCREEN?

- Substance use history with NIDA Quick Screen (nursing) will be recorded using EHRS-Ad hoc form.
    - NIDA (National Institute on Drug Abuse) Quick Screens questionnaire (Screening and Assessment Tools Chart | National Institute on Drug Abuse (NIDA) (nih.gov).
    - Positive NIDA-Quick screen will trigger a NIDA-Modified Assist assessment
- Order testing of urine or other biological specimens for the presence of drugs as clinically indicated.

FOLLOW-UP

- All patients who have positive NIDA Quick Screen are referred to the Licensed Clinical Social Workers for substance use disorder assessment and consideration of Medication Assisted Treatment (MAT) for opioid or alcohol use disorders, as clinically indicated. See more detailed information in Substance Use Disorder Care Guide.

TOBACCO USE [26]

WHO TO SCREEN?

- Adults, including pregnant persons.

HOW OFTEN AND WHEN?

- Annual and periodic visits.

HOW TO SCREEN?

Record smoking/other tobacco use history:

- Treat smoking status as a vital sign and recording smoking status at every health visit.
- EHRS/ enter Smoking History. Smoking history is under Social History tab. Answer:
  - Smoker: Current/Former
  - Cigarettes (one pack is 20 cigarettes)
  - Number of year smoked
  - Age started smoking
  - Age stopped smoking

After obtaining information, calculate number of pack years: one pack-year is the equivalent of smoking an average of 20 cigarettes/1 pack— per day for a year.

FOLLOW-UP

- Refer individuals between ages 50 to 80 years who have 20 pack-year or more smoking and have not quit smoking within the past 15 years to primary care provider for LDCT (low dose chest CT) for lung cancer screening.
- Refer individuals who are currently smoking (use tobacco) to health care provider for behavioral interventions and pharmacotherapy for cessation of tobacco use.

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