Vermont Department of Corrections

Request for Proposals

Project Title: Comprehensive Health Services

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1 REQUEST FOR PROPOSAL (RFP) OVERVIEW

1.1 Request for Proposal Objective

The Vermont Department of Corrections (herein referred to as the "DOC" or the "State") is soliciting proposals for comprehensive health services for incarcerated individuals. The State may enter into a contract to have the selected offeror (herein referred to as the "Contractor" or the "Offeror") perform the work outlined in Section 5 – Scope of Work. This request for proposals (RFP) provides details on what is required to submit a proposal in response to this RFP, how proposals will be evaluated, and what will be required of the Contractor in performing the work.

1.2 RFP Overview

1. The DOC is responsible for ensuring healthcare is provided to incarcerated individuals. The DOC Health Services Division (HSD) oversees a comprehensive health services program that provides health services to incarcerated individuals as guaranteed by the 8th Amendment of the United States Constitution, required by state law, and in compliance with the National Commission for Correctional Health Care (NCCHC) standards for ongoing accreditation.

2. "Comprehensive health services," as used or implied within this RFP and subsequent contract(s) shall, unless otherwise noted, means an integrated, holistic system of care that includes but is not limited to medical, mental health, substance abuse, dental, vision, on-site and off-site specialty, pharmacy, care coordination, and emergency services. Comprehensive health services shall be provided to incarcerated individuals housed at any Vermont DOC facility throughout the state.

3. "The Contractor," as used or implied within this RFP and subsequent contract(s) shall, unless otherwise noted, refer to the Contractor providing comprehensive health services.

4. The Contractor shall be committed to working with all divisions within DOC as well as other departments within Vermont's Agency of Human Services (AHS). In addition, the Contractor shall be committed to working with community-based organizations including Federally Qualified Health Centers (FQHCs), Vermont's Opioid Use Disorder Treatment System "hubs and spokes," Designated Agencies (DAs), Specialized Services Agencies (SSAs), Vermont Chronic Care Initiative (VCCI), Planned Parenthood of Northern New England (PPNNE), Prisoners' Rights Office (PRO), Disability Rights Vermont (DRVT), and Vermont Information Technology Leaders (VITL). The integration of services, and the ability of the Contractor to link patients to care across all points of transition, are core requirements under this RFP.

5. This RFP is generated in consideration of the mission and vision of AHS and the Vermont DOC, as well as the goals of Vermont Act 48 *An act relating to a universal and unified health system*. The Contractor shall align the provision of comprehensive health services in DOC facilities to the extent possible with Act 48 and all other current and future health reform efforts implemented in Vermont.

6. The DOC HSD has created this RFP to represent the desired state of the comprehensive health services program. It is important to note that the contents of this RFP do not necessarily represent the current state and therefore the Contractor shall be required to submit a change management plan within the first six months of the contract to achieve the desired state over time. This RFP incorporates the basic requirements of the NCCHC standards as well as Vermont specific standard of care and requirements. Where Vermont specific standard of care is higher than that of the NCCHC, it is noted in detail.

7. The DOC HSD has created this framework of the desired state based on the current health systems as well as the future and desired health systems within the DOC and AHS. The expectation is that the DOC HSD will create and guide the implementation of health systems and the Contractor will provide the comprehensive health services necessary to carry out the DOC HSD's vision of the Comprehensive Health Services program.

1.3 General Requirements

1. The Contractor shall:
   a. Maintain NCCHC accreditation at all Vermont DOC facilities and provide services to incarcerated individuals in full compliance with the *Standards for Health Services in Prisons,* 2018 Edition, or any subsequent edition published by NCCHC. If the requirements listed in the RFP and subsequent contract(s) represent a higher standard of care than that of NCCHC standards, the RFP and subsequent contract(s) language will apply.
   b. Comply with all current and future state and federal law, DOC policies, directives, rules, interim memos, Memorandums of Understanding (MOUs), intergovernmental agreements, settlement agreements and stipulations (see Appendix 1 – Stipulations and Agreements), guidance documents, and AHS policies.
   c. Adjust and modify the services that are provided to comply with updates or changes to DOC policies, directives, rules, interim memos, MOUs, intergovernmental agreements, standard operating procedures, guidance documents, laws, standards, or the operational needs of the DOC.
   d. Act with integrity and transparency as a partner to the State.
   e. Maintain complete, accurate, and detailed records of all services delivered.
   f. In the event of a dispute between the Contractor and the State, defer to the authority of the DOC Health Services Director or designee.

1.4 Department Background and Philosophy

DOC is a department within Vermont's AHS. The DOC is a unified system, providing jail and prison services currently in six facilities in Vermont. In addition, the Vermont DOC facilities provide services to individuals held for the United States Marshals Service for federal detention as well as other jurisdictions. Additional information regarding Vermont correctional facilities, the volume of services provided, and the demographics of the DOC population is available on the DOC's webpage.

2 PRICE PROPOSALS & PERFORMANCE-BASED FINANCIAL MODEL

2.1 Price Proposals and Pay-for-Performance (P4P) Financial Model

1. Refer to Appendix 2 – Price Proposal PIPM Calculator and Tabs A-H. In consideration of efforts in the State to develop a single-payer financing system, the DOC is seeking price proposals that include per individual per month (PIPM) rates for comprehensive health services, pharmacy, off-site services, regional office, corporate overhead/profit, and pay-for-performance (P4P) incentives. Offerors shall complete Appendix 2 and submit it to the State as the official price proposal for years 1-5 of the contract. The price proposal includes:
   a. **Tab A. Comprehensive Health Services** – The offeror's proposed PIPM rate for comprehensive health services.
   b. **Tab B. Pharmacy** – The Offeror's proposed PIPM rate for pharmacy services including Contractor management fees.
   c. **Tab C. Off-Site Services** – The Offeror's proposed PIPM rate for all off-site services.
   d. **Tab D. Regional Office** – The Offeror's proposed PIPM rate for regional office expenses (including bonuses) and all expenses necessary to providing statewide oversight, supervision, and governance of all aspects of health service operations outlined in this RFP. This proposed total should be inclusive of all regional office employee compensation.
   e. **Tab E. P4P Incentive** – An automatic calculation of the total available P4P incentive payment per year (an amount determined by the State and the Contractor during negotiations) as a percentage of the Offeror's total annual price proposal, excluding "Corporate Overhead and Profit." Offerors shall not modify the formulas in Tab E.
   f. **Tab F. Corporate Overhead & Profit** – The Offeror's proposed PIPM rate for corporate overhead and profit. As the State operates with a limited budget, this amount will be subject to contract negotiation.
   g. **Tab G. Price Proposal Summary** – An automatic calculation of the Offeror's total price proposal for the contract. Offers shall not modify the formulas in Tab G.
   h. **Tab H. Innovative Reform Initiatives** – The Offeror's estimated PIPM rate for Innovative Reform Initiatives. Appendix 2 has been configured by the State so that the costs from Tab H are **not** considered in the Contractor's total price proposal for this RFP. In addition, the Contractor shall **not** receive the PIPM rate associated with proposed innovative reform initiatives unless the DOC Health Services Director has verified, in writing, that the financial, staffing, and other necessary resources are available to deliver an effective (including cost-effective) initiative.

2. The total PIPM rate will be based on an average daily population (ADP) between 1150-1250 individuals. The Contractor and the DOC will negotiate unique PIPM rates when the ADP is outside of that range. A change in the ADP may or may not result in a change in the PIPM or ADP range.

3. At the end of each contract year, the Contractor shall provide an annual budget-to-actual financial report which fully reconciles to the original price proposal. The Contractor and the DOC Health Services Director or designee shall determine if there are areas of overspending or areas of savings

4. If in any particular contract year the Contractor’s actual expenses in one category of the budget (e.g. Pharmaceuticals) is less than the budgeted amount the Contractor shall apply the difference in the actual and budgeted amounts (Contractor Savings) to reduce expenses that may be in excess of their budgeted amounts in another budget category.

5. In the event that the Contractor’s overall expenses are less than the overall budgeted amount, the Contractor shall submit reimbursement to the State in the amount of any Contractor Savings, and the funds shall be utilized at the discretion of the DOC Health Services Director or designee. The Contractor shall also have the opportunity to earn (e.g., as profit or as working capital to improve performance) an additional monthly amount. This shall be a percentage of the total budgeted costs of Comprehensive Health Services, Pharmaceuticals, Off-Site Services and Regional Office expenses, and shall be determined by the State and the Contractor during negotiations.

6. For each contract year:
   In the event that the Contractor’s overall expenses are more than the overall budgeted amount, the Contractor shall be responsible for the first three percent over the budgeted amount. In the event that the Contractor’s overall expenses are more than the overall budgeted amount by more than three percent, the State shall be responsible for the second three percent over the budgeted amount.
   In the event that the Contractor’s overall expenses are more than the overall budgeted amount by more than six percent, the State and the Contractor shall negotiate in good faith responsibility for additional overages and consider factors that lead to the overages.

2.2 Payment Adjustments

All performance incentives, liquidated damages, and holdbacks will be documented by the State and discussed with Contractor. If the Contractor disagrees with the findings they may submit additional material in support of the standard having been met. These materials will be reviewed by the DOC Health Services Director or designee who shall have final decision-making authority.

2.2.1 Holdbacks for Reporting and NCCHC Accreditation

1. A five percent holdback of the Contractor’s total monthly invoice may be retained if the Contractor fails to provide timely and accurate reporting requirements as outlined in Section 5.3.4 – Administrative Meetings and Reports. The State shall release the holdback for that month once the Contractor has fulfilled the reporting requirements specified here and in Section 5.3.4. If at any time there are three or more months with active holdback, the Contract Monitoring and Improvement Process outlined in Section 4.2 – Deficiencies and Contract Monitoring will automatically be initiated.

2. The Contractor shall maintain NCCHC accreditation for healthcare services for every current and future facility in the State. If certification accreditation by the NCCHC is lost at any time, a $500.00 holdback per day per non-accredited facility will be assessed against the

Contractor until the non-accredited facility(ies) receive(s) either provisional or full accreditation. If NCCHC issues provisional accreditations, the $500.00 per day/per facility will be waived up to one 180 days. The beginning and ending dates of the holdback will be governed by any written communication from the NCCHC.

2.2.2 Liquidated Damages

1. Failure to comply with the requirements of this contract and subsequently, failure on the Contractor's part to verify that deficiencies or contract compliance issues have been addressed within the specified timeframe may result in liquidated damages. The process and rate for liquidated damages will be provided during contract negotiations. Any liquidated damages deducted from the Contractor's standard monthly invoice shall not be reimbursed later.

2. Liquidated damages will be documented by the State and discussed with Contractor. If the Contractor disagrees with the findings, they may submit additional material in support of the standard having been met. These materials will be reviewed by the DOC Health Services Director or designee who shall have final decision-making authority.

3. The parties agree that liquidated damages shall not apply in situations where the Contractor's failed performance is related to events or actions outside of the control of the Contractor.

4. Refer to Section 2.2 – Payment Adjustments for more information on liquidated damages.

2.2.3 Calculating Pay-for-Performance Incentive Payments

1. Throughout this section, refer to Appendix 3 – Description of Pay-for-Performance (P4P) Metrics and Appendix 4 – Pay-for-Performance and Payment Adjustments Calculator. P4P shall be defined as: Financial incentives earned by the Contractor based upon a fixed model of performance indicators, the Contractor's actual performance for a given reporting period, and a minimum score for achievement. The Contractor shall have the opportunity to earn P4P incentives based on the proportion of the range that is achieved for a specific metric. The percentage achieved will be calculated based on the overall performance of all sites.

2. Refer to Appendix 2 – Price Proposal PIPM Calculator. To encourage the provision of high-quality services that lead to improvements in health outcomes and processes, the Contractor will have the opportunity to earn an additional amount (determined by the State and the Contractor during negotiations) of the total yearly price proposal, excluding the "Corporate Overhead and Profit" indicated on Tab F. The maximum available P4P incentive payment for the contract term will be auto-calculated in Appendix 2, Tab E and added to the Offeror's total price proposal (see Tab G), though this amount will ultimately be determined by the total overall cost proposal and the funds that are ultimately appropriated for this contract.

3. Refer to Appendix 3 – Description of Pay-for-Performance (P4P) Metrics, which will be linked to the financial incentives described above in Tab E of Appendix 2. At any time during the contract term, the State may add, eliminate, or modify any metric in Appendix 3 to reflect the priorities of the State and any quality improvement/corrective action planning that

has occurred. Changes to the set of metrics in Appendix 3 will not impact the total available amount that the Contractor could earn in additional financial incentive payments.

4. Refer to Appendix 4 – Pay-for-Performance and Payment Adjustments Calculator. This tool will be used to calculate the Contractor's monthly P4P incentive payment. For each P4P metric, the Contractor shall submit the numerator and denominator calculations to the DOC HSD, and the DOC HSD will enter the data into Appendix 4. The DOC HSD will add the calculated incentive payment to the Contractor's monthly remittance.

2.3 Catastrophic Loss

The State will cover expenses for catastrophic loss cases, defined as off-site health care expenses exceeding $85,000 per contract year, per individual. The Contractor shall be responsible for paying the initial $85,000 for catastrophic loss cases and should include these potential costs in the total PIPM price proposal. The threshold for catastrophic loss cases was derived from historical off-site financial data.

2.4 Claims Processing

The Contractor shall maintain a claims processing system that complies with all state and federal regulations.

3 INNOVATIVE INITIATIVES

3.1 Introduction

1. In addition to the Scope of Work outlines in Section 5 of this RFP, the DOC is interested in receiving proposals for innovative initiatives. These initiatives will be considered outside of the required services but may be accepted and included as part of the contract at the DOC's discretion.

2. Vermont DOC will consider new innovative initiatives that advance the objectives put forth in this RFP. Offerors shall describe the purpose of each initiative, underlying research demonstrating the initiative's potential for achieving the goals in this RFP, an implementation plan, metrics which could be used to monitor the success of the initiative, and a projection of cost.

3.2 Requested Initiatives

1. DOC is particularly interested in the innovation initiatives list below, however the Contractor may propose other initiatives.
   a. **Technology-Assisted Care (TAC) Programs** – The intent of these programs would be to increase access to assessment and treatment of suicidality, substance use and mental health disorders. Offerors could propose a specific program or multiple programs within their proposal. Technology-assisted therapy would be offered in conjunction with traditional face-to-face therapy.
   b. **Technology-Enabled Activity Tracking Program** – The intent of this program would be to improve patient's management of certain chronic diseases (e.g., diabetes, hypertension). The program would offer wearable technology devices that measure personal metrics including heart rate, sleep quality, the number of steps walked, and the number of steps climbed.
   c. **Use of Non-Pharmacological Interventions for the Management of Chronic Pain and Other Conditions** – Intervention could include but should not be limited to physical therapy, acupuncture, yoga, stress management, meditation, cryotherapy, virtual reality, and visualization.
   d. **Innovative Equipment for Medication Dispensing** – This may include crushing machines.
   e. **Behavioral Economics and Contingency Management** – The DOC is seeking innovations to use Behavioral Economics and Contingency Management theories to enhance the delivery of healthcare to improve patient outcomes. See for reference the Contingency management: what it is and why psychiatrists should want to use it, Contingency Management: Incentive for Sobriety, and What is Behavioral Economics: Helping people lead healthier lives.
   f. **Other initiatives that the Offeror would like the DOC to consider**.

4 CONTRACT MONITORING

4.1 DOC Quality Oversight and Performance Indicators

1. The DOC HSD is responsible for monitoring all aspects of care and services provided under this contract. To successfully fulfill these responsibilities, the DOC HSD will conduct regular and ad hoc chart reviews to verify and validate the delivery of services provided by the Contractor. These reviews may be scheduled in advance or may be unannounced. The DOC HSD also utilizes information and data from a variety of sources including:
   a. Grievances and appeals
   b. Electronic Health Record (EHR) reports and audits
   c. Case reviews
   d. Reports from DOC staff
   e. Communication with community providers
   f. Communication with advocate groups
   g. Constituency services

2. The Contractor shall generate reports as defined in 5.3.4 – Administrative Meetings and Reports and the Contractor shall make available other relevant information (e.g. detailed personnel records, attendance data, staff vacancy reports, clinical documentation, corporate quality improvement records, etc.) as requested by the DOC.

3. In addition, DOC contracts with a Health Services Monitor to provide third-party quality assurance functions. Audits and reviews by the Health Services Monitor will occur as requested by the DOC Health Services Director or designee. The Contractor shall comply with all requests for information by the Health Services Monitor.

4. When deficiencies are identified, the Contractor shall perform all remediation as requested by the State within a specified timeframe (see Section 4.2 Deficiencies and Contract Compliance).

5. Compliance with this section is subject to Liquidated Damages as outlined in Section 2.2.2.

4.2 Deficiencies and Contract Compliance

1. Deficiencies or contract compliance issues shall be addressed through the Contract Monitoring and Improvement process which is a component of the Continuous Quality Improvement (CQI) Program. In response to the Health Services Director's request which shall include documentation of the deficiency and the specific section of the contract where there is a deficiency or area of non-compliance, the Contractor shall create a plan for improvement that includes but is not limited to:
   a. A description of the deficiency or contract compliance issue
   b. Any barriers to addressing the issue
   c. A detailed list of actions that will occur to address the issue
   d. A detailed list of the resources necessary to address the issue
   e. A timeline for addressing the issue

    f. Status of resolution

2. All elements of the plan must be documented clearly and approved by the DOC HSD.

3. Compliance with this section is subject to Liquidated Damages as outlined in Section 2.2.2.

5 SCOPE OF WORK

5.1 Vermont DOC Requirements

While NCCHC accreditation is required and at a minimum, the NCCHC standards must be met, the DOC RFP and subsequent contract(s) have additional requirement with which the Contractor must comply. This section outlines Vermont specific RFP and subsequent contract(s) requirements that are not included within the NCCHC framework. These requirements include state and federal law, DOC policies, directives, rules, interim memos, MOUs, intergovernmental agreements, settlement agreements and stipulations (see Appendix 1), standard operating procedures, guidance documents, and AHS policies.

5.1.1 Communication Between DOC HSD and the Contractor

1. The Contractor shall maintain open communication with the DOC HSD to ensure contract compliance. Accordingly, the Contractor shall:
   a. Coordinate all activities with the DOC.
   b. Communicate with management, at each correctional facility, all relevant information regarding a patient's physical and mental health needs that should be considered in determining security.
   c. Cooperate with investigations by any State or federal agencies or law enforcement.

2. In addition, the Contractor's regional office staff shall meet with the DOC at least weekly or as determined by the DOC Health Services Director to discuss health services or contract issues.

3. For all communication pathways, the DOC HSD will define how communication should occur to include:
   a. The DOC staff to be included.
   b. The method of communication.
   c. The frequency of communication.
   d. The threshold for receiving communication.

4. For email notifications, the Contractor must utilize an email and encryption platform which will allow the DOC to immediately forward the email to other parties and save in a format accessible to future DOC staff.

5. In addition, the Contractor shall:
   a. Notify the DOC Health Services Director or designee when patients are determined to need emergency transfer to an outside medical facility. The notification will adhere to the specifications of the DOC Health Services Director, and shall include, at a minimum:
      i. Patient's name
      ii. Patient's date of birth
      iii. A brief description of problem
      iv. Vital signs (if taken)
      v. Transfer location

b. Notify the DOC Health Services Director or designee when patients are returned to a correctional facility from an outside medical facility. The notification will adhere to the specifications of the DOC Health Services Director and shall include, at a minimum,
    i. Patient's name
    ii. Patient's date of birth
    iii. A brief summary of the patient's condition upon return.
    iv. Transfer location
c. Provide periodic updates from the outside medical facility commensurate with the patient status and level of care, and provide all updates to the DOC Health Services Director or designee.
d. Notify the Facility Superintendent and DOC Health Services Director or designee of all unaccounted-for controlled substances or sharps immediately when discrepancy is identified.
e. Provide a daily written report related to mental health and/or substance use to the DOC Health Services Director or designee which shall include, at a minimum, the status of patients that:
    i. Are awaiting voluntary or involuntary hospitalization placement
    ii. Are acutely decompensating
    iii. Are self-injurious
    iv. Are on suicide watch
    v. Are on involuntary med orders
    vi. Are going to or returning from inpatient psychiatric hospitalization
    vii. Are inducted on or tapered from Medication Assisted Treatment (MAT).
f. Provide a weekly report to the DOC Health Services Director or designee which includes, at a minimum, a brief summary of patients located in special mental health housing units.
g. Notify the DOC Health Services Director or designee of staff terminations to include:
    i. Staff name
    ii. Staff position and licensure, if applicable
    iii. Date of termination
    iv. Reason for termination
    v. Status of any reports filed to regulatory or professional standard entities
h. Provide real-time updates to a staff directory with any of the following:
    i. New hire
    ii. Termination
    iii. Change of role
    iv. If none of the above, the staff directory will be submitted monthly.
i. Notify the DOC Health Services Director or designee of any possible or known privacy or security breaches as defined by the Health Insurance Portability and Accountability Act (HIPAA) or Vermont 42 CRF Part 2. Notification should occur as soon as possible but no later than 24 hours after the issue is discovered.
j. Notify the DOC Health Services Director or designee of any serious adverse events including:
    i. Death of a patient
    ii. Near death of a patient
    iii. Attempted suicide or self-harm incident requiring additional care or monitoring
    iv. Medication errors that reach the patient and require additional care or monitoring

   v. Other events that reach the patient and require additional care or monitoring.

k. Provide the DOC Health Services Director or designee with weekly reports indicating patients with pending or scheduled off-site appointments, including:
   i. Patient name
   ii. Patient date of birth
   iii. Location of the appointment
   iv. The anticipated length of the appointment
   v. The reason for the appointment.

6. Compliance with this section is subject to Liquidated Damages as outlined in Section 2.2.2.

5.1.2 Human Resources Requirements

1. The Contractor shall:
   a. Utilize recruitment strategies that are, at a minimum, consistent with industry standards with the understanding that Vermont is a rural state with limited access to health care professionals.
   b. Submit all candidates for Health Service Administrator and all regional office positions to the DOC Health Services Director for approval before making an offer or hiring the candidate.
   c. Perform criminal history checks prior to employment, and every five years thereafter on all staff. These criminal history checks shall include:
      i. State abuse registry checks
      ii. Fingerprint-supported background check
      iii. State and national criminal history checks
   d. Comply with all Federal Prison Rape Elimination Act (PREA) hiring and onboarding standards including 115.17, 115.21, 115.32, 115.35, 115.64, 115.81, and 115.82, 115.83.
   e. Require that all employees maintain DOC security clearance as a condition of employment and inform staff that pending the results of any investigation, the DOC may suspend the employee's security clearance, effectively barring them from the facility.
   f. Whenever necessary, report any security incidents, violations, sexual abuse or illegal activity to the Office of Professional Regulation as required by Vermont law (see Mandatory Report of Disciplinary Action and Drug Diversion Reporting Form).
   g. Provide personnel information to include disciplinary and termination decisions to the DOC Health Services Director or designee, inclusive of professional complaints to the Office of Professional Regulation, allegations of misconduct, and any unsatisfactory review, peer review, or corrective action plan.
   h. Notify the HSD of all employees terminated for cause and explain the reason for termination.
   i. Require that all regional office staff are based in Vermont unless otherwise approved by the Health Services Director or designee.
   j. Limit the amount of time that regional office staff backfill at the facilities. The focus of regional office roles shall be on the supervision of staff, quality assurance/quality improvement activities, chart review, and providing consultation and technical assistance at the request of the DOC.
   k. To the extent possible, avoid the regular use of Agency, per diem, or traveler staff to fulfill the staffing requirements of the contract. The State acknowledges the difficulties of

hiring in certain job categories, especially RNs, medical providers, and mental health professionals. The Contractor shall utilize all available means to maintain a staffing vacancy rate of less than 10 percent.

l. Develop an employee grievance and resolution process that provides the Contractor's staff with a confidential means to address work-related issues. The Contractor shall provide to the DOC Health Services Director or designee all employee grievance information upon request.

m. Develop a mechanism for employees who voluntarily terminate to anonymously report information regarding the reason that they terminated employment with the Contractor. Staff shall be informed of this mechanism at the time of their hire.

n. Develop a process for staff to become designated as a "Qualified Mental Health Professional" by the Commissioner of Department of Mental Health (DMH) as appropriate for the role.

5.1.3 Utilization Management

The DOC is interested in the Contractor's Utilization Management process and is seeking a process that balances access to and quality of care with cost effectiveness. The Contractor shall provide to the DOC Health Services Director a clear and thorough description of the process that includes any necessary information (e.g. the role of all parties involved in the process, the timeframe for review, and for what services this process is required) for the assessment of the process prior to its implementation in Vermont.

5.1.4 Contaminated Waste

The Contractor shall be responsible for and may subcontract with a company authorized to provide for the disposal of all bio-hazardous and contaminated waste.

5.1.5 Contractor's Role in Out-of-State Transfers

1. The DOC maintains contracts for the provision of supplemental housing units outside of Vermont. The Contractor shall:
   a. Complete all portions of the medical and mental health review (using forms and protocols established by the DOC Health Services Director or designee) which precedes out-of-state transfer.
   b. Review patient records to determine if a patient has any medical conditions which would exclude them from out-of-state transfer.
   c. Provide continuity of care and care coordination for patients going to or returning from an out-of-state facility.
   d. Provide patient health information to the receiving state/jurisdiction as required.
   e. Complete the review and all necessary documentation within 10 business days of receiving the request.
   f. Adhere to the APA Rule 98-44 *Out of State Transfers*, DOC Administrative Directive #371.21 *Out of State Transfer Interstate Compact/Federal Bureau of Prisons*, and DOC Administrative Directive #371.22 *Out of State Selection, Transfer, and Supplemental Facility Placement* and corresponding Interim Memo: *Out of State Eligibility*.

2. Compliance with this section is subject to Liquidated Damages as outlined in Section 2.2.2.

5.1.6 Services for Incapacitated Persons (INCAPs)

The Contractor shall comply with the DOC Administrative Directive #306.01 *Incapacitated Persons*, and the Interim Revision Memo – *Addition to Administrative Directive #306.01 Incapacitated Persons*.

5.1.7 Patients with a Serious Functional Impairment (SFI) or with Serious Mental Illness (SMI)

1. To provide continuity of care for patients currently or historically designated as SFI or with SMI, the Contractor shall:
   a. For patients clinically designated as SFI during a previous incarceration, determine within 30 days if the patient should be re-designated as SFI. For patients previously designated as SFI, there is no predetermination in advance of meeting the criteria.
   b. Coordinate all intake and discharge planning with appropriate agencies, including the DMH, DAs, SSAs, the Vermont Department of Health (VDH), Division Of Alcohol & Drug Abuse Programs (ADAP), and Department of Aging and Independent Living (DAIL).
   c. Require mental health professionals perform ongoing assessments of patients' mental health and functional status when there is a concern that a patient's condition cannot be treated within the DOC setting and a referral for hospital level of care may be appropriate.
   d. Process all referrals for hospital-level care through the appropriate channels, including the processes for "Emergency Evaluation" or voluntary admissions per Vermont Act 78, "An Act Relating to Offenders with Mental Illness, Inmate Records, and Inmate Services" and related "Memorandum of Understanding (MOU) between VDH and Vermont DOC".
   e. Provide that any patient determined to be "a person in need of treatment" pursuant to 18 V.S.A. §7504 is seen by a qualified mental health professional (QMHP), as defined by NCCHC, twice daily unless clinically contraindicated while waiting for hospitalization.
   f. Provide that all SFI patients have an Individualized Treatment Plan to address their functional impairment.

2. In accordance with Sec.1. 28 V.S.A. § 701(a) subdivisions 1, 2 and 3, and APA Rule #05-49 Classification, Treatment, and Use of Administrative and Disciplinary Segregation for Inmates with a Serious Functional Impairment, for patients that are in segregation, the Contractor shall:
   a. Utilize mental health staff to perform self-harm watch and mental health evaluations on patients designated as SFI at least three times per week.
   b. Utilize QMHPs (as defined by NCCHC) to conduct periodic re-evaluation as required by statute.
   c. Document all checks and encounters in the patient's EHR, to include at least:
      i. The results and clinical impressions of a brief mental status exam.
      ii. Any observable elements of mental status.
      iii. Other observations (including those provided by DOC security staff) of the patient's

recent behavior such as social functioning, personal hygiene, and activities of daily living (ADL).

iv. Administration of the Columbia Suicide Severity Rating Scale.

v. Indications that the patient is decompensating and may require a higher level of care (i.e., inpatient psychiatric hospitalization).

vi. The development of Individual Treatment Plans that are relevant to the patient's conditions.

d. Ensure a QMHP assesses all patients with a SFI or SMI for contraindications prior to placement in disciplinary or administrative segregation.

e. Provide alternatives to segregation when contraindications exist.

f. Have a physician review and approve/deny administrative or disciplinary segregation placement based on medical judgement for any patient with a SFI or SMI. A physician must review all disciplinary segregation placements regarding a patient with a SFI or SMI prior to placement. A SFI or SMI patient cannot be placed in disciplinary segregation without the approval of a physician.

g. Ensure a QMHP determines if the behavior for which the patient received the disciplinary report proximately results from a SFI or SMI. The QMHP shall inform and recommend options for disposition to the Hearing Officer (DOC staff).

h. Ensure a Facility Psychiatrist or Advance Practice Nurse is available to the Hearing Officer during due process hearings when involving a patient with SFI or SMI.

i. Patients with a SFI or SMI shall receive daily visits from Qualified Health Care Professionals (QHCPs) or QMHPs to assess their status and initiate/refer for any needed changes in the treatment regimen. These assessments shall document physical observations, the patient's affect, any suicidal or self-harming ideation, and health complaints. The needs of patients who are experiencing a current, severe psychiatric crisis, including acute psychosis and suicidal depression, shall be addressed promptly, consistent with the patient's willingness to accept treatment. Alternative placements, consistent with their security, health and mental health needs, shall be considered.

5.1.8 Multidisciplinary Case Planning

The Contractor's QHCPs, including QMHPs, shall cooperate with casework and security staff in the development of case plans for sentenced patients. QHCPs shall advise whether the patient will require accommodations (including accommodations through the Americans with Disabilities Act (ADA)) to successfully complete mandated intervention services prior to re-entering the community, pursuant to conviction status and risk assessment. As necessary, the QMHP shall order further assessments to determine what additional accommodations may be required. These case planning activities are in addition to the otherwise required discharge planning.

5.1.9 Health Services Network:

1. The Contractor shall:

   a. Ensure that the following requirements are met with the installation and maintenance of their Network within the DOC facilities:

      i. All persons who enter Vermont Correctional Facilities must first pass a background check as required. Refer to Section 5.1.2 for more information.

ii. The Contractor must support their own software. Technical support must be provided 24 hours a day, seven days a week and 365 days a year by the Contractor.
iii. The Contractor shall provide, support, and maintain any software, hardware, interfaces, and communications infrastructure required to operate. The Contractor must provide their own Internet connectivity, e-mail, and account management.
iv. The Contractor must be experienced in, and provide documented experience of, operating their own Network for facilities with the size and scope of the State.
v. The Contractor must provide evidence of an acceptable staffing plan, identifying the background of the responsible staff, job descriptions, and written work plan that demonstrates the ability of the Contractor to fulfill the IT equipment and network requirements of this document. The State reserves the right to approve all system administration personnel who have access to the system, and to conduct background investigations of all assigned system administration Contractor employees.

b. Provide a single point-of-contact for any service outage or remedial maintenance issue that may arise 24 hours a day, seven days a week, and 365 days a year. This shall include:
   i. A 24-hour, toll-free service number.
   ii. A live customer service representative must be available at all times for service calls.
   iii. All service requests must result in an immediate trouble ticket generation with severity level assignment.
   iv. Trouble tickets must track all activities related to the service call, including resolution time and method.
c. Have a Network with:
   i. 24/7 availability.
   ii. A 99.9% uptime including all scheduled and unanticipated updates.
   iii. The ability to handle 100+ concurrent users for their staff operations within the DOC facilities.
d. Provide on-site repair time, method, and level of services for all locations. The Contractor shall have the ability to handle emergencies and an escalation plan.
e. Have an automated tracking system for problem requests as they are opened, updated, and closed by the field technicians, providing detail to show the problem and final resolution of said problem.
f. Provide the State with a complete list of business, cellular, and pager numbers for its staff/subcontractors, managers, administrators, technicians, etc. including the Contractor's management home and emergency telephone numbers.
g. Provide a copy of the Contractor's current repair procedure policy for both normal maintenance and emergency outages as it relates to this contract.
h. Have the ability to remotely diagnose and repair the systems covered in this contract. Repair technicians must have remote access to all system controls via a secured Wide Area Network (WAN) or modem connection supplied by the Contractor at no cost to the State.
i. Provide system software that will provide continuous self-test diagnostics without State personnel intervention. When the system detects a problem, alarms indicating system malfunctions and network problems will be sent to the Contractor. The system software will include remote diagnostic programs to indicate the operational status of critical system components.

j. Provide a complete solution including all equipment, software, and infrastructure necessary to provide the services required in this contract.
k. Be responsible for all equipment, software, and infrastructure including Contractor network and connectivity in its entirety or its individual components including, but not limited to, normal wear/use, patient abuse, natural disaster, or patient unrest. System or component replacement will be performed at no cost to the State and will occur immediately upon notification to the Contractor of the system problem by the Location or State designee.
l. Provide any and all equipment in areas accessed by patients that will be sturdy, vandal resistant, and composed of durable, tamper-free equipment suitable for a detention environment.
m. Provide solution hardware that must be of detention grade quality; tamperproof user end equipment is required; a minimum of moving, removable, metallic parts, or any object which could be used as or fashioned into an offensive item, must not be present at the user end, if applicable.
n. Ensure that all equipment providing input will have a tamperproof functionless keyboard with internal track balls and industry standard shatterproof monitor, is applicable.
o. Be responsible for all cables and power cords which must be secured.
p. Provide equipment that is compliant with ADA guidelines.
q. Provide all components of their System and Network including hardware, software, networking, infrastructure, storage, archiving, etc. including physical size and descriptions of all equipment/hardware. The Contractor shall maintain and support all components including version upgrades, patches, hardware upgrades, and replacement plan, network connectivity, backups, retention strategy, disaster recovery, redundancy, and change management.
r. Provide any environmental conditions required for the System and Network. The Contractor shall include any air conditioning or heating requirements for equipment provided. The Contractor is required to supply the necessary heating or cooling system.
s. For each location installation, provide an implementation plan which includes an installation schedule. The plan, including quantities of equipment, must be approved by the State before initiation and any updates or changes to this plan must be submitted to and approved by the State. Please note that any and all installations must be accomplished during normal business hours at each location or as directed by the location's onsite Superintendent. For additional information regarding transition planning see Section 5.2 – Contractor Transition and Onboarding Requirements.
t. Adhere to all applicable State, Agency, and Departmental IT policies and procedures regarding information protection and security.
u. Obtain the State's written permission before proceeding with any work that requires cutting into or through girders, beams, concrete or tile floors, partitions or ceilings, or any work that may impair fireproofing or moisture proofing, or potentially cause and structural damage.
v. Understand that the use of existing or in-place conduit, raceways, cable ways, cable, inside wiring, telephone set mountings, switches, terminal boxes, and terminals within the location are at the risk of the Contractor. No exposed wiring will be permitted. Ownership of any wiring or conduit placed under this Contract by the Contractor becomes the State's property upon termination and/or expiration of the Contract.

w. Agree that, should any cabling work be required as part of any installation, all new cable shall be used and marked clearly and legibly at both ends, and must meet all applicable Electronic Industries Alliance (EIA) and Telecommunications Industry Association (TIA) wiring standards for commercial buildings. All new cabling required by the Contractor shall be installed by the Contractor at no cost to the State.
x. Restore to original condition, at its own cost, any damage to the State's property caused by maintenance, installation, or removal by personnel associated with the Contractor including, but not limited to, repairs to walls and ceilings.
y. Clean up and remove all debris and packaging material resulting from work performed.
z. Provide and install adequate surge and lightning protection equipment on all equipment used robust enough in order to support the Contractor provided system/equipment for 30 minutes in the event of a power outage. This shall include an uninterruptable power supply (UPS) for the switch, if required. UPS units must be adequate for the size of each location. Adequacy must be documented based on UPS manufacturer's recommendations. The Contractor shall provide, install, and maintain (according to manufacturer's specification) all UPS equipment at each of the locations. The Contractor shall replace all UPS equipment upon expiration of the manufacturer's life cycle of the installed product. The use of traditional "power strips" for surge protection is not acceptable.
aa. Upon completion of initial installation and ongoing installations, provide the State with a list of identifying information for all equipment including, but not limited to, serial numbers, make/model, telephone numbers, and locations of each unit.
bb. Provide details on auditing capabilities/report within each identified System and Network.

5.1.10 Offender Management System

1. The Contractor shall enter information into the DOC's Offender Management System (OMS) as determined appropriate by the DOC Health Services Director or designee. This information shall include at a minimum:
    a. The appropriate mobility code (see Appendix 5 – Mobility Codes) so that patients for whom transfer is contraindicated are not transferred without approval of appropriate health services staff.
    b. Information about patients with special needs such as SFI/SMI, individuals on the MAT program including type of medication, special passes such as a bottom bunk or bottom tier.
    c. Appropriate Alerts, defined by the DOC Health Services Director or designee.
    d. Other information at the request of the DOC Health Services Director or designee.

5.1.11 Breaking Free and other TAC

1. The Contractor shall provide funding for Breaking Free through the existing contractual agreement with DOC's telecommunications vendor, ViaPath. This should be included in the Appendix 2 – Price Proposal PIPM Calculator.

2. The Contractor shall also develop an agreement with Voi, Inc. for use of Systematic Expert Risk Assessment for Suicide (SERAS).

5.1.12 Americans with Disabilities Act (ADA)

1. The Contractor shall:
   a. Comply with DOC Administrative Directive #371.01 *Americans with Disabilities Act* and Interim Memo.
   b. Comply with DOC Administrative Directive #316 *Effective Communication*.
   c. Comply with any settlement agreements. Public agreements will be provided upon request.
   d. Defer to the DOC's ADA Director in the event that the Contractor and the DOC disagree on an ADA related issue.
   e. Provide prosthetics and other assistive devices that improve patient's level of functioning to that of a non-disabled patient. All prosthetics and other medical devices must meet all applicable quality standards and DOC security requirements.
   f. Establish contracts or agreements with local prosthetic companies to provide prosthetic devices to patients as determined necessary by the Contractor, the ADA Director, or designee.
   g. Request that the company representative make preliminary measurements and fittings on-site whenever possible.
   h. Give precedence to the safety/security needs of the facility in cases where a patient's ADA accommodation conflicts with the safety/security needs of the facility. The Contractor shall provide an alternative treatment plan to maximize the patient's level of functioning while also addressing DOC's safety/security requirements.

5.1.13 Act 153

The Contractor shall comply with Vermont Act 153, "An act relating to inmate access to prescription drugs."

5.1.14 Optical Services

1. The Contractor shall:
   a. When a visual deficiency beyond 20/40 is identified, refer the patient to the Contractor's optical service provider.
   b. Consult with the Vermont Division of the Blind and Visually Impaired for all patients who are identified by the optical service provider as needing supplemental expert services. Any consultation with the Vermont Division of the Blind and Visually Impaired shall trigger an ADA accommodation request pursuant to the DOC Administrative Directive #371.01 *Americans with Disabilities Act*.
   c. Pay for the dispensing, evaluation, and fitting services of an optometrist.
   d. Provide all monocular patients with a referral to the optometrist for a discussion of vision preservation without regard for visual acuity by Snellen testing.
   e. Provide one set of eyeglasses to patients as prescribed and deemed necessary by the optometrist.
   f. Provide all eligible patients follow-up eye exams every two years.
   g. Require that the patient bare responsibility for the cost of replacement of lost or damaged prescription eyewear due to the patient's negligence. DOC recognizes that some cases (e.g.,

indigence) may require an alternate approach.

5.1.15 Treatment for Patients with Gender Dysphoria

1. The Contractor shall:
   a. Use Vermont Medicaid guidelines as a framework for providing gender affirming care.
   b. Refer to the AHS Administrative Rule 4.238, "Gender Affirmation Surgery for the Treatment of Gender Dysphoria," for guidance on surgical care for individuals with gender dysphoria.
   c. Employ or subcontract with DOC approved qualified health care providers that are subject matter experts in care for this population.

2. There shall be no additional barriers or review processes required for access to gender affirming care.

5.1.16 Treatment for Patients with Hepatitis C

The Contractor shall provide Hepatitis C (HCV) treatment in accordance with Appendix 6 – Treatment of Hepatitis C.

5.1.17 Mental Health Units

The Contractor shall provide services necessary to comply with Vermont Act 78, "An Act Relating to Offenders with Mental Illness, Inmate Records, and Inmate Services," related MOUs. See Health Services Procedure: Mental Health Units.

5.2 Contract Transition and Onboarding Requirements

5.2.1 Transition Plan

1. The Contractor shall provide a comprehensive transition plan that addresses all aspects of the contract transition to include:
   a. Contract deliverables related to the contract transition
   b. Action items
   c. Person(s) responsible for each item
   d. Start date for each item
   e. Target completion date for each item
   f. Status of each item
   g. Completion date of each item

2. The DOC Health Services Director and the Contractor's project manager (PM) will agree on the exact format of the transition plan at or before the initial transition begins. The transition plan shall include, at a minimum, the items listed in Appendix 7 – Onboarding and Transition Requirements.

3. Compliance with this section is subject to Liquidated Damages as outlined in Section 2.2.2.

5.2.2 Project Manager

1. Upon completion of the contract negotiations process, the Contractor shall assign a PM to oversee the contract transition. The PM shall:
   a. Be responsible to the DOC for all aspects of the transition.
   b. Be located in Vermont for the duration of the contract transition.
   c. Coordinate all the tasks necessary to successfully transition the contract. These tasks will include but not be limited to:
      i. Assigning staff, scheduling meetings, reviewing status reports, addressing project issues and change orders, and preparing presentations for State stakeholders.
   d. Have daily contact with the DOC Health Services Director and/or designees in a manner approved by the DOC Health Services Director.
   e. Provide written "Weekly Status Reports" to the DOC Health Services Director. "Weekly Status Reports" shall include, at a minimum:
      i. All tasks accomplished, incomplete, or behind schedule in the previous week (with reasons given for those tasks behind schedule and plans for completion).
      ii. All tasks planned for the coming two weeks.
      iii. An updated status of all tasks (entered into the transition plan and attached to the status report).
      iv. The status of any corrective actions.
      v. Notice to the State, as soon as the Contractor is aware, if required deliverables will not be completed on time.
   f. At the discretion of the DOC Health Services Director, schedule and facilitate project team meetings, either in person or via video conference. These meetings may include status updates of all aspects of the transition.

2. A successful PM shall have overall authority and responsibility for the contract deliverables, schedule, and successful implementation of the Contractor's resources to fulfill the requirements of the contract related to the contract transition.

3. Compliance with this section is subject to Liquidated Damages as outlined in Section 2.2.2.

5.2.3 Transition of Contractor Staff

1. The Contractor shall:
   a. Make every effort to minimize the impact of the contract transition on contractor staff and on the operation of the DOC's health services program.
   b. Interview and review all staff currently employed by the DOC's Contractor, including those in the Contractor's regional office. All employees, if eligible, will have the right of first refusal for positions with the future Contractor, pursuant to the staffing requirements set forth in the final contract.
   c. Propose all staff, new or incumbent, to the DOC Health Services Director or designee(s) for approval. The DOC reserves the right to approve or deny all proposed staff during the contract transition.

d. The DOC Health Services Director shall review the employment of all incumbent and future employees of the Contractor’s regional office and determine approval for employment.
e. Verify that all personnel are licensed, certified, and/or registered, as necessary, in conformance with Vermont laws and regulatory requirements.
f. Require that all staff, new and incumbent, are subject to the DOC’s staff onboarding requirements, including background checks, fingerprinting requirements, and the Federal PREA standard requirements.

2. Staff retained from the previous contract will not receive lower hourly wages, salaries, or benefits than earned prior to the start of the new contract. Considerations shall be made on a case-by-case basis for situations where the current hourly wage, salary, or benefits are outside of the market value. Retained staff will maintain their pre-existing hire date for the purposes of evaluations, merit increases, and calculations of vacation, sick, annual, or other leave accruals. Retained staff will not be subject to waiting periods for health insurance, 401(k) plans, employee stock options (if available), or any other benefits. Fringe benefits for existing staff shall be comparable to those earned leading up to the contract transition and shall begin immediately.

3. Refer to Appendix 8 – Current Staffing Matrix. The State does not guarantee that the current staffing pattern, or those required in these specifications, or any contained in an approved proposal, to be sufficient for the Contractor to carry out the responsibilities detailed in this RFP. The Contractor shall adjust schedules and staffing patterns as needed, according to staffing workloads, DOC operational needs, the needs of the patient population, and settlement agreements. Staffing levels may also be adjusted based on the results of quality assurance activities.

5.2.4 Transition of Network

1. The Contractor shall:
   a. Work with the State and any incumbent vendor to ensure an orderly transition of services and responsibilities under the Contract and to ensure the continuity of the services required by the State.
   b. Have a transition plan that minimizes lost revenue to the State for a smooth “cutover” to the new equipment and/or network.
   c. Upon expiration, termination, or cancellation of the Contract, cooperate in an orderly transfer of responsibility and/or the continuity of the services required under the terms of the Contract to an organization designated by the State.
   d. Remove its equipment at the conclusion of the Contract in a manner that will allow the reuse of wire distribution.
   e. Agree the workstations and associated infrastructure shall become the property of the State at the expiration, cancellation, or termination of this Contract.
   f. Discontinue providing service or accepting new assignments under the terms of the Contract, on a date specified by the State.

5.3 Section A – Governance and Administration

5.3.1 Access to Care

The Contractor shall, at a minimum, comply with NCCHC standard P-A-01.

5.3.2 Responsible Health Authority

The Contractor shall, at a minimum, comply with NCCHC standard P-A-02.

5.3.3 Medical Autonomy

1. The Contractor shall, at a minimum, comply with NCCHC standard P-A-03.

2. The Contractor shall immediately report to the DOC Health Services Director or designee any instances in which clinical staff believe that their medical autonomy or clinical recommendations are limited or jeopardized by custody or other non-clinical staff except when there is a direct threat to the safety and security of a facility or persons therein.

5.3.4 Administrative Meetings and Reports

1. The Contractor shall, at a minimum, comply with NCCHC standard P-A-04.

2. The Contractor shall also facilitate or participate, as determined by the State, the following meetings, to be held at a frequency defined by the State:
   a. Pharmacy and Therapeutics (P&T) Committee
   b. Medical Administrative Committee (MAC)/Continuous Quality Improvement (at each facility)
   c. CQI Committee (see Section 5.3.6 – Continuous Quality Improvement Program)
   d. EHR Committee
   e. Mortality and Morbidity Reviews
   f. Executive Business Meeting
   g. Contract Monitoring and Improvement meetings (see section 4.2 – Deficiencies and Contract Compliance)
   h. Incident debriefings
   i. Daily DOC "Morning Meetings," (or other venue as determined by the Superintendent). The Contractor shall be prepared to discuss:
      i. Any patient with physical or mental health needs
      ii. Any patient with, requesting, or in need of ADA accommodation
      iii. Any patient with behavioral issues or concerns
      iv. Any information pertinent to the health and safety of any person at the facility
   j. Additional meetings at the discretion of the State

3. The Contractor shall perform the following with regards to all administrative meetings it is required to facilitate under the Contract:
   a. Invite and ensure attendance of all required participants, as determined by the State.
   b. Compile meeting records and notes and distribute them to all required participants

regardless of attendance.
   c. For monthly and quarterly meetings:
      i. Create an agenda to be submitted for DOC additions or edits no later than five business days prior to the meeting date.
      ii. Compile and distribute all materials for consideration and discussion at the meeting no later than three business days prior to the meeting date. If relevant materials are unavailable or not yet available, they should be distributed as soon as practicable.

4. The Contractor shall also:
   a. Configure and provide reports to the State as requested. Refer to Appendix 9 – Current Reporting Requirements for a summary of all current reports. Templates for each report will be provided to Offerors upon request.
   b. Produce all reports utilizing the State's EHR and other electronic databases or systems (or provide a transition plan to get to this state of which the timeline shall be approved by the State).
   c. Configure and batch all required reports related to patient care within the EHR.
   d. Provide all reports in the format requested by the State.
   e. Provide monthly and quarterly reports within 15 days of the close of the previous month or quarter.

5. The State reserves the right to request additional or different reporting information from the Contractor throughout the term of the contract, on either an *ad hoc* or regular basis. The Contractor shall comply with the State's request including any provided timelines.

6. The State reserves the right to request verification that State data stored and shared maintains compliance with all State and Federal laws. This includes email communications, SharePoint or other document repositories, or other methods of communication.

7. The Contractor shall also comply with Section 5.1.1 – Communication Between DOC HSD and the Contractor.

8. Compliance with this section is subject to Liquidated Damages as outlined in Section 2.2.2.

5.3.5 Policies and Procedures

1. The Contractor shall, at a minimum, comply with NCCHC standard P-A-05.

2. The Contractor shall also have policies and procedures that comply with all Vermont specific requirements as outlined in Section 5.1 – Vermont DOC Requirements and throughout this document. The State must approve all Contractor policies and procedures before they are considered active and modifications to include the Vermont specific requirements shall not cause delay in the process. In the absence of a State-approved policy or procedure on a specific matter, the DOC HSD shall designate a policy or procedure with which the Contractor must comply.

3. Compliance with this section is subject to Liquidated Damages as outlined in Section 2.2.2.

5.3.6 Continuous Quality Improvement Program

1. The Contractor shall, at a minimum, comply with NCCHC standard P-A-06.

2. The DOC Health Services Director or designee will approve a standardized format for the monthly Continuous Quality Improvement Program meetings and all attendees, and will be a partner in all Contractor CQI processes.

3. The Contractor shall also comply with Section 4 – Contract Monitoring.

4. Compliance with this section is subject to Liquidated Damages as outlined in Section 2.2.2.

5.3.7 Privacy of Care

The Contractor shall, at a minimum, comply with NCCHC standard P-A-07.

5.3.8 Health Records

1. The Contractor shall, at a minimum, comply with NCCHC standard P-A-08.

2. In addition, the Contractor shall utilize the EHR system provided by the DOC. The current EHR vendor for the Department of Corrections is CorrecTek, Inc. Should the DOC decide to modify or change EHR systems, the Contractor shall cooperate with the DOC in all electronic system transition plans including any plans to update the EHR to meet the needs of the contract and achieve the desired state.

3. The Contractor shall provide information on the Contractor staff role, job title, and access needs for the creation of a user's EHR account. The State will provide written approval, request for additional information, or denial through the method as determined by the State. All new users, user modifications, and user terminations to the EHR, need to be approved by DOC staff through methods determined by the State.

5.3.9 Procedures in the Event of an Patient Death

1. The Contractor shall, at a minimum, comply with NCCHC standard P-A-09.

2. The Contractor shall also comply with DOC Administrative Directive #353 *Death Response and Review* and #405 *Incident Reporting*, which outlines the roles of the DOC and the Contractor in the event of a death. Information regarding any and all deaths shall be freely shared with the DOC including any Contractor incident reports, reviews, and findings. The Contractor shall complete all remediation required by DOC or third-party review and comply with any CQI or Corrective Action Plan (CAP) process upon DOC request. The Mortality Review format must be approved the DOC Health Services Director or designee. All Mortality and Morbidity Reviews must be completed and provided to the DOC Health Services Director within 30 days of the event. This process is protected as part of the Peer Review Process and is privileged and confidential pursuant to 26 V.S.A. §§ 1441-1443, and is exempt from public disclosure.

3. Compliance with this section is subject to Liquidated Damages as outlined in Section 2.2.2.

5.3.10 Grievance Process for Health Care Complaints

1. The Contractor shall, at a minimum, comply with NCCHC standard P-A-10.

2. The Contractor shall also comply with DOC Administrative Directive #320.01 – *Offender Grievance System for Field and Facilities Directive*.

3. Compliance with this section is subject to Liquidated Damages as outlined in Section 2.2.2.

5.4 Section B – Health Promotion, Safety, and Disease Prevention

5.4.1 Healthy Lifestyle (Education and) Promotion

1. The Contractor shall, at a minimum, comply with NCCHC standard P-B-01.

2. Vermont's correctional facilities are "tobacco free" for all patients and staff. The Contractor shall (as applicable) provide patients with self-reported use of tobacco products with the following which will be approved by DOC in collaboration with VDH:
   a. Information on the health impacts of continued use.
   b. Group interventions and support programs, written materials, and individual education.
   c. As part of release planning, information on community resources that can provide support with tobacco use cessation.

5.4.2 Infectious Disease Prevention and Control

1. The Contractor shall, at a minimum, comply with NCCHC standard P-B-02.

2. The Contractor shall also comply with Appendix 10 – DOC's COVID-19 Facility Protocol.

5.4.3 Clinical Preventative Services

The Contractor shall, at a minimum, comply with NCCHC standard P-B-03.

5.4.4 Medical Surveillance of Incarcerated Individual Workers

1. The Contractor shall, at a minimum, comply with NCCHC standard P-B-04.

2. The Contractor shall also:
   a. Assess or review patients for work camp placement within 10 business days of receiving the request and provide weekly updates on the status of clearances.
   b. Complete documentation for work clearances, which shall include, at a minimum:
      a. A statement that the patient's health record was reviewed.
      b. An indication that all pertinent medical history (e.g., communicable diseases, cardiac problems, pulmonary problems, allergies, and back problems) was

reviewed.

c. Any current signs and symptoms of illness.
d. A brief, focused physical examination and vital signs.
e. Verification the patient has no medical conditions that preclude food service work based on criteria provided by VDH.
f. Documentation of assessment and/or screening for hepatitis A and B. The Contractor shall offer testing for immunity to both. Where no immunity is present, the Contractor shall (as clinically appropriate) offer the patient vaccination against both. Patients found with chronic, active hepatitis B shall be referred to chronic disease clinic.

5.4.5 Suicide Prevention and Intervention

1. The Contractor shall, at a minimum, comply with NCCHC standard P-B-05.

2. The Contractor shall also comply with the DOC's Suicide Taskforce's procedures.

5.4.6 Contraception

1. The Contractor shall, at a minimum, comply with NCCHC standard P-B-06.

2. The Contractor shall also comply with Vermont Act 153.

5.4.7 Communication on Patients' Health Needs

1. The Contractor shall, at a minimum, comply with NCCHC standard P-B-07.

2. The Contractor shall also participate in DOC Facility "morning meetings." The Contractor shall be prepared to discuss patients with significant health or mental health needs, accommodations, and/or concerning behaviors with DOC staff during these meetings. For additional information refer to Section 5.1.1 – Communication Between DOC HSD and the Contractor, and Section 5.3.4 – Administrative Meetings and Reports.

5.4.8 Patient Safety

1. The Contractor shall, at a minimum, comply with NCCHC standard P-B-08.

2. For addition information regarding patient safety and adverse events, see Section 4 – Contract Monitoring and Section 5.3.6 – Continuous Quality Improvement Program.

5.4.9 Staff Safety

The Contractor shall, at a minimum, comply with NCCHC standard P-B-09.

5.5 Section C – Personnel and Training

5.5.1 Credentials (and Licensure)

1. The Contractor shall, at a minimum, comply with NCCHC standard P-C-01.

2. The Contractor shall also comply with all Vermont specific laws and requirements including those of the Vermont Office of Professional Regulation and the Vermont Board of Medical Practice.

5.5.2 Clinical Performance Enhancement

1. The Contractor shall, at a minimum, comply with NCCHC standard P-C-02.

2. The Contractor shall also:
   a. Ensure that all clinical performance enhancement and/or peer reviews are conducted in a format approved by the DOC Health Services Director or designee.
   b. Include performance indicators that align with the expectations of the contract.

5.5.3 Professional Development

1. The Contractor shall, at a minimum, comply with NCCHC standard P-C-03.

2. The Contractor shall also utilize industry standard methods of professional development including:
   a. The development and use of Professional Development Plans (PDPs).
   b. Utilizing a nationally recognized model for clinical supervision that is approved by the DOC Health Services Director or designee.

5.5.4 Health (and Mental Health) Training for Correctional Officers

1. The Contractor shall, at a minimum, comply with NCCHC standard P-C-04.

2. The Contractor shall also:
   a. Provide special training to medical and corrections staff in accordance with the requirements set forth in 28 V.S.A §907.
   b. Coordinate with the DOC HSD, and subsequently facility leadership, to develop the training schedule and content.

5.5.5 Medication Administration Training

The Contractor shall, at a minimum, comply with NCCHC standard P-C-05.

5.5.6 Incarcerated Individual Workers

Not relevant in Vermont.

5.5.7 Staffing

1. The Contractor shall, at a minimum, comply with NCCHC standard P-C-07.

2. The Contractor shall also:
   a. Employ medical, dental, mental health, substance abuse, and other professional staff sufficient in number and professional expertise to deliver a comprehensive health services program that meets the expectations of the contract. The Contractor should be aware that the current staffing may not be able to meet these expectations (see Appendix 8 – Current Staffing Matrix).
   b. Adjust work schedules and staffing patterns as needed, according to staffing workloads, DOC operational needs, the needs of the patient population, and settlement agreements. Staffing levels may also be adjusted based on the results of quality assurance activities.
   c. Provide nursing staff on-site at each correctional facility, 24 hours per day, seven days per week, 365 days per year.
   d. Staff the infirmary at Southern State Correctional Facility by census number and the acuity level of the population not to go below one Licensed Nursing Assistant (LNA) and one Registered Nurse (RN) on each shift.
   e. Staff all other infirmaries by census number and the acuity level of the population.
   f. Provide at least one RN on-site daily at each facility.
   g. Provide at least one RN on-call for each facility on each shift when one is not on-site.
   h. Require a physician is on call for each facility if not onsite.
   i. Provide access to urgent and emergent on-call and on-site mental health services on a 24 hours a day, seven days a week, 365 days a year basis.
   j. Provide on-site, in-person Vermont DMH certified QMHP's on first and second shift (6 a.m. through 9 p.m.) daily. On-call coverage with Vermont DMH certified QMHP's can provide coverage at other times. While on-call the Vermont DMH certified QMHP shall, as needed, be either able to report to the correctional facility or evaluate the patient via tele-health within one hour of being called for services that include, but are not limited to:
      i. Face-to-face encounters with patient.
      ii. Assessments to determine if the patient requires a hospital level of care.
      iii. Immediate notification to the DOC Health Services Director or designee of any patient that requires inpatient psychiatric hospitalization.

3. Compliance with this section is subject to Liquidated Damages as outlined in Section 2.2.2.

5.5.8 Healthcare Liaison

Not relevant in Vermont.

5.5.9 Orientation for Health Staff

1. The Contractor shall, at a minimum, comply with NCCHC standard P-C-09.

2. The Contractor shall also:
   a. Provide training in other evidence-based intervention as defined by the DOC Health Services Director or designee (e.g. motivational interviewing, cognitive behavioral therapy, "Risk, Need and Responsivity" concepts, specific, measurable, attainable, realistic, and time-limited (SMART) model for the development of Individualized

Treatment Plans, and the standards for clinical documentation).
b. Require that staff attend a local facility safety and security orientation. This orientation includes PREA Orientation required prior to unsupervised time with incarcerated individuals.
c. Require that staff attend mandated trainings referenced in PREA Standards 115.31, 115. 32, and 115.35.
d. Require that all staff complete mandated reporter training prior to working with incarcerated individuals and are aware of their mandated reporting requirements under the 33 V.S.A. §4914 and 33 V.S.A. §§ 6902, 6903, 6904, 6908, 6909, 6913.

5.6 Section D – Ancillary Health Care Services

5.6.1 Pharmaceutical Operations

1. The Contractor shall, at a minimum, comply with NCCHC standard P-D-01.

2. The Contractor shall also:
   a. Contract with one or more community (including hospital) pharmacies near each correctional facility which shall serve as Back Up Pharmacies (BUPs). The Contractor shall:
      i. Utilize the BUPs for the purposes of providing timely access to essential medications for which no substitute is available within the stock supply. The pharmacy shall provide a method for identifying medications that a patient may bring with them due to the nature of the drug (i.e., the medication cannot be immediately provided through stock of through the BUP).
      ii. Direct staff to access the BUP as an occasional supplement to, not as substitution for, the Pharmaceutical Prime Vendor (PPV).
      iii. Establish a protocol for the delivery of the pharmaceuticals from each BUP in a manner that does not utilize the Contractor's or State's employees. The State understands that extraordinary circumstances may occur where the use of the Contractor's or State's employees is unavoidable. The Contractor shall inform the DOC Health Services Director or designee prior to utilizing Contractor or State employees to pick up and deliver pharmaceutics from the BUP to DOC facilities.
   b. Make pharmaceuticals available in the following manner:
      i. Routine administration shall occur within two hours of the time medication is scheduled to be administered.
      ii. Stat/urgent medication administration shall occur within one hour of the provider's order.
   c. Participate in any required communication to any Federal or State regulatory agencies related to unaccounted discrepancies or loss of controlled substances.

5.6.2 Medication Services

1. The Contractor shall, at a minimum, comply with NCCHC standard P-D-02.

2. The Contractor shall also:
   a. Comply with Vermont Act 153.

b. Establish a P&T Committee that shall:
    i. Be composed of Vermont physicians, other prescribers, pharmacists, nurses, administrators, quality improvement managers, and other health service staff that participate in the pharmaceutical operations. The DOC Health Services Director shall approve the list of attendees and members of the DOC HSD shall be included in all P&T meetings, discussions, and work.
    ii. Establish a medication formulary that is as closely aligned with the Vermont Medicaid preferred drug list as possible.
    iii. Establish a process for the review and approval of all non-formulary requests through the EHR by the Contractor's Statewide Medical Director.
    iv. Maintain the list of "essential medications" to guide staff's decisions regarding medication ordering, interchange, substitution, and refusals.
    v. Evaluate, educate, and advise medical staff and administrators in all matters that relate to the use of medications, including pertinent new medications and U.S. Food and Drug Administration (FDA) changes/black box warnings.
    vi. Review physician prescribing utilization reports and refer any concerns to the CQI process.

3. All appropriate Contractor staff shall have access to utilize the Vermont Prescription Monitoring System (VPMS) as described Vermont State statutes.

5.6.3 Clinic Space, Equipment, and Supplies

1. The Contractor shall, at a minimum, comply with NCCHC standard P-D-03.

2. The Contractor shall also:
    a. Provide, maintain, and replace, as needed, all medical, mental health, substance abuse, dental, and office supplies and equipment (including computers and all other IT equipment per Section 5.1.9 – Health Services Network, continuous positive airway pressure (CPAP) machines, infirmary and special medical beds, wheelchairs) necessary to carry out the terms of the contract.
    b. In collaboration with the DOC, continuously maintain the health services area so that it is safe and sanitary for the provision of health care.
    c. Maintain all supplies and equipment in good working order, as defined by the manufacturer.
    d. Maintain all X-ray equipment available for routine films at Southern State Correctional Facility in accordance with all state and federal standards.
    e. Adhere to the DOC Administrative Directive #417 *Key Control – Facilities*, DOC Administrative Directive covering Facility Security, DOC Administrative Directive #201 *Fiscal Management*, and APA Rule 80-21 *Control of Tools and Equipment*.
    f. Develop and implement a process and procedure for the control, inventory, and secure management of all medications, syringes, needles, dental instruments, and other sharps. The Contractor shall:
        i. Store and maintain all sharps within security regulations and guidelines set forth by DOC, NCCHC, Vermont's Occupational and Health Administration (VOSHA), and Centers for Disease Control and Prevention (CDC) guidelines.
        ii. On a perpetual inventory, document the use of each needle, syringe, scalpel, or

other sharp.

iii. Every day, account for all medications, syringes, needles, dental instruments, and other sharps. At a minimum, the procedure shall require:
iv. Require that at change of shift, two nurses count all narcotics, sharps, and any other items subject to abuse. If the count is correct, each nurse will sign the control record. Notify the Facility Management and DOC Health Services Director of all unaccounted-for discrepancies as defined in Section 5.1.1 – Communication between DOC HSD and Contractor.

g. Procure and maintain emergency medical equipment in a secure location, determined by DOC.
h. Procure and maintain Automated External Defibrillators (AEDs) sufficient in number to meet the needs of each facility. The Contractor's Statewide Medical Director shall determine the number and placement of AEDs in each facility, with approval from the DOC Health Services Director or designee, and work with the DOC HSD and DOC Facility Leadership to implement.
i. Ensure necessary equipment is onsite to allow for moving infirmary, non-ambulatory, and critically ill patients during an evacuation or other emergency.
j. Provide and maintain first aid kits by doing the following:
   i. Secure first aid kits with a plastic tear-away lock. If the lock is broken, staff will initiate a supply request to replace it.
   ii. Check and replenish the contents of each kit monthly or as requested.
   iii. Document monthly kit checks.
   iv. Determine the location and contents of the first aid kits for each site in coordination with the Contractor's Statewide Medical Director, Contractor's facility healthcare staff, and facility management.

5.6.4 On-Site (and Off-Site) Diagnostic Services

1. The Contractor shall, at a minimum, comply with NCCHC standard P-D-04.

2. The Contractor shall also:
   a. Provide directly or sub-contract with a laboratory to provide full laboratory services, diagnostic testing, and a fully detailed lab manual with instructions in all areas of specimen collection, handling, and processing. This includes but is not limited to:
      i. Available routine, stat, and special tests.
      ii. Turn-around times.
      iii. Procedures for the safe storage and transport of specimens.
      iv. Critical values reporting
      v. Special chemistry and toxicology analysis
      vi. The location of reference laboratories for tests not conducted by the primary lab Contractor.
      vii. Timely pickup and delivery of specimens
      viii. Accurate reporting within a reasonable timeframe
      ix. Maintenance of an electronic log to document the type and number of specimens sent and returned.
      x. Immediate reporting of lost specimens so that the lab tests(s) may be repeated. Lost

specimens shall be reported to the DOC Facility Management and the Health Services Director or designee.

xi. A process for physicians to review, date, and initial laboratory results.
xii. A procedure for the timely review of laboratory results if the patient's primary provider is absent.
xiii. Upon reviewing the results of labs, document the results in the patient's EHR.
xiv. Informing patients of the results in a timely fashion.
xv. Re-attempting to draw labs as needed if a patient initially refuses.
xvi. Developing a process whereby providers can re-evaluate the patient and re-order laboratory tests, as appropriate.

b. Verify that the any laboratory subcontractors:
   i. Meet federal, state, and local licensure, certification or credentialing as required including Clinical Laboratory Improvement Amendments (CLIA)
   ii. Provide proof of professional liability insurance
   iii. Operate according to a Business Associate Agreement
   iv. Are registered to do business in Vermont.

5.6.5 Medical Diets

1. The Contractor shall, at a minimum, comply with NCCHC standard P-D-05.

2. The Contractor shall also:
   a. Comply with the DOC Administrative Directive #354 *Food Services Operations*.
   b. Document the need for medical diets in the OMS and in the patient's EHR.

5.6.6 Patient Escort

The Contractor shall, at a minimum, comply with NCCHC standard P-D-06.

5.6.7 Emergency Services and Response Plan

1. The Contractor shall, at a minimum, comply with NCCHC standard P-D-07.

2. The Contractor shall also:
   a. Comply with the DOC Administrative Directive #414.03 *Emergency Preparedness.*
   b. Provide emergency medical care necessary to stabilize any person, including DOC employees, contracted employees, volunteers, INCAPs (see Section 5.1.6) or visitors who are injured or become emergently ill while at a DOC facility until care is transferred to another qualified entity. Any required follow-up care will be the responsibility of the individual.
   c. Provide care to incarcerated individuals injured while working. For injuries that are covered under workers' compensation insurance, coordinate follow-up care with the employer's workers' compensation insurer until either the incarcerated individual's treating physician has released the individual to return to work or until the individual is discharged from the DOC facility, whichever occurs first. This includes providing necessary information, as requested, to the worker's compensation insurer to ensure the proper reporting and resolution of claims which take place on State property.

5.6.8 Hospital and Specialty Care

The Contractor shall, at a minimum, comply with NCCHC standard P-D-08.

5.7 Section E – Patient Care and Treatment

5.7.1 Information on Health Services

1. The Contractor shall, at a minimum, comply with NCCHC standard P-E-01.

2. The Contractor shall also document in the patient's EHR anytime an interpreter is used during health services and update the "Overview" and "Alerts" within the EHR to indicate the need for an interpreter.

5.7.2 Receiving Screening

1. The Contractor shall, at a minimum, comply with NCCHC standard P-E-02.

2. The Contractor shall also comply with Appendix 11 – Mental Health and Substance Use Workflow, Appendix 12 – Initial Intake Flow Diagram (focus on clinical pathway for Suicide prevention), 28 V.S.A. § 801, 28 V.S.A. § 905, 28 V.S.A. § 906, 28 V.S.A. § 907, and DOC Administrative Directive #362 *Suicide Prevention and Response to Self-Injurious Behaviors*.

3. The Contractor shall use a standardized "Receiving Screening" form (approved by the DOC Health Services Director or designee) and provide screening for all patients within four hours of admission. In addition to the elements outlined in P-E-02, the screening will include:
   a. A HIPAA compliant authorization for treatment (including authorization for Uses and Disclosures for Treatment, Payment, and Health Care Operations (TPO)), signed by the patient.
   b. A signed acknowledgement that information regarding the ADA has been provided verbally and in writing.
   c. A review of any current disabilities the patient has and any need for accommodations under the ADA and follow up in accordance with the DOC Administrative Directive #316 *Effective Communication*.
   d. Provision of ADA accommodations required to meet the immediate needs of the patient.
   e. Opt-out testing for HIV/AIDS in accordance with Appendix 13 – MOU with VDH and DOC for HIV Testing.
   f. Opt-out testing for HCV.
   g. A process to verify and track insurance enrollment status through discharge.
   h. A review of any records of previous mental health services provided in the current or prior incarceration episode(s).
   i. Texas Christian University -5 Substance use Screen (TCU-5)- if positive of OUD disposition is referral to QHCP for TCU Opioid Supplemental and further assessment as clinically indicated.
   j. Correctional Mental Health Screen for Men and Women (CMHS-M/W)
   k. Screening for Traumatic Brain Injury – HELPS Brain Injury Screening tool- if positive

disposition is referral to QHCP and further assessment as clinically indicated.
l. Screening for Dementia and neurologic disorders using the Short-Blessed Test- if positive disposition is referral to QHCP and further assessment as clinically indicated.
m. A brief screening on tobacco use that is approved by DOC in collaboration with the VDH.
n. Urine drug screen
o. Routine referrals to medical or mental health will result in an "Initial Health Assessment" or "Mental Health and Substance Use Evaluation", respectively, within seven days – refer to Appendix 11 – Mental Health and Substance Use Workflow.
p. Other fields, at the discretion of the DOC Health Services Director or designee.

5.7.3 Transfer Screening

1. The Contractor shall, at a minimum, comply with NCCHC standard P-E-03.

2. The Contractor shall also have QHCPs review the transfer form and all pertinent health records within twelve hours of the patient's arrival at the receiving facility.

5.7.4 Initial Health Assessment

1. The Contractor shall, at a minimum, comply with NCCHC standard P-E-04.

2. The Contractor shall also:
   a. Obtain the patient's authorization for treatment, if it has not been obtained prior to this time (see Section 5.7.2 – Receiving Screening).
   b. Use a standardized "Initial Health Assessment" form (approved by the DOC Health Services Director or designee). In addition to the elements outlined in P-E-02, the assessment will include:
      i. A documented review of the Receiving Screening results.
      ii. A documented opportunity for HIV testing and brief counseling.
      iii. A documented opportunity for HCV screening.
      iv. A documented review of any positive results on the HELPS screening to determine if a patient has a traumatic brain injury and to develop an appropriate treatment plan.
      v. Date and time of completion.
      vi. Signature and title of individual completing the assessment.
   c. Obtain signed releases of information from the patient, if not already completed, to coordinate with community providers who treated the patient prior to incarceration.

5.7.5 Mental Health (and Substance Use) Screening and Evaluation

1. The Contractor shall, at a minimum, comply with NCCHC standard P-E-05.

2. The Contractor shall also refer to Section 5.7.2 – Receiving Screening, Appendix 11 – Mental Health and Substance Use Workflow, 28 V.S.A. § 801, 28 V.S.A. § 905, 28 V.S.A. § 906, 28 V.S.A. § 907, and the Rules Governing Medication-Assisted Therapy for Opioid Dependence for Office-Based Opioid Treatment (OBOT) Providers Prescribing

Buprenorphine. The Mental Health and Substance Use Evaluation, in addition to the elements outlined in P-E-05, shall include:

a. Evaluation using the Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (Structured Clinical Interview for DSM-5 (SCID-5); or its successor or as otherwise specified by the DOC Health Services Director or designee). Using the results of the SCID-5, the clinician will decide whether the patient meets the clinical criteria for a mental health and/or substance use disorder consistent with the DSM-5 and shall cause a DSM-5 diagnostic impression into the EHR.
b. Evaluation using the Personality Inventory for DSM-5-Brief Form (PID-5-BF) or as otherwise specified by the DOC Health Services Director or designee).
c. Evaluation using the Corrections Modified Global Assessment of Functioning (CM-GAF) as indicated to determine clinical SFI.
d. Urine drug screen results reviewed with patient.
e. Administration of the General Ability Measure for Adults (GAMA) (or other tool as specified by the DOC Health Services Director or designee) for patients suspected of having low cognitive functioning.

5.7.6 Oral Care

1. The Contractor shall, at a minimum, comply with NCCHC standard P-E-06.

2. The Contractor shall also:
   a. Provide a manual of dental operations, a written general orientation for all dental staff, and a mandatory orientation and training for all dental staff, specific to their job duties.
   b. Provide an accounting of any dental backlog, if applicable, to the DOC Health Services Director or designee on a weekly basis.
   c. Maintain any subcontractor arrangements with dental providers in conformance with 26 V.S.A. Chapter 12.
   d. Refer patients who require treatment beyond the capabilities of the Contractor's licensed dentist to an off-site dental specialist.
   e. Provide dental prostheses, including dentures, as determined to be medically necessary.

5.7.7 Nonemergency Healthcare Requests and Services

1. The Contractor shall, at a minimum, comply with NCCHC standard P-E-07.

2. The Contractor shall also:
   a. Provide unimpeded access to comprehensive health services in compliance with 28 V.S.A. § 801.
   b. Provide a mechanism for incarcerated individuals to have records of any healthcare requests.
   c. Document in the patient's EHR all sick slips and responses in a way that supports data reporting and monitoring.

5.7.8 Nursing Assessment Protocols and Procedures

1. The Contractor shall, at a minimum, comply with NCCHC standard P-E-08.

2. The Contractor shall also ensure that nurse assessment protocols and pathways comply with and 26 V.S.A. Chapter 26 and other applicable state statutes, scope of practice requirements, and standards of care.

5.7.9 Continuity, Coordination, and Quality of Care During Incarceration

1. The Contractor shall, at a minimum, comply with NCCHC standard P-E-09.

2. The Contractor shall also:
   a. Provide continuity of care in accordance with DOC Administrative Directive #371.02 *Case Management*.
   b. Provide a plan that includes appropriate staffing (e.g. Statewide Director of Care Coordination and Care Coordinator(s)) to supervise the continuity of care practices and services to address the needs of individual patients and the population.
   c. Develop and implement processes (utilizing the EHR) to standardize and improve care coordination and continuity of care activities.
   d. Enter appropriate alerts or special needs into the OMS and the EHR.

5.7.10 Discharge Planning

1. The Contractor shall, at a minimum, comply with NCCHC standard P-E-10.

2. The Contractor shall also:
   a. Coordinate with the DOC staff including the Corrections Service Specialist (CSS) for release planning.
   b. Provide patients with a discharge plan or "Continuity of Care Document."
   c. Schedule follow up care for any ongoing or current treatment needs and inform the patient of all pending appointments in the community, including the date, time, location, phone number, and name of the provider.
   d. Share the "Continuity of Care Document" and other specified information with the CSS and others as appropriate.
      i. Provide all patients with at a minimum, a 30-day supply of bridge medications or prescriptions.
      ii. Refer patients to the VCCI and other community organizations as appropriate.
      iii. Comply with Section 5.1.7 - Patients with Serious Mental Illness or with a Serious Functional Impairment regarding discharge planning for individuals that are SFI/SMI.
      iv. Comply with Section 5.1.8 – Multidisciplinary Case Planning.

5.8 Section F – Special Needs and Services

5.8.1 Patients with Chronic Disease and Other Special Needs

1. The Contractor shall, at a minimum, comply with NCCHC standard P-F-01.

2. The Contractor shall also:
   a. Utilize a chronic disease model and develop, whenever needed, appropriate encounter forms and templates in the EHR.
   b. Comply with any Vermont specific requirements as outlined in Section 5.1.
   c. Comply with DOC Administrative Directive #316 *Effective Communication*.
   d. Comply with reporting requirements as outlined in Appendix 9 – Current Reporting Requirements or any subsequent requirements at the discretion of the DOC Health Services Director or designee.
   e. For patients who have a mental health condition, substance use disorder, or psychiatric disability or disorder, develop and maintain "Mental Health - Individualized Treatment Plans" which are SMART. The Individualized Treatment Plans will include, but not be limited to:
      i. Current medications.
      ii. Current SCID-5 Diagnostic Impression.
      iii. Current CM-GAF results (if applicable e.g. assessing for Serious Functional Impairment/SFI)
      iv. Collateral information including from Community High School of Vermont, past community treatment providers, etc.
      v. Problem statements relevant to current diagnosis and corresponding treatment goals.
      vi. Specific goals of treatment.
      vii. Objectives of treatment (what the patient will do to achieve the goals).
      viii. Evidenced based treatment offered/provided.
      ix. Type, frequency, and duration of all interventions.
      x. Duration of the plan, including the date that progress towards the goals will be reviewed.
      xi. ADA accommodations needed.

      Treatment plans will be updated every ninety days or as clinically indicated. As part of this update, the patient shall be re-assessed for diagnostic impression, treatment plan revised as clinically indicated and master problem list in the EHR updated.

5.8.2 Infirmary-Level Care

1. The Contractor shall, at a minimum, comply with NCCHC standard P-F-02.

2. The Contractor shall also:
   a. Provide direct nursing observation of patients in the infirmary at all times.
   b. Provide sufficient staffing in the infirmary so that patients are always able to gain a QHCPs attention through visual or auditory signals.
   c. Require that the Director of Nursing at each site with an infirmary be a RN.
   d. Admit and discharge patients from the infirmary based on the clinical discretion of the

Statewide Medical Director or facility-level provider.

e. In the patient's EHR, create an infirmary record upon admission and maintain it through discharge. The record shall include but not be limited to:
    i. Admitting orders, including the admitting diagnosis, medications, medication administration record, diet, activity restrictions, any required diagnostic tests, and the frequency of vital sign follow-up.
    ii. A nursing plan of care developed by a RN with measurable goals and objectives, consistent with the format promulgated by the North American Nursing Diagnosis Association.
    iii. Discharge orders, if applicable, with the discharge plan.
f. Develop a manual of infirmary nursing policies and procedures. The manual will be consistent with, 26 V.S.A. Chapter 28, Vermont State Board of Nursing APRN/RN/LPN Scope of Practice, and licensing requirements, and approved by the DOC Health Services Director or designee.

5.8.3 Mental Health Services:

1. The Contractor shall, at a minimum, comply with NCCHC standard P-F-03.

2. The Contractor shall also:
    a. Require that treatment recommendations be developed by the QMHP based on the mental health evaluation diagnostic impressions and provided to the patient orally and in writing within 14 calendar days of the completed evaluation as outlined in the "Mental Health (and Substance Use) Screening and Evaluation" section of the Mental Health and Substance Use Workflow. Psychoeducation about a menu of treatment and recovery options will also be provided.
    b. Provide substance abuse group or individual treatment such as Integrated Change Therapy, Seeking Safety, Marlatt's Relapse Prevention, Mindfulness and Motivational Interviewing, or other modalities recommended by the DOC Health Services Director or designee.
    c. Provide access to technology-enabled mental health and substance abuse treatment and recovery (when available).
    d. Refer the patient to Peer Recovery and Support Services (when available).
    e. Make available and seek consent for behavioral health treatment, pharmacotherapy, or both as appropriate. If the patient does not consent, this shall be documented in the patient's EHR and no further action shall be needed unless clinical presentation changes and/or the patient re-initiates.
    f. Develop a patient-centered treatment plan addressing the patient identified problem and the treatment and recovery options available should the patient consent to behavioral treatment. Determine the frequency of treatment based on clinical need.
        i. Community Outpatient level of care standard is 1x/week.
        ii. Community Intensive Outpatient standard level of care can be met by combining 1x/week outpatient individual with these modalities: group, support group and use of tablet-based recovery support.
    g. Refer patients that consent to pharmacotherapy as part of the patient centered treatment plan to a qualified psychiatric provider.

h. Add patients to the mental health caseload and develop a treatment plan within 14 days when the results of the mental health evaluation indicate that the patient is a person with a mental health condition.
i. Indicate follow-up timeframes in days or weeks and determine follow-up timeframes based on clinical need (Level of Care Utilization System (LOCUS)/American Society of Addiction Medicine (ASAM)/Diagnostic Impression). Unless the patient has been discharged from the mental health caseload or refuses behavioral treatment, follow up timeframes shall not be indicated as "PRN" or "at the request of the individual" or "through sick call".
j. Document referral to inpatient psychiatric facilities, including when the patient was initially referred, the outcome of the referral (accepted or denied), reasons for denial, date of placement, and latency between the initial referral and date of placement.
k. Adopt or provide a policy consistent with Appendix 14 - Emergency Involuntary Medication Policy.
l. See 18 V.S.A. § 7624 as revised or amended which relates to the involuntary administration of medications in inpatient settings. The Vermont DOC is not considered an "inpatient" setting. The Contractor shall not participate in the administration of involuntary medications. Patients in need of involuntary medications may be transferred to the emergency room or referred to an inpatient setting (e.g., an inpatient psychiatric facility) where involuntary medication procedures may commence.

5.8.4 Medically Supervised Withdrawal and (Medication Assisted) Treatment

1. The Contractor shall, at a minimum, comply with NCCHC standard P-F-04.

2. The Contractor shall also:
   a. Adopt or provide a policy consistent with Appendix 15 – MAT Policy and Procedure
   b. Adopt or provide a policy consistent with Appendix 16 – MAT Clinical Guidelines.
   c. Comply with any grants related to MAT services (e.g RSAT grant for residential services).

5.8.5 Intoxication and Withdrawal

The Contractor shall, at a minimum, comply with NCCHC standard P-F-05.

5.8.6 Counseling and Care of the Pregnant Patient

1. The Contractor shall, at a minimum, comply with NCCHC standard P-F-05.

2. The Contractor shall also:
   a. Coordinate with off-site specialty services when appropriate (e.g. birthing plans, breast pumping and milk storage, high-risk pre-natal care, and delivery services.)
   b. Coordinate with an off-site provider to for abortion services if desired by the patient. The cost of abortion services will be borne by the DOC.

5.8.7 Response to Sexual Abuse

1. The Contractor shall, at a minimum, comply with NCCHC standard P-F-06.

2. The Contractor shall also:
   a. Comply with the Prison Rape Elimination Act of 2003 (Federal Law 42 U.S.C. 15601 et. seq.).
   b. Comply with the DOC's Administrative Directive #409.09 *Prison Rape Elimination Act (PREA) Staff Sexual Misconduct Facilities,* which is the primary policy document that supports the adherence to PREA and its corresponding standards. However, the DOC also embeds PREA requirements throughout DOC Directives and in facility specific documents that establish local policies.
   c. Not provide services outside of those required to assess the patient for physical injuries that may potentially require immediate medical attention. In other words, the Contractor shall not provide what could be considered a "forensic" examination.
   d. Assist DOC in coordinating transfer of the patient to a local hospital emergency department where the patient shall be offered an examination by a Sexual Assault Nurse Examiner (SANE) or other QHCP.
   e. When evaluating the extent of injuries and/or the need for outside medical services, not take intentional or accidental actions that may remove, dilute, or destroy evidence.

5.8.8 Care for the Terminally Ill

1. The Contractor shall, at a minimum, comply with NCCHC standard P-F-07.

2. The Contractor shall also provide advance care directives, palliative care, and hospice care to include:
   a. Referring, utilizing, and adhering to 18 VSA §§9700-9731 related to advance directives for healthcare, disposition of remains, and surrogate decision making.
   b. Utilizing the appropriate advance care directive forms and instructions provided by the Vermont Ethics Network. The completed forms should be recorded in the EHR. A copy shall be sent to the DOC Health Services Director or designee and shall be sent to the Statewide registry for recording.
   c. Maintaining space located at Southern State Correctional Facility, Northern State Correctional Facility, and Chittenden Regional Correctional Facility where palliative and hospice care is provided.
   d. Complying with the DOC Administrative Directive #373.02 *Temporary Furlough to Obtain Medical Services: Medical Furlough and Medical Parole*.

5.9 Section G – Medical Legal Issues

5.9.1 Restraint and Seclusion

1. The Contractor shall, at a minimum, comply with NCCHC standard P-G-01.

2. The Contractor shall also comply with DOC Administrative Directive #413.08 *Use of Restraints and Roles of Security and Health Care Professionals in Facilities*, the DOC's Interim Memo to Administrative Directive #413.08, DOC Administrative #413.10 *Use of Restraint Chair*, and APA Rule 05-049 *Classification, Treatment, and the Use of Administrative Segregation and Disciplinary Segregation for Inmates with Serious Mental Illness.*

5.9.2 Segregated Patients

1. The Contractor shall, at a minimum, comply with NCCHC standard P-G-02.

2. The Contractor shall also:
   a. Screen patients for contraindications to segregation placement using a DOC approved screening tool prior to placement.
   b. Contribute, participate, and meet the health-related expectations of plan for the patient to transition from segregation to the general population.
   c. Refer to 28 V.S.A. § 853 and 28 V.S.A. § 857 for the Vermont specific definition and requirements of segregation. Vermont does not utilize solitary confinement as referenced within this standard.
   d. Comply with Section 5.1.7 – Patients with Serious Mental Illness or with a Serious Functional Impairment

5.9.3 Emergency Psychotropic Medications

1. The Contractor shall, at a minimum, comply with NCCHC standard P-G-03.

2. The Contractor shall comply with Appendix 14 – Emergency Psychotropic Medications.

5.9.4 Therapeutic Relationship, Forensic Information, and Disciplinary Actions

The Contractor shall, at a minimum, comply with NCCHC standard P-G-04.

5.9.5 Informed Consent and Right to Refuse

1. The Contractor shall, at a minimum, comply with NCCHC standard P-G-05.

2. The Contractor shall also require that all examinations, treatments, and procedures be governed by informed consent practices that are applicable in the State of Vermont.

5.9.6 Medical and Other Research

1. The Contractor shall, at a minimum, comply with NCCHC standard P-G-06.

2. The Contractor shall also comply with the DOC's Administrative Directive #08 *Relationships with Outside Entities*. At no time shall the Contractor agree to an patient's request for, or pursue participation on behalf of, an patient in medical or other research without informing the DOC Health Services Director or designee.

5.9.7 Executions

Not relevant in Vermont.

6 PROPOSAL REQUIREMENTS

6.1 Proposal Guidelines

This RFP defines the scope of work required and work/management structure within which the chosen Contractor must operate. To be considered for selection, Offerors must complete all responses to this RFP in the format described in this document. Proposals not meeting the requirements described in this RFP will not be considered. The State reserves the right to accept or reject any or all proposals. Selected State staff will evaluate proposals. If a proposal is selected, the chosen Contractor will be invited to negotiate a contract for all or part of the activities outlined in this RFP at the discretion of the DOC.

6.2 Single Point of Contact

The DOC Health Services Program Technician is the sole contact for this proposal. All communications concerning this RFP are to be addressed in writing to the attention of the Health Services Program Technician as listed on cover sheet of this proposal. Attempts by Offerors to contact any other party could result in the rejection of their proposal as determined by the DOC.

6.3 Question and Answer Period

1. Any Offeror requiring clarification of any section of this proposal or wishing to submit questions may do so according to the 4.4 Timetable schedule listed in this section. Questions may be e-mailed to the Health Services Program Technician as listed on page one of this proposal. Any clarification or questions submitted following the last day of the question period will not receive a response.

2. At the close of the question period a copy of all questions or comments and the State's responses will be posted on the State's web site: http://www.vermontbusinessregistry.com Every effort will be made to have these available soon after the question period ends, contingent on the number and complexity of the questions.

6.4 Timetable

The table below presents the DOC schedule for this RFP and contracting process. Please note that the DOC may change this schedule at any point.

RFP published	May 13, 2022
Written questions due	June 30, 2022
Response to questions	July 15, 2022
Proposal due	August 31, 2022
Anticipated Contract start date	July 1, 2023

6.5 Proposal Submission

1. Offerors must submit one original (with signed covered letter), 10 copies, and the unredacted electronic version of the proposal.

2. All pages of the Offeror's proposal containing confidential and proprietary information must be clearly marked "Proprietary and Confidential." After completion of this bid process, all proposal materials are in the public domain. Proposals may not be marked "Proprietary and Confidential" in their entirety.

3. The proposal must be organized in the order described below. Use the numbering designations outlined.

4. Offerors will submit their proposal to:

   Kim Gorton, Health Services Program Technician II
   Vermont Department of Corrections
   NOB 2 South, 280 State Drive
   Waterbury, VT 05671-2000

5. The closing date for the receipt of proposals is August 31, 2022.

6. Bid must be delivered to the contact at the address listed above by end-of-business on the closing date. Proposals or unsolicited amendments submitted after that time will not be accepted and will be returned to the Offeror. There are no exceptions to the closing date conditions.

7. Delivery Methods:
   a. U.S. MAIL: Offerors are cautioned that it is their responsibility to originate the mailing of bids in sufficient time to insure receipt by the State prior to the due date.
   b. EXPRESS DELIVERY: If bids are being sent via an express delivery service, be certain that the RFP designation is clearly shown on the outside of the delivery envelope or box.
   c. ELECTRONIC/EMAIL: An electronic version of the proposal is required in addition to copies as noted above.
   d. FAXED BIDS: Faxed bids will not be accepted.

6.6 Proposal Format

The format of the Offeror's proposal must include, at a minimum the following chapters, numbered as follows:

Response Section I: Cover Letter, Vermont Tax Certificate, and Insurance Certificate

The cover letter must be signed and dated by a person authorized to legally bind the Offeror to a contractual relationship, e.g., the President or Executive Director if a corporation, the

managing partner if a partnership, or the proprietor if a sole proprietorship. This must be completed and submitted as part of the response for the proposal to be considered valid.

The cover letter must include directly or by attachment the following information about the Offeror and any proposed subcontractors:

1. Name, address, principal place of business, telephone number, and fax number/email address of legal entity or individual with whom contract would be written.

2. Legal status of the Offeror (sole proprietorship, partnership, corporation, etc.) and the year the entity was organized to do business, as the entity now substantially exists.

3. Disclose if you, your Chief Financial Officer (or equivalent), or any persons who may be directly involved in this funded agreement including any executive level individuals or individuals assigned to this contract, over the past five years has been convicted, imprisoned, placed on probation or under supervision, or fined for any violation of any law including motor vehicle violations.

4. Disclose if you, your Chief Financial Officer (or equivalent), or any persons who may be directly involved in this funded agreement including any executive level individuals or individuals assigned to this contract, has been convicted of a felony.

5. Number of years of experience carrying out the activities outlined in this RFP.

6. Offerors should provide the organizational structure, including corporate structure through the regional office team that shall serve as the conduit for communication between DOC and the Contractor, facility level management, and the clinical care team. This should also include any governance or board structure.

7. Provision of a single point of contact to coordinate the RFP and contract negotiation process.

8. Statement showing agreement that Offeror's procedures shall be in compliance with all applicable Vermont specific requirements.

9. Insurance Certificate must be included in Response Section I.

10. Vermont Tax Certificate must be included in Response Section I.

Response Section II: Policies, Procedures, and Guidelines

Please provide all corporate policies, procedures, and guidelines related to the services requested within this document along with a statement attesting to the organization's understanding that these may need to be modified to comply with Vermont specific requirements as outlined in Section 5.1 of this document and throughout. In addition, include the organization's experience and approach to modifying policies, procedures, and guidelines to meet the individual needs of the contract/client including the process, responsible

person(s), and timeline.

Response Section III: Ability and Approach to Implement the Activities and Specifications of this Contract

For all sections within Section 5 – Scope of Work, please respond to include, as appropriate:

1. Philosophy or approach including evidence-based approaches when appropriate
2. Experience performing the services.
3. Operationalizing across whole integrated system of six facilities.
4. If the Offeror should choose not to address a certain Activity, Deliverable or Condition, the Offeror's proposal must clearly explain why and what the Offeror proposes as an alternative.

Response Section IV: References

Offeror must provide at least three (3) references along with the name, title, phone number, and email address of the person who can speak to the offeror's work and experience relevant to the services outlined within the scope of this RFP. These references should be willing to provide this information verbally or in writing.

Offeror must provide a list of current and former contracts held for services relevant to the size and scope of this RFP.

Offeror must provide a list of litigation including case names, docket numbers, and outcomes or current status.

Response Section V: Staffing

Offeror should submit a staffing plan that meets the needs and services requested within this document. In addition, Offerors should:

1. Consider that the requested services represent the desired state and not necessarily the current state.
2. Consider that there are recruitment challenges specific to Vermont and recruiting in rural locations.
3. Speak to approach/plan when staff needed are not available.

Response Section VI: Proposed Transition Plan

Offeror shall submit the proposed transition plan as described in Section 5.2 – Contract Transition and Onboarding Requirements.

Response Section VII: Quality Control

Refer to sections Section 4 – Contract Monitoring and Section 5.3.6 – Continuous Quality

Improvement Program and provide a statement attesting to understanding this and how the organization will comply and offer any enhancements.

Response Section VIII: Price Proposal and Financial Information

Submit Appendix 2 – Price Proposal

Submit the following information:

1. Current Ratio, as calculated by the formula: Current Ratio = Current Assets/Current Liabilities
2. Days in Cash, as calculated by the formula: Days in Cash = (Cash + Cash Equivalents – Restricted Cash) / [(Operating Expenses – Depreciation)/365]
3. Solvency Ratio, as calculated by the formula: Solvency Ratio = (Net Income + Depreciation) / (Short-Term Liabilities + Long-term Liabilities)
4. Debt Service Coverage Ratio, as calculated by the formula: Debt Service Coverage Ratio = earnings before interest, taxes, depreciation, and amortization (EBITDA) / (Principal + Interest Payments)
5. Available borrowing capacity
6. Available bonding capacity

Provide a complete set of audited financial statements for the past five years.

Provide evidence to support the Offeror's available surety bond or letter of credit (minimum of $500,000).

Provide balance sheet/financial statements, showing that the Offeror has been in business continually for the last three years.

Response Section IX: Innovative Initiatives

Provide any proposals for innovative initiatives as outlined in Section 3 – Innovative Initiatives (including the price proposals for these initiatives in the Appendix 2 – Price Proposal).

Response Section X: Contract Draft

Review Appendix 17 – Contract Template and provide a thorough response to each Attachment indicating if the Offeror has any concerns or requested changes. This should include the Attachment, section and subsection reference for all responses.

Provide a statement indicating that the Offeror has reviewed the terms and all provisions of the Request for Proposal, the State of Vermont contract template and insurance requirements and accepts conditions set forth. In addition, regardless of activities and services proposed by the Offeror, the State will expect the Offeror to comply with the scope as outlined in the contract.

7 PROPOSAL EVALUATION

7.1 Method of Award

1. The evaluation team will determine if each proposal is sufficiently responsive to the RFP to permit a complete evaluation of the individual/organization and experience. Proposals must comply with the instructions to Offerors contained in Section 6 – Proposal Requirements. Failure to comply with the instructions shall deem the proposal non-responsive and subject to rejection without further consideration. The State reserves the right to waive irregularities.

2. The State reserves the right to accept or reject any or all proposals. Upon completion of the evaluation process, the DOC will select one Offeror based on the evaluation findings and other criteria deemed relevant for ensuring that the decision made is in the best interest of the DOC. The selected Offeror will be requested to enter into negotiation with the State of Vermont on contract specifications, including detailed work plans, deliverables and timetables.

3. In the event the DOC is not successful in negotiating a contract with a selected Offeror, the DOC reserves the option of negotiating with another Offeror.

4. Any contract negotiated must undergo review and signature according to statute and policy.

5. Award of a contract and any renewals thereof are contingent upon availability of funds.

6. The contract is for an initial three-year term, beginning July 1, 2023, through June 30, 2026. The contract may be renewed without rebidding for up to two consecutive, one year periods as determined appropriate and in the best interest of the DOC with approval from the Administration.

7.2 Scoring Information

The DOC evaluation review team will evaluate proposals based on the criteria listed in Section 6 of this document. Proposals will be assigned points and scored as follows:

Section/Area of Review	Percent of Total Score
Price Proposal and Financial Information	20
Contract Monitoring	10
Scope of Work	70
Vermont DOC Requirements	30
Contract Transition and Onboarding	10
NCCHC Sections A-G	30