Evaluation of the Federal Bureau of Prisons' Colorectal Cancer Screening Practices for Inmates and Its Clinical Follow-up on Screenings

★ ★ ★

EVALUATION AND INSPECTIONS DIVISION

25-057

MAY 2025

EXECUTIVE SUMMARY

Evaluation of the Federal Bureau of Prisons' Colorectal Cancer Screening Practices for Inmates and Its Clinical Follow-up on Screenings

Introduction

The Federal Bureau of Prisons (BOP) is responsible for the safekeeping and care of federal offenders. This includes providing medical care to over 140,000 inmates and pretrial detainees in BOP-managed facilities. Prior OIG reports have identified concerns with BOP health services, including staffing and timely access to medical care. See Appendix 2.

The U.S. Department of Justice Office of the Inspector General (OIG) initiated this evaluation to assess the BOP's provision of colorectal cancer (CRC) screening to inmates and clinical follow-up on positive CRC screening results. This evaluation follows concerns identified during OIG unannounced inspections of BOP institutions and the deaths of two high-profile BOP inmates from CRC.

CRC is one of the most common cancers in the United States and a leading cause of cancer deaths; but regular screening can help prevent CRC and detect it early, when it might be easier to treat. The BOP's Preventive Health Care Screening Clinical Guidance (clinical guidance) states that sentenced inmates at average risk for CRC should be screened annually using a guaiac fecal occult blood test (gFOBT) or a fecal immunochemical test (FIT) starting at age 45 and stopping at age 75. If either test is positive, indicating blood in the stool, the clinical guidance recommends that the inmate receive a colonoscopy. For inmates at increased risk for CRC, for example those with a history of polyps, the clinical guidance advises providers to follow the American Cancer Society's recommendations for screening, given that procedures can vary based on an inmate's specific risk factors.

Recommendations

We make 13 recommendations to assist the BOP in improving inmate CRC screening rates and follow-up practices.

Results of the Evaluation

We evaluated the BOP's CRC screening rates from January 2020 through April 2024, as well as its follow-up care for inmates who received positive CRC screening results during the period January 2022 through December 2023. As of April 2024, the BOP housed a total of 37,942 inmates between the ages of 45 and 74 at average risk for CRC. In addition, the BOP identified 9,588 inmates, as of May 2024, who were potentially at increased risk for CRC. From January 2022 through December 2023, a total of 3,926 average-risk and increased-risk inmates had a positive CRC screening test result.

The OIG also examined during this evaluation the cases of two high-profile BOP inmates, Robert Hanssen and Frederick Bardell, both of whom died of CRC. In June 2023, Hanssen died of metastatic colon cancer. Hanssen had multiple positive gFOBT results while incarcerated at Administrative Maximum Facility Florence, yet he never received a CRC diagnosis or a colonoscopy. In February 2021, 9 days after being released from Federal Correctional Institution (FCI) Seagoville following a compassionate release order, Bardell died of metastatic colon cancer. While at FCI Seagoville, Bardell reported seeing blood in his stool but did not complete a successful colonoscopy for over 6 months. During that period, Bardell had a pre-colonoscopy evaluation appointment, an unsuccessful colonoscopy, and then a successful colonoscopy that led to his CRC diagnosis. These appointments occurred weeks to months later than the BOP's target dates for them.

Our evaluation identified several serious operational and managerial deficiencies that the BOP must address to ensure that inmates receive proper screening and treatment for CRC. We also identified challenges in the BOP's Bureau Electronic Medical Records System (BEMR) that limit the BOP's ability to identify, monitor,

and document inmate screening needs to minimize future CRC risks to those inmates.

Less than Two-Thirds of Average-Risk Inmates Ages 45 through 74 Were Offered a CRC Screening, and Less than Half of Average-Risk Inmates Had a Current Annual Screening as of April 2024

Of the 37,942 inmates ages 45 through 74 at average risk for CRC, we found that less than two-thirds (24,345) were offered a CRC screening between April 2023 and April 2024. We further found that CRC screening offer rates varied widely by BOP facility, with some facilities having a greater than 90 percent offer rate while others had a less than 10 percent rate.

Among the 24,345 inmates who were offered a CRC screening, we found that about 27 percent (6,549) refused. As a result, overall, we found that only about 47 percent of average-risk inmates (17,796 of 37,942) completed an annual CRC screening. We further found that only 10 of the BOP's 97 facilities met the BOP's National Performance Measures for sustained or demonstrated performance by completing screenings for 76 percent or more of their average-risk population.

The OIG reviewed screening histories for a judgmental sample of 327 of the 3,926 inmates who had a positive FIT or gFOBT in either calendar year 2022 or calendar year 2023 to determine whether they had received, consistent with BOP clinical guidance, an annual screening offer in the years prior to their positive CRC screening result. We found that 57 percent (188 of 327 inmates) received fewer than the expected number of annual screening offers in prior years based on their age. Moreover, for 51 inmates (16 percent), we found that their positive CRC screening result followed their first and only documented CRC screening offer even though they should have previously received, based on their age, multiple annual screening offers. The failure to provide annual screenings as directed by BOP clinical guidance creates greater health risks and potentially poorer clinical outcomes for inmates and can result in substantially increased healthcare costs for the BOP.

We identify in this report a variety of reasons why inmates were either not offered screening or chose not to participate, as well as a number of actions the BOP should take to improve its CRC screening rates for average-risk inmates.

Fourteen Percent of Our Sample of Inmates Who Had a Positive CRC Screening Result Had No Documented Follow-up or Insufficient Documentation of Follow-up

The OIG reviewed BEMR medical records for our judgmental sample of 327 inmates. We found that 90 percent of inmates in our sample received some form of follow-up from a BOP medical provider and that 75 percent were offered a colonoscopy. However, around 10 percent had no documented follow-up. An additional 4 percent that had some initial follow-up did not have sufficient documentation to allow us to determine the follow-up that ultimately occurred.

Inmates in Our Sample Waited an Average of 8 Months for a Colonoscopy Following a Positive CRC Screening Result

The BOP does not have established timeliness metrics for inmates with a positive CRC screening to access a colonoscopy. We were told by a Central Office official responsible for oversight of Health Services programs that community practice generally aims to complete a colonoscopy within 90 days of a positive CRC screening. For the 133 of 327 inmates in our judgmental sample for whom we assessed the timeliness of a follow-up colonoscopy, we found that the average wait time between a positive CRC screening and a colonoscopy was 8 months. Only 12 of the 133 inmates received a colonoscopy within 90 days, with 8 inmates waiting over 18 months.

Gaps Exist in the BOP's Processes to Identify, Monitor, and Document Future Screening Needs for Inmates at Increased Risk for CRC

Despite the BOP's guidance to identify the increased-risk inmate population, we found that the BOP does not have a way to accurately and comprehensively identify the entire increased-risk population due to limitations within BEMR. As a result, the BOP's ability to ensure that increased-risk inmates receive appropriate screening is limited. Furthermore, we found that the BOP lacks robust oversight regarding whether clinical providers appropriately screen and monitor the increased-risk population. Finally, the OIG determined that the BOP does not have a standardized method within BEMR to document the need for future CRC screenings for increased-risk inmates.

Table of Contents

Introduction

The Federal Bureau of Prisons (BOP) is responsible for the safekeeping and care of federal offenders. As part of this mission, the BOP provides medical care to the over 140,000 federal inmates and pretrial detainees housed in BOP-managed facilities. According to the BOP, it aims to effectively deliver medically necessary healthcare to inmates in accordance with proven standards of care without compromising public safety concerns inherent to the BOP's overall mission. As part of the care provided to inmates and detainees, the BOP's Preventive Health Care Screening Clinical Guidance (clinical guidance) defines a scope of preventive healthcare screening services related to infectious diseases, chronic diseases, cognitive impairment, and routine cancer screenings.

Colorectal cancer (CRC) screening is one of the preventive screenings that the BOP provides. CRC is a type of cancer that starts in the colon or rectum. According to the American Cancer Society (ACS), CRC is the third most common cancer, excluding skin cancers, in both men and women in the United States. CRC is also a leading cause of cancer deaths in the United States; however, death rates due to CRC have decreased in the past several decades, due in part to increased screening and early detection. Screening can help detect CRC early, before it has had a chance to spread, and when it might be easier to treat. Additionally, routine screening can help identify growths, called polyps, on the inner lining of the colon or rectum. While most polyps are noncancerous, some types of polyps can turn into cancer over time. Early identification of precancerous polyps means that they can be removed before they have the opportunity to become cancer.

This report details the results of the U.S. Department of Justice (DOJ) Office of the Inspector General's (OIG) evaluation of the BOP's CRC screening practices for inmates and its clinical follow-up on positive screenings. We assessed the BOP's provision of routine CRC screening for individuals at average risk for CRC and the identification of inmates at increased risk for CRC. We also examined the type and timeliness of steps taken when an inmate's screening test was positive, indicating the need for additional clinical follow-up. This report also discusses case studies, including two involving high-profile inmate deaths from CRC, which help demonstrate how broader challenges with the BOP's CRC screening and follow-up processes can affect the care of individual inmates.

Background

The BOP's Health Services for Inmates

Each of the BOP's 97 facilities operates an on-site Health Services Department that provides urgent and routine healthcare services.[1] Additionally, each facility has procedures to handle medical emergencies during hours that healthcare providers are not on site. Although most Health Services employees are on site only during locally established business hours, there are clinical providers on call 24 hours a day. The Health Services Department also offers sick call, an inmate-initiated request for medical care. The Health Services Department triages sick call complaints, and clinical providers assess, diagnose, and treat ailments and schedule follow-up appointments as appropriate. Seven of the BOP's 97 facilities are considered medical

[1] As of April 2024, there were 121 BOP-managed institutions housing inmates. However, the BOP's data often considers Federal Correctional Complexes, in which multiple institutions are collocated, to be single facilities, instead of counting each institution separately. Because the BOP reported CRC screening metrics for 97 facilities, instead of 121 institutions, this report uses 97 as the total number of BOP facilities.

centers, which offer 24-hour inpatient care units and a variety of specialized services, such as dialysis, oncology, prosthetics and orthotics, and dementia care.

Within each BOP facility, the Health Services Department is led jointly by a Health Services Administrator, who is responsible for planning and directing various areas of the department, such as supply procurement and sanitation oversight, and a Clinical Director (CD), who is a medical physician responsible for the clinical care provided to inmates at the facility. Additionally, the CD oversees other clinical providers at the facility. In each of the BOP's six geographical regions, a Regional Medical Director (RMD) and a Regional Health Services Administrator provide oversight of the Health Services Departments by monitoring healthcare performance and providing support as needed, including working with the facilities to take corrective actions and ensuring efficient health services. At the BOP Central Office, the Health Services Division (HSD) oversees all aspects of inmate healthcare, including healthcare delivery and quality improvement of Health Services programs. The HSD also makes recommendations to improve the efficiency of Health Services Department operations and develops policies and other clinical guidance used to inform practice at the regional and facility levels.

CRC Screening in the BOP

The BOP's Clinical Guidance for CRC Screening

The BOP's clinical guidance is the primary source of inmate CRC screening guidelines for Health Services Department employees to follow. The BOP develops its clinical guidance based on guidance and recommendations from the U.S. Preventive Services Task Force, ACS, and American Gastroenterological Association. Subject matter experts within the BOP are responsible for reviewing the recommendations and updating the BOP's clinical guidance to align with any changes to the recommendations.

The BOP's clinical guidance provides two CRC risk categories: average risk and increased risk. We summarize both in Table 1 below.

Table 1

BOP Clinical Guidance for CRC Screening

Level of Risk	Recommended Screening
Average Risk • No increased-risk factors	Beginning at age 45 and stopping at age 75, screening includes a gFOBT or FIT every year. If either is positive, a colonoscopy is recommended.
Increased Risk • History of polyps at prior colonoscopy • History of CRC • Family history • Genetic predisposition • Inflammatory bowel disease	Follow the ACS recommendations for CRC early detection.

Note: gFOBT=guaiac fecal occult blood test; FIT=fecal immunochemical test.

Source: BOP clinical guidance

The BOP considers an inmate to be at increased risk for CRC if they have a family or personal history of CRC or have been diagnosed with polyps during a previous colonoscopy, have a genetic predisposition for CRC, or have inflammatory bowel disease. The BOP's clinical guidance recommends that its providers consult the ACS recommendations for screening practices and timelines, given that screening procedures are specific to the individual case and can vary depending on the inmate's personal and family health history.

For sentenced, average-risk inmates, the BOP's clinical guidance recommends that inmates receive an annual stool-based screening beginning at age 45 and stopping at age 75. If one of the stool-based screening tests yields a positive result, the BOP's clinical guidance recommends performing a colonoscopy to look for signs of cancer or polyps. Despite this guidance, clinical decisions are up to the discretion of the facility's CD; the implementation of clinical guidelines, unlike BOP policy, is not binding. This means that CDs and facility clinical providers have the discretion to order screening tests based on personal observation, sick call complaints, or other pertinent information, even if doing so strays from the BOP's clinical guidance.

The BOP uses two types of stool-based screenings: the guaiac fecal occult blood test (gFOBT) and the fecal immunochemical test (FIT). While both are diagnostic tests to detect hidden (occult) blood in the stool, they use different mechanisms. The gFOBT detects blood via reaction with a chemical called guaiac. Certain medications, supplements, and foods can affect the accuracy of the gFOBT results, so inmates should avoid substances like nonsteroidal anti-inflammatory drugs (ibuprofen or aspirin), vitamin C, and red meat in the days before the test. Furthermore, the gFOBT requires three consecutive stool samples and is unable to determine whether any detected blood is from the colon or other parts of the digestive tract. FIT uses antibodies to specifically identify hemoglobin, a protein found in blood. FIT does not require any medication or dietary restrictions and is less likely than the gFOBT to react to blood found in other parts of the digestive tract besides the colon. According to the U.S. Preventive Services Task Force, both the gFOBT and FIT can be used effectively to screen for CRC; however, research suggests that FIT increases CRC detection compared to the gFOBT.[2] In Table 2 below, we summarize the two stool-based screening tests the BOP uses.

[2] Feng Guo et al., "Benefits of Switching from Guaiac-based Faecal Occult Blood to Faecal Immunochemical Testing: Experience from the Wallonia-Brussels Colorectal Cancer Screening Programme," *British Journal of Cancer* 122 (7) (2020), pmc.ncbi.nlm.nih.gov/articles/PMC7109124 (accessed December 20, 2024).

Table 2

Stool-Based CRC Screening Tests

gFOBT	FIT
Uses a chemical reaction to find hidden blood in the stool	Uses antibodies to detect human-origin hemoglobin in the stool
Cannot determine which part of the digestive tract detected blood is from	Less likely than gFOBT to react to blood found in other parts of the digestive tract besides the colon
Medical/dietary restrictions	No dietary restrictions
Requires three consecutive stools	One stool sample collected

Sources: ACS, BOP clinical guidance, and National Cancer Institute

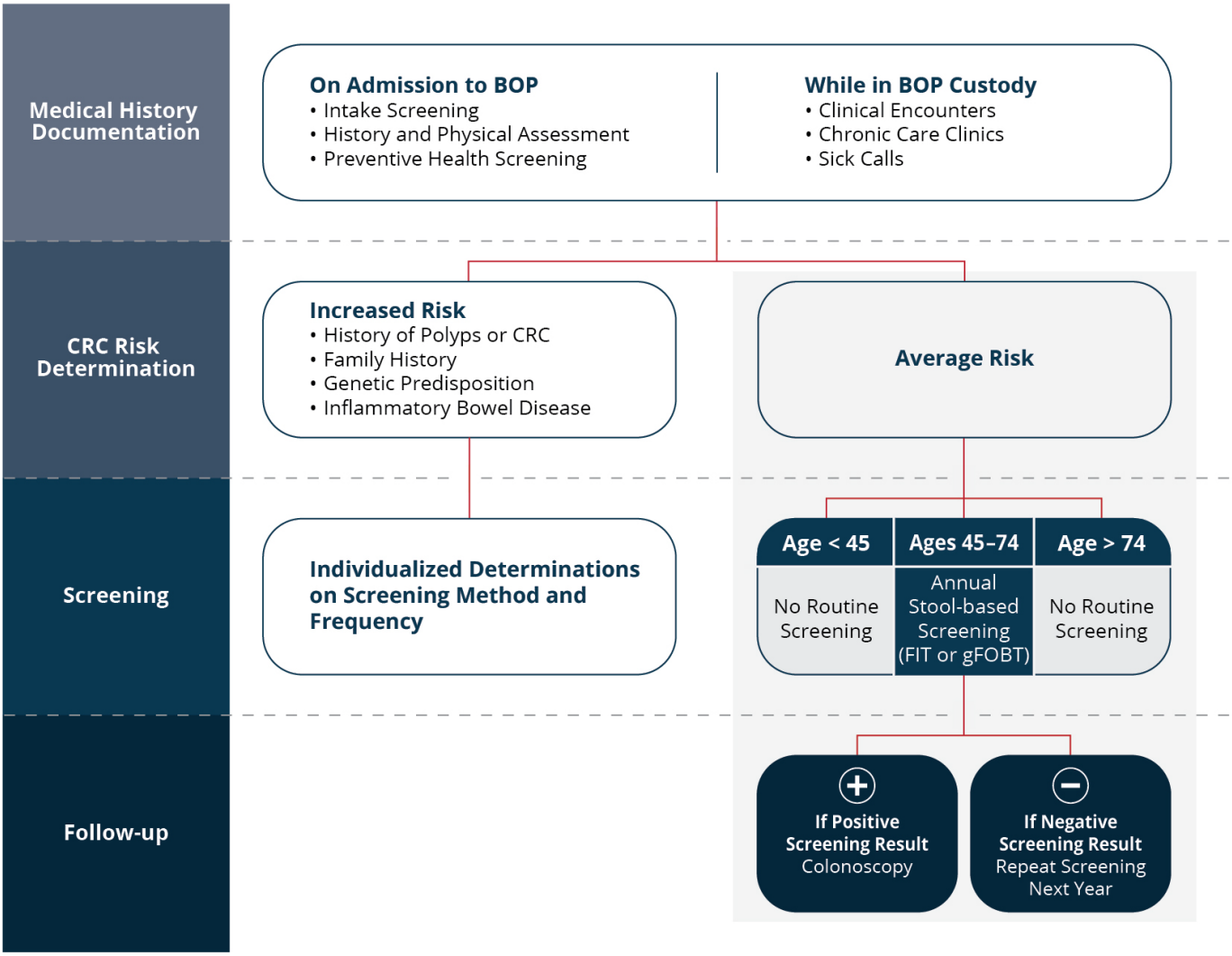
In addition to the stool-based CRC screening tests, U.S. Preventive Services Task Force, ACS, and American Gastroenterological Association guidelines state that a colonoscopy can also be used as a routine screening method. During a colonoscopy, a camera is used to visualize the colon directly and detect any signs of precancerous polyp formation; identified polyps can be removed during the procedure. In addition to the added benefit of being able to remove polyps during the procedure, routine screening using a colonoscopy can be done less frequently than stool-based tests and does not require the patient to collect their own stool; but it is invasive, requires advance bowel preparation, and must be done at a surgical facility under sedation/anesthesia. In addition, there are logistical and security challenges associated with taking an inmate out of a facility for a colonoscopy. The BOP considers these challenges, along with the cost and resources required to perform the colonoscopy, against the benefits of performing a colonoscopy as the first screening for average-risk inmates. Ultimately, the BOP's clinical guidance does not recommend routine colonoscopy for an average-risk inmate unless a stool-based screening is performed first and positively identifies blood in the stool. However, this guidance does not prevent a clinical provider from ordering a colonoscopy for an inmate if they determine that a colonoscopy would be the most appropriate screening method.

The BOP's CRC Clinical Screening and Follow-up Process

To determine whether an inmate is at average risk or increased risk for CRC, the BOP relies on a variety of information, such as intake screenings, a medical history and physical examinations, and preventive health screenings. Additionally, while in BOP custody, inmates have the opportunity to discuss their medical care and relay any concerns to the Health Services Department. In Figure 1 below, we outline the CRC screening process, including medical history documentation, risk determination, screening, and appropriate follow-up.

Figure 1

Overview of CRC Screening and Follow-up



Source: BOP clinical guidance

If an inmate's screening test is positive for blood in the stool, a colonoscopy should be performed to investigate the cause. The Health Services Department orders a colonoscopy or pre-colonoscopy evaluation appointment, depending on the requirements of external providers. The facility's Utilization Review Committee, which is chaired by the CD, reviews the order and determines whether the procedure is medically necessary, as well as the time frame in which it should be completed. The colonoscopy appointment is then scheduled. The inmate begins bowel preparation 48–72 hours prior to their colonoscopy appointment date. Bowel preparation is the process of cleaning out the colon and rectum so the entire lining can be seen clearly during the colonoscopy. During the preparation, the inmate is placed on nothing-by-mouth status and should not consume solid foods. During the last 24 hours of the bowel preparation, the inmate is required to consume a prescription laxative. These food restrictions and laxative are necessary to ensure that the physician conducting the colonoscopy

has a clear view of the colon. Bowel preparation is done in a more restrictive area of the inmate's facility, such as a Special Housing Unit, for security and privacy reasons. Restrictive housing helps ensure that the inmate cannot notify family and friends that they will be outside of the facility for the medical trip, while providing a greater level of privacy for the inmate to manage the effects of the laxative.

Documentation in the BOP's Electronic Medical Records System

The BOP uses a custom information technology system, the Bureau Electronic Medical Records System (BEMR), as its electronic health records system to manage and document the health of inmates. It includes the ability to record, track, and access inmate medical information such as diagnoses, treatments, medical history, medications prescribed, lab results, and appointments.

The BOP documents inmate CRC screenings, colonoscopy referrals, appointments, and results, as well as any cancer diagnoses, in BEMR. After an inmate has completed their CRC screening, Health Services Department employees will enter the results in BEMR within the inmate's medical record. This information is recorded in a flowsheet designated for CRC screening, which contains the date of the test, the testing modality, and the result. If an inmate refuses a CRC screening, they are required to sign a Medical Treatment Refusal form. After the Medical Treatment Refusal form is signed, the BOP is required to scan the signed form into the inmate's BEMR medical record.

Performance Measures and Monitoring

The BOP's National Performance Measures

The BOP's National Performance Measures (NPM) are a set of standardized, clinical metrics to evaluate the delivery of healthcare against national standards and among BOP facilities. The BOP defines a series of performance levels to evaluate NPM progress (see Table 3).

The BOP expects facilities to track NPM and encourages facilities to identify steps to achieve the next performance level. The BOP's NPM Technical Guidance suggests clinical and administrative actions the facility could take to improve its NPM. The NPM benchmark for CRC is the percentage of inmates with a completed CRC screening in the prior year that are between the ages of 45 and 74, are not at increased risk, and have not had a previous colonoscopy.

Table 3

The BOP's NPM Benchmarks

BOP Performance Level	Performance Percentage
Sustained Performance	90–100%
Demonstrated Performance	76–89%
Developed Performance	51–75%
Limited Performance	26–50%
Inadequate Performance	0–25%

Source: BOP NPM Technical Guidance

CRC Screening Dashboard

To view NPM progress, the BOP uses a CRC Screening Dashboard based on BEMR data. This dashboard shows CRC trends over time, rosters of average- and increased-risk inmates, the number of average-risk inmates at each BOP facility, and a summary of average-risk inmates who have been offered, refused, or

completed CRC screenings. The dashboard does not provide summary information for increased-risk inmates, as their screening needs may vary based on their risk factors. Increased-risk inmate data is not used in NPM calculations. Health Services employees can use the dashboard to identify average- and increased-risk inmates who are due for screening, while Regional and Central Office employees can use the dashboard for monitoring facility adherence to CRC screenings and progress on performance metrics.

Prior Work Related to the Evaluation

The OIG has previously conducted oversight on the provision of healthcare within BOP facilities, including the provision of CRC screening. In 2024, the OIG published three BOP facility inspection reports in which CRC screening and transporting inmates to external medical appointments were among the issues addressed. The inspection of Federal Correctional Institution (FCI) Lewisburg found that the BOP facility failed to screen more than half of the eligible population for CRC and experienced significant delays in completing colonoscopy appointments, while the inspections of FCI Sheridan and Federal Medical Center Devens reported a lack of sufficient custody staff to escort inmates to external medical appointments. In addition to the inspections, a 2022 OIG audit reported issues with the BOP's ability to track canceled and rescheduled appointments with external providers. Due to the lack of available data, the OIG could not determine the full impact that canceled or rescheduled appointments had on inmate healthcare. Other OIG evaluations have identified issues that may contribute to the BOP's challenges related to CRC screening discussed in this report. For example, reports published in 2016 and 2023 found that the BOP has faced ongoing challenges in medical staffing. Additionally, the OIG's 2023 capstone review of the BOP's response to the coronavirus disease 2019 pandemic found that the pandemic negatively affected the BOP's Health Services operations. For additional information and links to the OIG's published work related to inmate healthcare, see Appendix 2.

Scope and Methodology of the OIG Evaluation

Our evaluation focused on CRC screening and follow-up procedures as they occurred at BOP facilities, specifically (1) annual screening of inmates for CRC and (2) completeness and timeliness of follow-up for inmates who received a positive screening result. The scope of this evaluation encompassed a snapshot of CRC screening from April 2024; positive CRC screenings that occurred between January 2022 and December 2023; and the subsequent follow-up care, especially colonoscopies, that the inmates received. We also conducted a limited review of CRC screening histories for (1) average-risk inmates BOP-wide between January 2020 and April 2024 and (2) a judgmental sample of individual inmates over calendar years 2018 through 2023. Our fieldwork included document review, data collection and analysis, and interviews. We interviewed BOP Central Office officials, employees from all six BOP Regional Offices, and Health Services employees from 14 BOP facilities. For a more detailed description of our scope and methodology, see Appendix 1.

Results of the Evaluation

We found significant issues in the BOP's CRC screening of inmates and its clinical follow-up for inmates with positive screening results as directed by the BOP's Preventive Health Care Screening Clinical Guidance (clinical guidance). For the period between April 2023 and April 2024, these issues included having offered screening to less than two-thirds of average-risk inmates ages 45 through 74 and having completed screening for less than half of average-risk inmates ages 45 through 74. Additionally, we found that inmates age 75 were not included in BOP tools used to identify and track which inmates need annual screening. We also found a lack of timely clinical follow-up by the BOP for inmates with positive CRC screening results, and 14 percent of cases that we reviewed lacked sufficient documentation for the OIG to assess what follow-up care, if any, was provided by the BOP following the positive CRC screening results. Finally, we found a lack of oversight to ensure the proper screening and monitoring of inmates at increased risk for CRC.

Less than Two-Thirds of Average-Risk Inmates Ages 45 through 74 Were Offered a CRC Screening, and Less than Half of Average-Risk Inmates Had a Current Annual Screening as of April 2024

We identified several issues related to the BOP's CRC screening practices for inmates at average risk. First, we found that less than two-thirds of average-risk inmates ages 45 through 74 were offered screening between April 2023 and April 2024, with screening offers varying widely by BOP facility. Second, we found that, during the same period, 27 percent of inmates refused annual CRC screening when it was offered to them. Third, we found that, as a result of low screening offers and inmate refusals, less than half of average-risk inmates had a completed, up-to-date CRC screening, with only 10 of the BOP's 97 facilities meeting the BOP's National Performance Measures (NPM) for sustained or demonstrated performance in CRC screening completion.[4] Finally, we found that annual CRC screening has been inconsistent over time, both considering the average-risk population broadly and when looking at screening histories for a sample of individual inmates.

The BOP's Clinical Guidance and CRC Screening Dashboard Excluded Inmates Age 75

The U.S. Preventive Services Task Force and the American Cancer Society (ACS) both recommend routine CRC screening for individuals at average risk beginning at age 45 and continuing through age 75.[3] The BOP's clinical guidance, however, specifies that routine screening stops at age 75. In line with the BOP's guidance, the BOP's NPM and CRC Screening Dashboard rosters incorporate inmates ages 45–74 at average risk. That means that inmates who are 75 years of age are not identified in the dashboard rosters, which facilities use to identify and track inmates who need annual CRC screening. After the OIG shared this finding with the BOP, the BOP reported that it would adjust the CRC Screening Dashboard to include inmates age 75. However, because this age range discrepancy existed at the time of our fieldwork, the data presented in the rest of this section covers annual screening for average-risk inmates ages 45–74 rather than 45–75.

Sources: OIG interviews, data analysis, and document review

The failure to provide annual screening as directed by BOP clinical guidance creates greater health

[3] For individuals ages 76–85, the U.S. Preventive Services Task Force and the ACS recommend selectively offering screening to individuals based on the individual's overall health, prior screening history, and preferences.

[4] As noted in the Background, CRC screening data counts complexes as single facilities instead of as multiple separate institutions, so this report uses 97 as the total number of BOP facilities.

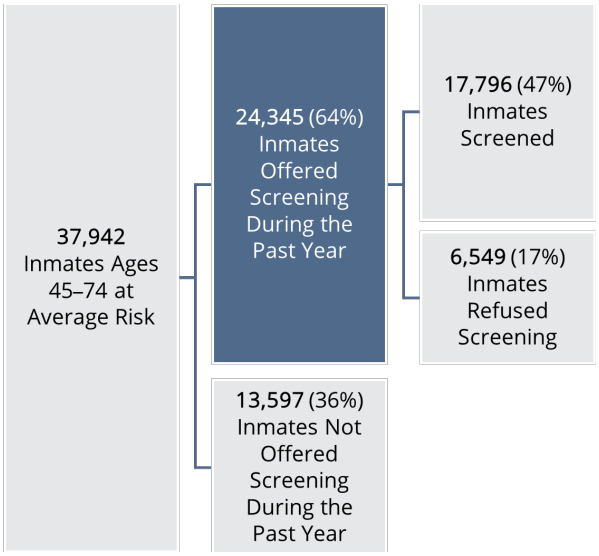
risks and potentially poorer clinical outcomes for inmates and can result in substantially increased healthcare costs for the BOP. There are a number of actions the BOP should take to improve its CRC screening rates for average-risk inmates.

The BOP Offered Annual CRC Screenings to Less than Two-Thirds of Average-Risk Inmates Between the Ages of 45 and 74 During the Period April 2023–April 2024

In order for an inmate to complete the annual CRC screening recommended by the BOP's clinical guidance, a Health Services employee must first offer the inmate a fecal immunochemical test (FIT) or guaiac fecal occult blood test (gFOBT). As of April 2024, the BOP identified 37,942 inmates between the ages of 45 and 74 at average risk for CRC. We found that only about 64 percent (24,345 of 37,942) of those inmates had a documented CRC screening offer during the period April 2023–April 2024 (see Figure 2). This means that the remaining 13,597 inmates had neither a current test result nor a documented screening refusal in their medical records. In addition, inmates age 75 are not included in this data, despite medical community recommendations that include individuals age 75 in the cohort for annual CRC screening, as noted in the text box above. Although there were only 152 inmates age 75 in BOP custody at the beginning of April 2024, these inmates may not have received the same opportunity to participate in CRC screening, as other individuals in the age range, as recommended by the broader medical community.

Figure 2

Total CRC Screening Offers for Average-Risk Inmates Ages 45–74, April 2024



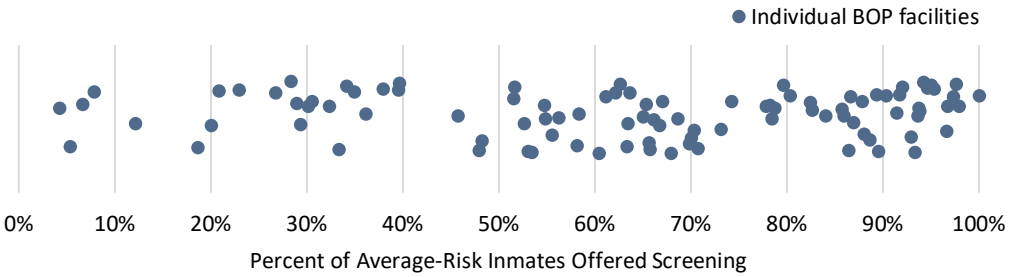
Source: OIG analysis of BOP data

We further found that screening offers varied widely by BOP facility. As shown in Figure 3 below, screening offers ranged from 100 percent of average-risk inmates offered screening at one BOP facility down to 4 percent of average-risk inmates offered screening at another facility.[5] We determined that approximately 27 percent of BOP facilities had not offered screening to over 50 percent of their average-risk inmate population. As a result, average-risk inmates assigned to different facilities had extremely different levels of access to CRC preventive care, placing inmates at facilities with less access to preventive CRC screening at a higher risk for adverse CRC health outcomes.

[5] The OIG previously reported on CRC screening offers at Federal Medical Center (FMC) Devens, noting that 93 percent of inmates at average risk for CRC had been offered screening as of April 2024. See Appendix 2, Item II.

Figure 3

Distribution of Screening Offers at BOP Facilities, as a Percentage of the Facilities' Total Average-Risk Inmates, April 2024



Source: OIG analysis of BOP data

As part of our evaluation, the OIG interviewed Health Services employees at 14 BOP facilities, including a variety of sizes, facility types, and locations across the six BOP geographic regions, as well as regional Health Services employees, to understand facility processes for annual CRC screening and the challenges associated with implementing the BOP's clinical guidance. Based on these interviews, we identified four factors that affect BOP facilities' ability to consistently offer yearly CRC screening to average-risk inmates as directed by BOP clinical guidance. Two of the factors are related to the BOP's ongoing difficulties with adequately staffing Health Services, also discussed in prior OIG work.[6] The OIG believes that BOP facilities should address these areas to improve CRC screening offers, and we make a recommendation to address these factors later in this report.

1. **Vacancies in Key Areas of Responsibility.** The OIG found that how a BOP facility chooses to assign CRC screening responsibilities affects its ability to offer screening. Interviewees at both the facility and regional levels identified key-role vacancies that they believe limit BOP facilities' ability to offer screenings. For example, if a facility's phlebotomist or medical assistant is tasked with conducting CRC screenings, a vacancy in that role may cause screening rates to decrease. Reliance on a single individual to run the CRC screening process jeopardizes a facility's ability to continually offer CRC screenings. Seven of the 14 facilities relied on a single Health Services employee to conduct CRC screenings. At four of those facilities, the Health Services position responsible for screening was vacant or about to become vacant. Several facilities described significant variations in their screening rates depending on whether the Health Services position typically responsible for CRC screening was filled.

2. **Vacancies Affecting Prioritization of Routine Screening.** Interviewees reported that vacancies and staffing levels across Health Services more broadly can limit a facility's ability to prioritize preventive care. We were told that staffing shortages often mean that employees have to prioritize addressing urgent medical needs and daily responsibilities, such as medication delivery and sick call, over preventive care. Health Services employees at 6 of the 14 facilities pointed to their facility's overall Health Services staffing level as a contributing factor in their ability to offer CRC screening.

[6] The OIG has previously reported on the BOP's medical staffing challenges. See Appendix 2, Items III and IV.

3. **Method of Offering Routine Screening.** Employees described three main ways that inmates are offered CRC screening: (1) using the BOP's CRC Screening Dashboard to identify inmates who are due for annual screening and having them report to Health Services to collect the testing materials; (2) using regularly scheduled clinical encounters, such as new arrival screenings or chronic care appointments, as an opportunity to offer screening; and (3) using mass screening, whereby the facility offers screening to large groups of inmates at one time. Some described a combination of methods, which we observe may help balance the potential benefits and drawbacks for each. For example, the majority of interviewees described using the CRC Screening Dashboard, which lets facilities identify inmates as they become due for screening; but successful use of this method requires employees to monitor the dashboard and offer screening consistently to avoid falling behind. Combining screening offers with regularly scheduled appointments is efficient, but there is a risk that offering screening could be overlooked during an appointment typically focused on other health issues. Further, inmates who are generally healthy may not have annual appointments scheduled. The interviewees at the two facilities using mass screening described it as a way to address low screening rates, but mass screening requires a plan for future screening to maintain screening rates over time and does not timely catch inmates who enter the facility between mass screening events. However, one interviewee noted that mass screening may help normalize screening since everyone is offered screening at once.

4. **Lack of Inmate Compliance.** Health Services employees also described challenges with inmates returning samples for processing. When an inmate fails to return their sample, employees said, they must restart the screening process and call the inmate back to Health Services to sign a Medical Treatment Refusal form or receive new testing materials, which has associated time and material costs. Until an inmate has either a completed screening result or a documented refusal, the BOP does not count the inmate as having received a CRC screening offer.

Overall, these four factors have a significant role in BOP facilities offering CRC screening to the average-risk inmate population on an annual basis. These factors can exist independently or overlap with one another, creating additional complexity and implementation challenges. For example, Health Services employees at Federal Correctional Institution (FCI) Pekin in Illinois told the OIG that prior to the coronavirus disease 2019 (COVID-19) pandemic the facility ran monthly preventive health clinics, which allowed Health Services employees to offer CRC screening alongside other annual screenings, such as for tuberculosis. However, employee vacancies have rendered FCI Pekin unable to offer preventive health clinics. Instead, the Clinical Director (CD) assumed responsibility for CRC screening, by monitoring the CRC Screening Dashboard and ordering screening for inmates as needed, until departing FCI Pekin to take another role. At the time of our fieldwork, interviewees reported that FCI Pekin no longer had a consistent CRC screening process. In contrast, a Health Services employee at FCI La Tuna in Texas told the OIG that CRC screening is a shared responsibility among multiple Health Services employees. Specifically, they said that multiple employees monitor the CRC Screening Dashboard, call inmates to Health Services to receive test materials, counsel the inmates about the screening, and follow up with inmates who have not returned their sample. The interviewee credited this shared responsibility model for FCI La Tuna's ability to maintain consistently high rates of screening offers.

Of the Average-Risk Inmates Who Were Offered Annual CRC Screening, Over a Quarter Refused

We found that about 27 percent (6,549 of 24,345) of average-risk inmates who were offered CRC screening between April 2023 and April 2024 refused the screening. With limited exception, medical care within the

BOP is voluntary and requires consent, so an inmate who is offered a CRC screening can refuse to participate.[7] However, if an inmate refuses, the BOP is responsible for obtaining and uploading a signed Medical Treatment Refusal form into the inmate's electronic health record in the BOP's Bureau Electronic Medical Records System (BEMR).

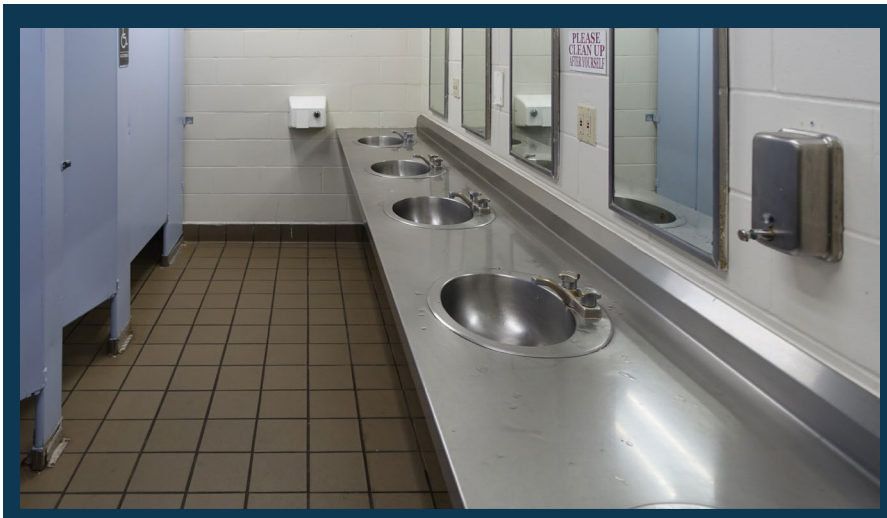
A BOP Health Services official stated that CRC screening compliance is a universal challenge in the United States and that the BOP encounters barriers in addition to those also seen in the community. Whereas BOP inmates and individuals in the community may both refuse screening because they do not see the value of screening or find the idea of collecting a stool sample embarrassing or unpleasant, Health Services employees also identified refusal reasons specific to an incarcerated population. For example:

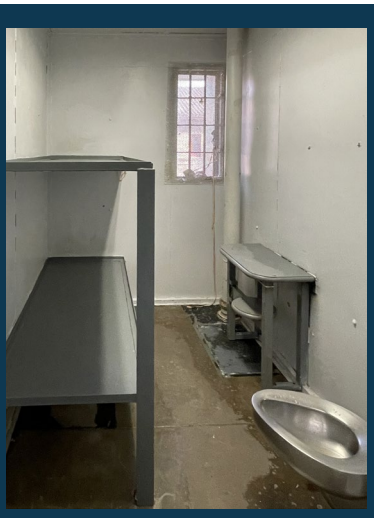
- Inmates may be embarrassed to collect stool samples because they share bathroom facilities where privacy is limited. The photos below show examples of shared bathroom facilities.

- Inmates pending a transfer to another BOP facility may forego screening until they reach their destination facility.

- Inmates nearing the end of their sentence may be concerned that the CRC screening process could delay their transition to a Residential Reentry Center (halfway house), which could occur if the screening reveals a health concern that requires treatment.

- Inmates may be mistrustful of BOP Health Services employees or of the BOP more broadly.

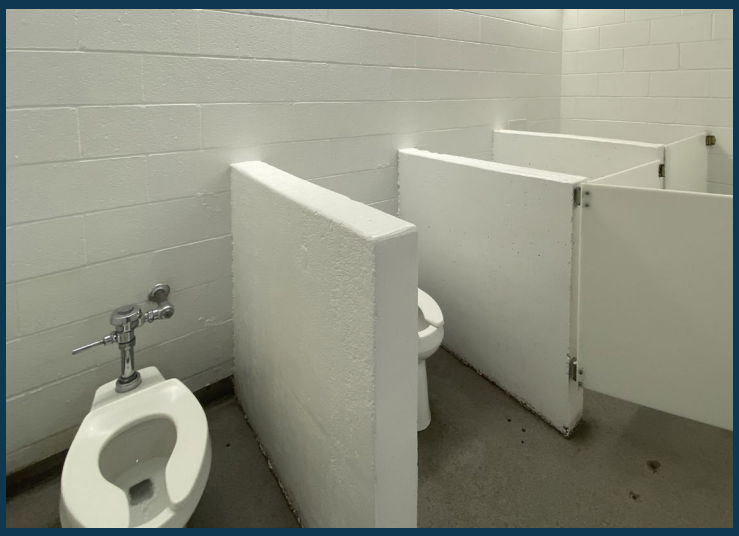




Left, A Shared Bathroom in a Dormitory-style Housing Unit at FCI Tallahassee (May 2023), *Right,* An Unoccupied Two-person Cell at FCI Lewisburg, Showing Shared Furniture and Toilet Facilities Typical of Cell-style Housing Units (February 2024)

Source: OIG, Dates Noted Above

[7] See BOP Program Statement 6031.05, Patient Care, May 14, 2024, Section 41, "Involuntary Medical Treatment/Refusal of Treatment by Inmates," www.bop.gov/policy/progstat/6031.05.pdf (accessed October 23, 2024).



Shared Bathroom Facilities in a Housing Unit at Federal Medical Center Devens (April 2024)

Source: OIG, Date Noted Above

In the text box below, we describe a case from our sample that, unfortunately, resulted in a fatal health outcome following an inmate's repeated refusals of CRC screening. Although inmates have the right to refuse to participate, there are clear patient care benefits to preventive screening. For this reason, the BOP's NPM for CRC screening focuses on completed screening rather than screening offers, with the stated intent of "direct[ing] health care professionals to focus on improving patient care rather than improving the metric via exclusions." In other words, the BOP has decided that inmates who are offered screening but refuse to participate are not counted as having been successfully screened. To help facilities improve in this area, the BOP provides technical guidance in connection with its NPM (NPM Technical Guidance), which includes a list of suggested actions facilities could take, several of which emphasize patient education, including for inmates who have previously refused screening. Interviewees at several facilities pointed to the use of one-on-one counseling of inmates as a way to improve patient participation in screening, and one facility described occasionally reoffering screening to inmates who previously refused, in case they have changed their mind.

Inmate Case Study: Screening Refusal

Over the course of several years, an FCI Seagoville inmate displayed alarming symptoms such as anemia and rectal bleeding. Health Services employees attempted to administer stool-based CRC screenings and schedule screening colonoscopies; however, the inmate refused a gFOBT three times and refused to have a colonoscopy twice. Eventually, after his symptoms worsened, the BOP sent the inmate to a nearby hospital, where a computed tomography scan revealed concerns in the colon. At that time, the inmate refused to complete the requisite bowel preparation for a colonoscopy. The inmate later agreed to have a colonoscopy, which identified a malignant growth in his rectum. The inmate had a colectomy to remove the tumor but suffered postoperative complications that resulted in his death.

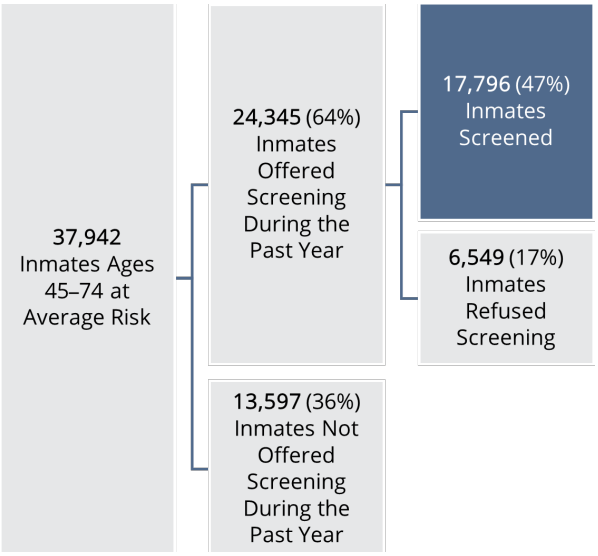
Source: OIG review of inmate medical record

Less than Half of Inmates Between the Ages of 45 and 74 at Average Risk Had Completed an Annual CRC Screening During the Previous Year, as of April 2024

Since not all inmates between the ages of 45 and 74 at average risk were offered CRC screening, and some inmates chose not to participate when offered screening, we found that only about 47 percent (17,796 of 37,942) of average-risk inmates had a completed annual CRC screening in the previous year, as of April 2024 (see Figure 4). In comparison, federal government data sources described a range of CRC screening rates in the United States. An estimated 63.5 percent of adults ages 45 to 75 were up-to-date on CRC screening according to 2023 National Health Interview Survey data.[8] An estimated 41 percent of adults ages 45 to 75 who were patients at health centers were up-to-date on CRC screening according to 2023 Uniform Data System data, which compiles standardized data reporting from health centers that provide primary healthcare services to medically underserved communities.[9]

Figure 4

Total Completed CRC Screenings for Average-Risk Inmates Ages 45–74 as of April 2024



Source: OIG analysis of BOP data

We also found that screening completion varied widely by BOP facility. Of the BOP's 97 facilities, completed CRC screenings ranged from 94 percent of average-risk inmates screened at one facility down to 0 percent of average-risk inmates screened at another facility.[10] In Table 4 below, we

[8] U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion, "Increase the Proportion of Adults Who Get Screened for Colorectal Cancer—C-07," *Healthy People 2030,* odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/cancer/increase-proportion-adults-who-get-screened-colorectal-cancer-c-07 (accessed March 13, 2025).

This data includes adults who were up-to-date on CRC screening using any of the screening methods, not just stool-based screening, recommended by the U.S. Preventive Services Task Force. The data excludes those who had a history of CRC but not other CRC risk factors. In response to a draft of this report, the BOP noted that the broader U.S. population may not be directly comparable to the BOP inmate population due to demographic differences in a variety of categories including sex, race or ethnicity, socioeconomic status, and educational attainment.

[9] U.S. Department of Health and Human Services Health Resources and Services Administration, 2023 Uniform Data System Trends Data Brief (August 2024).

This data includes patients at Health Resources and Services Administration-funded health centers who were screened for CRC by a variety of screening methods, not just stool-based screening. In response to a draft of this report, the BOP suggested that the demographic make-up of this population may be more comparable to the BOP inmate population. The data excludes patients meeting advanced illness criteria, receiving palliative or hospice care, or living long-term in a nursing home, as well as patients with a history of CRC or total colectomy.

[10] The OIG previously reported on the provision of CRC screening at FCI Lewisburg. See Appendix 2, Item I.

apply the BOP's NPM for CRC screening (described above) to BOP facilities' performance. As shown, 10 (see green shading) of the BOP's 97 facilities had sustained or demonstrated performance based on the BOP's NPM, with only 2 facilities achieving completed screenings for 90 percent or more of their average-risk population. Almost three-quarters of average-risk inmates—27,656 inmates—were designated at 66 facilities (gold shading) with developed or limited performance based on the BOP's NPM. Twenty-one facilities (red shading), which house 6,852 average-risk inmates, were identified as having inadequate performance based on the BOP's NPM, meaning that 25 percent or less of the average-risk population at these 21 facilities had a completed screening.

Table 4

Facility Performance Toward CRC Screening Completion Under the BOP's NPM, April 2024

BOP Performance Level (Percentage of Average-Risk Inmates with a Completed Screening)	Number of Facilities at Each Performance Level	For Facilities at Each Performance Level:		
		Number of Average-Risk Inmates with Current Screening	Number of Average-Risk Inmates	% of All Average-Risk Inmates BOP-wide
Sustained Performance (90% +)	2	488	521	1%
Demonstrated Performance (76–89%)	8	2,357	2,913	8%
Developed Performance (51–75%)	30	7,830	12,859	34%
Limited Performance (26–50%)	36	6,143	14,797	39%
Inadequate Performance (0–25%)	21	978	6,852	18%

Source: OIG analysis of BOP data

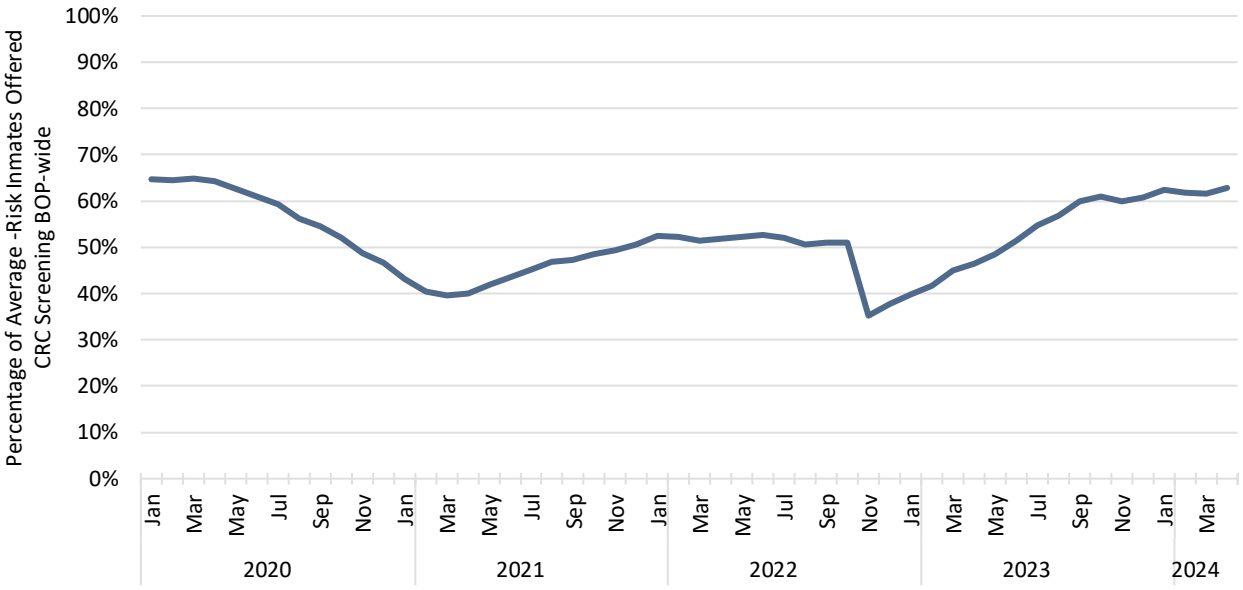
We found that low screening offers and high screening refusals can both cause a facility to struggle with CRC screening completion. For example, for BOP facilities in the "inadequate performance" range (red shading), about 43 percent (9 of 21) had very low screening offers; specifically, less than 25 percent of average-risk inmates were offered screening at these facilities. In contrast, 3 of the 21 facilities had relatively high screening offers but most inmates chose not to participate in screening, which resulted in a low overall screening completion rate. As a result, facilities looking to improve their CRC screening performance might need to focus their efforts in different areas. In response to a draft of this report, the BOP asserted that age may affect CRC screening completion, noting that in 2021 the U.S. Preventive Services Task Force lowered the recommended starting age for routine CRC screening from age 50 to age 45 and that research suggests that U.S. screening rates for individuals ages 45 to 49 lag behind screening for individuals in the 50–75 age range. Given that BOP inmates at the younger end of the recommended screening age range make up a large proportion of inmates eligible for annual CRC screening, considering ways to increase screening across age groups may be another way for facilities to focus their efforts to improve CRC screening performance.

Annual CRC Screening Offers Have Been Inconsistent Over Time

Since stool-based CRC screening should occur annually for inmates at average risk between the ages of 45 and 75, we also examined screening offers over time, both BOP-wide and for a sample of individual inmates. As shown in Figure 5 below, April 2024 had the highest BOP-wide average monthly CRC screening rate since April 2020, following a drop in the percentage of average-risk inmates offered screening between April 2020 and April 2021 and a sharp drop in the percentage of average-risk inmates offered screening between October and November 2022. BOP Health Services employees we spoke with reported that CRC screening rates dropped in 2020 due to the COVID-19 pandemic, during which the BOP paused many of its preventive care activities.[11] As normal operations resumed during 2021 and 2022, CRC screening offers increased. In 2022, the BOP's clinical guidance decreased the starting age for routine screening from age 50 to age 45, in line with updated recommendations from the U.S. Preventive Services Task Force issued in 2021. This caused a sudden drop in the rate of screening offers because expanding the age range suddenly increased the number of inmates who were not up-to-date on screening. As of April 2024, the BOP had returned to pre-pandemic screening offer levels but over one-third of average-risk inmates still did not have a documented annual CRC screening offer from the previous year.

Figure 5

Average Monthly CRC Screening Offer Rates BOP-wide, January 2020–April 2024



Source: OIG analysis of BOP data

To determine whether individual inmates received annual screening offers over time, the OIG reviewed screening histories for a sample of 327 inmates who had a positive FIT or gFOBT in either calendar year

[11] The OIG has previously reported on how the COVID-19 pandemic affected health services at the BOP. See Appendix 2, Items IVand V.

2022 or calendar year 2023.[12] For each inmate in our sample, we examined 6 years' worth of preventive CRC screening history to determine the number of expected screening offers based on age. For example, if an inmate was age 60 in 2023, we would expect to see a CRC screening each year from 2018 through 2023 because they would have been in the age range for recommended annual CRC screening under both the BOP's pre-2022 clinical guidance and the clinical guidance update in 2022. If an inmate was age 50 in 2023, we would expect to see two screening offers because they would have been in the age range for routine CRC following the clinical guidance update in 2022 only. If an inmate was age 45 in 2023, we would expect to see only one screening offer. We found that 57 percent (188 of 327) of inmates in our sample received fewer than the expected number of annual screening offers based on their age. More concerning, we found that 51 inmates (16 percent) who should have received multiple annual screening offers based on their age received positive screening results the first and only time they were offered CRC screening. There is a risk that, because these individuals did not receive annual screening as early and as consistently as they should have, any underlying causes of their positive screening results were not identified and treated as early as they could have been.

While our review of screening history overlaps with the COVID-19 pandemic, during which the BOP had to reduce or postpone preventive care activities, we note that it is especially important for the BOP to offer screening to individuals who have not been offered screening consistently. The U.S. Preventive Services Task Force emphasizes that stool-based screening using the gFOBT or FIT requires commitment and adherence to the annual screening interval to achieve the benefits of screening. In the text box below, we discuss a case that highlights the importance of consistency with routine screening.

Inmate Case Study: Routine Screening Helps Detect CRC

An average-risk inmate received a negative FIT result when offered routine screening upon arrival at a Federal Prison Camp (FPC). The inmate was screened again 1 year later, per the BOP's clinical guidance, and received a positive FIT result. The inmate received a colonoscopy at a community hospital, as recommended by BOP guidance, during which a polyp was found, biopsied, and identified as an adenocarcinoma of the sigmoid colon. The inmate had a procedure to remove the sigmoid colon and was discharged to the FPC upon recovery. In this case, proper adherence to the BOP's screening guidance resulted in timely detection and treatment of CRC.

Source: OIG review of inmate medical records

There Are Opportunities for the BOP to Improve Its Annual CRC Screening Rates

CRC screening can improve health outcomes by detecting cancer early, when it might be easier to treat. Additionally, regular preventive screening improves the chance that precancerous polyps are found and removed before they become cancer, mitigating the need for more costly treatments. The BOP's clinical guidance recommends that a positive FIT or gFOBT should be followed by a colonoscopy, which allows for the direct visualization of any abnormal areas in the colon and rectum and the removal of suspicious polyps. The low rate of annual CRC screening completion within the BOP may lead to increased health risks for inmates who are not screened and therefore would not receive the potential benefits of early detection.

[12] We selected this sample to align with our analysis of clinical follow-up on positive screening results, discussed later in this report. See Appendix 1 for information about our sampling, data collection, and analysis methodology.

In addition to filling critical healthcare positions and addressing staffing shortages, Health Services employees at the BOP's Central Office, Regional Offices, and facilities described other opportunities to improve completed CRC screening rates. While specific practices may not be applicable at every facility, the practices generally fall into four categories:

1. **Establish a Consistent Screening Process.** Interviewees reported that facilities with a consistent screening process have a better opportunity to maintain screening results over time. BOP Regional Medical Directors (RMD) we interviewed recommended approaches such as offering screening by month of birth or opting to do a set, manageable number of screenings per week. Given the number of inmates identified as being at average risk for CRC as of April 2024, the OIG notes that most facilities would need to offer CRC screening to 10 or fewer inmates each week to successfully offer screening to all average-risk inmates at each facility over the course of a year.

2. **Distribute Responsibility for Screening.** Interviews with employees at several facilities highlighted the importance of having someone assigned to conduct screening as a key element of a successful screening program. However, as we noted above, assigning responsibility to a single individual would increase the risk of program instability should that individual leave their role. Ensuring that responsibilities are shared and that roles have assigned backup would promote continuity of care and make screening less vulnerable to employee turnover.

3. **Emphasize Inmate Participation.** Of the 14 facilities where we conducted interviews, we found that facilities with interviewees who emphasized the importance of inmate education had the lowest rates of refusal. As highlighted above, there are a variety of reasons why an inmate might refuse to participate in screening but actively addressing such concerns and normalizing CRC screening for the inmate population were consistent themes among facilities with low refusal rates. One interviewee stated: "Once [inmates] feel that they are getting the care that maybe they should…or even deserve…in their eyes, they almost feel like, 'you know what, you're right, I should be doing this.' And then we get a lot more compliance."

4. **Consider the Type of Test Used.** While BOP and broader medical community guidance state that FIT and gFOBT screenings are both recommended choices for stool-based CRC screening, BOP employees we interviewed overwhelmingly preferred the FIT for a few reasons. First, many employees told the OIG that the FIT was easier and more efficient, requiring only one sample compared to the three samples required by the gFOBT. Second, employees reported better inmate compliance with returning FIT samples. For example, FCI Bennettsville Health Services employees attributed their high screening rate in April 2024 to a switch from the gFOBT to FIT in 2023. Finally, interviewees noted that the FIT is less prone to false positives, which can occur with the gFOBT if the recommended medication and dietary restrictions are not followed. In contrast, BOP employees at facilities using the gFOBT generally did not report a rationale for selecting that test. The BOP noted that there are also budgetary considerations: at an estimated $5.28 per screening, the FIT is approximately twice as expensive as the gFOBT, which costs an estimated $2.67 per screening. In total, screening all 37,942 average-risk inmates between the ages of 45 and 74 identified as of April 2024 would cost approximately $200,300 by FIT and $101,300 by gFOBT.

Some of the regional Health Services employees we interviewed said that they create a plan with the facilities in their respective regions to improve low CRC screening rates. The BOP's NPM Technical Guidance also suggests a variety of clinical and administrative actions the facilities could take to improve their screening performance. However, while the NPM Technical Guidance encourages facilities to identify and implement any applicable actions to improve performance, it does not require them to do so. Given that only 10 BOP facilities had sustained or demonstrated CRC screening performance based on the BOP's NPM as of April 2024 (i.e., completed screenings for 76 percent or more of their average-risk population (see Table 4, above)), the OIG believes that it is important for the BOP to learn from what is going well at the higher-performing facilities and that creating a CRC plan tailored to each BOP facility would be beneficial. Accordingly, we recommend that the BOP evaluate the CRC screening practices of the 40 facilities that are meeting the sustained, demonstrated, or developed CRC screening performance levels and use that assessment to identify any best practices that may be effective BOP-wide.

We further recommend that the BOP require each facility to develop a written plan for consistent CRC screening that details how the facility will identify the average-risk population; the screening process, to include timeframes; and assigned employee responsibilities. Given that CRC screening is voluntary, inmate education is imperative, not only to improve acceptance rates but also to allow inmates to feel more comfortable participating in screening. This may place inmates in a better position to inform clinical providers if they have or develop risk factors that would put them at increased risk for CRC, which we will discuss below. Therefore, the facilities' written plans should also include providing CRC screening education to their inmate populations. Each facility's plan should take into account staffing challenges and the other factors identified in this report that contribute to the BOP's failure to consistently offer CRC screening, as well as any best practices identified during the BOP's evaluation of the 40 facilities referenced above. To ensure that the plans developed assist the facilities in improving CRC screening rates, we further recommend that the BOP establish a process for the Central or Regional Offices to periodically review the facilities' written CRC screening and education plans and to work with the facilities to make changes to the plans that address new and ongoing factors that affect their ability to consistently provide screening.

Additionally, we believe that, given the benefits of switching from the gFOBT to FIT reported by facilities, the FIT better meets the BOP's needs. As a result, we recommend that the BOP transition to using the FIT as the primary stool-based method of screening for CRC. In response to a draft of this report, the BOP reported that it has already demonstrated a strong preference for the FIT, as approximately 83 percent of inmates who received CRC screening in calendar year 2024 were screened using a FIT. However, we believe that formalizing FIT as the primary method would help facilitate the transition for those facilities that are still using gFOBT without a compelling reason to do so. Finally, in addition to taking steps to improve BOP facilities' ability to offer and complete CRC screening, it is important that the BOP ensure that it tracks CRC screenings for the full cohort of average-risk inmates for whom annual CRC screening is recommended. To accomplish this, we recommend that the BOP update the clinical guidance and NPMs to match the age range described in the U.S. Preventive Services Task Force and the ACA recommendations on preventive CRC screening.

Fourteen Percent of Our Sample of Inmates Who Had a Positive CRC Screening Result Had No Documented Follow-up or Insufficient Documentation of Follow-up

From January 2022 through December 2023, 3,926 inmates had a positive CRC screening test and about 83 percent (3,272 of 3,926) of those inmates were between 45 and 75 years old.[13] According to the BOP's clinical guidance, when an inmate's CRC screening test is positive, a colonoscopy is recommended.[14] To assess whether the BOP was conducting appropriate follow-up care, the OIG judgmentally sampled 327 of the inmates who had a positive screening result and reviewed their medical records in BEMR (for a more detailed description of our methodology, see Appendix 1). We found that, for inmates with a positive CRC screening result in our sample, the majority received some form of clinical follow-up; although, as discussed in the next section, we identified serious concerns about the wait times for inmates with positive CRC screening tests to receive a colonoscopy. We further found that around 10 percent of inmates with a positive CRC screening had no follow-up documented in their medical record. An additional 4 percent had some initial follow-up, but the documentation was not sufficient to determine whether or what follow-through ultimately occurred.

Ten Percent of the Inmates in Our Sample Had No Documented Follow-up

We found that the BOP provided initial follow-up care for 90 percent (294 of 327) of the inmates in our sample of inmates who had a positive CRC screening result. For our evaluation purposes, initial follow-up care, as we summarize in Table 5 below, includes a pre-colonoscopy evaluation appointment with an external provider, colonoscopy, or repeat screening with a stool-based screening test. Our evaluation revealed that about 10 percent of inmates (33 of 327) in our sample with a positive CRC screening result did not have any documented follow-up with any BOP clinical provider. It is unclear whether these inmates did not receive follow-up on their CRC screenings or whether follow-up occurred but was not properly documented. Regardless, it is incumbent on the BOP to follow up and document such actions, not only for continuity of inmate care but also for accountability, as illustrated in the case of Robert Hanssen described in the text box and in the Case Studies section of the report.

Inmate Case Study: Lack of Documented Follow-up Care

In June 2023 at Administrative Maximum Facility (ADX) Florence, inmate Robert Hanssen died of metastatic colon cancer, having never received a CRC diagnosis. Between 2016 and 2022, Hanssen received three positive gFOBT results; however, there is no record of Hanssen receiving a colonoscopy nor are there any signed Medical Treatment Refusal forms. Additionally, despite multiple clinical encounters for chronic conditions and urinary tract infections, there was no documented investigation into the root causes of Hanssen's symptoms, which the OIG's medical experts believe were likely caused by colon cancer.

When the OIG reviewed the circumstances of Hanssen's death, the lack of documentation made it impossible to determine the reasons for the lack of follow-up care on the positive gFOBT results, including whether it was due to ADX Florence employees' lack of adherence to the BOP's clinical guidance or whether inmate refusal was a contributing factor. We describe this case in greater detail in the Case Studies section of the report.

Source: OIG review of inmate medical records

[13] Outside the age range for routine CRC screening, inmates may take a FIT or gFOBT screening due to symptoms they experience.

[14] At a BOP facility, the clinical practice of medicine is ultimately at the discretion of the facility's CD, and, while the BOP publishes clinical guidance that informs clinicians of best practices, this guidance, unlike BOP policy, is nonbinding.

Table 5

Follow-up Actions After a Positive CRC Screening Result, January 2022–December 2023

Follow-up Action	Count	Percentage
Offered a colonoscopy	117	36%
Offered another initial follow-up action	177	54%
Offered a pre-colonoscopy evaluation appointment	*161*	*49%*
Retested with FIT or gFOBT	*16*	*5%*
No follow-up documented	33	10%
Total	**327**	**100%**

Source: OIG analysis of a sample of BEMR data

Four Percent of the Inmates in Our Sample Had Insufficient Documentation to Determine Whether Appropriate Follow-up Occurred After the Initial Follow-up Action

As part of our review of a sample of inmate medical records, the OIG also examined (1) whether a colonoscopy was ultimately offered following a pre-colonoscopy evaluation appointment or retest and (2) whether a colonoscopy ultimately occurred. In total, 246 of the 327 inmates in our sample were *offered* a colonoscopy , including 117 who were offered a colonoscopy right away and 129 who were offered a colonoscopy after completing a different initial follow-up action.[15] We found that 4 percent of inmates in our sample had insufficient documentation to determine whether appropriate follow-up had occurred, including five cases in which a colonoscopy was ultimately not offered following an initial follow-up action and nine cases in which the inmate was offered a colonoscopy but there was no documented follow-through.

In Five Cases, There Was Insufficient Documentation to Determine Why an Inmate Was Not Ultimately Offered a Colonoscopy Following an Initial Follow-up Action

We found that, of the 161 inmates in our sample who first received a pre-colonoscopy evaluation appointment and 16 inmates who first received a retest, 15 percent (26 of 177) were not ultimately offered a colonoscopy (see Table 6, below). For 19 of those cases, we identified documentation in the inmates' medical records that provided rationales for not offering a colonoscopy. For example, we found cases in which clinical providers did not order a colonoscopy because the inmate received a retest and the results were negative for blood in the stool, because the inmate met with a specialist who deemed a colonoscopy not medically necessary, or because the inmate had just recently completed a colonoscopy. In the remaining five cases, we did not find documentation in the medical record explaining why no colonoscopy was ordered. Four of the five inmates with no documentation in their medical record were transferred to

[15] The 81 inmates who were not offered a colonoscopy at any point during our sample period include 33 inmates who had no documented follow-up (see Table 5), as well as 24 inmates who had an initial follow-up step but were not ultimately offered a colonoscopy and 24 inmates pending completion of the initial pre-colonoscopy evaluation appointment, depicted in Table 6 below.

another facility where the CD discontinued the pending appointment, and there was no documentation indicating further follow-up. The remaining inmate was retested and received a second positive screening result, but there was no documented follow-up on the retest. The lack of documentation in these five cases is concerning due to the apparent lack of continuity of care, especially for the inmates who were transferred. Inmates should receive follow-up care on their positive CRC screening results regardless of where they are housed. The absence of documented follow-up suggests that the BOP's guidance was not followed in these instances.

Table 6

Outcome *After* the Initial Follow-up Action on Positive CRC Screening Results

Outcome After the Initial Follow-up Action	Count	Percentage of Cases with an Initial Follow-up Action
Colonoscopy ultimately offered	129	73%
No colonoscopy offered, reasons documented	19	11%
No colonoscopy offered, no reasons documented	5	3%
Initial follow-up action pending[a]	24	14%
Total	**177**	**100%**

Notes: This table is specific to the 177 of the 327 inmates in our sample who were offered a pre-colonoscopy evaluation appointment or a retest with a FIT or gFOBT as an *initial* follow-up action. As shown previously in Table 5, the remaining 150 inmates in our total sample population of 327 were either offered a colonoscopy right away or had no follow-up actions documented in their medical record. Percentages do not total 100 percent due to rounding.

[a] Pending actions had not been completed when we concluded our data collection and validation in August 2024.

Source: OIG analysis of a sample of BEMR data

In Nine Cases, There Was Insufficient Documentation to Determine Whether Appropriate Follow-through on Clinical Follow-up Actions Had Occurred

We found that, of the 246 inmates in our sample who were offered a colonoscopy, 76 percent (187 of 246) had a completed or pending colonoscopy appointment; for 18 percent (45 of 246), there was a written indication in the file that the inmate refused a colonoscopy; and, for the remaining 6 percent (14 of 246), the colonoscopy did not occur for other reasons (see Table 7, below). According to BOP policy, an inmate can refuse a recommended medical course of action by signing a Medical Treatment Refusal form.[16] Once the inmate signs the form, the BOP is responsible for uploading the form into the inmate's BEMR record. We examined whether inmate refusals were appropriately documented. Of the 45 inmates in our sample for which there was a written indication in the file that the inmate refused a colonoscopy following a positive gFOBT or FIT result, 2 inmates did not have a signed Medical Treatment Refusal form in their medical

[16] See BOP Program Statement 6031.05, Patient Care, May 14, 2024, Section 41, "Involuntary Medical Treatment/Refusal of Treatment by Inmates," www.bop.gov/policy/progstat/6031.05.pdf (accessed October 23, 2024).

record. In these two cases, the clinical providers documented the inmate refusals in clinical notes. Of the 14 cases in which the inmate's colonoscopy appointment did not occur for other reasons, there was insufficient documentation to determine whether appropriate follow-through occurred in 9 of them. In eight of the cases, the colonoscopies appear not to have occurred because the inmate transferred to another BOP facility but there was no documentation indicating further follow-up; in the ninth case, there was no documentation of further follow-up occurring after the inmate was offered a colonoscopy. The remaining five cases in which the colonoscopy did not occur had sufficient documentation to indicate why the colonoscopy did not occur and that alternative follow-up care was ongoing.

Table 7

Status of Follow-through on Colonoscopy Offers, as of August 2024

Colonoscopy Status	Count	Percentage of Cases with a Colonoscopy Offer
Colonoscopy completed	145	59%
Colonoscopy pending	42	17%
Colonoscopy refused	45	18%
Colonoscopy did not occur, alternative follow-up documented	5	2%
Colonoscopy did not occur, no reasons documented	9	4%
Total	**246**	**100%**

Notes: Two hundred forty-six of the 327 inmates in our sample had been offered a colonoscopy as of August 2024. The remaining inmates in the sample either had no follow-up actions documented in their medical record, were ultimately not offered a colonoscopy following an initial follow-up action, or were still pending completion of the initial pre-colonoscopy evaluation appointment. Clinical actions taken after August 2024 are not reflected in the dataset.

Source: OIG analysis of a sample of BEMR data

We identified three areas in which there were gaps in documentation: (1) initial clinical follow-up on the positive screening result, (2) colonoscopy offers following a pre-colonoscopy evaluation appointment or retest, and (3) follow-through on the colonoscopy. In total, we found that 14 percent of the cases in our sample (47 of 327) had unclear documentation related to whether and which clinical follow-up had occurred. The lack of clear documentation in BEMR represents a risk that inmates may not be receiving appropriate care, either because they are not receiving the care that the BOP expects or because future medical decisions could be made using incomplete health records. The scope of our analysis did not allow us to determine the underlying causes of these gaps in documentation, as processes can vary by facility. However, as evinced by our findings, there is clear room for improvement.

In the Robert Hanssen case described in the text box above and in the Case Studies section, the BOP determined that ADX Florence failed to follow up on Hanssen's positive gFOBT results. In response, ADX Florence developed a risk-reduction strategy that reiterated its expected processes for following up on

positive CRC screenings and documenting inmate refusals. We believe that BOP facilities could benefit from assessing follow-up processes proactively, instead of merely in response to a death. Therefore, we recommend that the BOP require facilities to review positive gFOBT and FIT results from the past 12 months to determine whether appropriate follow-up on positive tests occurred in all cases, and develop an after-action plan to correct deficiencies, which could include developing standardized guidance and training to ensure that appropriate follow-up occurs and is properly documented, as needed.

Inmates in Our Sample Waited an Average of 8 Months for a Colonoscopy Following a Positive CRC Screening Result

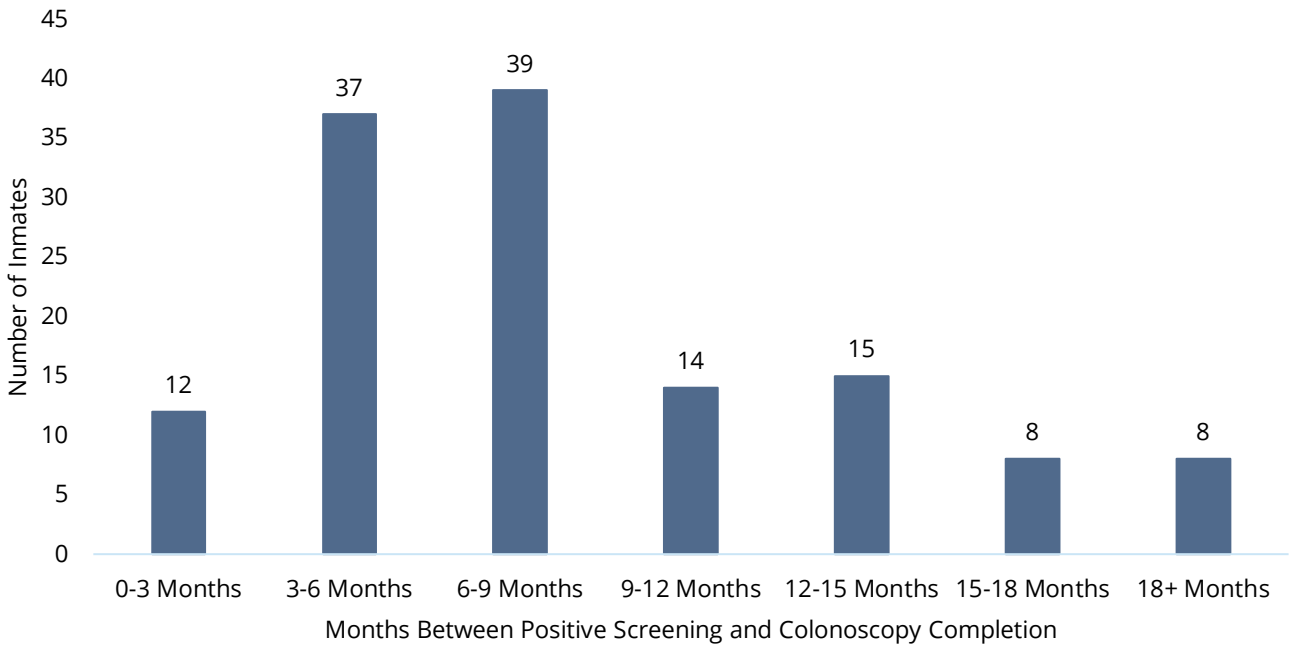
Timely follow-up after a positive screening result is an important aspect of ensuring positive health outcomes.[17] We found that the BOP does not have any established metrics for appropriate colonoscopy wait times, in part because each facility depends on community provider availability and other factors discussed below. A Central Office official responsible for oversight of Health Services Division programs said that community practice generally aims to complete a colonoscopy within 90 days of a positive screening result. Facility Health Services interviewees estimated that the average time between a positive screening result and colonoscopy was 4–8 months. The OIG was able to conduct a timeliness analysis for 133 of the 145 inmates in our sample who had completed a colonoscopy by the time we concluded our data collection and validation in August 2024.[18] We found that for those 133 inmates the average wait time between the positive screening result and colonoscopy was 8 months, with a median of 7 months. As shown in Figure 6 below, only 12 inmates in our timeliness analysis (9 percent) received a colonoscopy within 90 days (3 months) of their positive screening result. Eight of the inmates in our sample had over 18 months elapse between their positive CRC screening result and their colonoscopy, including three inmates who waited more than 2 years between their positive screening result and colonoscopy.

[17] The OIG previously reported on colonoscopy wait times at FCI Lewisburg. See Appendix 2, Item I.

[18] Of the 145 inmates who had a completed colonoscopy, we excluded 12 inmates from the timeliness analysis because their most recent positive screening result occurred after the colonoscopy had already been ordered, an atypical order of events. See Appendix 1 for more information.

Figure 6

Distribution of Colonoscopy Wait Times Following a Positive Screening Result, January 2022–December 2023 (in Months)



Note: This timeliness analysis includes the 133 inmates in our sample who had a positive screening result followed by a colonoscopy offer and a completed colonoscopy by the time we concluded our data collection and validation in August 2024.

Source: OIG analysis of a sample of BEMR data

In addition to looking at the wait time between positive screening results and colonoscopy completion, we also looked at the wait time between the BOP ordering a colonoscopy and the colonoscopy being performed. We found that the 133 inmates included in our timeliness analysis waited for a colonoscopy an average of 4 months after it had been ordered. To better understand the timeliness of colonoscopies for all inmates in BOP custody, the OIG requested the total number of colonoscopies completed between January 2022 and December 2023, regardless of reason. The OIG found that during this period the BOP completed 4,742 colonoscopies and that the average time between ordering a colonoscopy and when the colonoscopy was performed was approximately 6 months.

Pre-Colonoscopy Evaluation Appointments Increase the Time Required to Complete a Colonoscopy

Through our interviews with BOP Health Services employees, the OIG learned that external providers sometimes require an evaluation or consultation appointment prior to performing the colonoscopy, which may delay care as the facility must schedule and coordinate two separate external medical trips. In fact, we found that 66 percent (64 of 97) of BOP facilities work with at least 1 external provider that requires a pre-colonoscopy evaluation appointment prior to scheduling the actual colonoscopy.

Additionally, we found that the requirement for a pre-colonoscopy evaluation appointment by external providers had a significant effect for the inmates in our timeliness analysis, adding an average of 4 months to the total time it took the BOP to complete an inmate's colonoscopy. Specifically, inmates who first required a pre-colonoscopy evaluation appointment waited an average of 10 months compared to 6 months for inmates who did not have to complete a pre-colonoscopy evaluation appointment. Moreover, we found that that the pre-colonoscopy evaluation appointment, on average, took 4 months to complete. In Table 8 below, we summarize the number of completed colonoscopies and the average wait time by the BOP's initial follow-up action.

Table 8

Average Number of Months Between Positive Screening and Colonoscopy

Follow-up Actions	Number of Inmates	Average Number of Months
Completed a pre-colonoscopy evaluation appointment and then a colonoscopy	62	10
Completed a colonoscopy	69	6

Note: This table does not include two inmates who completed a second FIT or gFOBT and then a colonoscopy.

Source: OIG analysis of a sample of BEMR data

Several of the BOP clinical providers we interviewed stated that they believe that the pre-colonoscopy evaluation appointment is a burden on BOP facilities. These appointments may not be medically necessary, given that we found that about 34 percent (33 of 97) of BOP facilities work with external providers that do not require a pre-colonoscopy evaluation prior to scheduling a colonoscopy. Interviewees stated that, ultimately, facilities must comply with the steps required by the external providers they work with. This is especially true for cases in which there is a limited number of external providers in the community to perform colonoscopies for BOP inmates.

Among the 64 facilities for which at least 1 external provider requires a pre-colonoscopy appointment, 55 percent (35 of 64) have in their network only 1 provider that performs colonoscopies. As a result, facilities' ability to provide timely healthcare may be limited by the requirements imposed by external providers. However, we believe that there are opportunities for BOP facilities to work with external providers in the local community to find alternatives that would reduce the need for a separate, external medical trip for a pre-colonoscopy evaluation appointment. Some facilities are already using alternatives, as discussed below:

- **Telehealth for Pre-Colonoscopy Evaluations.** Among the 64 facilities that work with at least 1 external provider that requires a pre-colonoscopy evaluation prior to a colonoscopy, 8 facilities have providers that conduct telehealth appointments. While this does not entirely reduce the burden on BOP employees, telehealth allows the Health Services, Custody, and Transportation Departments to focus on external medical appointments that cannot be conducted virtually. There may be room for expansion of telehealth consultations, as 32 of the 97 BOP facilities already use telehealth for appointments with external providers in other specialties.

- **On-site Visits for Pre-Colonoscopy Evaluations.** Among the 64 facilities that work with at least 1 external provider that requires a pre-colonoscopy evaluation prior to a colonoscopy, 9 facilities work with providers that perform on-site consultations at the facility. This eliminates the need to transport inmates off site for the appointments.

- **Working with External Providers to Eliminate the Pre-colonoscopy Evaluation.** As noted above, 34 percent (33 of 97) of BOP facilities work with external providers that do not require a pre-colonoscopy evaluation prior to scheduling a colonoscopy. From our interviews with RMDs, we learned that strong working relations between a facility's CD and external providers may allow facilities to eliminate the need for pre-colonoscopy evaluation appointments. Additionally, strong relationships may prevent unnecessary redundancies, such as those described in the text box below.

Inmate Case Study: Repeat Pre-Colonoscopy Evaluations

An inmate at Federal Correctional Complex (FCC) Victorville experienced significant delays and unnecessary redundancies following a positive CRC screening result. The BOP sent him to three separate pre-colonoscopy evaluation appointments with the same external provider over 2 years. Each time the provider recommended a colonoscopy, however, the BOP never sent the inmate for the actual colonoscopy. There was no documentation explaining why the repeated evaluations were necessary or why the colonoscopy never occurred. The OIG is concerned about the breakdown in communication that appears to have occurred between the CD and external providers, which resulted in this redundancy.

Source: OIG review of inmate medical records

While each of the above alternatives may not be feasible at every BOP facility, we believe that the BOP could benefit from closer exploration of these options to eliminate or reduce a time-consuming and possibly unnecessary step in the process of completing inmate colonoscopies. Therefore, we recommend that the BOP consider strategies and practices to eliminate the need for off-site pre-colonoscopy evaluations at each facility and develop and distribute best practices for establishing relationships with external providers in the community.

More Than Half of the Colonoscopy Appointments We Reviewed Occurred After Their Target Dates, with Limited Information Available on the Causes of the Delays

One mechanism BOP facilities use to attempt to ensure that medical appointments are scheduled and conducted in a timely manner is to assign a target date and priority level for each appointment. The CD or a Utilization Review Committee reviews the appointment's target date and priority level to determine whether they should be adjusted based on the severity and circumstances of the inmate's medical condition.[19]

[19] If an inmate is experiencing a medical emergency, the Utilization Review Committee process is circumvented and the inmate is provided care as quickly as possible.

Health Services employees we interviewed reported a variety of target time frames generally ranging from 30 to 120 days for routine appointments and 7 to 30 days for urgent appointments. From our sample of 327 inmates who received a positive CRC screening result between January 2022 and December 2023, we looked at the 133 inmates in our timeliness analysis. Of those completed colonoscopies, 54 percent (72 of 133) of the appointments occurred after their target date.[20] In the text box, we describe a case in which external appointments repeatedly occurred well beyond the target date. Delays in care can pose serious risks to an inmate's health outcomes.

Inmate Case Study: Delayed Follow-up

In February 2021, Frederick Bardell died of metastatic colon cancer 9 days after being released from FCI Seagoville following a compassionate release order. In July 2020, Bardell told medical staff that he had been seeing blood in his stool for 8 months by the time he reported symptoms to Health Services. Over the next 6 months, Bardell had a pre-colonoscopy evaluation with a gastroenterologist, an unsuccessful colonoscopy due to poor bowel preparation, and a successful colonoscopy that ultimately led to his CRC diagnosis. However, each of these appointments occurred weeks to months later than its target date. Bardell ultimately received a diagnosis of adenocarcinoma only 2 weeks before his death. We describe this case in greater detail in the Case Studies section of the report.

Source: OIG review of inmate medical records

Through our review of Bureau Electronic Medical Records System (BEMR) records and interviews with BOP Health Services employees at facilities and Regional Offices, we identified several other points in the colonoscopy process where delays and impediments can occur. There is limited data available on how these factors affect colonoscopy timeliness, as well as how frequently they occur; but they include the following:

- **Inmate Participation.** Interviewees reported that inmates not wanting to complete the bowel preparation, which at many facilities occurs in the Special Housing Unit, was a common reason for inmates refusing a colonoscopy. As stated earlier, inmates can sign a Medical Treatment Refusal form at any point to refuse a CRC screening or a colonoscopy. Signing a refusal does not preclude future care, and one interviewee reported that inmates who refuse a colonoscopy sometimes decide to have the procedure at a later date. While this is ultimately a positive outcome for inmate care, it adds time to the process as appointments need to be rescheduled.

- **Inmate Colonoscopy Preparation Completion.** During bowel preparation, in addition to abstaining from solid foods, inmates are required to consume a prescription laxative 24 hours prior to their colonoscopy to ensure clear images during the procedure. If the bowel preparation is inadequate, the colonoscopy cannot be properly completed and the appointment has to be rescheduled. During interviews, BOP Health Services employees stated that some inmates find the prescription laxative unpleasant and are unable or unwilling to consume all of it, which can affect the success of the colonoscopy preparation.

- **Employee Coordination.** The need for interdepartmental coordination within BOP facilities can present a challenge to completing colonoscopies. Facilitating an inmate's bowel preparation requires coordination among the Health Services Department to order the bowel preparation and inform the

[20] We note that BOP employees can adjust the target date of an appointment after it has been set and there is no way to track whether the date had been changed. Therefore, it is possible that this is an undercount of inmates whose colonoscopy appointment exceeded the target date.

other departments, the Custody Department to move the inmate to the space used for bowel preparation, and the Food Services Department to provide liquid meals in lieu of solid food. If bowel preparation does not occur because of mistakes in any of these departments, the colonoscopy must be rescheduled.

- **Colonoscopy Providers.** The number of colonoscopy providers available to the BOP may be limited due to the facility's location, providers' willingness to treat BOP inmates, and/or uncompetitive fee and pay structures. Over half of BOP facilities (50 of 97) reported to us that they rely on a single provider to perform colonoscopies. In addition, colonoscopy providers serve the broader community and local demand for specialist services affects appointment availability and wait times.

- **Custody and Transport Staffing.** Facilities are generally limited in the number of external medical trips into the community that they can schedule each weekday given the availability of Custody employees to escort inmates to their appointments.[21] Facilities reported being able to schedule anywhere from 1 to 14 trips a day, with complexes and medical centers generally allowing more trips per day than other facilities. In addition to caps on the number of external medical trips that can be scheduled each weekday, facilities sometimes lack the requisite Custody employees to transport inmates on the day of the appointment.[22] This can result in an appointment cancellation, require the appointment to be rescheduled, and contribute to timeliness concerns.

- **Inmate Transfers.** Although, as discussed above, a consultation order follows an inmate transferred to another BOP facility, a transferred inmate may experience a delay in care while a clinical provider at the receiving facility reviews whether the consultation is still medically necessary and either cancels the inmate's pending consultation or reorders it for scheduling with a local external provider. If the local external provider requires a pre-colonoscopy evaluation appointment, that can further increase the wait time, as we discussed above. From our review of inmate cases, we found that canceled appointments frequently have no documentation in the inmate's medical files indicating why these changes were made, which may affect an inmate's continuity of care after the transfer.

In addition to timeliness concerns, delays, interruptions, and restarts can have downstream repercussions on inmate health outcomes and facility relationships with external providers. For example, an inmate who has completed the bowel preparation, but whose appointment is canceled, may be reluctant to repeat the process. Additionally, external providers may grow frustrated by repeated cancellations, which in turn may worsen relations between the facility and the community. According to one interviewee, in some cases a canceled appointment may result in a financial penalty that the facility must pay to the external provider.

During interviews, some facilities described how they identified and addressed these challenges. For example, Federal Detention Center (FDC) Philadelphia had expressed difficulty in coordinating transportation to external medical appointments, especially for pretrial inmates, whose transportation requires coordination with the U.S. Marshals Service or state-level agencies. To address these challenges,

[21] Facilities do not limit the transport of inmates to hospitals during medical emergencies.

[22] The OIG previously reported on external medical appointment cancellations at FMC Devens and FCI Sheridan because BOP employees were not available to escort inmates to the appointments. See Appendix 2, Items II and VI.

FDC Philadelphia implemented a common calendar, containing information related to inmates' upcoming medical trips for colonoscopy, which it sends to the agency responsible for transporting the inmates to their appointments. FCC Hazelton utilized a similar strategy to mitigate issues with interdepartmental communications, sending to all departments a weekly email listing all patients undergoing colonoscopy preparation and external medical trips for the week.

We observed that reasons for delayed and rescheduled appointments are not consistently documented in BEMR. Therefore, we cannot assess how frequently these factors affect an inmate's colonoscopy timeline. In turn, we question whether the BOP has a clear picture of how these factors affect external medical appointments. While some delays may be outside the BOP's control, appropriate oversight would allow the BOP's clinical providers to assess when additional actions may be necessary. In December 2024, the BOP issued a new template for documenting Utilization Review Committee meeting minutes, with the aim of ensuring that policy requirements for the meetings are met and "to foster uniformity, improve documentation quality, and enhance operational efficiency." The new template instructions state that "it is imperative to review the status of past due consultations," and BOP Central Office officials stated that the new template is intended to help facilities identify delays and take steps to address them. BOP Central Office officials told us that they expect Utilization Review Committees to document reasons for each appointment delay, as well as intended next steps, in the meeting template or in the consultation requests in BEMR. However, the guidance documents we reviewed do not state this expectation, so it is not clear whether facilities will ultimately use the Utilization and Review process in a way that will ensure consistent documentation and action to address causes of delays for individual inmate appointments.

The OIG identified deficiencies with the BOP's recordkeeping with regard to canceled and rescheduled appointments in a 2022 audit report and issued a recommendation to address these issues.[23] Specifically, the report recommended that the BOP implement a reliable, consistent process throughout all facilities to monitor wait times for outside inmate appointments and the causes for canceled or rescheduled appointments to ensure that inmates receive timely medical care. Our findings in this report reiterate the need for a consistent process to monitor the causes of appointment cancellations and rescheduling, which would allow the BOP to identify trends and challenges that may need to be addressed. As such, we reiterate the recommendation from the 2022 audit report and will coordinate the resolution of the recommendation for the two reports together.

Gaps Exist in the BOP's Processes to Identify, Monitor, and Document Future Screening Needs for Inmates at Increased Risk for CRC

In addition to providing CRC screening for the average-risk inmate population, the BOP is also responsible for identifying and screening the increased-risk inmate population. According to the BOP's clinical guidance, an inmate is considered at increased risk for CRC if they have a history of CRC in their medical record; a family history of CRC; genetic predispositions, such as Lynch syndrome; inflammatory bowel disease, such as ulcerative colitis; or a history of polyps discovered during a prior colonoscopy. The BOP's guidance stipulates that, if an inmate is classified as being at increased risk, the clinical provider should follow American Cancer Society (ACS) screening recommendations. The ACS summarizes screening recommendations from other professional medical organizations for several types of risk factors, noting that a screening schedule depends on the specifics of the individual's risk factors. For example, some

[23] See Appendix 2, Item VII.

individuals with a family history of colon cancer may need more frequent colonoscopies, possibly beginning before age 45, while others can be screened using the average-risk guidelines. In Table 9 below, we summarize screening recommendations for specific risk factors.

Table 9

Screening Recommendations by Individual Risk Factor

Risk Factor	Recommended Screening
Family history of colon cancer	Depending on the family member and age of diagnosis: • average-risk guidelines possibly applicable • more frequent colonoscopies, possibly starting before age 45
History of polyp removal	Colonoscopy 3 years after polyp removal, perhaps sooner or later depending on size, type, and number of polyps
Previous incidence of colon or rectal cancer	Regular colonoscopies starting 1 year after surgery to remove cancer
Previous incidence of radiation to the abdomen or pelvic region as a form of cancer treatment	Colonoscopy or stool-based test starting 10 years after radiation was received or at age 35, whichever is later More frequent screening, such as a colonoscopy every 3–5 years
Inflammatory bowel disease (e.g., Crohn's disease or ulcerative colitis)	Colonoscopy (not FIT or gFOBT) starting at least 8 years after diagnosis, with follow-up colonoscopies every 1–3 years
Genetic syndromes, e.g., Lynch syndrome or familial adenomatous polyposis	Colonoscopy (not FIT or gFOBT) starting as early as the teenage years, with frequent follow up colonoscopies

Source: ACS

Despite the BOP's guidance for screening inmates at increased risk for CRC, we found that the BOP does not have a way to accurately and comprehensively identify the entire increased-risk population due to limitations within BEMR. As a result, clinical providers are limited in their ability to order the appropriate CRC screening for increased-risk inmates. Furthermore, we found that there is limited oversight into whether clinical providers are appropriately screening and monitoring increased-risk inmates. Finally, the OIG identified that the BOP does not have a standardized method to document future CRC screening needs for increased-risk inmates within BEMR. Consequently, there is a risk that inmates will not receive recommended care due to differences in how employees use BEMR.

The BOP Does Not Have a Complete and Accurate Way to Identify the Entire Increased-Risk Population

As of May 2024, the BOP identified 9,588 inmates potentially at increased risk for CRC. However, we found that the BOP cannot identify the true increased-risk population because of limitations within BEMR. BEMR does not have a dedicated field to specify that an inmate is at increased risk for CRC. Instead, the BOP compiles an increased-risk roster in its CRC Screening Dashboard based on two types of information from BEMR: (1) a small set of International Classification of Diseases-10 (ICD-10) diagnosis codes, which are used

for standardized documentation and reporting of patient diagnoses across the medical community, and (2) whether the inmate previously completed a colonoscopy while in BOP custody.

The OIG identified limitations with the use of these two types of information to compile the increased-risk roster. For the first, we found that the ICD-10 diagnosis codes used to populate the increased-risk roster do not cover the full list of possible increased-risk factors. Specifically, the increased-risk roster does not incorporate ICD-10 codes for family history of CRC, previous incidence of radiation to the abdomen, or genetic syndromes. Further, we found that some of the ICD-10 codes incorporated in the increased-risk roster are not consistently used within BEMR. For example, we identified cases in which inmates had a history of polyps documented in their medical record, but not using the ICD-10 code, which would prompt inclusion in the increased-risk roster. The BOP reported that, while additional ICD-10 codes could be incorporated into the increased-risk roster, one limitation of using ICD-10 codes is that they require providers to manually enter the codes. The BOP reported that keeping diagnosis codes up-to-date and reconciling inmate diagnosis lists has been an ongoing challenge.

For the second type of information used to compile the increased-risk roster, whether the inmate previously completed a colonoscopy while in BOP custody, the BOP does not have a way to differentiate between inmates with normal and abnormal colonoscopy results, as they are stored as scanned documents rather than data fields that could be queried. As a result, the BOP's increased-risk roster includes even inmates who had a normal colonoscopy while in BOP custody to make sure that those at increased risk due to an abnormal colonoscopy are captured. Of the 9,588 inmates identified as potentially at increased risk, 85 percent (8,143 of 9,588) are included merely because they had a colonoscopy, regardless of the result of the colonoscopy. Finally, while unrelated to the technical limitations of BEMR and the CRC Screening Dashboard, BOP Health Services employees told the OIG that the medical record is limited by what inmates know about their own medical and family history and what they choose to share with BOP clinical providers.

BOP employees responsible for the CRC Screening Dashboard emphasized that the increased-risk roster should be used to help BOP clinical providers identify inmates who may be at an increased risk for CRC, but that providers should consider each inmate individually. However, by properly identifying the entire increased-risk population, the BOP could ensure that increased-risk inmates are receiving individualized screening based on their specific risk factors, which could prevent future harms of CRC. The limitations of the tools that exist hinder the BOP's ability to identify and monitor increased-risk inmates who may require additional screenings or medical interventions. Therefore, we recommend that the BOP develop and distribute guidance on how to consistently input ICD-10 codes for CRC increased-risk factors within BEMR so clinical providers can more completely and accurately identify inmates at increased risk for CRC. Once this is complete, we further recommend that the BOP ensure that increased-risk inmates are properly categorized in the increased-risk roster within the CRC Screening Dashboard based on their specific risk factor(s) (e.g., family history).

The BOP Lacks Sufficient Oversight to Ensure that the Increased-Risk Population Is Being Appropriately Screened and Monitored

The OIG did not review whether appropriate screening occurred for individual inmates identified as being at increased risk for CRC, in part because of the individualized nature of screening recommendations for this population. Instead, we considered the oversight the BOP performs on appropriate screening and monitoring for inmates at increased risk for CRC. We found that the BOP lacks sufficient oversight

mechanisms to ensure that inmates identified as being at increased risk for CRC are appropriately screened and monitored. A BOP Central Office official told us that the peer review process, which evaluates professional care given by BOP providers, including Clinical Directors (CD), would be the most likely oversight mechanism for assessing whether appropriate screening of inmates at increased risk is occurring. However, four of the five Regional Medical Directors (RMD) we interviewed stated that the peer review process was an inadequate oversight mechanism to ensure appropriate identification and screening practices for the increased-risk population. We reviewed documentation of the peer review process for BOP physicians and CDs and found that it does not specifically examine management of inmates at increased risk for CRC. One RMD noted that the only way that an increased-risk inmate would be reviewed is if one of those case files was randomly selected during the peer review process. The absence of a consistent review mechanism means that there may be limited feedback on clinical decisions concerning the increased-risk population, which, in turn, could lead to variations in quality of care provided. Without appropriate oversight and quality control, clinical providers may be missing opportunities for early detection and intervention. Therefore, we recommend that the BOP institute or append to the current peer review process for CDs and other BOP physicians who directly supervise clinical employees, as appropriate, an evaluation of the management of inmates at increased risk for CRC.

The BOP Does Not Have a Standardized Method in BEMR for Documenting the Timing of Future Screening for Inmates at Increased Risk for CRC

We found that the BOP lacks a standardized method in BEMR for documenting the type and frequency of future screening for inmates at increased risk for CRC. Depending on the individual's increased-risk factors, future FIT or gFOBT screening and/or a colonoscopy may be necessary. For example, an inmate who previously had polyps removed may have to return for another colonoscopy after 3 years; however, depending on the type, size, and number of polyps detected, the inmate may need to return earlier. RMDs attributed the lack of uniform BEMR documentation to variation in clinical provider preferences. Though it is the clinical provider's responsibility to order and follow up with future screening for increased-risk inmates, there is a lack of standardized provider documentation and workflow in BEMR. In turn, this creates a potential risk that CRC screening and follow-up could be affected by providers' ability to find relevant information in the medical record.

During our review of increased-risk inmates' medical records, and through interviews with RMDs, we identified three distinct methods BOP clinical providers use to document future screening needs:

1. The clinical provider immediately orders an external consultation for the next colonoscopy, regardless of how far in the future it will be. An interviewee who preferred this method told the OIG that it was useful because consultation orders follow inmates if they transfer to another BOP facility. However, we observed variation in how facilities handle pending consultations after inmate transfers, so there is still a risk that the consultation order could be canceled.

2. The clinical provider schedules a chart review of the inmate's medical record the year before the next screening is due. An interviewee who preferred this method told the OIG that a chart review is less likely to be canceled than an external consultation order if the inmate transfers to another BOP facility. However, this method requires the provider conducting the chart review to identify the need for and to order the screening. When the frequency of screening can be as long as 10 years between colonoscopies and the level of documentation can vary, there is a risk that a provider could miss

that a colonoscopy had occurred a decade ago and make clinical determinations about needed screening based on incomplete information.

3. The clinical provider updates the inmate's list of current diagnoses to reflect a history of colonoscopy or polyp removal and includes the date for the next screening as a comment. However, as noted above, the BOP reported that ensuring that inmate current diagnosis lists are up-to-date has been an ongoing challenge.

These three techniques are intended to make it easier for BOP providers to know when an inmate at increased risk for CRC needs future screening. However, as described above, there are limitations to each of the techniques. Furthermore, the fact that the BOP uses multiple documentation methods undercuts what each technique is trying to address: the risk that future preventive screening for increased-risk inmates is overlooked. Therefore, we recommend that the BOP standardize the process for ordering, or otherwise documenting within BEMR, when a future screening is required for inmates at increased risk for CRC.

Case Studies on CRC Screening and Clinical Follow-up

The OIG conducted in-depth, independent medical reviews for two high-profile BOP inmates, Robert Hanssen and Frederick Bardell, who died of CRC. In the case of Robert Hanssen, we found a lack of proper follow-up medical care and documentation after Hanssen received multiple positive guaiac fecal occult blood test (gFOBT) results.[24] Frederick Bardell also experienced inadequate care due to significant delays in the timeliness of his care following suspected CRC.[25] Each case study illustrates common challenges in CRC screening and follow-up within the BOP and how the lack of proper follow-up and oversight may have contributed to these deaths. We discuss them below.

Robert Hanssen: No Documented Follow-up Care

On June 5, 2023, at age 79, BOP inmate Robert Hanssen died while incarcerated at Administrative Maximum Facility (ADX) Florence, Colorado. At the time of his death, the BOP assumed that Hanssen died of natural causes given his medical history of multiple chronic conditions; however, following his autopsy, the BOP learned that Hanssen died of colon cancer, specifically, metastatic colon adenocarcinoma.

According to Bureau Electronic Medical Records System (BEMR) records, between 2016 and 2022 Hanssen had eight gFOBTs conducted at ADX Florence and three of those tests returned positive. In Table 10, we provide the date of each gFOBT and the result.

In response to Hanssen's first positive gFOBT in June 2019, a BOP mid-level provider counseled him to agree to a colonoscopy.[26] Hanssen expressed reluctance, so instead the mid-level provider ordered

Table 10

Robert Hanssen's CRC Screenings in BOP Custody

gFOBT Date	Result
February 9, 2016	Negative
April 11, 2017	Negative
June 6, 2018	Negative
June 1, 2019	Positive
June 22, 2019	Positive
May 23, 2020	Negative
June 15, 2021	Positive
July 4, 2022	Negative

Source: OIG review of inmate medical records

[24] Hanssen was a Supervisory Special Agent with the Federal Bureau of Investigation when he was arrested for spying for Russia and the former Soviet Union, and he is considered to have been the most damaging spy in FBI history. He pled guilty to espionage and other charges and in 2002 was sentenced to life in prison.

[25] In an order dated October 4, 2022, Judge Roy B. Dalton, Jr., in the U.S. District Court, Middle District of Florida, who had previously reviewed Mr. Bardell's petitions for compassionate release, recommended that the Attorney General, the OIG, or other appropriate investigative offices undertake an examination into the conditions of Mr. Bardell's confinement and treatment, as well as the BOP's alleged misrepresentations to the court. The OIG initiated an investigation, which is ongoing, in response to the allegations in Judge Dalton's order. See DOJ OIG, Press Release, "Department of Justice Office of the Inspector General Announces Initiation of Investigation," October 14, 2022, oig.justice.gov/news/ department-justice-office-inspector-general-announces-initiation-investigation-0.

[26] In the BOP, mid-level providers are physician assistants, nurse practitioners, and unlicensed medical graduates who provide health care under a Practice Agreement with a licensed physician.

a second gFOBT to confirm the positive result. The second gFOBT also returned positive. The mid-level provider documented the test results in BEMR and noted that Hanssen should have a colonoscopy. However, there is no record in BEMR that a colonoscopy was discussed with Hanssen, nor is there any record that a colonoscopy consultation was ordered or that Hanssen signed a Medical Treatment Refusal form.

Because of his age, Hanssen received another gFOBT in May 2020 as part of routine CRC screening under the BOP's Preventive Health Care Screening Clinical Guidance (clinical guidance). This gFOBT returned negative, and therefore he was not tested again for another year. In June 2021, Hanssen was screened again for CRC and the test returned positive. In response to this positive test, a BOP mid-level provider added an administrative note in BEMR to record the positive gFOBT and noted that Hanssen was scheduled for a chronic care appointment with a BOP physician in July 2021. Similar to the two positive gFOBT screenings in 2019, there is no record in BEMR that a colonoscopy was ordered, refused, or discussed with Hanssen at that chronic care appointment or at any other point following the 2021positive test. Finally, Hanssen's last gFOBT, in July 2022, returned a negative result. Following each set of positive gFOBT screenings, in June 2019 and June 2021, there was a contradicting negative result. Although the gFOBT can yield false-positive results, there was no indication in the records of clinical follow-up with Hanssen to determine whether that was the case.

According to BOP records, between 2022 and his death in June 2023, Hanssen had several interactions with BOP clinical providers to discuss his diagnosed chronic conditions, such as diabetes. Additionally, he went to sick call for treatment related to urinary concerns and lower-abdominal pain. In response, the BOP prescribed Hanssen antibiotics for a urinary tract infection (UTI) and, following his return to sick call with similar concerns, a mid-level provider performed an abdominal examination but noted no abnormalities. However, there is no indication of what part, if any, of Hanssen's medical record was reviewed during these clinical encounters, so it is unclear whether the mid-level provider considered Hanssen's history of positive gFOBT results at those times. Following Hanssen's autopsy, the coroner reported a bladder fistula, an abnormal connection between the bladder and colon, which had led to his recurring UTIs; the BOP's medical opinion was that the bladder fistula was most likely a result of the invasion of adjacent colon cancer into the bladder wall. During Hanssen's incarceration, he was treated multiple times for urinary problems; however, the records did not reflect that medical personnel fully investigated why Hanssen had repeated urinary concerns. If there had been, the OIG's independent medical expert believes that clinical providers might have been able to link them to CRC.

Following Hanssen's death, the BOP completed a Multi-Level Mortality Review and a Root Cause Analysis to assess whether, clinically and correctionally, the facility had provided Hanssen appropriate medical care and, if not, to identify areas for improvement and provide recommendations to prevent recurrence.[27] The BOP found, as did the OIG in our independent medical review, a failure by the BOP to follow up on Hanssen's positive gFOBT results. Specifically, BEMR records failed to demonstrate any discussion with Hanssen about his positive gFOBT in June 2019, June 2021, or during his annual chronic care appointments. Additionally, records failed to demonstrate that a colonoscopy consultation was ordered or that Hanssen refused the colonoscopy and signed a Medical Treatment Refusal form. Following the Multi-Level Mortality Review and Root Cause Analysis, ADX Florence developed a risk-reduction strategy that includes a

[27] The OIG has previously described the Multi-Level Mortality Review and Root Cause Analysis processes. See Appendix 2, Item VIII.

standardized process for how positive gFOBT results will be communicated to clinical providers, as well as a renewed expectation that a colonoscopy consultation will be ordered or that a signed Medical Treatment Refusal form will be added to the inmate's electronic medical record.

Given the concerns with ADX Florence's lack of follow-up actions on Hanssen's two sets of positive gFOBT results, as well as concerns regarding clinical providers' review of Hanssen's medical record when he reported to sick call for UTIs and lower abdominal pain, the OIG spoke with ADX Florence's Clinical Director (CD) and Health Services Administrator, as well as the Regional Medical Director (RMD) for the BOP's Western Region, which oversees ADX Florence. The RMD and CD both stated that, in their view, Hanssen had not been neglected given the frequency and extent of his clinical encounters with providers. However, they acknowledged that ADX Florence did not satisfy the BOP's expectations regarding internal documentation of follow-up on the positive gFOBT results.

The BOP is responsible for the care and safekeeping of its inmates. We agree with the BOP's Multi-Level Mortality Review and Root Cause Analysis that the BOP failed in its responsibility to appropriately follow up on Hanssen's multiple positive gFOBT results. We also concluded that the BOP failed to ensure that it maintained proper documentation and accurate healthcare records. Documentation is crucial, not only for continuity of care, but also for accountability purposes. Without proper documentation, it is impossible to determine, both in Hanssen's case and other similar cases, whether the lack of CRC screening compliance was due to Health Services employees' failure to comply with the BOP's clinical guidance or whether inmate refusal to follow recommended medical care was a contributing factor. Hanssen's case study demonstrates the importance of having standardized follow-up procedures for positive fecal immunochemical test and gFOBT screenings, as well as appropriate follow-up documentation.

Frederick Bardell: Significantly Delayed Follow-up Care

On February 17, 2021, Frederick Bardell died at age 54 of metastatic colon cancer 9 days after he was released from Federal Correctional Institution (FCI) Seagoville pursuant to a compassionate release order. The OIG has initiated a separate investigation into the circumstances surrounding Bardell's release from prison and subsequent death. When our investigation is concluded, we will proceed with our usual process for releasing our findings publicly in accordance with relevant laws and DOJ and OIG policies. In this report, we summarize Bardell's CRC screening history and delays in diagnostic examinations to highlight the importance of timeliness of care; the challenges of healthcare in the BOP; and how these factors, individually and when combined, can lead to poor healthcare outcomes.

Between February 2017 and September 2019, Bardell was offered three CRC screenings. As seen in Table 11 below, Bardell refused the gFOBT twice and completed one test, which returned negative in 2019.

Table 11

Frederick Bardell's CRC Screenings in BOP Custody

gFOBT Date	BOP Location	Decision	Result
February 10, 2017	FCI Jesup	Refused	N/A
April 3, 2018	FCI Seagoville	Refused	N/A
September 9, 2019	FCI Seagoville	Accepted	Negative

Source: OIG review of inmate medical records

On July 15, 2020, Bardell reported to sick call at FCI Seagoville, complaining about blood in his stool and changes in his bowel movements. During this encounter, Bardell relayed that he first started seeing blood in his stool 8 months prior but that his symptoms had increased in frequency and severity. In response, the BOP ordered laboratory tests and a diagnostic colonoscopy consultation with an external gastroenterologist. This colonoscopy consultation was marked as "urgent," with a target date of July 27, 2020. However, this pre-colonoscopy evaluation appointment with a gastroenterologist was not completed until October 2, nearly 3 months after his initial sick call appointment and more than 2 months after the target date.

During the intervening months, Bardell's laboratory tests were completed and reviewed by an FCI Seagoville physician. In an administrative note dated September 9, 2020, the physician wrote that Bardell had an elevated carcinoembryonic antigen marker.[28] The physician ordered an urgent computed tomography (CT) scan of Bardell's abdomen and pelvis. The CT scan, completed on September 17, revealed localized areas of wall thickening and narrowing of the sigmoid colon, as well as multiple lesions of various and significant sizes throughout the liver. According to the BOP physician, these results were "highly suspicious for metastatic disease and should be considered as such until proven otherwise." In response, the BOP ordered an oncology consultation marked "urgent" with a target date of October 29, 2020. We found no documentation that Bardell received the urgent oncology consultation.

During Bardell's pre-colonoscopy evaluation appointment with the external gastroenterologist on October 2, the gastroenterologist reviewed the CT scan, discussed Bardell's symptoms, and recommended a colonoscopy and esophagogastroduodenoscopy (EGD). Following the colonoscopy consultation with the gastroenterologist, the BOP ordered the colonoscopy and EGD with a target date of October 12, 2020. However, Bardell's colonoscopy and EGD were not completed until December 18, more than 2 months after the target date and 5 months after his initial sick call encounter when he complained about the increased severity of blood in his stool.

During Bardell's procedure on December 18, 2020, both the EGD and colonoscopy were completed but the colonoscopy was noted to be poorly visualized and deemed unsuccessful due to poor bowel preparation. As a result, the gastroenterologist recommended that Bardell return for another colonoscopy and the BOP

[28] Carcinoembryonic antigen markers are protein indicators used to help identify certain types of cancer, including CRC.

complied, ordering the procedure with a target date of January 8, 2021. However, the BOP set the priority status as "routine" despite prior clinical encounter documentation in BEMR emphasizing urgency.

On January 29, 41 days after Bardell's unsuccessful colonoscopy and less than 3 weeks before his death, Bardell underwent his second colonoscopy. This time, the bowel preparation was successful; during the procedure, several colonic polyps were removed and evidence of a circumferential and obstructing rectal mass was detected and biopsied.

On February 3, 5 days following his successful colonoscopy, Bardell reported to sick call and complained of severe weakness, abdominal pain, loss of appetite, and weight loss. In the examination notes, the BOP indicated that Bardell had evidence of jaundice and symptoms indicative of liver disease. Later that afternoon, Bardell's colonoscopy and biopsy results were returned to the BOP and the pathologist's note confirmed adenocarcinoma with focal invasion, meaning that the cancer started in colorectal cells and began to invade nearby tissues. After reviewing the pathologist's report, the BOP ordered an urgent positron emission tomography scan with a target date of February 9, 2021, and an urgent surgical consultation with a target date of February 23.

On February 8, 2021, Bardell was released from FCI Seagoville pursuant to a court order that granted him compassionate release. He passed away 9 days later, on February 17. On October 4, 2022, the court held the BOP in contempt for releasing Bardell from FCI Seagoville without waiting for a release plan, in disregard of the court order. In response to the information contained in the court order, the OIG initiated an investigation, which is currently ongoing, of the conditions of Bardell's confinement and treatment and possible misrepresentations to the court in connection with Bardell's case.

During this OIG evaluation, we identified several serious areas of concern in our review of Bardell's electronic medical record. First, Bardell had to wait months for a colonoscopy despite the conditions he reported during his sick call visit on July 15, 2020; the laboratory results on September 9, 2020; and the CT scan results on September 17, 2020. Second, there is no evidence that Bardell was seen in FCI Seagoville's medical clinic between the initial sick call on July 15, 2020, and the sick call on February 3, 2021. As a result, nearly all of Bardell's medical documentation is either from external specialists, such as the gastroenterologist and pathologist, or administrative notes from FCI Seagoville's mid-level providers or physicians who never examined Bardell directly. Third, there was no documentation of Bardell having an oncology consultation, despite an urgent order placed on September 22, 2020. Fourth, Bardell's last visit to sick call on February 3, 2021, 2 weeks before his death, showed significant concern of cancer progression, yet urgent actions were not taken. Finally, Bardell was not seen by external providers for consultations, which the BOP ordered and marked urgent, by their target dates. Ultimately, the BOP is responsible for timely clinical care and clinical procedures for inmates and Bardell's case study illustrates the serious dangers that can occur when medical care is delayed.

Conclusion and Recommendations

Conclusion

The BOP's Preventive Health Care Screening Clinical Guidance (clinical guidance) recommends that inmates at average risk receive annual CRC screening starting at age 45 and stopping at age 75 and that appropriate follow-up care be provided for inmates who have a positive screening result. We found significant issues in the BOP's screening and clinical follow-up policies and procedures, including failure to screen all inmates ages 45–75 per medical community guidelines, a lack of oversight to ensure the proper screening and monitoring of inmates at increased risk, and a lack of timely follow-up for all inmates who have had a positive screening result. These issues can negatively affect health outcomes for inmates in BOP custody.

We observed failures by BOP facilities to comply with the BOP clinical guidance for screening inmates for CRC. As of April 2024, across all BOP facilities, less than two-thirds of inmates eligible for CRC screening had been offered a screening, with less than half of the inmates ultimately screened. Screening rates among facilities varied significantly, with some offering little to no screening and others offering screenings to a large portion of the eligible inmate population. Deficiencies in CRC screening resulted from employee vacancies, the de-prioritization of preventive healthcare due to low staffing levels, methods of administering annual screenings, and inmate noncompliance. We noted that inmates not offered CRC screenings are at higher risk of adverse health outcomes.

The BOP's clinical guidance also recommends that inmates who receive a positive CRC screening result receive a colonoscopy to identify the underlying cause. However, we found that the BOP's medical records for 10 percent of inmates in our sample of inmates with a positive screening result had no documentation indicating that any follow-up had occurred after the positive CRC screening. The lack of documentation is concerning because lack of follow-up poses a potentially serious risk to inmates' health, as seen in the case of Robert Hanssen. In addition, we found that inmates who did receive follow-up care after a positive CRC screening result often experienced lengthy wait times for colonoscopies and the case of Frederick Bardell demonstrates the potentially serious dangers of delayed inmate care. While some of the factors contributing to lengthy colonoscopy wait times, such as the number of available external providers in the community, may be outside the BOP's control, the BOP is ultimately responsible for ensuring that inmates receive critical medical care in timely fashion, and we found that the BOP can take a number of steps to address delays. These include building relations with external providers; standardizing how changes to appointments are documented; and improving coordination between the Custody, Food Services, and Health Services Departments. Additionally, the BOP can develop a systematic way to track the reasons for colonoscopy appointment cancellation or rescheduling so that it can better assess how to reduce their incidence.

Finally, recommended CRC screening may vary for inmates at increased risk for CRC, based on their individual risk factors. We found, however, that the BOP does not have an accurate roster of all inmates at increased risk within its care due to limitations in the Bureau Electronic Medical Records System. The BOP also lacks a sufficient oversight mechanism to monitor CRC screening for the increased-risk inmate population and to document the timing of future screening. As a result, the BOP lacks the ability to ensure that the increased-risk population is being appropriately screened.

Recommendations

To improve routine CRC screening for inmates at average risk for CRC, identification and oversight of screening for inmates at increased risk for CRC, and timely follow-up on positive CRC screening results, we recommend that the BOP:

1. Evaluate the colorectal cancer screening practices of the 40 facilities that are meeting the sustained, demonstrated, or developed colorectal cancer screening performance levels and use that assessment to identify any best practices that may be effective BOP-wide.

2. Require each BOP facility to develop a written plan for consistent colorectal cancer screening that details: how the facility will identify the average-risk population; the screening process, to include timeframes; assigned employee responsibilities; and plans for providing colorectal cancer screening education to inmates. Each facility's evaluation should take into account staffing challenges and the other factors identified in this report that contribute to the BOP's failure to consistently offer colorectal cancer screening, as well as any best practices identified during the BOP's evaluation of the 40 facilities referenced in the report.

3. Establish a process for the Central or Regional Offices to periodically review the facilities' written colorectal cancer screening and education plans and to work with the facilities to make changes to the plans that address new and ongoing factors that affect the ability to consistently provide screening.

4. Transition to using the fecal immunochemical test as the primary stool-based screening method for colorectal cancer.

5. Update the Preventive Health Care Screening Clinical Guidance and National Performance Measures to match the age range described in the U.S. Preventive Services Task Force and American Cancer Society recommendations on preventive colorectal cancer screening.

6. Require facilities to review positive fecal immunochemical test and guaiac fecal occult blood test results from the past 12 months to determine whether appropriate follow-up on positive test results occurred in all cases, and develop an after-action plan to correct deficiencies, which could include developing standardized guidance and training to ensure that appropriate follow-up occurs and is properly documented, as needed.

7. Consider strategies and practices to eliminate the need for off-site pre-colonoscopy evaluations at each facility.

8. Develop and distribute best practices for facilities to establish relationships with external medical providers in the community.

9. Implement a reliable, consistent process throughout all BOP facilities to monitor and analyze wait times for outside inmate appointments and the causes for canceled or rescheduled appointments in order to ensure that inmates receive timely medical care.

10. Develop and distribute guidance on how to consistently input International Classification of Diseases-10 codes for colorectal cancer increased-risk factors within the Bureau Electronic Medical Records System so they can more completely and accurately identify inmates at increased risk for colorectal cancer.

11. Following completion of Recommendation 10, ensure that increased-risk inmates are properly categorized in the increased-risk roster within the Colorectal Cancer Screening Dashboard based on their specific risk factor(s) (e.g., family history).

12. Institute or append to the current peer review process for Clinical Directors and other BOP physicians who directly supervise clinical employees, as appropriate, an evaluation of the management of inmates at increased risk for colorectal cancer.

13. Standardize the process for ordering, or otherwise documenting within the Bureau Electronic Medical Records System, when a future screening is required for inmates at increased risk for colorectal cancer.

Appendix 1: Purpose, Scope, and Methodology

Standards

The OIG conducted this evaluation in accordance with the Council of the Inspectors General on Integrity and Efficiency's Quality Standards for Inspection and Evaluation (December 2020).

Purpose and Scope

The OIG initiated this evaluation in April 2024 to examine the BOP's provision of CRC screening to inmates and clinical follow-up of CRC screening test results. This evaluation sought to (1) analyze the completion of preventive CRC screening for BOP inmates at average risk and at increased risk for CRC, (2) analyze the completeness and timeliness of follow-up processes for inmates who receive a positive screening result, and (3) contextualize the CRC screening processes using case studies. As part of our analysis, we sought to identify any potential deficiencies and systematic issues in providing care for inmates.

The scope of this evaluation encompassed a snapshot of CRC screening from April 2024; positive CRC screenings that occurred between January 2022 and December 2023; and the subsequent follow-up care, especially colonoscopies, that the inmates received. We also conducted a limited review of CRC screening history for (1) average-risk inmates BOP-wide between January 2020 and April 2024 and (2) a sample of individual inmates over the period 2018–2023. The evaluation also incorporated CRC case studies including the 2021 death of former inmate Frederick Bardell and 2023 death of inmate Robert Hanssen.

Methodology

Our fieldwork spanned April–September 2024 and included document review, interviews, and data collection and analysis. The following sections provide additional information about our methodology.

Document Review

We reviewed BOP policies and guidance related to the provision CRC screening, technical information about the BOP's National Performance Measures (NPM) and CRC Screening Dashboard, and facility-level instructions that are provided to inmates along with the CRC screening materials. We also reviewed documentation surrounding CRC-related deaths, including medical records, Multi-Level Mortality Review reports, external review comments, and Root Cause Analysis reports, where applicable. Additionally, we reviewed medical community CRC screening guidance from the U.S. Preventive Services Task Force and American Cancer Society.

Interviews

We conducted video teleconference interviews with a total of 30 BOP employees at the BOP's Central Office, at 6 Regional Offices, and at 14 BOP facilities across the country. We conducted interviews at Federal Correctional Institution (FCI) Beckley, FCI Bennettsville, Federal Medical Center (FMC) Carswell, FCI Danbury, FCI Fort Dix, Federal Correctional Complex (FCC) Hazelton, FCI La Tuna, FCI Pekin, Federal Prison Camp (FPC) Pensacola, Federal Detention Center (FDC) Philadelphia, FCI Phoenix, FMC Rochester, FDC SeaTac, and FCC Victorville. We selected these facilities to represent a variety of characteristics including region, type of

facility, security level, and population size, as well as high and low CRC screening and refusal levels. See Table 12 below.

Through interviews, we sought to understand the BOP's preventive CRC screening program and how it is implemented at individual facilities, challenges and best practices related to CRC screening at individual facilities, oversight of CRC screening, and CRC screening data and dashboards.

Table 12

Summary of BOP Facilities Selected for Interviews Using CRC Screening Data from April 2024

Facility	Region	Security Level(s)	Inmates Housed	Average-Risk Population Size	% of Average-Risk Inmates with Current Screening Offer	% of Average-Risk Patients Offered Screening Who Refused	% of Average-Risk Inmates with Current Screening
FCI Beckley	Mid-Atlantic	Med, Min	Male	297	95%	1%	93%
FCI Bennettsville	Southeast	Med, Min	Male	354	70%	15%	60%
FMC Carswell	South Central	Admin	Female	282	93%	32%	63%
FCI Danbury	Northeast	Low, Min	Female, Male	345	8%	41%	5%
FCI Fort Dix	Northeast	Low, Min	Male	1,513	91%	30%	64%
FCC Hazelton	Mid-Atlantic	High, Med, Min	Female, Male	865	21%	43%	12%
FCI La Tuna	South Central	Low, Min	Male	224	97%	3%	94%
FCI Pekin	North Central	Med, Min	Female, Male	417	60%	68%	19%
FPC Pensacola	Southeast	Min	Male	205	98%	59%	40%
FDC Philadelphia	Northeast	Admin	Female, Male	12	58%	71%	17%
FCI Phoenix	Western	Med, Min	Female, Male	236	4%	40%	3%
FMC Rochester	North Central	Admin	Male	232	95%	32%	65%
FDC SeaTac	Western	Admin	Female, Male	94	94%	32%	64%
FCC Victorville	Western	High, Med, Min	Female, Male	1,085	12%	60%	5%

Note: Med=Medium; Min=Minimum; Admin=Administrative.

Source: OIG analysis of BOP data

Data Collection and Analysis

We analyzed a variety of data provided by the BOP and collected from the Bureau Electronic Medical Records System (BEMR) by the OIG to evaluate the BOP's provision of CRC screening and clinical follow-up on positive CRC screening results. Specifically, we used five different datasets to conduct our analyses:

1. April 2024 CRC Screening Snapshot. We analyzed a snapshot of April 2024 CRC screening data from the BOP's CRC Screening Dashboard to understand the BOP's CRC screening completion, screening offers, and screening refusals BOP-wide, as well as by facility. This dataset encompassed 37,942 inmates between the ages of 45 and 75 at average risk for CRC. We also examined how facility screening completion in April 2024 compared to the BOP's NPM for CRC screening.

2. Monthly CRC Screening Offer Snapshots. To examine BOP-wide screening offers over time, we analyzed a dataset of monthly snapshots of CRC screening data for average-risk inmates from January 2020 through April 2024.

3. Completed Colonoscopies. To understand the timeliness of colonoscopies for inmates in BOP custody, we analyzed a BOP dataset of colonoscopies completed between January 2022 and December 2023. These completed colonoscopies are not necessarily related to follow-up on positive stool-based screening results. We excluded 21 colonoscopies from this dataset due to potential data entry errors and ultimately analyzed the time between order and completion for 4,742 colonoscopies. We also compared the results of this analysis to the timeliness analysis conducted on a sample of inmates, as described below.

4. External Colonoscopy Providers. To understand the ways that BOP facilities work with external providers who conduct colonoscopies, we requested and analyzed data from all facilities about the number of colonoscopy providers they work with, whether the external providers require pre-colonoscopy evaluation appointments, and whether they use on-site or telehealth visits for these appointments.

5. OIG Sample of Inmates Who Had a Positive CRC Screening Result. The OIG developed a dataset using data collected from BEMR for a sample of inmates in order to support the analysis of clinical follow-up that occurred for the most recent positive CRC screening results, timeliness of the clinical follow-up, CRC screening history, and presence of increased-risk factors for the inmates in the sample. The OIG created a judgmental sample of 327 inmates who had a positive CRC screening result between January 2022 and December 2023. This sample was created from a larger dataset of 3,926 inmates who had a positive screening result during that period. We then removed any inmates not in BOP custody at the time of our data collection. From the remaining population, the OIG randomly selected inmates and collected additional healthcare information from BEMR for the inmates, including information on documented CRC risk factors, CRC screening history, external consultation orders, and colonoscopy results. If a randomly selected inmate exited BOP custody before BEMR data could be collected, they were replaced in the sample by an alternative, randomly selected inmate. A second reviewer checked and validated each piece of information collected from BEMR before we analyzed the dataset. The data validation occurred in July and August 2024, and clinical actions taken after that period are not reflected in the dataset. If data could not be validated because the inmate was no longer in custody, we removed the inmate from the sample. The final dataset contained 327 inmates who had a positive CRC screening result between January 2022 and December 2023. Using this dataset, we completed a series of analyses:

    a. To examine CRC screening history, we collected information on CRC screenings for each inmate from calendar year 2018 through 2023. For each year, we determined whether that

inmate would have been expected to receive an annual CRC screening based on their age and the recommended age range for CRC screening under the BOP Preventive Health Care Screening Clinical Guidance (clinical guidance) in place during that year. We then compared the total expected number of screenings, i.e., the number of years in which the inmate was in the age range for screening, against the number of actual screening offers, i.e., the number of years in which the inmate was offered a screening.

b. To make determinations about whether clinical follow-up on positive CRC screening results occurred, we examined whether each inmate in the sample had been offered an initial follow-up step, such as a pre-colonoscopy evaluation appointment or a retest with a fecal immunochemical test (FIT) or guaiac fecal occult blood test (gFOBT). If there was no initial follow-up step documented, we then examined whether the inmate had been offered a colonoscopy right away. If an inmate's medical records did not include documentation of either a colonoscopy order or another follow-up step taken following the positive screening result, we concluded that the inmate had no documented follow-up.

c. To make determinations about whether the 177 inmates in our sample who first received an initial follow-up action such as a pre-colonoscopy evaluation appointment or a retest with a FIT or gFOBT subsequently received appropriate follow-up care, we examined whether those inmates were ultimately offered a colonoscopy. If inmates were subsequently offered a colonoscopy, we concluded that they had received appropriate follow-up care according to the BOP's clinical guidance, which recommends following a positive stool-based screening result with a colonoscopy. If inmates were not subsequently offered a colonoscopy, we then examined whether the rationale for not offering a colonoscopy had been documented in the medical records. If we did not identify documentation explaining the rationale for not offering a colonoscopy, we concluded that there was insufficient documentation to determine whether appropriate follow-up care had occurred.

d. To determine whether inmates in our sample received appropriate follow-through on clinical follow-up actions, we examined colonoscopy completion data for the 246 inmates in our sample who had been offered a colonoscopy, including 117 who were offered a colonoscopy right away and 129 who were offered a colonoscopy after completing a different initial follow-up action. If inmates had a completed colonoscopy or a pending colonoscopy at the conclusion of our data collection and validation in August 2024, or if they had a documented colonoscopy refusal, we concluded that they had received, or were receiving, appropriate follow-through. If inmates had neither a completed or pending colonoscopy nor a documented refusal, we then examined whether there was documentation in BEMR explaining why the offered colonoscopy was no longer needed. If we did not identify documentation noting why the colonoscopy would not be occurring, we concluded that there was insufficient documentation to determine whether appropriate follow-up care had occurred.

e. To assess the timeliness of follow-up after a positive CRC screening result, we started with the subset of 145 inmates who had a completed colonoscopy following their positive CRC screening result by the time we concluded our data collection and validation in August 2024. Due to limitations in the way we collected the data from BEMR, we had to exclude

12 inmates from the timeliness analysis because their most recent positive screening result occurred after the colonoscopy had already been ordered. The remaining 133 inmates in the analysis all had a positive screening result, followed by a colonoscopy order leading to the colonoscopy. Using this subset of 133 inmates, we examined the average wait time between a positive screening result and completed colonoscopy. We also compared differences in wait times for inmates who first had to complete a pre-colonoscopy evaluation appointment and those who did not. For this analysis, we further excluded the two cases in which the inmates had first received a retest with FIT or gFOBT before completing a colonoscopy, as the cohort was too small for us to draw meaningful conclusions. Additionally, we examined the wait time between the colonoscopy order and completed colonoscopy for the 133 inmates in our timeliness analysis and compared it to the timeliness of all colonoscopies completed between January 2022 and December 2023, as described above. As a final timeliness analysis, we compared colonoscopy completion dates against the target dates for the appointments, which the BOP uses to specify how soon the appointments should occur, to determine how frequently appointments occurred outside of the timeframes in which the BOP would have expected them to occur.

External Subject Matter Experts Assisting the OIG

To assist the OIG in its efforts to collect data from BEMR, review clinical documents, and make assessments about the medical care provided to inmates, the OIG contracted the services of three healthcare subject matter experts: one physician and two registered nurses.

Appendix 2: DOJ OIG and Other Oversight Agency Related Work

I. For prior OIG reporting on **delays in CRC screening**, see DOJ OIG, *Inspection of the Federal Bureau of Prisons' Federal Correctional Institution Lewisburg*, Evaluation and Inspections (E&I) Report 24-113 (September 2024), oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-lewisburg.

II. For prior OIG reporting on **CRC screening offers** and **external medical appointment cancellations**, see DOJ OIG, *Inspection of the Federal Bureau of Prisons' Federal Medical Center Devens*, E&I Report 25-009 (December 2024), oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-medical-center-devens.

III. For prior OIG reporting on the **BOP's medical staffing challenges**, see DOJ OIG, *Review of the Federal Bureau of Prisons' Medical Staffing Challenges*, E&I Report 16-02 (March 2016), oig.justice.gov/reports/review-federal-bureau-prisons-medical-staffing-challenges.

IV. For additional prior OIG reporting on the **BOP's medical staffing challenges and the effect on health services during the coronavirus disease 2019 (COVID-19) pandemic**, see Pandemic Response Accountability Committee, *Review of Personnel Shortages in Federal Health Care Programs During the COVID-19 Pandemic* (September 2023), www.oversight.gov/reports/other/review-personnel-shortages-federal-health-care-programs-during-covid-19-pandemic (accessed February 24, 2025).

V. For additional prior OIG reporting on **the effects of the COVID-19 pandemic on BOP Health Services operations**, see DOJ OIG, *Capstone Review of the Federal Bureau of Prisons' Response to the Coronavirus Disease 2019 Pandemic*, E&I Report 23-054 (March 2023), oig.justice.gov/reports/capstone-review-federal-bureau-prisons-response-coronavirus-disease-2019-pandemic.

VI. For prior OIG reporting on **external medical appointment cancellations**, see DOJ OIG, *Inspection of the Federal Bureau of Prisons' Federal Correctional Institution Sheridan*, E&I Report 24-070 (May 2024), oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-sheridan.

VII. For prior OIG reporting on **the BOP's ability to track canceled and rescheduled appointments**, see DOJ OIG, *Audit of the Federal Bureau of Prisons Comprehensive Medical Services Contracts Awarded to the University of Massachusetts Medical School*, Audit Report 22-052 (March 2022), oig.justice.gov/reports/audit-federal-bureau-prisons-comprehensive-medical-services-contracts-awarded-university.

VIII. For prior OIG reporting on **the Multi-Level Mortality Review and Root Cause Analysis processes**, see DOJ OIG, *Evaluation of Issues Surrounding Inmate Deaths in Federal Bureau of Prisons Institutions*, E&I Report 24-041 (February 2024), oig.justice.gov/reports/evaluation-issues-surrounding-inmate-deaths-federal-bureau-prisons-institutions.

Appendix 3: The BOP's Response to the Draft Report

U.S. Department of Justice

Federal Bureau of Prisons

Office of the Director *Washington, DC 20534*

May 2, 2025

MEMORANDUM FOR ALLISON RUSSO
ASSISTANT INSPECTOR GENERAL
EVALUATION AND INSPECTIONS

FROM: William K. Marshall III 05/02/2025
William K. Marshall III, Director

SUBJECT: Response to the Office of Inspector General's (OIG) Draft Report: Evaluation of the Federal Bureau of Prisons' Colorectal Cancer Screening Practices for Inmates and Its Clinical Follow-up on Screenings

The Federal Bureau of Prisons (Bureau) thanks the Office of Inspector General (OIG) for its thorough evaluation and appreciates the opportunity to formally respond to the draft report entitled, "Evaluation of the Federal Bureau of Prisons' Colorectal Cancer Screening Practices for Inmates and Its Clinical Follow-up on Screenings."

The Bureau recognizes the importance of timely colorectal cancer screening. If detected early, colorectal cancer has a 5-year survival rate of 90%, with survival declining steeply the later it is caught. Colorectal cancer screening is sometimes avoided due to fear, embarrassment, or anxiety about the test or potential results. Additionally, the importance of screening may not be fully understood by patients, especially if they feel healthy or are unaware of their options. While the Bureau has issued extensive guidance on preventive health care delivery and expectations for community-standard care, longstanding staffing issues have unfortunately compromised efforts to implement a sustainable and consistent screening process for colorectal cancer in some Bureau facilities. However, the Bureau is fully committed to its ongoing efforts to improve in these areas and to that end, offers the following responses to OIG's recommendations.

Recommendation 1: Evaluate the [colorectal cancer] CRC screening practices of the 40 facilities that are meeting the sustained, demonstrated, or developed colorectal cancer screening performance levels and use that assessment to identify any best practices that may be effective BOP-wide.

FBOP Response: The Bureau concurs with this recommendation. Importantly, the Bureau notes that differing institutional demographics/characteristics may play a role in determining which best practices indicated as meeting the sustained, demonstrated, or developed colorectal cancer screening performance levels in the assessment referenced above are translatable for application at other Bureau facilities. As an example, a process considered best practice at a Bureau medical center, may also be best practice for other medical and Care3 facilities; however, it may be determined this same practice lacks efficiency at mainline Care1 and Care2 medical facilities and the Bureau's detention facilities. Accordingly, the Bureau's Health Services Division (HSD) will solicit examples of "best practices" from the 40 facilities meeting the sustained demonstrated or developed performance levels for colorectal cancer screening and will methodically develop a plan for evaluating and disseminating best practices.

Recommendation 2: Require each BOP facility to develop a written plan for consistent colorectal cancer screening that details: how the facility will identify the average-risk population; the screening process, to include timeframes; assigned employee responsibilities; and plans for providing colorectal cancer screening education to inmates. Each facility's evaluation should take into account staffing challenges and the other factors identified in this report that contribute to the BOP's failure to consistently offer colorectal cancer screening, as well as any best practices identified during the BOP's evaluation of the 40 facilities referenced in the report.

FBOP Response: The Bureau concurs with this recommendation. Upon determination of best practices, completed through adherence to recommendation 1, HSD will evaluate the identified best practices and develop instructions and templates for implementation of the modalities determined most successful in completing CRC screening and education on the topics of Colorectal Cancer and associated screening to assist facilities in the development of a local written plan. If the written plan denotes new/altered duties specific to a particular employee or position description, the facility will ensure it is subjected to the appropriate development and review process.

Recommendation 3: Establish a process for the Central or Regional Offices to periodically review the facilities' written colorectal cancer screening and education plans and to work with the facilities to make changes to the plans that address new and ongoing factors that affect the ability to consistently provide screening.

FBOP Response: The Bureau concurs with this recommendation. The Bureau will establish a process for its regional offices to periodically review facility-specific written CRC plans. Regional reviews will include an evaluation of both the plans/curriculum for educating the inmate population, as well as the need for revisions to the plan itself based on each facility's ongoing level of performance on the National Performance Measure (NPM) related to Colorectal Cancer screening. NPMs are a set of standardized metrics used to assess and compare the performance of clinicians at all Bureau facilities. The NPMs aim to identify areas for improvement in quality of healthcare delivery, preventative health, and chronic disease

management. HSD believes that this process of periodic review will result in appropriately addressing new and ongoing factors that may affect consistent screening.

Recommendation 4: Transition to using the fecal immunochemical test as the primary stool-based screening method for colorectal cancer.

FBOP Response: The Bureau concurs with this recommendation. The Bureau sees the benefits of FIT over gFOBT for Colorectal Cancer Screening and has already begun to take action toward meeting this recommendation. The Bureau will update preventive health clinical guidance to recommend use of FIT for CRC screening over gFOBT unless a clinically compelling reason exists to use the gFOBT method, as determined by the medical provider ordering the screen. Updating the relevant preventative health clinical guidance will facilitate the transition to using the Fecal Immunochemical Test as the primary stool-based screening method for Colorectal Cancer.

Recommendation 5: Update the Preventive Health Care Screening Clinical Guidance and National Performance Measures to match the age range described in the U.S. Preventive Services Task Force and American Cancer Society recommendations on preventive colorectal cancer screening.

FBOP response: The Bureau concurs with this recommendation. The Bureau has already updated the HSD dashboards[1] that capture CRC screening information to match the age range described in the U.S. Preventive Services Task Force and American Cancer Society recommendations on Preventive Colorectal Cancer Screening.

Additionally, the Bureau recently updated and reissued its Preventive Health Care Screening Clinical Guidance in December 2024. The new guidance recommends annual Colorectal Cancer screening for patients aged 45 through 75. The Bureau's NPMs, noted previously in the response to recommendation 3, are currently undergoing an update and will reflect a similar language clarification (recommending screening for patients aged 45 and over). The NPM update is anticipated to be issued in summer 2025.

Recommendation 6: Require facilities to review positive fecal immunochemical test and guaiac fecal occult blood test results from the past 12 months to determine whether appropriate follow-up on positive test results occurred in all cases, and develop an after-action plan to correct deficiencies, which could include developing standardized guidance and training to ensure that appropriate follow-up occurs and is properly documented, as needed.

---

[1] The HSD dashboards are a collection of nearly 50 business intelligence and clinical decision support tools created over the last seven years which utilize available data, primarily from BEMR and Sentry. Access and security are targeted to users based on specific locations and roles, including all health services clinical and administrative staff at the institution, region, and Central Office levels, Wardens, and the Bureau's Executive Team.

FBOP Response: The Bureau concurs with this recommendation. The Bureau is currently determining the most effective plan to require facilities to review positive Fecal Immunochemical Test and Guaiac Fecal Occult Blood Test results from the past 12 months to determine whether appropriate follow-up on positive test results occurred in all cases. If deficiencies in proper follow-up exist, the Bureau will develop and begin implementation of appropriate after-action plans to increase the level of compliance of appropriate follow-up procedures for positive test result with the eventual goal ensuring follow-up in all instances where a positive test result occurs.

Recommendation 7: Consider strategies and practices to eliminate the need for off-site pre-colonoscopy evaluations at each facility.

FBOP Response: The Bureau concurs with this recommendation. The Bureau is currently working to expand its telehealth capabilities. A survey was recently deployed to all institution Health Services Administrators (HSAs) and Telehealth Coordinators requesting them to provide updated information on available hardware and other possible barriers to implementation. HSD is currently awaiting the responses from the HSAs and Telehealth Coordinators and will determine whether and how to use these survey results to inform expanding telehealth capabilities and provide operational support where needed. Pre-colonoscopy evaluations are generally well-suited for the use of telehealth. As institution comprehensive contracts are renewed, contract language is being updated to include telehealth services. Therefore, as more sites implement telehealth programs, the Bureau will work to include pre-colonoscopy visits via telehealth where the comprehensive medical contract will allow.

Recommendation 8: Develop and distribute best practices for facilities to establish relationships with external medical providers in the community.

FBOP Response: The Bureau concurs with this recommendation. The Bureau will develop and distribute best practices for facilities to establish relationships with community-based, external medical providers. In determining which best practices to distribute to the HSAs, HSD will develop a plan to review and analyze best practice options to ensure that they are supported by appropriate medical literature in peer reviewed resources for use in a correctional setting prior to determining whether to recommend them for widespread use among Bureau facilities.

Best practices approved by HSD for widespread dissemination will be distributed to HSAs during future field calls facilitated by HSD and will be posted to the Bureau's Sallyport (intranet) page intended to share and distribute best practices. As stated in the Bureau's response to recommendation 1, above, differing institutional demographics/characteristics may play a role in determining which best practices are translatable for application at other Bureau facilities.

Recommendation 9: Implement a reliable, consistent process throughout all BOP facilities to monitor and analyze wait times for outside inmate appointments and the causes for canceled or rescheduled appointments in order to ensure that inmates receive timely medical care.

FBOP Response: The Bureau concurs with this recommendation. The Bureau has engaged the software vendor for the Bureau Electronic Medical Record (BEMR) to create an enhancement to meet the requirements of this recommendation. That enhancement has been created and is currently under testing. Implementation of the enhancement is dependent upon the results of testing. Once this BEMR enhancement has been implemented it will generate structured data which will be collected and analyzed to determine causes of delays to timely medical care.

Recommendation 10: Develop and distribute guidance on how to consistently input International Classification of Diseases-10 codes for colorectal cancer increased-risk factors within the Bureau Electronic Medical Records System so they can more completely and accurately identify inmates at increased risk for colorectal cancer.

FBOP Response: The Bureau concurs with this recommendation. The Bureau will explore options to develop and distribute guidance on how to consistently input International Classification of Diseases-10 codes for Colorectal Cancer increased-risk factors within BEMR to more completely and accurately identify inmates at increased risk for colorectal cancer. Specifically, HSD will review what options are available in BEMR to capture and code risk factors accurately and consistently across all facilities. Once these procedures are developed, HSD will update and reissue its Preventive Health Care Screening Clinical Guidance to the field with this information and instructions included.

Recommendation 11: Following completion of Recommendation 10, ensure that increased-risk inmates are properly categorized in the increased-risk roster within the Colorectal Cancer Screening Dashboard based on their specific risk factor(s) (e.g., family history).

FBOP Response: The Bureau concurs with this recommendation. As changes to coding are implemented as outlined above in recommendation 10, the HSD dashboards will be updated to reflect the impact of those changes. The resulting updates will ensure that inmates at increased risk are properly categorized in the increased-risk roster within the Colorectal Cancer Screening Dashboard based on specific risk factors.

Recommendation 12: Institute or append to the current peer review process for Clinical Directors and other BOP physicians who directly supervise clinical employees, as appropriate, an evaluation of the management of inmates at increased risk for colorectal cancer.

FBOP Response: The Bureau concurs with this recommendation. The Bureau will ensure the inclusion of CRC screening and overall facility performance as part of each Clinical Director's or supervisory clinician's peer review for those roles involved in direct patient care. The Bureau has already begun a comprehensive evaluation of its peer review and privileging process, which will afford the Bureau the opportunity to make these updates.

Recommendation 13: Standardize the process for ordering, or otherwise documenting within the Bureau Electronic Medical Records System, when a future screening is required for inmates at increased risk for colorectal cancer.

FBOP Response: The Bureau concurs with this recommendation. The Bureau will include in a future update to the Preventive Health clinical guidance recommendations for either ordering or documenting future CRC screening needs. The standardized approach will also be included in the written CRC plan noted above in recommendation 2. It is anticipated that this action will standardize practice between facilities, leading to fewer missed screening windows as patients transfer between facilities.

Appendix 4: OIG Analysis of the BOP's Response

The OIG provided a draft of this report to the BOP for its comment. The BOP's response is included in Appendix 3 to this report. The OIG's analysis of the BOP's response and the actions necessary to close the recommendations are discussed below.

Recommendation 1

Evaluate the colorectal cancer screening practices of the 40 facilities that are meeting the sustained, demonstrated, or developed colorectal cancer screening performance levels and use that assessment to identify any best practices that may be effective BOP-wide.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation. The BOP noted that differing institution demographics and characteristics may play a role in determining which best practices are translatable to other BOP facilities. Accordingly, the BOP stated that the Health Services Division (HSD) will solicit examples of best practices from the 40 facilities meeting the sustained, demonstrated, or developed performance levels for CRC screening and will methodically develop a plan for evaluating and disseminating best practices.

OIG Analysis: The BOP's planned actions are responsive to this recommendation. By August 20, 2025, please provide documentation of the HSD's solicitation of best practices for CRC screening and its plan for evaluating and disseminating the best practices.

Recommendation 2

Require each BOP facility to develop a written plan for consistent colorectal cancer screening that details: how the facility will identify the average-risk population; the screening process, to include timeframes; assigned employee responsibilities; and plans for providing colorectal cancer screening education to inmates. Each facility's evaluation should take into account staffing challenges and the other factors identified in this report that contribute to the BOP's failure to consistently offer colorectal cancer screening, as well as any best practices identified during the BOP's evaluation of the 40 facilities referenced in the report.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation. The BOP stated that, upon determination of best practices completed as part the BOP's response to Recommendation 1, the HSD will evaluate identified best practices and develop instructions and templates for implementation of the modalities determined most successful in completing CRC screening and education on CRC topics to assist facilities in the development of a local written plan. The BOP further stated that, if facilities' written plans denote new or altered duties specific to a particular employee or position description, facilities will ensure that the plans are subjected to the appropriate development and review process.

OIG Analysis: The BOP's planned actions are responsive to this recommendation. By August 20, 2025, please provide examples of the instructions and templates developed to assist facilities in creating local written plans for CRC screening, if the BOP's determination of best practices in response to Recommendation 1 has been completed. Otherwise, please provide an estimated timeline for the development of these materials.

Recommendation 3

Establish a process for the Central or Regional Offices to periodically review the facilities' written colorectal cancer screening and education plans and to work with the facilities to make changes to the plans that address new and ongoing factors that affect the ability to consistently provide screening.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation. The BOP stated that it would establish a process for its Regional Offices to periodically review facility-specific written CRC plans. The BOP specified that the reviews will include an evaluation of both the plans and the curriculum for educating the inmate population, as well as the need for revisions to the plans based on each facility's ongoing level of performance in the National Performance Measures (NPM) related to CRC screening. The BOP's HSD believes that this process of periodic review will result in the BOP appropriately addressing new and ongoing factors that may affect consistent screening.

OIG Analysis: The BOP's planned actions are responsive to this recommendation. By August 20, 2025, please provide documentation showing the establishment of the Regional Office periodic review process for facility-specific written CRC screening plans or an estimated timeline for the establishment of this process. Once facility-specific written CRC screening plans have been created as part of the BOP's response to Recommendation 2 and the Regional Office review process has started, please provide documentation that review of facility-specific written plans is occurring.

Recommendation 4

Transition to using the fecal immunochemical test as the primary stool-based screening method for colorectal cancer.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation. The BOP stated that it sees the benefits of the fecal immunochemical test (FIT) over the guaiac fecal occult blood test (gFOBT) and has begun to take action toward meeting the recommendation. The BOP stated that it will update preventive health clinical guidance to recommend the use of FIT for CRC screening unless a clinically compelling reason exists to use the gFOBT method, as determined by the medical provider ordering the screening.

OIG Analysis: The BOP's actions are responsive to this recommendation. By August 20, 2025, please provide a copy of the updated Preventive Health Care Screening Clinical Guidance recommending the use of FIT for CRC screening. If the updated guidance has not yet been issued, please provide an estimated timeline for its issuance.

Recommendation 5

Update the Preventive Health Care Screening Clinical Guidance and National Performance Measures to match the age range described in the U.S. Preventive Services Task Force and American Cancer Society recommendations on preventive colorectal cancer screening.

Status: Resolved.

BOP Response: The BOP concurred with the recommendation. The BOP stated that it has updated the HSD dashboards that capture CRC screening information to match the age range described in the U.S. Preventive Services Task Force and American Cancer Society recommendations on preventive CRC screening. The BOP further stated that it updated and reissued its Preventive Health Care Screening Clinical Guidance in December 2024 and that the new guidance recommends annual CRC screening for patients ages 45 through 75. Finally, the BOP stated that it is updating its NPM, which will reflect a similar language clarification about screening, and that it anticipates issuing the updated NPM in the summer of 2025.

OIG Analysis: The BOP's actions are responsive to this recommendation. By August 20, 2025, please provide: (1) a copy of the updated Preventive Health Care Screening Clinical Guidance and (2) a copy of the updated NPM. If the updated guidance has not yet been issued, please provide an estimated timeline for issuance.

Recommendation 6

Require facilities to review positive fecal immunochemical test and guaiac fecal occult blood test results from the past 12 months to determine whether appropriate follow-up on positive test results occurred in all cases, and develop an after-action plan to correct deficiencies, which could include developing standardized guidance and training to ensure that appropriate follow-up occurs and is properly documented, as needed.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation. The BOP stated that it is currently determining the most effective method to require facilities to review positive CRC screening results from the past 12 months to determine whether appropriate follow-up on positive test results occurred in all cases. If deficiencies exist, the BOP will develop appropriate after-action plans to increase compliance with appropriate follow-up procedures for positive test results.

OIG Analysis: The BOP's actions are responsive to this recommendation. By August 20, 2025, please provide a copy of the plan to require facilities to determine whether appropriate follow-up on positive CRC screening test results occurred in all cases. If the plan has not been completed, please provide an estimated timeline for completion.

Recommendation 7

Consider strategies and practices to eliminate the need for off-site pre-colonoscopy evaluations at each facility.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation. The BOP stated that it recently administered a survey to all Health Services Administrators and Telehealth Coordinators to provide information on available hardware and other possible barriers to implementing telehealth. The BOP further stated that the HSD will then determine whether and how to use the survey results to inform expanding telehealth capabilities. The BOP also plans to update institutions' comprehensive contracts to include telehealth services as they are renewed and will work to include pre-colonoscopy via telehealth where the comprehensive medical contract will allow.

OIG Analysis: The BOP's actions are responsive to this recommendation. By August 20, 2025, please provide: (1) documentation of the survey results informing the expansion of telehealth and (2) examples of amended comprehensive contracts to include pre-colonoscopy visits via telehealth, if available. If documentation is not yet available, please provide an estimated timeline for completion.

Recommendation 8

Develop and distribute best practices for facilities to establish relationships with external medical providers in the community.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation. The BOP stated that it will develop and distribute best practices for facilities to establish relationships with community-based, external medical providers. The BOP also stated that the HSD will develop a plan to review and analyze best practice options to ensure that they are supported by peer-reviewed medical literature for use in correctional settings, prior to determining whether to recommend them for widespread use among BOP facilities, and that approved best practices will be disseminated through field calls and posted on the BOP's intranet.

OIG Analysis: The BOP's actions are responsive to this recommendation. By August 20, 2025, please provide a copy of the BOP's best practices for establishing relationships with community-based, external medical providers, as well as documentation demonstrating the dissemination of the identified best practices. If the best practices are still under development, please provide an estimated timeline for completion.

Recommendation 9

Implement a reliable, consistent process throughout all BOP facilities to monitor and analyze wait times for outside inmate appointments and the causes for canceled or rescheduled appointments in order to ensure that inmates receive timely medical care.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation. The BOP stated that it engaged the software vendor for the Bureau Electronic Medical Records System (BEMR) to create an enhancement to meet the requirements of this recommendation and that the enhancement is currently under testing. The BOP reported that the BEMR enhancement, once implemented, will generate structured data, which will be collected and analyzed to determine causes of delays to timely medical care.

OIG Analysis: The BOP's actions are responsive to this recommendation. This recommendation mirrors Recommendation 10 from the OIG's 2022 *Audit of the Federal Bureau of Prisons Comprehensive Medical Services Contracts Awarded to the University of Massachusetts Medical School* (UMass Audit Report), and the OIG will handle the resolution of this recommendation in both reports, together.[29] As such, the BOP's status updates regarding actions taken to address UMass Audit Report Recommendation 10 will fulfill the BOP's resolution obligation to keep the OIG informed of action it has taken to address the recommendation from the current report. The OIG will coordinate internally the analysis of BOP updates relevant to this recommendation in the context of both reports. As of the issuance of the current report, UMass Audit Report Recommendation 10 remains resolved; therefore, the recommendation from the current report is resolved.

Recommendation 10

Develop and distribute guidance on how to consistently input International Classification of Diseases-10 codes for colorectal cancer increased-risk factors within the Bureau Electronic Medical Records System so they can more completely and accurately identify inmates at increased risk for colorectal cancer.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation. The BOP stated that it will explore options to develop and distribute guidance on how to consistently input International Classification of Diseases-10 (ICD-10) codes for CRC increased-risk factors within BEMR to completely and accurately identify inmates at increased risk for CRC. Further, the BOP stated that it will review available options within BEMR to capture this information. The BOP stated that it will update and reissue its Preventive Health Care Screening Clinical Guidance to include this guidance.

OIG Analysis: The BOP's actions are responsive to this recommendation. By August 20, 2025, please provide a copy of the updated Preventive Health Care Screening Clinical Guidance that includes guidance on how to consistently input ICD-10 codes for CRC increased-risk factors into BEMR. If the updated guidance has not yet been issued, please provide an estimated timeline for its issuance.

Recommendation 11

Following completion of Recommendation 10, ensure that increased-risk inmates are properly categorized in the increased-risk roster within the Colorectal Cancer Screening Dashboard based on their specific risk factor(s) (e.g., family history).

Status: Resolved.

BOP Response: The BOP concurred with this recommendation. The BOP stated that it will update HSD dashboards to reflect the effects of the changes introduced in its response to Recommendation 10.

[29] DOJ OIG, *Audit of the Federal Bureau of Prisons Comprehensive Medical Services Contracts Awarded to the University of Massachusetts Medical School*, Audit Report 22-052 (March 2022), oig.justice.gov/reports/audit-federal-bureau-prisons-comprehensive-medical-services-contracts-awarded-university.

OIG Analysis: The BOP's actions are responsive to this recommendation. By August 20, 2025, please provide documentation showing the updates to the HSD dashboards. If HSD dashboards have not yet been updated, please provide an estimated timeline for implementing the changes.

Recommendation 12

Institute or append to the current peer review process for Clinical Directors and other BOP physicians who directly supervise clinical employees, as appropriate, an evaluation of the management of inmates at increased risk for colorectal cancer.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation. The BOP stated that it will include CRC screening and facility performance as part of each Clinical Director's or supervisory clinician's peer review for roles involved in direct inmate patient care. The BOP stated that it will have the opportunity to make these updates as part of an ongoing evaluation of its peer review and privileging process.

OIG Analysis: The BOP's actions are responsive to this recommendation. By August 20, 2025, please provide documentation showing the CRC screening and facility performance additions, including any specific to inmates at increased risk for CRC, to the peer review process. If the updates to the peer review process are still in process, please provide an estimated timeline for their completion.

Recommendation 13

Standardize the process for ordering, or otherwise documenting within the Bureau Electronic Medical Records System, when a future screening is required for inmates at increased risk for colorectal cancer.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation. The BOP stated that it will update its Preventive Health Care Screening Clinical Guidance with recommendations for ordering or documenting future CRC screening needs. Further, the BOP stated that it will include this information in the written plans developed in response to Recommendation 2.

OIG Analysis: The BOP's actions are responsive to this recommendation. By August 20, 2025, please provide a copy of the updated Preventive Health Care Screening Clinical Guidance that describes ordering or documenting future CRC screening needs. If the updated guidance has not yet been issued, please provide an estimated timeline for its issuance. Once instructions and templates for facility-written plans for CRC screening have been developed as part of the BOP's response to Recommendation 2, please also provide copies to demonstrate the inclusion of the approach for ordering or documenting future CRC screening needs.