DEPARTMENT OF CORRECTIONS

Policy:	**500.050**
Title:	**Health Screenings and Full Health Appraisals**
Effective Date:	**2/19/26**

PURPOSE: To identify and meet the medical, dental and mental health needs of incarcerated persons/residents and ensure continuity of care to support compliance with the Americans with Disabilities Act (ADA).

APPLICABILITY: All Minnesota Department of Corrections (DOC) facilities

DEFINITIONS:

Commissioner examination – a physical examination or mental health assessment ordered by the commissioner or designee.

Initial health screening – a structured inquiry and observation conducted at intake or upon intra-system transfer to identify immediate medical or mental health needs, ensure safety, and provide reasonable accommodations.

Initial physical examination – a comprehensive health appraisal completed on all incarcerated people/residents who have been incarcerated for 30 days or more, unless otherwise directed.

Intra-system transfers – Incarcerated people transferred within the DOC system, including all incarcerated people/residents on the DOC count who are housed out-of-facility (HOF), as well as incarcerated people/residents on writs.

Periodic physical examination – conducted upon request, up to annually for incarcerated people/residents under age 19 or over age 50, and every two years for those ages 19–50.

Release physical – A health appraisal requested by the incarcerated person/resident prior to release from incarceration.

PROCEDURES:

A. Medical clearance at intake

1. Incarcerated people/residents who are not medically stable (including people who are unconscious, semiconscious, bleeding, or otherwise obviously in need of immediate medical attention) must involve notice to the director of clinical operations, designee, or on-call medical provider and then medical clearance must be obtained prior to admission.

2. Admission or return following referral to an emergency department is contingent upon obtaining medical clearance.

B. Initial health screening

1. The initial health screening must be completed within 24 hours of admission to a DOC facility by a health-trained or qualified staff. Minnesota Correctional Facility-Willow River/Moose Lake (MFC-WR/ML) is considered one facility with two sites. The initial health screening is not required upon transfer to the Challenge Incarceration Program (CIP) site. See also Policy 202.040, "Incarcerated Person Intake Screening and Processing," Policy 202.041, "Juvenile Facility Admissions," Policy 202.057, "Sexual Abuse/Harassment Prevention, Reporting, and Response," and Policy 500.1261 "Health Care for Juvenile Residents and Youthful Offenders," for more information.

2. All incarcerated people/residents receive an initial health screening upon entry into the DOC system or in-transit to another DOC facility. Findings are recorded in the electronic health record, which is available at each facility until the incarcerated person/resident reaches their long-term facility placement. Initial health screenings must be reviewed at each subsequent facility to ensure continuity of care.

3. Initial health screenings must be documented using the approved health screening form in the electronic medical health record and include:
   a) Medical Screening:
      (1) Current medical complaints;
      (2) Chronic health conditions (for example, diabetes, asthma, hypertension, seizure disorder);
      (3) Recent hospitalizations or surgeries;
      (4) Medication history, including prescribed and psychotropic medications;
      (5) Known allergies (drug, food, environmental);
      (6) Pain assessment and history of recent injuries or trauma; and
      (7) Communicable disease symptoms (fever, cough, rash, night sweats).

   b) Behavioral Health/Mental Health Screening:
      (1) Suicide risk screening using facility-approved tool;
      (2) Current or past mental health treatment;
      (3) History of suicide attempts or self-injury;
      (4) Thoughts of self-harm or harm to others;
      (5) Signs of acute psychosis or severe anxiety/depression; and
      (6) Substance use history and date/time of last use.

   c) Intoxication and withdrawal screening
      (1) Observable signs of intoxication;
      (2) Risk factors for withdrawal from, alcohol, opiates and/or benzodiazepines; and
      (3) History of withdrawal seizures.

   d) Dental screening
      (1) Dental pain;
      (2) Facial swelling or abscess; and
      (3) Recent dental trauma

   e) Special needs/functional assessment

(1) Mobility limitations;
(2) Use of medical assistive devices (for example, walker, brace, cane);
(3) Hearing or visual impairments;
(4) Cognitive or developmental concerns;
(5) Pregnancy status or postpartum considerations; and
(6) Need for interpreter services.

f) Observation of the following:
(1) Level of consciousness, orientation, responsiveness;
(2) Skin condition (rashes, infestations, lesions, bruising);
(3) Signs of distress, shortness of breath, or acute pain;
(4) Behavioral presentation (agitation, withdrawal, confusion); and
(5) Evidence of trauma.

g) Medical disposition determination:
(1) General population;
(2) General population with prompt referral to medical, dental or mental health; and
(3) Immediate referral to appropriate health care service for emergency treatment.

C. Initial physical examination

1. A comprehensive health appraisal must be completed for each incarcerated person /resident (excluding intra-system transfers) within 14 days. If there is documented evidence of a DOC completed physical exam or comprehensive health appraisal within the previous 90 days, a new health appraisal is not required except as designated by the health authority.

2. Incarcerated people/residents housed outside of DOC facilities for 90 days or more must also receive a comprehensive health appraisal upon return.

3. If a physician examination or comprehensive health appraisal is not indicated, the reason must be documented in the incarcerated person's /resident's electronic health record.

4. Physical examinations and comprehensive health appraisals must be conducted by a physician, nurse practitioner, or physician assistant, with diagnostic testing and follow-up as appropriate.

5. Components of the comprehensive health appraisal:
a) Medical history
(1) Past and current medial conditions;
(2) Hospitilizations, surgeries, major diagnoses;
(3) Sexual/reproductive history (pregnancy, contraception needs);
(4) Immunization history;
(5) Family medical history (as clinically appropriate);
(6) Communicable disease risks; and
(7) Medication history and adherence issues.

b) Physical examination
   (1) Hands-on head-to-toe exam, documented in detail;
   (2) Vital signs;
   (3) Review of body systems (HEENT, cardiac, pulmonary, GI, GU, musculoskeletal, neuro, skin); and
   (4) Identification of functional impairments.

c) Mental health assessment
   (1) Mental status exam;
   (2) Psychiatric history;
   (3) Current symptoms (depression, anxiety, psychosis);
   (4) Suicide risk evaluation;
   (5) Substance use disorder history; and
   (6) Prior psychiatric diagnoses and treatment.

d) Dental Assessment
   (1) Visual dental inspection;
   (2) Documentation of dental pain level; and
   (3) Determination of urgent vs. routine dental follow-up.

e) Laboratory and diagnostic testing

6. Problem list and treatment plan
   a) A current, active problem list must be created or updated, including:
      (1) Medical diagnoses;
      (2) Dental issues;
      (3) Functional impairments; and
      (4) Special needs (mobility, hearing/vision, language)

   b) A medical plan of care must be initiated for:
      (1) Chronic diseases;
      (2) Medications;
      (3) Specialty referrals;
      (4) Mental health follow-up;
      (5) Dental follow-up; and
      (6) Health education needs

7. Referrals
   a) The assessment must produce referrals to:
      (1) Medical provider;
      (2) Mental health provider;
      (3) Dental clinic;
      (4) Chronic disease clinics;
      (5) Reproductive health services; and
      (6) Special accommodations.

D. Periodic and release physical examinations
Conducted by health services staff when requested by the incarcerated person and documented in the electronic health record.

E Commissioner examination
Conducted by health services, as ordered by the commissioner or designee, and documented in the electronic health record.

H. All health screenings, examinations, and appraisals must be documented in the electronic health record. Annual documentation audits are conducted and retained by RN Supervisor or designee.

INTERNAL CONTROLS:

A. All health screenings, examinations, and appraisals are documented in the electronic health record.

B. Annual documentation audits are conducted and retained by RN Supervisor or designee.

STATE CORRECTIONAL FACILITY SECURITY AUDIT STANDARDS: None

REFERENCES: Minn. Stat. §241.01, subd.3a
Policy 500.520, "Tuberculosis Prevention and Control for Offenders"
Policy 202.040, "Offender Intake Screening and Processing"
Policy 202.041, "Juvenile Facility Admissions"
Policy 500.1261 "Health Care for Juvenile Residents and Youthful Offenders"

REPLACES: Policy 500.050, "Health Screenings and Full Health Appraisals," 4/17/18.
All facility policies, division directives, memos, or other communications whether verbal, written, or transmitted by electronic means regarding this topic.

ATTACHMENTS: None

APPROVED BY:
Commissioner of Corrections