Crawford County

Commissioners' Office

REQUEST FOR PROPOSALS

INCARCERATED INDIVIDUAL HEALTH CARE SERVICES
CRAWFORD COUNTY CORRECTIONAL FACILITY – SAEGERTOWN, PENNSYLVANIA

AUGUST 1, 2025

A complete proposal to this RFP must be received
no later than 4:00 pm Eastern Standard Time
On **Friday, September 26, 2025** to:

Attention: Theresa Chimiak
Procurement Department
Crawford County Courthouse
903 Diamond Park – Meadville, PA 16335
(814) 333-7300, extension #7420
Email address: tmchimiak@co.crawford.pa.us

- **Late proposals will not be accepted.**
- **Proposals that are not submitted as described in Section 12.3 will not be accepted.**

Key Events Timeline

All deadlines are at 4:00 PM EST on the date shown. The Key Events and dates are tentative and subject to change.

Key Events

Event/Action	Date/Time
RFP release date	August 1, 2025
Deadline to submit Visitor Request for Bidders' Conference	August 12, 2025
Anticipated date County will notify visitors of approval (or denial)	August 14, 2025
Bidders' Conference	August 15, 2025
Beginning date for submitting written questions	August 1, 2025
Deadline for submitting written questions	August 22, 2025
Anticipated date of responses to questions	September 10, 2025
Deadline for submitting proposals	September 26, 2025
Anticipated date to notify selected bidder(s) for presentations	October 17, 2025
Anticipated date of bidder presentations	October 24, 2025
Anticipated date to notify bidders of selected Vendor	October 31, 2025
Anticipated date of Award Letter; based on contract agreements	November 21, 2025
Anticipated date of finalizing the contract	December 1, 2025
Anticipated contract start date	January 1, 2026

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Introduction

On behalf of Crawford County, the Board of Commissioners is seeking a correctional health care vendor to provide health services within the Crawford County Correctional Facility in Saegertown, PA. The successful vendor will be tasked with providing primary, dental, and Mental Health (MH) care and services to all incarcerated individuals across all levels of custody, meeting the community standard of care. Specifics related to "care" are further defined below, but this generally includes screening, assessment, treatment, care management, and all other health-related needs of incarcerated individuals, including, but not limited to, daily and routine care; medication management; care for chronic health conditions; care during MH crises (e.g., suicidal ideation, psychiatric decompensation); recommended screening for infectious diseases; treatment for moderate to serious MH conditions, to include cognitive, developmental, and other disabilities and conditions; treatment for substance use disorders; and treatment for comorbid conditions.

Section 1: Background

Section Content

1.1 Overarching Goals and Terms

1.1.1

Facility plans to enter into a contract with Vendor effective at 12:01 AM on the 1st day of January 2026 for a period of two years. Crawford County may elect to extend this Agreement for three one-year periods by ninety day advance written notice upon the same terms and conditions herein.

1.1.2

Vendor shall be responsible for providing comprehensive medically necessary health care in an ethical and humane manner to all individuals in custody, whether housed in Facility buildings or offsite, inclusive of individuals who are admitted/booked by proxy (i.e., are not physically present in the facility at the time they become the custodial responsibility of Facility). The care provided shall be constitutionally adequate, consistent with all federal and state civil rights laws and regulations, and consistent with the community standard of care. For individuals who have additional needs and health care vulnerabilities beyond those of the general incarcerated population, including, but not limited to women, the elderly, individuals who are cognitively impaired (e.g., dementia), individuals with disabilities, youth, and individuals identifying as LGBTQIA+, Vendor shall provide care for those needs consistent with the community standard of care.

1.1.3

Vendor shall provide first aid and other emergency care to staff, volunteers, visitors, or other non-incarcerated individuals on Facility property if the emergency occurs when Vendor staff are on premises, and until such time as community emergency services assume responsibility for the patient's care. Vendor is not responsible for providing non-urgent care (over-the-counter medication, etc.) to Correctional Facility Staff outside of true emergency situations.

1.1.4

Vendor shall also provide safe collection and disposal of all medical and biohazard waste.

1.1.5

The Crawford County Commissioners or their designee is the official County representative for this RFP and subsequent contract. Communication between the County and Vendor shall be directed through the Crawford County Commissioners or such other representative as the Commissioners shall designate.

1.1.6

The Board's contract with the Vendor shall include the following termination provisions:

- Termination by mutual agreement. In the event the parties mutually agree in writing, this Agreement may be terminated on the terms and dates stipulated therein.
- Termination without cause. Crawford County shall have the right to terminate this Agreement without cause and/or for convenience by providing Vendor thirty calendar days written notice via certified mail, return receipt requested; overnight courier with proof of delivery; or hand delivery with proof of delivery. Both parties acknowledge that they have received good, valuable, and sufficient consideration from each other, the receipt and adequacy of which are, hereby acknowledged by each party, for the County's right to terminate this Agreement without cause and/or for convenience. The parties agree that if the County erroneously, improperly, or unjustifiably terminates for cause, such termination shall be deemed a termination for convenience, which shall be effective as stated within this section.
- Termination for cause. In the event of a material breach of the contract, either party may provide the other party with written notice of the material breach. The other party shall have thirty days from the date of its receipt of such notification to cure such material breach. If the material breach is not cured within that time period, the nonbreaching party may, at its sole discretion, terminate the contract immediately. Material breaches shall include, but are not limited to, violations of local, state, or federal laws or regulations; removal from an accreditation program by the accrediting body; and noncompliance with the community standard of care, Facility policies and procedures, the terms or conditions required of any court order, settlement agreement, stipulation or other similar instrument, or the terms and conditions of the contract. Facility may, at its sole discretion, terminate this contract for cause if Vendor made any material misrepresentation in its written (bid submission) or oral (presentation) responses, assertions, or representations to this RFP.
- Termination for change in Vendor business status. Crawford County, in its discretion, may terminate this Agreement immediately upon Vendor's insolvency, bankruptcy, placement in receivership, or change of ownership.
- Termination for lack of funds. In the event the funds to finance this Agreement become unavailable, Crawford County may provide Vendor with thirty days' written notice of termination. Nothing in this provision shall be deemed or construed to prevent the parties from negotiating a new Agreement in this event.

1.2 Adherence to Standards, Regulations, and Laws

1.2.1

Vendor shall operate in compliance with 37 Pa. Code §95.232; all federal, state (including state-mandated jail standards), and local laws, ordinances, regulations; the Prison Rape Elimination Act of 2003; and the ADA. Vendor shall operate in compliance with any such requirements that do not exist now but are imposed during the life of the contract. Vendor shall cooperate with any monitoring required by any of the above.

1.2.2

Vendor shall adhere to the requirements of Pennsylvania's Medicaid Reentry Section 1115 Waiver program when defined by State including care, documentation, and reporting.

Pennsylvania's program has been named Keystones of Health. The program is currently under development and services are subject to change. Here is a link to proposed services for incarcerated individuals. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/keystones-of-health/documents/Keystones-of-Health-Reentry-Fact-Sheet.pdf.

1.2.3

Vendor shall adhere to the current edition of NCCHC Standards for Jails, the current ACA Standards for Jails incorporating any updates contained in ACA Standards Supplements and ACA Standards Committee Meeting Minutes, and any state-mandated correctional standards. If the relevant set of standards is updated, Vendor shall be required to adhere to the updated standards no later than six months after their publication. Where the standards conflict with any other requirement in this RFP, Vendor shall adhere to the more stringent requirement.

1.2.4

Vendor accreditation with NCCHC is preferred.

Section 2: Description of the Setting

Section Content

2.1 Community

2.1.1

Crawford County is located in northwest Pennsylvania, and is home to about 90,000 people, primarily White, with an average age of 38 years, and a median household income of $60,000. The Correctional Facility is a County-owned and operated secure institution with 180 jail cells and 265 beds. The facility exists for supervised custody of pre-trial defendants awaiting disposition of criminal charges, and for incarceration and rehabilitation of post-trial offenders serving sentences of up to two years. On average, in 2024, the daily incarcerated individual population was 164, the length of stay was 45 days, and the gender breakdown was 75 percent male and 25 percent female. The facility is administered by a Warden and governed by a Prison Board comprised of the three County Commissioners, President Judge, District Attorney, Sheriff and Treasurer. To facilitate healthcare services, the jail has a waiting room, an examination room, a medication room, a records/supply room, a nursing station and two hospital beds. Facility has a staff of approximately forty-six full time officers, two transport officers, one captain, six lieutenants, and numerous per diem officers. The County last issued an RFP for Incarcerated Individual Care in 2011. The current contractor has provided healthcare to the facility since 2011.

2.2 Facility and Custody Operations

2.2.1

A copy of the “Crawford County Correctional Facility – Inmate Handbook, dated 2024” is available upon request.

To access Facility, vendor employees will be expected to carry clear bags only, will be subject to search and inventory, and must clear the metal detector upon entry. Periodically, Facility experiences power surges that may impact operations.

During 2024, Facility processed the following population:

Population Information		January 1, 2024 thru December 31, 2024			
		Males	**Females**	**Other**	**Total**
Incarcerated Individuals in Jail		691	234	405	1330
Under 18	*<1%*				
18-35	*45%*				
36-55	*46%*				
Over 55	*8%*				
Number of Incarcerated Individuals Released		566	213	405	1184
Number of Days in the Period	365				
Average Daily Population	164				
Average Length of Stay	45.19				
Incarcerated Individuals Held > 24 Hours		633	214	380	1227

2.3 Health Care Operations

2.3.1

Due to security concerns, Facility Floor Plan and space details will not be published. Vendor is encouraged to request Facility Tour to learn more about the size and type of space available.

2.3.2

Facility currently has one nurse supervisor, five LPNs, one Medical Assistant, and one MH case worker. Additionally, a medical provider is on-site one day a week. Facility also offers psychiatric and dental services. Tuberculosis screenings are performed on all commitments.

2.3.3

The current health record system will not remain in place. Vendor is expected to bring its own health record system for use during the contract period.

2.3.4

Facility uses JailCore as its custody information management system. Vendor will have access to the JailCore system.

2.3.5

Because of security breaches due to the presence of cell phones, Facility does not permit use of such devices within the facility. Facility may make exceptions, on a case by case basis, for on-call medical staff. Any use of such devices should be coordinated with the Facility Warden or Deputy.

2.3.6

Facility maintains a Language line/video in all locations where scheduled care takes place and portable phones are available for emergency response to locations outside the clinic.

2.3.7

Incarcerated individuals can report a medical / mental illness or other health problem by 1) signing their name on the Sick Call Sign-up Form posted in their housing unit; 2) completing a Medical Request Form, located behind each sick call box, or 3) submitting an electronic request using their tablets. Incarcerated individuals must place all written medical requests in the locked (gray) identified Medical Request Box. Requests for the medical department cannot be submitted to the housing unit office.

For emergency treatment, incarcerated individuals should notify the Housing Officer or another staff member immediately.

2.3.8

No fees will be charged to an incarcerated individual for initial screening, initial physical exams, psychiatric services, emergency services, or treatment of chronic illness. Incarcerated individuals may be required to pay for certain medical services, though, at the discretion of the medical department supervisor. For example, if an incarcerated individual is not referred to the doctor after initial screening by the medical staff but demands to see the doctor, a fee will be charged for this service. If the doctor determines that the incarcerated individual should have been initially referred, the fee will be refunded to the incarcerated individual. Additional examples include but are not limited to:

- An accidental cut requiring stitches would most likely qualify as an emergency and not require a fee.
- A twisted ankle from activities in the recreation yard is not necessarily an emergency and may result in a fee.
- Treatment provided as a result of behavior which is criminal or in violation of jail policy will require a fee.
- Treatment required for self-inflicted injuries or injuries occurring during an altercation will require a fee.

In 2024, Facility fees were as follows (no services will be denied if an incarcerated individual cannot pay the fee):

- Nursing Encounter $4.00
- Provider Encounter $6.00
- Dental Encounter $4.00
- Prescription Medication None*

*Facility officials would like to implement a fee for over-the-counter medications.

2.3.9

The following medical cases occurred during 2024:

Utilization	
Requests for Non-Urgent Care:	
General	12
Work Injuries	11
Due to Incarcerated Individual Disputes	22
Due to MH	16
Detox Related	5
Common Chronic Health Conditions:	
High Blood Pressure	3
Diabetes	42
Seizure Disorder	4
Suicide Watch / Attempts	10
ER Visits	34
Hospital Admissions	5

2.3.10

Facility Correctional Staff handle incarcerated individual movement, as required for Restricted Housing Incarcerated Individuals. Incarcerated individual movement is performed during allocated times only. Vendor will deliver medication to incarcerated individual pods with monitoring performed by Correctional Staff.

Facility Correctional Staff conduct security rounds and patient checks, and are available for additional timed safety or welfare checks as needed by Vendor personnel.

Facility Correctional Staff perform unannounced cell checks for medications and will notify health care staff of any possession or usage patterns that are inconsistent with the way medication was prescribed. Correctional Staff will confiscate any medication.

2.3.11

Medications will be dispensed as ordered by the Medical Providers. Medical nursing staff will pass medications from within the housing unit. Housing unit officers shall monitor medication pass in accordance with Provision 2.3.12 below. If incarcerated individuals have questions regarding their medication, they are prohibited from discussing the issues during medication pass but may submit their questions using the sick call system or speak to the medical staff when they are on the unit other than during medication pass. Medical staff shall never openly discuss an incarcerated individual's diagnosis, treatment, or prognosis in the presence of other incarcerated individuals. All discussion will be conducted under private consultation.

2.3.12

Housing unit officers shall monitor medication pass. Incarcerated individuals are prohibited from discussing medical issues with the medical staff or correctional staff during medication pass. Televisions will remain in the 'off' position during medication pass. All incidents of "cheeking" or "palming" of medication will be investigated and disciplinary action taken. The Medical Provider will be notified of such occurrences. Incarcerated individuals will be required to have their mouth checked for compliance. Failure to comply with this directive can result in disciplinary action. Incarcerated individuals are not permitted to harass, badger, argue, or be disrespectful toward the nursing staff. If an incarcerated individual has a complaint, they will be required to follow established procedures and address their complaint in writing through the Inmate Request system or Grievance system. Correction staff shall never openly discuss an incarcerated individual's diagnosis, treatment, or prognosis in the presence of other incarcerated individuals. All discussion will be conducted under private consultation.

2.3.13

Incarcerated individuals shall follow the Inmate Grievance process in the Facility Handbook, for healthcare-related claims and issues arising from care provided by the Vendor.

1. First level contact is usually with a correctional officer or counselor.
2. If the incarcerated individual's complaint is not satisfied at the first level, they can discuss it with a Lieutenant.
3. If the complaint is still not satisfied, the incarcerated individual can discuss it with a Captain.
4. If the complaint is still not satisfied and the incarcerated individual wishes to file a grievance, they must follow the grievance procedure by filling out the grievance form in its entirety (including all names, dates, times, what happened or occurred) and placing it in the designated black box in the housing unit marked GRIEVANCE BOX.

    - Grievance officer will review the complaint and file a response within ten working days.
    - If the incarcerated individual is not satisfied with the Grievance Officer's findings, he/she may submit an appeal to the Deputy Warden, for review. The Deputy Warden has fifteen working days to respond to the grievance.

- If grievance is not resolved following the Deputy Warden's review, the incarcerated individual may submit an appeal to the Warden. Within thirty working days, the Warden will review the complaint and render a decision based on the policies, directives and procedure of this facility and applicable laws and regulation.
- If the grievance is not resolved following the Warden's review, the incarcerated individual has the option to appeal to the Prison Board. Within thirty working days, the Prison Board reviews the complaint and renders a decision based on policies, directives, and procedure of the facility and applicable laws and regulation.

Incarcerated individuals' grievances can also be submitted using the inmate visitation kiosk.

2.3.14

Facility has no pending lawsuits at the time of RFP issuance.

2.4 Medicaid

2.4.1

The State of Pennsylvania is a Medicaid expansion state.

Our state is a Medicaid suspension state. Coverage is suspended upon notification of incarceration.

Our state has applied for a Medicaid Reentry Section 1115 Waiver which was approved by Centers for Medicare and Medicaid Services.

Section 3: Vendor Resources

Section Content

3.1 Staffing Model

3.1.1

Vendor shall employ a minimum of:

- 2.0 FTE Nurses present during day shift;
- 2.0 FTE Nurses present during evening shift;
- 1.0 FTE Nurse present during night shift;
- 1.5 FTE MH provider available during business hours; and
- 1.0 FTE Medical Practitioner present one day a week.

3.1.2

Vendor agrees to provide adequate supervision of clinical staff to ensure safe patient care and to satisfy any regulatory requirements for supervision.

3.1.3

Vendor shall ensure that all staff on duty have active licenses, certifications, and/or registrations to legally perform the tasks they are performing or expected to perform.

3.2 Staff Salary and Compensation

3.2.1

For each type of position listed in Provision 3.1.1, indicate the minimal compensation you will offer. Compensation should be expressed as the hourly compensation and should include the monetary value of any benefits, whether benefits are offered, and any other enhancements to compensation

(e.g., bonuses, incentives). Label this response: **3.2.1 For each type of position listed in Provision 3.1.1, the minimal salary and benefits Vendor will offer.** *No word limit.*

3.3 Recruitment and Retention

3.3.1

Describe your plan for initial recruitment, ongoing filling of vacancies, and retention of frontline positions. Include a description of your recruiting resources, systems, and personnel. Label this response: **3.3.1 Plan for initial recruitment and ongoing filling of vacancies, with description of recruiting resources, systems, and personnel.** *600-word limit.*

3.3.2

Vendor shall notify Facility within two business days of any vacancy and its plans to fill the position. Vendor shall update Facility weekly on the status of any vacancies.

3.3.3

a. Vendor shall reimburse Facility for unspent staffing expense when positions are unstaffed. A position is unstaffed when an appropriately qualified individual is not performing the duties of that position. A position for which no one has been hired to fill the position and no one is temporarily filling the position is an example of an unstaffed position. Another example is the portion of a shift for which a full-time employed incumbent fails to report to work and for which no replacement reports to work for that period when the incumbent is absent. Unspent staffing expense is calculated as the sum of the hourly salary of the most recent incumbent in the vacant position plus the prorated hourly monetary value of benefits multiplied by the number of hours the position is unstaffed, or, if the most recent incumbent was a contractor, the hourly compensation of that contractor multiplied by the number of hours the position is unstaffed. If the position never had an incumbent (i.e., before the contract start date), unspent staffing expense is calculated using the corresponding data from the list of minimum salaries submitted in response to Provision 3.2.1.

b. Facility will deduct the amounts so calculated from its monthly payment to Vendor. Vendor shall also be responsible for paying liquidated damages resulting from understaffing as defined in Appendix A – Key Performance Indicators.

c. Vendor shall keep all positions filled and, if a frontline or first-level supervisory position is vacant or the incumbent is not at their post due to leave of absence, vacation, training, or any other extended absence, Vendor shall backfill the post (i.e., ensure that another qualified staff member is at the post).

d. Vendor shall fill a minimum of 85% of frontline and first-level supervisory positions with full-time employed staff or part-time employed staff working more than half-time (20 hours

per week). The following categories of workers do not contribute to this 85% requirement: contract workers contracted for less than six months; “PRN,” temporary, or pool workers, whether employed or contracted, if they are not scheduled to work at least twenty hours per week on a regular basis; agency staff; a full-time employee working more than 40 hours per week (in other words, a person may not contribute more than 1.0 FTE to the 85% calculation).

Neither reimbursement for unspent staffing expense or imposition of liquidated damages shall be construed to relieve Vendor of their responsibilities described herein and thus failure of Vendor to have staff in positions and at their assigned post will, at the sole discretion of Facility, be grounds for termination of the contract for cause.

3.3.4

All Vendor personnel who work on facility property may be subject to a background check at any time, at the Facility’s expense. All Vendor personnel who work on facility property may be subject to a drug screening as part of initial employment testing or at the discretion of the Facility Warden or Deputy, also at the Facility’s expense.

3.3.5

Vendor is required to notify Facility if any Vendor personnel who work on facility property experience any event that would affect their ability to pass a background check.

3.3.6

If at any time during the course of their employment or contract engagement, a Vendor employee or contractor engages in conduct (either on or off duty) that, at the sole discretion of Facility, threatens the security or reputation of Facility or would otherwise render that person ineligible for a security clearance, Facility reserves the right to withdraw that person’s security clearance and shall immediately notify Vendor.

3.3.7

Facility reserves the right, at its sole discretion, not to permit an individual on facility property based on results of a background check, drug screen, violations of any Facility rule or code of conduct, or a Facility or Vendor internal investigation.

3.4 Staff Continuation or Transition

3.4.1

Vendor agrees to honor and grant all paid time off earned but unused by employees of previous vendor for any individual who was an employee in good standing at the time the previous vendor’s

contract ends and who Vendor hires to work at Facility, whether or not there is a gap in employment.

3.4.2

Upon termination of the contract, if any individual who was an employee in good standing of Vendor within the final 30 days of Vendor's contract and will not continue to have employment by either Vendor or the new entity that will be taking over for Vendor, Vendor agrees to fully compensate the employee for any earned but unused paid leave.

3.5 Staff Overtime

3.5.1

Health care staff responsible for direct patient care shall not be mandated to work beyond the following limits: more than twelve hours in any 24-hour period; less than eight hours off between any two shifts; more than sixty hours in any seven consecutive days. Time spent on call is not included in the time limits.

The above limits on overtime may be extended during emergency situations in which a patient's safety is in jeopardy and no reasonable alternative can be found or during a declared emergency (e.g., prison riot, natural disaster). For purposes of the overtime limits, "emergency situations" are defined as unforeseen events that could not be prudently planned for and do not regularly occur. Failure to hire or retain adequate staffing is not an emergency situation.

3.6 Staff Preparedness

3.6.1

Describe your systems and processes for ensuring that clinical professionals have onsite access to up-to-date clinical resource materials. Label this response: **3.6.1 Systems and processes for ensuring clinical professionals have onsite access to up-to-date clinical resource materials.** *250-word limit.*

3.6.2

Vendor shall ensure that all of its employees and contractors have at all times a valid license, certification, registration, or other required credential to legally and safely perform the clinical activity they are responsible for and are up to date on all legally required continuing education. Vendor Facility Contract Liaison shall immediately notify Facility officials upon discovery of its staff or contractors performing clinical activities under this contract without the required credentials or continuing education.

Vendor agrees to provide all of its staff and contractors with all relevant training prior to staff members beginning work at Facility. Such training includes, but is not limited to, training on corrections-specific clinical issues, P&Ps, ethical standards, the emergency response plan, and professional ethics. The content, manner of training, verification of successful learning, and frequency of update or refresher training shall be consistent with reasonable industry standards.

3.6.3

Vendor agrees to assure that all MH clinicians (psychiatric practitioners, psychologists, master's-level counselors) have satisfactorily completed dedicated training in suicide assessment, treatment, and management within the past four years and every four years subsequently. Trainings must be of at least two hours in length and approved by any state that mandates such training for similarly credentialed professionals practicing in its state.

3.6.4

Vendor staff shall successfully complete Facility orientation and training on the first day of employment. Facility is responsible for the cost of provision of the orientation and/or training. Vendor is responsible for compensating the individual for the time spent in orientation and/or training. Facility reserves the right to bar any Vendor staff or subcontractor who has not successfully completed this training.

3.6.5

Describe your process for privileging your employed or contracted staff. Label this response: **3.6.5 Process for privileging employees and contracted staff.** *2-page limit.*

3.7 Policies and Procedures

3.7.1

The following requirements apply to health-related P&Ps:

a. All P&Ps shall be site specific (e.g., the policy statement "If Facility utilizes a paper health record…" would not be acceptable; a site either has a paper record or it does not.);
b. Vendor shall review health care-related P&Ps annually;
c. Vendor shall propose updates to P&Ps whenever there is a relevant change of the theater of operation (e.g., changes in the community, physical plant, operations, a pandemic) or updates are required due to a change in law, regulations, or accreditation standards. Vendor shall submit all proposed P&P updates or changes via their Facility Contract Liaison for approval.
d. Vendor shall annotate in P&Ps all changes to P&Ps with the reason for the change.

Facility does not have its own P&Ps but reserves the right to adopt, maintain, and modify, as its own, some or all of Vendor's P&Ps at contract end at no cost to Facility, without limitation, and without regard to whether in the future Facility self-operates health services, contracts with Vendor, or contracts with another vendor.

Section 4: Internal and External Coordination

Section Content

4.1 Interface Between Vendor and Facility

4.1.1

Vendor agrees to designate a Facility Contract Liaison. This individual or designee will serve as the primary route of communication between Vendor and Facility.

4.1.2

Vendor Facility Contract Liaison agrees to inform Facility officials of any critical information derived from Vendor meetings.

4.1.3

Vendor Facility Contract Liaison shall meet with designated Facility staff monthly and at other times as requested by Facility to address the current state of the contract and performance.

4.1.4

When requested, Vendor shall fully cooperate with and/or participate in Facility administrative activities or projects affecting, involving, or otherwise related to health services. In recognition of the need for communication, coordination, and collaboration among all operations of the facility, if requested, Vendor shall participate in Facility management meetings, even if not directly related to the delivery of health care.

4.1.5

Vendor clinical staff shall participate in all joint training exercises (e.g., man-down response, fire drill) scheduled by Facility, including exercise debriefing. Facility anticipates conducting such exercises approximately once per quarter for each shift.

4.2 Responsiveness to Requests for Data

4.2.1

Vendor Facility Contract Liaison shall immediately notify Facility officials of any requests for information from regulatory agencies, other government agencies, or parties acting on behalf of government agencies as well as Freedom of Information Act requests. Unless otherwise directed by the Facility officials, Vendor shall comply, in accordance with local and federal law, with such requests in a timely manner, including, but not limited to, provision of data or other information, access to the physical plant, access to personnel, and access to patients. Vendor Facility Contract Liaison shall immediately notify Facility officials of any other requests for information or access from the media, the public, or other entities; this is not meant to apply to requests for clinical information about a specific patient from care providers or family members in accordance with HIPAA requirements.

4.2.2

Vendor shall make available to Facility, at Facility request and at no cost, all clinical and business records, documents, and other materials relating to the direct delivery of health services to patients covered under the contract if the delivery of health services to a patient or patients is an issue in any public records request, claim, litigation, or complaint related to or against Facility, Vendor, or their agents, contractors, and employees as soon as possible, but no more than five business days after receipt of such request.

4.2.3

Vendor shall make available to Facility or other entity as appropriate, at Facility request and at no cost, all clinical and business records, documents, and other materials relating to the delivery of health services to patients covered under the contract or the performance of this contract, for any purpose, including, but not limited to, monitoring of this contract by Facility or its agents, any governmental or governmentally required oversight or audit, or any court-mandated or approved monitoring as soon as possible, but no more than five business days after receipt of such request.

4.2.4

Vendor shall ensure full cooperation and compliance with standard public records requests, including with respect to wrongful death settlements.

4.2.5

Vendor shall make its employed and contracted staff available to, and the physical plant accessible to, any internal or external body charged with examining, reviewing, or investigating the provision of health care to incarcerated individuals of the facility.

4.2.6

Vendor shall cooperate with any data sharing agreements that exist at the contract start date or are developed during the course of the contract between Facility and other external partners (e.g., public health department).

4.3 Judicial Appearances and Deadlines

4.3.1

In the event Vendor receives notification and fails to provide Facility with notice of any court-, regulatory-, or lawsuit-related notification, appearance, hearing, document request, or deadline that relates to Facility, Facility is entitled to the reasonable costs that result from this failure or delay. Request for payments lies in Facility's sole discretion.

4.3.2

Vendor shall make company representatives and lawyers available, at Vendor's expense, to attend court appearances or hearings when an incarcerated individual has raised any concerns about the quality of health care in the facility.

4.3.3

Except where a notice of a court hearing or appearance has been provided to Facility representatives, Vendor shall email information concerning any court or regulatory hearing, deadline, document request, or appearance in which Vendor has been noticed as soon as possible, but no later than 24 hours after receipt of the same by Vendor.

4.3.4

Information and/or documents concerning any such court appearances requested by Facility must be provided by emailing or faxing such information and/or documents to Facility as soon as possible, but no later than 24 hours after the request.

4.3.5

Vendor shall supply Facility with (a) a summary of all court appearances within 24 hours of such appearance, including the date, time, and location of any future court appearances, and (b) any follow-up reports and/or documentation requested by a court or Facility within two business days of receipt of such request or sooner when specified.

4.4 Internal Investigations

4.4.1

Vendor agrees that, unless Facility or Vendor are defending a pending or threatened third-party claim, Vendor and its employed or contracted personnel who work for/at the facility shall fully cooperate in any internal investigations undertaken by the jurisdiction concerning the health care provided by Vendor or its personnel, subject to state and federal privacy and confidentiality laws and provided that Vendor's legal counsel is afforded the opportunity to be present. If the jurisdiction or Vendor is defending a pending or threatened claim, Facility internal affairs investigators shall be allowed to interview Vendor personnel who work for/at the facility by submitting written questions to Vendor. Vendor shall request that staff answer the written questions. If ambiguities or other reasonable concerns arise regarding a particular written question, the parties will discuss them as soon as possible to avoid unnecessary delays.

Section 5: Data and Information Sharing by Vendor

Section Content

5.1 Periodic (Scheduled) Reporting by Vendor to Facility

5.1.1

Vendor shall provide report(s) at no additional cost unless modified by written agreement of the parties. Vendor shall provide all reports that are listed below, are required or suggested by NCCHC standards or by ACA, are required to meet Prison Rape Elimination Act of 2003 standards, or are requested by Facility.

At a minimum, each report shall be prepared monthly and submitted to the Facility Contract Liaison no later than the 15th calendar day of the following month, with cumulative reports provided annually, submitted within 15 days of the month following the anniversary of each year of the contract. In the final year of the contract, regardless of renewal, Vendor shall provide this data a month before the end of the contract. Facility will withhold payment on any contract pending receipt of these data.

Vendor shall provide Facility with the following monthly data and aggregate trends. Additional information is required throughout the RFP, including KPIs, but may not be listed with the data points noted here.

a. Health Services and General Requests:

- Number of intake screenings and number within designated time frame;
- Number of intake MH screenings and number of evaluations;
- Number of intake suicide risk assessments; % of new incarcerated individuals placed under suicide prevention or watch protocols;
- Number of requests for nonurgent health care received by general category (MH, substance use, primary care, dental, chronic care, general complaints, injury/wound care); reports by gender;
- Number of pregnant females;
- Number of postpartum females;
- Number of patient-initiated health records requests;

- Number of people needing urgent dental, vision, and hearing services;
- Number with common chronic diseases (high blood pressure, asthma, heart disease, hepatitis C, HIV/AIDS, diabetes, seizure disorder, and any other diagnosis for which the prevalence in your facility is greater than 2%);
- Number with health care insurance by type; and
- Number enrolled in Medicaid.

b. Substance Use Disorder:

- Number of intake substance use screenings;
- Number of positive illegal substance use screenings by reported drug prevalence;
- Number of admissions with intoxication or risk of withdrawal for each of the major drug categories (non-fentanyl opioids, fentanyl, benzodiazepines, other sedatives, stimulants, other drugs, alcohol);
- Number under withdrawal protocols by type of withdrawal;
- Number receiving MOUD maintenance; and
- Number receiving MOUD induction by type; number refusing MOUD.

c. MH:

- Number under care with serious mental illness;
- Number reported having a prescription for psychotropic medications:
    - Medications by numbers receiving the same psychotropic medications as prescribed in the community, receiving psychotropic medications initiated/not previously on medications, and initiated different than previously prescribed and
    - Number refusing psychotropic medications;
- For those with serious mental illness, include the main diagnosis groups such as anxiety, depression, bipolar disorder, personality disorder, schizophrenia, and any other diagnosis for which the prevalence in your facility is greater than 2%;
- Number of suicide attempts and suicide deaths; and
- Number on suicide watch.

d. Co-Occurring Conditions, Brain Injury, and Other Disabilities:

- Number with co-occurring mental illness and substance use disorders;
- Number with disabilities by type: intellectual and developmental disability, acquired brain injury, hearing, sight, activities of daily living/mobility, other; and
- Number of supports and accommodations by type.

e. Urgent and Emergency Services:

- Number of health-related in-house emergency responses;
- Number and list of patients (without patient identifiers) transported to the ER showing mode of transportation to the ER, whether patient was admitted to the hospital, and diagnosis;

- List of hospital admissions (without patient identifiers) each with Medicare Severity Diagnosis Related Groups and the total cost of the hospitalization, and whether the cost was borne by the vendor, insurer, facility, or patient;
- Total number of inpatient and 1-day length of stays; trending reports for average cost per admission; average length of stay; and
- List of deaths, including deaths in facility, offsite while still in custody, and offsite after release from custody but resulting from a clinical event that began while in custody.

f. Other Nonurgent Health Services:

- Number of specialty visits and consultations by type;
- List of pharmaceuticals used with doses and volumes;
- Number of health care grievances; and
- Number of incarcerated individuals for whom Vendor provided medical clearance for work activities.

g. Staffing Information:

- Vacancy rates by position and length of time;
- Staff turnover by voluntary vs. involuntary departure;
- Use of temporary agency staff by position, length of time, and current status; and
- Current health care staffing in as much detail as possible.

5.1.2

Vendor agrees to allow Facility to share any Vendor-prepared report, including, but not limited to, current health care staffing, with any entity of Facility's choosing, including, but not limited to, using such information in a future RFP.

5.1.3

Vendor agrees to provide to Facility a list of all employees who are eligible to accumulate leave, showing the employee's position, current hourly salary, and the number of accrued hours of leave, by category of leave, as of the date the list was generated. Vendor is required to provide the list only once during the life of the contract within thirty days of written request by Facility.

5.1.4

Facility may request tailored reports which shall be provided by Vendor at no additional cost within five working days.

5.1.5

Vendor shall provide all reports in compliance with the Medicaid Reentry Section 1115 Waiver as identified by the state waiver.

5.1.6

Vendor shall produce all qualitative and quantitative reports described in this RFP or data referenced in the RFP that are used to monitor the contract. For example, a Key Performance Indicator is "All refusals for medications, clinical encounters, and interventions are received in person by health care staff and in accordance with policy." Thus, to facilitate Facility monitoring of that indicator, Vendor shall produce a list of all patients, within the time period requested by Facility, who refused a medication, the name of the medication, and the date and time of the refusal.

5.2 Episodic (Event Driven) Reporting by Vendor to Facility

5.2.1

Vendor Facility Contract Liaison shall notify Facility officials immediately of any critical incidents. Critical incidents include, but are not limited to, incarcerated individual death; injury or other harm to incarcerated individuals that may be the result of Vendor staff action or failure to act; attempted suicide or other self-harm; Vendor staff injury in the workplace; security breaches, including drugs and weapons smuggled into the facility or used on facility grounds; extortion, blackmail, or other coercive or abusive action or behavior by Facility staff or incarcerated individuals against Vendor staff or by Vendor staff against Facility staff or incarcerated individuals; and any other event that would reasonably be important for Facility managers to be aware of. In the case of an incarcerated individual death, incident must be reviewed by an independent individual selected by the County. Vendor shall provide, with the notification, any additional details required to be submitted by the state entity responsible for collecting this data. However, Facility does not expect Vendor's health care professionals to breach patient–professional confidentiality unless required by law.

5.3 Ownership/Sharing of Vendor Administrative Records

5.3.1

Vendor shall share with Facility, at Facility's request and within a reasonable time frame, all administrative records supporting the delivery of health care under the contract. This includes, but is not limited to, training records; compilations from operational or clinical records (e.g., list of all medications used last quarter); attendance rosters; employee payroll; subcontractor agreements and payment information; and video, sound, or photographic recordings that do not become part of a patient's health record (e.g., video recording of provision of clinical care during emergency responses). Vendor acknowledges and agrees that Facility may share any information provided by Vendor with third parties if necessary to conduct facility business. Vendor shall list or describe any such information that it will not share with Facility or that Facility may not share with third parties. Label this response: **5.3.1 Agreement that Facility may share any information provided by Vendor with third parties if necessary to conduct Facility business. List/description of any such**

information that will not be shared with Facility or that Facility may not share with third parties.
1-page limit.

5.4 Coordination Between Vendor and Other Entities

5.4.1

When sending a patient to the ER (hospital-based or freestanding urgent or emergency care center), Vendor shall:

a. Have the nurse provide written or oral report to the emergency room nurse;
b. Inform their practitioner if he/she is not already aware;
c. Have their practitioner make initial contact with the ER to provide clinical information and set any expectations for care;
d. Have their practitioner contact the ER at the end of care to ensure coordination of care and assure that the facility is a safe environment and appropriate milieu to continue care;
e. Obtain full health records of the visit prior to or upon arrival of the patient back at the facility;
f. Evaluate the patient prior to return to a living unit and determine whether all necessary care was provided at the ER; and
g. Timely implement all clinically appropriate ER recommendations and document the clinical rationale for any deviations from these recommendations.

5.4.2

Upon admission of an incarcerated individual to a community hospital, Vendor shall monitor the patient's condition and work with the community hospital providers to effectuate a transfer back to Facility as soon as it is safe to do so. Vendor shall obtain reasonable additional resources (personnel, supplies, equipment) if necessary to effectuate the transfer.

5.4.3

When an incarcerated individual is admitted and meets inpatient criterial, Vendor shall assist in the Medicaid enrollment of the individual upon discharge from the hospital.

5.4.4

Upon admission of an incarcerated individual to a community hospital, describe how Vendor will accomplish the following:

a. Bidirectional sharing of health records;

b. Monitoring the condition and progress of the patient;

c. Concurrent review to minimize length of hospitalization; and

d. Communicating with the hospital to coordinate safe transfer back to Facility.

Label this response: **5.4.4 Upon admission of an incarcerated individual to a community hospital, how Vendor will accomplish bidirectional sharing of health records, monitoring the patient, concurrent review, and coordinating return to Facility.** *400-word limit.*

5.4.5

Vendor shall notify the Pennsylvania Department of Health of any patients who acquire a reportable disease under local or state law or regulations within the time frame required by the law or regulation.

5.4.6

Describe how you will coordinate care or exchange health information with other health care vendors or community resources/providers who are not employed by Vendor (and other than ER/urgent care or community hospital inpatient care addressed above) or data repositories, including, but not limited to, specialists to whom you refer a patient consultation and/or specialized care; state the Department of Corrections or other detention or forensic facility to which the incarcerated individual is being released from/transferred to; state vaccine database; state or community health information exchange; County MH counselors. In your description, address how you will ensure communication and coordination between you and each of these other entities, including how you will ensure that the patient's health record you maintain is complete (i.e., there is a unified health record). Also describe how you will resolve clinical disagreements between you and these other entities or among the other entities. Label this response: **5.4.6 How Vendor will coordinate care or exchange health information with other health care vendors or providers who are not employed by Vendor or data repositories.** *400-word limit.*

5.4.7

When requested to do so by Facility, and if the patient consents, Vendor shall assign an employee to communicate with a hospitalized patient's family regarding the patient's condition, treatment, and prognosis. Vendor's staff shall follow all of Facility policies regarding limits on information sharing due to security concerns.

5.5 Facility Recordings

5.5.1

The facility has still, sound, and video recordings that may include images of vendor staff (e.g., recording of emergency response, security cameras).

Vendor agrees to allow its staff to be included in recordings made as part of the operational need of Facility as allowed by state law. These recordings may be archived, shared with the public or authorities, and used for training or any other purpose without Vendor or Vendor staff's permission. There is no liability for doing so and Vendor, their staff, and all related parties expressly release Facility from any liabilities for doing so and waive any and all related claims.

Section 6: Cost Modeling, Billing, and Cost Recovery

Section Content

6.1. Cost Modeling

6.1.1

Submit a proposal for your costs under a capitated model for all care. Specify how often the model is readjusted. Label this response: **6.1.1 Cost proposal under a capitated model and how often the model is readjusted.** *No word limit.*

6.1.2

The contract base price must be guaranteed firm for two years. Vendor must also show what the base price would be in terms of equal monthly installments of $1/12^{th}$, which is how Facility will compensate Vendor. In addition, indicate what the cost per incarcerated individual per day and per year would average as derived from the base price. Be sure to specify any proposed price contingencies related to trends in the incarcerated individual population — for example, a per-diem charge above, or a refund below, an average census of 165. The subsequent base price for option years 3, 4 and 5 will be adjusted annually on each anniversary of the contract (to be continued if the contract is extended) as follows. The rate will be increased relative to the previous year by 3% or the average Consumer Price Index for All Urban Consumers, U.S. City Average, Expense category, Medical Care category, for the six consecutive months beginning seven months prior to the anniversary month, whichever is lower.

6.2 Facility vs. Vendor Costs

6.2.1

Unless otherwise stated in this RFP, Vendor shall bear all costs related to the provision of health care, including, but not limited to, the following:

a. Medical, dental, MH, and substance use-related care in facility;

b. Pregnancy-related and postpartum care and birth control, including specific care described elsewhere in this RFP;

c. Medical supplies;

d. Transportation services, including, but not limited to, nonemergency ambulance, 911 ambulance, and airborne evacuation;

e. Offsite use of emergency services, urgent care center, hospital, rehabilitation center, long-term care facility, and hospice care;

f. Medical evacuation ordered by Facility staff if they believe, using the reasonable judgment of a lay observer, that time is of the essence, whether this occurs before requesting authorization from Vendor staff, or after Vendor staff has been notified of the situation but have declined to authorize evacuation;

g. Offsite or onsite emergency care, urgent care, testing, imaging, other diagnostics, specialty care, radiation, physical therapy, and occupational therapy;

h. Pharmaceutical and pharmaceutical-related expenses, including, but not limited to, medications, medication administration supplies, pharmacy license, and pharmacy inspections;

i. The provision, maintenance, and repair of durable medical equipment, prosthetics, orthotics, corrective lenses, hearing aids, and other assistive devices, including the cost of such equipment if the patient is discharged to home with it, unless, upon discharge, the equipment can be paid for by another entity and the patient has seamless access to necessary equipment during reentry;

j. Biohazardous and pharmaceutical waste management and disposal;

k. Licenses, including, but not limited to, pharmaceutical, radiology, and dental activities, and Drug Enforcement Administration licensure;

l. Provision and operation of an EHR in accordance with the requirements described in Section 9;

m. Computer equipment, copying/printing equipment including faxing and scanning capabilities;

n. Wi-Fi access;

o. Legal defense of Vendor, Facility, County, and/or agent, employee, and/or contractor for claims/lawsuits related to the services contracted for, including attorneys' fees and costs and damages awarded via settlement or jury verdict;

p. Legal fees for appearance in court related to complaints about health care;

q. Fines, penalties, judgments, and settlements against Facility for failure to perform any activity required to be performed or facilitated by Vendor under the contract; and

r. See Provision 8.4.2 for details regarding the costs of supplies and equipment.

6.2.2

Vendor is not responsible for the following costs:

a. Neonatal care or
b. Care in state MH facilities for court-ordered restoration of competence.

6.2.3

Vendor is responsible for all costs related to the provision of health care, as described in this RFP, for individuals when they become the custodial responsibility of Facility, whether or not they are housed in the facility (e.g., "booking by proxy"). Conversely, if an individual who is being transferred to the authority of Facility is rejected at intake for any reason, including health care instability, and Facility does not assume custodial responsibility, Vendor is not responsible for any health care provided.

6.2.4

The science of medicine grows and evolves. New diseases, new treatments, and new approaches to care are likely to arise during the life of this contract. Where such changes are substantial in novelty, breadth, and cost, it is Facility's intention to negotiate amendments to the contract. Two examples of such changes are the discovery of highly effective treatments for hepatitis C, a highly prevalent disease among incarcerated individuals, along with national guidelines recommending widespread treatment, and the COVID-19 pandemic. It is Facility's expectation that Vendor will negotiate in good faith to arrive at amendments that are fair to both parties. On the other hand, where changes are incremental and/or not substantial in novelty, breadth, or cost, it is Facility's expectation that Vendor will adjust the care it provides, in accordance with the community standard of care; Vendor shall not be entitled to additional payment or other contract modifications. Examples of such incremental changes include availability of an expensive biologic disease-modifying drug for a disease that is not highly prevalent and for which none existed before; the shift in national guidelines for management of high cholesterol in certain at-risk individuals, recommending treatment with statins regardless of cholesterol levels.

6.3 Furniture and Equipment

6.3.1

Vendor shall inspect health care and non-health care equipment, furniture, and supplies of each health services area during Facility Tours. All health care and non-health care equipment, furniture, and supplies remaining onsite on the first day of the contract are owned or leased by Facility, unless otherwise specified. The final equipment list will be verified by the parties on the first day of the contract. Equipment, furniture, and supplies onsite on that day may be used/consumed by Vendor. Repair and replacement of equipment, furniture, and supplies, whether owned or leased by Vendor or by Facility, now or in the future, shall be the responsibility of Vendor during the term of the contract. If and when any equipment, furniture, or supplies require replacement, they shall be replaced with material that is state of the art at the time of replacement.

6.4 Pharmaceutical Purchasing and Costs

6.4.1

Vendor shall indicate cost methodology and any dispensing fees and/or management fees associated with prescriptions and stock items. Label this response: **6.4.1 Cost methodology and any dispensing fees and/or management fees associated with prescriptions and stock items.** *100-word limit*.

6.4.2

Indicate whether your bid considers any pharmaceutical price savings programs (e.g., 340B) and describe those programs. Label this response: **6.4.2 Whether bid considers any pharmaceutical price savings programs and description of those programs.** *100-word limit*. After the contract is signed, Vendor agrees to pursue any available special pricing programs that could be pursued only after contract signing or that become available during the life of the contract and agrees to notify Facility if it participates in any such programs. In the event Vendor does participate in any such program, Vendor agrees to negotiate a contract amendment with Facility whereby savings from such programs are shared between Vendor and Facility.

6.5 Cost Recovery

6.5.1

Facility and Vendor agree to cooperatively explore and implement agreed-upon billing opportunities as local, state, and federal laws and rules change.

6.5.2

Any funds recovered from any payor for care provided to incarcerated individuals by Vendor or paid for by Vendor, whether paid directly to Facility or Vendor, shall become the property of Facility.

6.5.3

Vendor understands and agrees that Facility is responsible to conduct a cost reconciliation in compliance with local and state fiscal rules and agrees to assist Facility as needed in this activity. Vendor and Facility agree to rectify any disputed charges identified within ninety days of completion of a facility audit report.

6.5.4

Vendor is responsible for timely application to payors, including, but not limited to, Medicaid, private health insurer, or grantor, for any health care provided to incarcerated individuals that those entities should cover. Vendor is responsible for cooperating with any inquiries from payors that are required for, or facilitate, payment. Vendor is responsible for paying for such care initially if there is any delay in payment by the payor.

6.6 Fees Charged to Patients

6.6.1

Facility charges a fee for certain health services as described in Provision 2.3.8. Vendor shall follow Facility P&P regarding generating a charge for services when allowed. Vendor shall not deny a patient any care described in this RFP due to the patient's inability to pay a fee. Any fees collected become the property of Facility.

6.7 Facility Payments to Vendor

6.7.1

Vendor Facility Contract Liaison shall submit a monthly invoice, via mail and email, to the Warden. The invoice amount shall be the monthly installment of $1/12^{th}$ the agreed upon base price. Vendor's invoice shall be dated no earlier than the first federally recognized business day of the following month. Facility shall render payment to Vendor within thirty calendar days of Facility receipt of an accurate and complete invoice, less any amount allowed by any other provision of the contract.

6.7.2

Vendor shall provide Facility timely access to any and all of Vendor's records that are necessary to verify the accuracy of any part of Facility payment to Vendor that is contingent upon Vendor's performance, activities, purchases or acquisitions, or payments.

6.7.3

At Facility's sole discretion, Facility may withhold part or all of a monthly payment to Vendor if Vendor has failed to produce complete, accurate, and true documentation necessary to verify the accuracy of any part of Facility payment to Vendor that is contingent upon Vendor's performance, activities, purchases or acquisitions, or payments, or has failed to produce any report or document required by the contract that was due by the time of the monthly payment.

6.8 Act 22 Rates

6.8.1

Pennsylvania law caps the fees medical providers can charge for incarcerated individual healthcare services at Medicaid and Medicare rates under Act 22.

Section 7: Contract Performance Monitoring

Section Content

7.1 Contract Monitoring

7.1.1

Facility will have sole discretion in recruiting and selecting individuals to serve as Facility monitors of Vendor performance under the contract. Selected individuals will report directly to the Warden.

7.2 Key Performance Indicators (KPIs)

7.2.1

Facility will conduct audits of the KPIs (see Appendix A) as often as monthly, at the County's discretion. For each event, Vendor shall identify and provide all relevant information, in usable format, within 14 business days after the end of the time period measured by the audit. For example, if a KPI measures whether Vendor conducted all required health screenings of newly admitted patients within four hours of admission, Vendor's list would include the names and identification number of all individuals admitted during the audit period, the date and time of admission, and the date and time of the screenings, if they were done. Vendor shall facilitate access to the health record by parties selected by Facility to conduct such audits. Continued performance below the specified level may result in application of penalties as agreed upon between the parties prior to contract signature. Facility will provide Vendor with results and explanations for all audits to allow Vendor the opportunity to contest the results. Any contest must be communicated by the Facility Contract Liaison within thirty days of receipt and include specific items with which it disagrees. Facility will take this input under advisement; any Facility decisions are final. Vendor shall submit a corrective action plan within two weeks of any subthreshold KPI finding. Severe, repeated, or chronic failures to satisfy performance indicators may, at the sole discretion of Facility, constitute cause for terminating this Agreement.

Section 8: Scope Of Health Services—Direct Care

Section Content

8.1 Health Care Delivery/Scope of Services

8.1.1

Vendor shall designate a health services administrator who ensures that Vendor maintains a minimally adequate system for health care delivery in compliance with the contract.

8.1.2

Vendor shall be responsible for providing all medically necessary health services, including, but not limited to, primary care from a primary care provider; MH care from a master’s-level or higher

licensed MH therapist, psychologist, or psychiatric practitioner (psychiatrist, nurse practitioner, physician assistant); dental care; nursing care; episodic care for new symptoms or complaints; diagnostic services; preventative services; and treatment for chronic, episodic, urgent, and emergent conditions, whether such care can be provided onsite by Vendor's employed or contracted staff or the care must be provided offsite by health care providers in the community.

8.1.3

All health care (see glossary for the scope of this term), and the documentation supporting that care, that is delivered to patients during a clinical encounter; in response to an inquiry from a nurse or patient; during a chart review or chart-based triage decision; or upon receipt of test results, a consultant's report, or other external health record shall be clinically appropriate. This shall include, but not be limited to, conducting the history and physical/psychological examination, forming and testing a differential diagnosis, arriving at a diagnosis, ordering and ensuring the provision of treatment for that diagnosis, ordering all follow-up care in a clinically appropriate time frame, and clinical documentation. In assessing the clinical appropriateness of care for the purposes of this provision, Facility recognizes that two reasonable clinicians might provide different care in the same situation. Clinically inappropriate care is any care that puts patients at significant risk of serious harm.

8.1.4

Orders from health (medical and MH) care staff in the outpatient and inpatient areas shall be completed within the time frame ordered. This includes, but is not limited to, diagnostic tests, follow-up visits with nurses or practitioners, requests for outside records, and treatments.

8.1.5

Vendor's staff shall conduct clinical encounters in venues and in a manner that allows for auditory and visual confidentiality from other patients and nonclinical staff. Visual confidentiality requirements apply at those times when an examination reveals portions of the patient's body or the patient is touched in ways that would not be visualized or touched, respectively, in the typical prison environment. Exceptions may be made for encounters where providing such confidentiality would legitimately jeopardize safety, including emergency situations, or would be clinically inappropriate (e.g., attempting to move a patient in a crisis cell to a clinical visit room). In those cases, breaches of confidentiality are limited to the measures required to ensure safety, and all staff shall maintain the confidentiality of any information they acquire because of the breach.

8.1.6

Vendor shall obtain oral or written informed consent consistent with community standards or the requirements of state or local laws, whichever is stricter. In addition, informed consent shall be obtained when beginning antipsychotic medication treatment or MH treatment of previous trauma. Some individuals (e.g., people with some disabilities or MH conditions) may require additional

explanation or support to understand and complete an informed consent. A global consent for any treatment, for example, a consent form that patients are asked to sign upon admission to a facility, is not an informed consent and does not satisfy any requirement for informed consent. Vendor shall inform patients of any limitations on confidentiality, consistent with state and local law and regulations. This information may be provided upon admission to the facility.

8.1.7

Vendor may use telehealth to deliver services under this Agreement as long it is clinically appropriate to do so. Where physical examination is required, clinical appropriateness may be achieved by the use of devices operated by assistants at the bedside (e.g., digital stethoscope) or surrogate examiners, provided that assistants and examiners are directed to do so by the clinician conducting the visit and are appropriately qualified to execute the activity, and in-person examination by the clinician is not necessary.

8.1.8

Vendor shall ensure control and accurate accounting and inventory of all instruments, scissors, syringes, needles, scalpels, and other sharp tools for which it is responsible.

8.2 Patient Evaluations

8.2.1

Whenever Vendor clinical staff are scheduled to be present in Facility, they shall prescreen every individual brought to Facility for admission, prior to the departure of the arresting officer. If the individual does not pass the prescreening, Vendor shall inform Facility staff member in charge of the reception area that the individual is not clinically safe to be accepted into Facility and should be deferred to a hospital. Vendor may use an LPN appropriately credentialed according to state law provided that (a) they use a structured prescreening form that does not require the LPN to make an assessment or clinical judgment, (b) they have immediate access to a medical practitioner for consultation, and (c) an intake screening is conducted as soon as possible but no later than four hours after the individual's arrival. If Vendor intends to use an LPN, submit a copy of the structured prescreening form these staff will use. Label this response: **8.2.1 The structured prescreening form LPN staff will use.** *1-page limit.*

8.2.2

Vendor shall conduct an intake screening as required by NCCHC Jail Standard J–E–02 Receiving Screening within four hours of arrival at the facility, augmented by the following:

a. Assess the individual's English language fluency; if not English fluent, determine a language in which the individual is fluent and ensure that that information is available to all Vendor

staff who will interact with the individual (e.g., making the information visible on all relevant screens of the patient's EHR).

b. Conduct the screening confidentially in a language in which the individual is fluent.

c. For all women, screen for pregnancy by urine test.

d. Screen for mental illness using the Brief Jail MH Screen (BJMHS) or the Correctional MH Screen (CMHS) for men or women.

e. Screen for cognitive impairment and mobility limitations.

f. Screen for current suicide risk using a validated instrument (e.g., Columbia-Suicide Severity Rating Scale).

g. Screen for the ability to perform activities of daily living and function safely in a correctional environment (e.g., ability to hear and understand commands, ability to evacuate in case of fire).

h. Educate the individual about how to access emergency, urgent, and routine care.

i. Complete screening requirements contained in Guidelines for Managing Substance Withdrawal in Jails.

j. Complete screening requirements contained in At-a-Glance: CDC Recommendations for Correctional and Detention Settings: Testing, Vaccination, and Treatment for HIV, Viral Hepatitis, TB, and STIs.

k. Inform the individual that even if their screening did not reveal a Substance Use Disorder requiring immediate attention, Substance Use Disorder treatment is available.

l. All screening tests are offered using an opt-out approach.

If the screening is conducted by an LPN or lesser-credentialed individual, any positive (abnormal) findings on any screenings shall be immediately communicated to a medical practitioner.

8.2.3

A master's-level or higher licensed MH professional will conduct a secondary screening within 12 hours of notification by the intake staff for any patient who screens positive for mental illness or increased suicide risk during the intake screening or is referred during the intake process for any other reason. If the patient requires routine ongoing MH/psychiatric services, the patient will be seen for a comprehensive MH and/or psychiatric evaluation within fourteen days. For emergent and urgent needs, a comprehensive evaluation or follow-up will be ordered within clinically appropriate time frames.

8.2.4

Vendor shall ask during intake if the patient is experiencing dental issues or has dental concerns. If the patient expresses concern, the intake official will refer the patient to the dentist for an examination.

8.2.5

Vendor shall communicate any functional needs of the patient identified during the screening process to custody staff as soon as the screening is completed. These needs include, but are not limited to, lower bunk; lower tier; accommodations for visual, auditory, mobility, or other impairments; and dietary restrictions due to food allergies.

8.2.6

Initial medication management: For patients admitted directly from the community, Vendor shall ask the patient about medications they are taking AND medications they have been prescribed but are not taking; confirm this information; query a community pharmacy database (e.g., Surescripts®, Express Scripts®, Optum Rx®) of Vendor's choosing to obtain a list of the patient's most current prescriptions in the community; and query the state's Prescription Drug Monitoring Program. Patients will receive the next dose of any confirmed medication they are taking. For example, if a patient is taking a medication twice a day and took the first dose of the day at its scheduled time before arrival, staff will administer the second dose of the day before day's end. For any medication that cannot be confirmed or that the patient reports they were prescribed but have not been taking, a prescriber will be contacted for patient-specific orders regarding the medication in question prior to the next scheduled (based on the patient's report) dose. If that medication is not available, clinically equivalent alternate medications are provided as clinically indicated.

Initial medication management: When a patient is admitted in transfer from another correctional or health care facility, the patient shall receive the next dose of any medication they were taking at the transferring facility. For example, if a patient is taking a medication twice a day and took the first dose of the day at its scheduled time before arrival, staff shall administer the second dose of the day before day's end. If that medication is not available, a prescriber will be contacted for patient-specific orders.

8.2.7

In the absence of a substantial clinical indication, medications that have been effective for the patient in a previous setting will be continued in Facility, whether or not on formulary. This expectation applies even if there has been a gap in the patient taking the medication. Prescriber comfort with, or general preference for, a particular medication does not constitute a clinical indication. If there is a substantial clinical indication to discontinue, replace, or change the dosage/dosing/formulation of a medication that was effective, the prescriber will make reasonable attempts to discuss the change with the patient's community provider of that medication if clinically appropriate, and will meet with the patient, explain the reason for the change, and provide education about the new plan.

8.2.8

Vendor shall conduct an intake health-focused assessment as required by NCCHC Standard J–E–04 Initial Health Assessment. If Vendor conducts an intake health assessment within 72 hours of arrival, Vendor must re-interview the patient later to confirm the information received during the initial intake health assessment. If a nurse conducts the focused assessment and identifies an abnormality on physical examination, the patient shall be examined by a medical practitioner in a clinically appropriate timeframe not to exceed fourteen days of the nurse's examination.

8.2.9

Vendor shall augment the above assessment with the following:

a. Screen for traumatic and acquired brain injury using a standardized tool;
b. Screen for post-traumatic stress disorder using a standardized tool;
c. Screen for functionally appropriate hearing, vision, and activities of daily living;
d. Screen for intellectual disability using a standardized tool; and
e. Educate the individual about how to file a grievance concerning the provision of health care.

8.2.10

For a patient who has previously been in the custody of Facility, Vendor shall obtain and review (a) paper health records from the most recent admission, if they exist, by no later than one business day after the patient's arrival, and (b) electronic health records, if they exist, immediately. If there is a community-based clinical database available to Facility or its agents, Vendor shall access and review that database within 12 hours of admission.

8.3 Nonurgent ("Episodic") Medical and MH Care

8.3.1

When a patient submits, through the nonurgent pathway, a request for care, communicates a health concern, or describes symptoms related to physical health, the patient shall be evaluated face-to-face (in person or, if clinically appropriate, by telehealth) in a timely manner, not to exceed 72 hours.

8.3.2

When a patient submits, through the nonurgent pathway, a request for care, communicates a health concern, or describes symptoms, related to a mental, emotional, or behavioral health need, the patient shall be cared for based on their current status on the MH caseload (i.e., under the care of a MH professional at Facility):

a. The patient is not currently on the MH caseload: The patient will be handled according to Provision 8.3.1, i.e., via the pathway for physical health needs. At the conclusion of that pathway, the patient shall be referred to a MH professional if clinically appropriate.

b. The patient is currently on the MH caseload: The patient's primary therapist or, if necessary, another master's-level counselor shall triage the request within 24 hours of receipt. "Triage" in this context means determining whether the request requires immediate attention and resolution or whether the request can safely be deferred until the primary therapist can address it. Documenting the word "triaged" is adequate evidence of triage. Primary therapists shall address the request within three business days of its submission. "Address" means evaluating the request, determining the clinical need, and, if an action is required (e.g., face-to-face visit), planning that action to occur in a clinically appropriate time frame. When the primary therapist is absent, another master's-level counselor or a psychologist completes these tasks in their stead within the same time frame.

8.3.3

Facility's mechanism for patients to request care for an episodic problem is described in Provision 8.3.1. For patients who cannot use this mechanism (e.g., individuals in segregation or without access to tablets or kiosks), Vendor is responsible for soliciting requests from such patients in person at least once per day and ensuring that such patients receive indicated care in accordance with Provisions 8.3.1 and 8.3.2.

8.3.4

Vendor agrees to adhere to the following procedures regarding patient refusals and cancellations. Patients may refuse any onsite or offsite provider-initiated health visit and cancel any patient-initiated visit. All cancellations of patient-initiated visits shall be made directly to Vendor staff by telephone, video, tablet message, or face-to-face. All refusals of provider-initiated onsite health visits shall be informed refusals and made by telephone, video, or face-to-face with a nurse or medical practitioner for medical visits or a master's-level therapist, psychologist, or psychiatric practitioner for MH visits within three days after the appointment. All refusals of offsite health visits shall be informed refusals and made by telephone, video, or face-to-face with a nurse or practitioner before the appointment. If a patient will not voluntarily participate in the direct communication with health care staff required here, health care staff shall go to the patient's location. For a refusal to be an informed refusal, the patient must have decision-making capacity; be informed of the reason for the intervention they are refusing; be informed of the risks and benefits of their decision; be offered reasonable alternatives, if any exist; and have all reasonable questions answered by a health professional who has sufficient knowledge of the clinical subject matter to safely conduct the refusal.

8.3.5

A medical practitioner must be onsite at least one day per week. Use of telehealth must be consistent with the requirements of Provision 8.1.7.

8.3.6

At the completion of an encounter in which the patient receives a new diagnosis (of a chronic, acute, or transient condition) or a new medication, medical staff shall, when appropriate, provide the patient with relevant educational materials in a language and at a level that the patient understands.

8.3.7

Describe your process for identifying which patients require placement in specialized health-related living units (e.g., MH residential unit, MH inpatient unit, MH close observation unit, medical infirmary, supportive/adaptive housing, medical isolation). Label this response: **8.3.7 Process for identifying which patients require placement in specialized health-related living units.** *400-word limit.*

8.3.8

Vendor shall care for patients with acute or chronic conditions in accordance with corrections-specific and non-corrections-specific national practice guidelines where such guidelines exist.

8.4 Urgent and Emergent Care

8.4.1

When on the premises, a nurse, or medical practitioner ("responding medical staff") must respond immediately to any emergency request from custody staff or a patient and for anyone (staff, incarcerated individual, visitor) on facility premises. The responding staff must be trained in first aid and CPR, including the provision of artificial respiration. Vendor P&P for emergency response must award to the responding medical staff, regardless of their credential, the authority to direct evacuation of the patient to the hospital without further approval, if, in their sole opinion, time is of the essence.

8.4.2

Responding medical staff shall have available to them, to bring to an emergency, necessary first aid equipment and supplies, including, but not limited to, supplies and equipment to control bleeding and ventilate and manage airways, supplemental oxygen, supplies and equipment to measure vital signs and blood sugar, nasal naloxone to reverse an opioid overdose, and emergency medications addressed in emergency protocols. Emergency protocols may include administration of medications by a non-prescriber without a patient-specific order if it is clinically appropriate to do so during the interval between arriving at the scene and when the responding staff can safely contact a medical practitioner for orders or the arrival of ambulance staff. Submit a copy of any emergency protocols you plan to utilize and a list of emergency supplies and equipment that will be available to responding staff. Label this response: **8.4.2 Emergency protocols Vendor plans to utilize;**

emergency supplies and equipment that will be available to responding staff. *Response limited to protocols and lists.*

8.4.3

A nurse or medical practitioner shall examine all incarcerated individuals after an altercation or use of force, whether or not an injury was reported. If a nurse is the examiner, he/she shall consult with a practitioner after the examination unless the examination is normal.

8.4.4

When notified by custody staff of a patient who states that they have a health care need that cannot wait for access through the nonurgent pathway, a nurse shall triage the patient immediately, either by seeing the patient or talking to the patient directly over the phone. Based on the triage results, the nurse shall discuss the patient with a medical practitioner or MH professional (licensed master's-level MH professional, psychologist, or psychiatric practitioner) in a clinically appropriate time frame, not to exceed four hours. Based on that interaction, the professional who was contacted shall see and treat the patient the same day; or instruct the nurse on treatment to provide and, if necessary, schedule the patient for further evaluation or treatment in a clinically appropriate time frame; or determine that the health care need is not urgent and that a reasonable patient would not have considered the health care need to be urgent and therefore defer treatment and instruct the patient to access care through the nonurgent pathway. All interactions with the patient, communications, decision-making, and care shall be documented in the patient's health record.

8.4.5

Vendor acknowledges that custody staff have the authority to arrange for evacuation of patients for emergency care without involvement of, or approval by, Vendor if, in the reasonable lay judgment of the custody staff, time is of the essence. Vendor further acknowledges that it is responsible for the costs of such care and any care that follows as a result.

8.5 Mental Health Services

8.5.1

Vendor shall provide a comprehensive MH care program to ensure that patients' MH care needs are treated in a clinically appropriate manner and time frame, using an appropriate combination of screening and assessment, individual psychotherapy, counseling, group therapy, residential treatment services, crisis intervention, medications, discharge planning/community linkage, and medications and monitoring of symptoms and side effects of medication.

8.5.2

Vendor shall assign all patients with an active MH diagnosis to a primary therapist. A primary therapist must be licensed as a master's-level therapist, psychologist, or psychiatric practitioner. If state law allows, a primary therapist may also be an unlicensed master's-level therapist supervised by a licensed psychologist. The primary therapist shall serve as the single point of contact and coordination for providing MH care for the patients assigned to them. When a patient's assigned primary therapist is unavailable, another therapist acts on their behalf. Vendor may assign the patient to a different primary therapist if a patient's living unit changes and the current primary therapist does not cover that unit. For each of their assigned patients, the primary therapist shall (a) ensure there is an up-to-date treatment plan, (b) ensure that the plan is being followed, (c) update the patient's master problem list, and (d) provide treatment in accordance with the treatment plan.

8.5.3

Vendor shall assign all patients receiving psychotropic medications to treat a mental illness to a psychiatric practitioner unless the patient's PCP documents that such assignment is not necessary because the PCP is managing the patient's psychotropic medications.

8.5.4

An MH provider shall always be available on-call when onsite MH staff are not available.

8.5.5

As cited in Provision 6.2.2, Vendor shall not be responsible for the cost of court-ordered competence to stand trial restoration in a state MH facility (or competence restoration conducted within Facility by the state or other entity).

8.5.6

Upon an individual's return to Facility following restoration of competence to stand trial, Vendor shall be responsible for implementation of the treatment plan recommended by the competence restoration facility staff, including, but not limited to, dispensation of the same medication(s), in the same formulation, at the same dose and dose frequency, unless clinically necessary to modify them. Vendor shall make every effort to maintain patient competence.

8.5.7

Individuals who are potentially suicidal, self-injurious, and/or require a heightened observation status will be identified and referred for further evaluation and/or appropriate stabilization/management immediately.

8.5.8

For any person who demonstrates suicide danger signs, verbalizes suicidal intent, or is otherwise deemed to be suicidal or self-injurious, Facility agrees to place them in a suicide-resistant cell, immediately notify health care staff, and maintain constant one-on-one observation. Vendor agrees to assess the patient by a master's-level or higher licensed MH professional within six hours to determine the level of risk and develop an appropriate treatment plan. The MH professional shall inform appropriate custody personnel in writing and orally, initially, and in the event of any changes, of the minimal frequency of suicide monitoring by custody staff and safety measures that should be in place (e.g., limiting access to clothing, utensils, reading materials, yard or recreation, showers, phone, and other objects). Until the MH professional determines that the risk of suicide/self-harm is low enough that the patient can be released from suicide precautions, a master's-level or higher licensed MH professional shall evaluate and provide appropriate clinical interventions to the patient at a clinically appropriate frequency, but no less often than daily, in a clinically appropriate setting. Use of closed-circuit TV monitoring may be used as an adjunct to, but not in place of, in-person observation. The use of other trained or untrained incarcerated individuals as companions or aides may be used as an adjunct to, but not in place of, custody or health care staff. A psychiatric practitioner shall evaluate the patient within one business day of admission to suicide watch.

8.5.9

When clinically necessary to conduct continuous suicide watch, Vendor shall be responsible for the watch. Vendor may engage appropriately trained and supervised nonprofessional staff to conduct such watch and provide social engagement with the patient.

8.5.10

Vendor's psychologist or psychiatric practitioner shall recommend housing patients on suicide watch in the same room with other suicide watch patients ("co-horting") whenever clinically safer than housing each patient in isolation. Facility agrees to accommodate such recommendations whenever space, custody staffing, and custody classification allow for it.

8.5.11

Vendor shall ensure that every patient on any level of suicide watch or in any type of crisis stabilization bed is evaluated at least daily in a clinically appropriate setting in person by a master's-level or higher licensed professional. For each patient, the professional shall develop a care plan that will include appropriate evaluation, patient-specific treatment, and follow-up during and following discharge from such status, including a follow-up visit within 24 hours of discharge from such status. The patient shall be offered appropriate treatment interventions aimed at stabilizing the patient and reducing the behaviors/symptoms that triggered the placement at least daily. A psychiatric practitioner shall assess the patient as soon as possible after admission to suicide watch or a crisis stabilization program, but no longer than one business day.

8.5.12

When a patient's MH needs exceed the scope of onsite MH services (e.g., the patient requires inpatient psychiatric hospitalization), the patient shall be referred to an appropriate clinical setting within a reasonable and clinically appropriate time frame. When timely transfer is not possible, the patient shall be monitored at least daily and provided with enhanced treatment services to ensure stability and decrease the risk for decompensation until the transfer can occur. Documentation shall reflect efforts made to secure a timely transfer.

8.6 Dental Care

8.6.1

Dental care is not limited to management of pain, extractions, and temporary fillings. Vendor shall provide all dental care to include dental restoration, periodontics, endodontics, prosthodontics, and oral surgery to treat medically necessary dental conditions and preserve functionally important teeth. When performing fillings, Vendor shall perform permanent fillings unless there is reasonable clinical uncertainty about whether the filling is the definitive care required by the tooth.

8.6.2

All patients are asked during intake if they are experiencing dental issues or have dental concerns. If the patient expresses concern, the intake official will refer the patient to the dentist for an examination.

8.6.3

Patients with dental nonurgent or emergent needs that cannot be safely managed by a primary care medical practitioner shall be seen by a dentist within two weeks of referral unless the referring practitioner orders the patient seen in a different time frame.

8.7 Specialty Care

8.7.1

If Vendor requires practitioners to obtain prior approval for any interventions, the process shall include the following elements:

a. If nurses are involved in the approval process, they can approve but cannot deny; denials must be executed by a medical practitioner along with documentation of the clinical basis for the denial.

b. The patient's practitioner (i.e., the ordering practitioner) must document acceptance of the denial (i.e., the practitioner is documenting that they are ordering a new plan of care) or must appeal the decision.

c. The appeal must be reviewed by a different medical practitioner than the one who issued the original denial.

d. The patient's practitioner must address a denial of an appeal in the same way described above for the initial denial.

e. The patient's practitioner's order for the intervention (the nature or the timing of the intervention) may be changed only by that practitioner or another practitioner who has a practitioner–patient relationship with the patient (e.g., a supervising practitioner who takes over care of the patient, a practitioner who is covering for a practitioner who is absent). Any changes must be clinically appropriate.

f. All activities described above must be documented in writing and become part of the patient's health record.

g. Notwithstanding any time required for the prior approval process, the order must be executed within the time frame ordered.

8.7.2

Describe which interventions, if any, require prior approval and how such requests for approval are processed. Label this response: **8.7.2 Interventions that require prior approval and how such requests for approval are processed.** *1-page limit.*

8.7.3

Vendor shall be responsible for arranging all clinically appropriate specialty care (either onsite or offsite), including, but not limited to, clinical specialists, hospital care, testing, and imaging. Vendor shall enter into contracts with providers of such care, as necessary, to accomplish this goal. Vendor shall coordinate with the identified custody transportation staff to ensure that visits occur at a time that is mutually acceptable given patient needs, specialist availability, and Facility resources. Describe your company's experience and resources for building networks of community-based specialty care providers and how you envision developing the network for Facility. Label this response: **8.7.3 Experience and resources for building networks of community-based specialty care providers and how Vendor envisions developing the network for Facility.** *1-page limit.*

8.7.4

Upon receipt of recommendations from a specialist to whom Vendor (Vendor's agent, or another specialist engaged by Vendor) referred a patient for clinical care or advice, Vendor shall follow those recommendations unless it is clinically inappropriate to do so, and such reasoning is documented.

8.8 Hepatitis C Virus

8.8.1

Vendor shall screen all incarcerated individuals for Hepatitis C Virus upon admission by blood test according to guidelines of the Centers for Disease Control and Prevention. Vendor shall continue Hepatitis C Virus treatment started in the community. Vendor shall provide counseling to patients whose screen is positive for Hepatitis C Virus. Vendor shall initiate treatment for patients with Hepatitis C Virus in accordance with national guidelines. Exceptions may be made for patients with markedly reduced life expectancy who would not be expected to benefit from treatment, or patients who cannot complete treatment within the time frame of their incarceration.

8.9 Transgender Health and Gender-Affirming Care

8.9.1

For transgender individuals arriving on hormone treatment, Vendor shall continue this same (medication and dose) treatment without interruption unless clinically indicated. For transgender individuals who are not on hormone treatment upon arrival and who will remain in Facility for more than one month, Vendor shall have the patient evaluated by a qualified practitioner and provide appropriate treatment, on a case-by-case basis, consistent with the current edition of Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People developed by the World Professional Association for Transgender Health.

8.10 Women's Health Care

8.10.1

Vendor shall provide:

a. Access to menstrual products that are free and readily available to individuals in accordance with the First Step Act's provisions over federal prisons;
b. Prenatal testing and care consistent with the guidelines of the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, or other national guidelines, as appropriate;
c. Pregnancy termination at the request of the patient consistent with the standard of care and in compliance with the law;
d. Sterilization at the request of the patient if coincident to another procedure;
e. Access to a reversible method of birth control of the patient's choosing prior to release;
f. The ability to pump breast milk in a private setting and a means to safely make the milk available to the infant;
g. Monitoring for and, when needed, treatment of postpartum depression; and
h. Access to specialty gynecologic and obstetric care as clinically indicated.

8.10.2

Vendor shall not require a pregnant patient to undergo induction of labor unless recommended by a board-certified obstetrician for clinical reasons.

8.10.2

Vendor shall provide breast and cervical cancer screening consistent with national guidelines.

8.11 Prison Rape Elimination Act of 2003 Care

8.11.1

Vendor shall provide all immediate and long-term physical and MH care that is required under Prison Rape Elimination Act of 2003 or that is otherwise clinically indicated. Vendor shall also follow all other requirements of Prison Rape Elimination Act of 2003 for staff within a facility. However, other than ensuring that any physical evidence is not destroyed, Vendor staff shall refer to a community hospital or other community resource a patient who requires initial clinical evaluation for a suspected rape.

8.12 Care to Assist Hearing and Sight

8.12.1

Vendor shall repair broken hearing aids and replace hearing aid batteries when necessary. Vendor shall evaluate hearing loss and provide assistive devices when necessary medically, to accomplish activities of daily living, or for compliance with the ADA or standard of care.

8.12.2

Vendor shall evaluate visual impairment and provide assistive devices when necessary medically, to accomplish activities of daily living, or for compliance with the ADA or standard of care.

8.13 Substance Use Disorder Services

8.13.1

For individuals who enter jail while taking prescription medications associated with physiological dependence (e.g., opioids, sedatives, anxiolytics, stimulants) or prescription medications to treat Alcohol Use Disorder or Opioid Use Disorder, health care staff should first immediately attempt to verify the prescription. Except as noted in Provision 8.13.6 with regard to access to methadone, verified medications (including MOUD) shall be continued, using the same medication at the same dose or a dose-equivalent within-class substitution without interruption unless otherwise ordered

by a prescriber based on documented clinical need. If the medication cannot be verified, the practitioner (medical or psychiatric) will be contacted as soon as possible for patient-specific orders regarding the medication in question prior to the next scheduled (based on the patient's report) dose. The practitioner's orders shall be consistent with national guidelines and clinically appropriate practice and Facility will not utilize a forced detoxification program or policy before evaluating a patient for Opioid Use Disorder and providing MOUD to a patient who would benefit or continuing a patient on MOUD.

8.13.2

Patients diagnosed with Substance Use Disorder, whether identified as being intoxicated, in withdrawal, or at risk of withdrawal, shall be offered and provided medication (including MOUD) and treatment consistent with national standards of care. The presence of illicit substances in the patient's urine or blood, or the absence of MOUD in the urine of a patient claiming to take the medication, should not preclude the patient from receiving MOUD in the facility unless there is a clinical reason to do so. Failure to provide MOUD because of the presence of illegal drugs in the body, because of a lapsed prescription, because the patient was never treated with MOUD, or because the patients diverted MOUD or took diverted MOUD while in custody violates the Americans with Disabilities Act and often the Rehabilitation Act.

8.13.3

If the intake screening indicates that the patient is at risk of withdrawal but there is no current evidence of intoxication or withdrawal, the patient shall be monitored using the appropriate tools. If the intake screening indicates that the patient is intoxicated or in withdrawal, or if a patient originally only at risk of withdrawal later manifests symptoms of withdrawal, the patient shall be managed according to policies/procedures/protocols and patient-specific orders, after consultation with a practitioner (medical or psychiatric). Patients withdrawing from opioids will be offered treatment using buprenorphine or methadone when clinically appropriate based on their clinical status, including Clinical Opiate Withdrawal Scale score. Patients who are intoxicated or in withdrawal will be comanaged with MH professionals including assessment for suicide risk. Patients will be discharged from acute substance-related treatment only upon a patient-specific order from the practitioner.

8.13.4

A nurse or practitioner (medical or psychiatric) shall make rounds in the acute substance-related treatment area daily.

8.13.5

Patients who are at risk of withdrawal but never manifest withdrawal may be released from monitoring without consultation with a practitioner (medical or psychiatric) provided that the

policies/procedures/protocols governing the release consider the expected time course of withdrawal for the particular drug(s) and the patients' history of substance use.

8.13.6

Patients with Alcohol Use Disorder shall be offered treatment with a medication approved by the Food and Drug Administration. Patients with Opioid Use Disorder shall be offered, as clinically appropriate, buprenorphine, naltrexone, or methadone. Decisions regarding which MOUD to use shall be made jointly by the practitioner (medical or psychiatric) and the patient and should be based on medical need, not funding, facility or staff preference, or security factors.

8.13.7

For patients receiving an oral buprenorphine medication, once the patient is on a stable dose, Vendor shall offer to convert the patient from the oral form to a long-acting injectable (Sublocade® or Brixadi®) if in the patient's best interest.

8.13.8

Vendor shall evaluate every patient for Opioid Use Disorder at intake and regularly (at least every two months) throughout their time in custody. Vendor shall provide MOUD to any patient who would benefit. Vendor shall begin treatment for Opioid Use Disorder as soon as clinically safe to do so without requiring patients to undergo complete withdrawal. If a patient opts for treatment with naltrexone, however, the patient will go through complete withdrawal prior to beginning treatment. The different MOUD medications are not interchangeable and a change in dosage or medication should only be made if medically appropriate and in the patient's best interest.

8.13.9

If a patient declines MOUD or elects to use naltrexone, Vendor shall use a tapering dose of buprenorphine supplemented, as clinically necessary, with supporting medication for pain, nausea, diarrhea, and alpha-adrenergic hyperactivity.

8.13.10

If a pregnant patient was prescribed and taking MOUD in the community, the medication should be continued throughout pregnancy. MOUD shall be continued after birth and for as long as the patient would benefit. If Vendor does not have access to an Opioid Treatment Program, Vendor shall either transfer the patient to the hospital or engage the assistance of a medical practitioner experienced in substance use disorder treatment in pregnant patients to convert the patient from methadone to buprenorphine if in the patient's best interest.

8.13.11

Once substance withdrawal is under control, Vendor shall offer all patients screening, brief intervention, and referral to treatment and shall provide information on linkage to services upon release. In addition to the provision of medications, patients who remain incarcerated beyond three weeks shall be offered substance dependence counseling, including, as appropriate, individual psychotherapy, counseling, group therapy, and residential treatment services.

8.13.12

Vendor shall provide care for Substance Use Disorder consistent with Guidelines for Managing Substance Withdrawal in Jails published by the Bureau of Justice Assistance and the National Institute of Corrections.

8.14 Hunger Strikes, Food or Water Refusal

8.14.1

When notified (or independently aware of) an incarcerated individual has declared that are on a hunger strike or is refusing food or water for more than one day or has had a significant change in eating habits, Vendor shall assess the patient's decision-making capacity and respond accordingly, monitor the patient's condition appropriately, create a treatment plan that includes appropriate multidisciplinary members, attempt to identify one or two members of the team who will have consistent interaction with the patient, educate the patient and staff who interact with the patient about the risks of the patient's behavior, and encourage and ensure any fluid, nutrient, or vitamin intake that will reduce the risk of harm (e.g., glucose and thiamine ingestion). Vendor shall honor the right to clinical autonomy for medical decisions of any patient with decision-making capacity.

8.15 Health Care for Individuals in Restrictive Housing Units

8.15.1

Within 24 hours of facility staff notification to Vendor that an individual has been, or will be, placed in a restrictive housing unit, a nurse, medical practitioner, or psychiatric practitioner will screen the patient's health record to determine whether the patient has any active acute or chronic medical or MH diagnoses. If the patient does have such a diagnosis, the patient's PCP (if the patient has medical diagnoses) and/or primary therapist (if the patient has MH diagnoses) will review the patient's case (including an examination, if appropriate) to determine whether such placement poses a health risk to the patient. If the PCP and/or primary therapist is not available, the patient may be evaluated by another practitioner/therapist acting on behalf of the PCP/primary therapist. This PCP and/or primary therapist review must be completed within the same initial 24-hour period. If the medical or MH review indicates that placement poses a risk, the clinician will immediately notify facility staff.

Note that the screening and review described in this provision is in addition to the evaluation after use of force described in Provision 8.4.3.

8.15.2

Vendor shall provide the same access to care and level of health care for incarcerated individuals in restrictive housing as this RFP requires for care of any individual in general population.

8.15.3

A nurse shall conduct welfare checks on any incarcerated individual in restricted housing at least daily. The check requires (a) sufficient oral and visual interaction with the incarcerated individual to make a general determination whether they appear to be unstable or in any distress mentally or physically, and (b) a specific inquiry as to whether they have any health care needs. Urgent needs are met immediately. Nonurgent needs result in an appointment no later than the next day in which episodic clinic is held. Rounds shall be conducted at least weekly by a professional who by their education, credentials, and experience are permitted by law to evaluate and care for the health and/or MH needs of patients. All health care evaluations – aside from the activities of the daily checks described above – will take place either wholly inside the patient's room or in another room appropriately equipped for the encounter and will be confidential from other incarcerated individuals.

8.16 Terminally Ill and End-of-Life Care

8.16.1

Vendor shall provide care for patients at end of life consistent with the community standard, including the use of medically necessary narcotics medications for pain relief. Vendor may provide such care itself or contract with an external provider (e.g., hospice) at its own expense. A qualified professional shall discuss end-of-life care and advance directives with any patient with serious acute conditions or with a life expectancy less than one year and offer to assist with execution of any advance directive documents. With the patient's consent, Vendor shall include family or friends in end-of-life planning.

8.16.2

When requested to do so by Facility, Vendor shall participate in notification of a next-of-kin following an incarcerated individual's death.

Vendor shall allow patients to participate in the state's death with dignity process, if passed in the future.

8.17 Patient Education

8.17.1

Vendor shall provide patients with education, at a minimum whenever a diagnosis is made, the status of a condition changes, there is an abnormal or unexpected test result or finding, or the patient requests education. The education may be oral or via another medium, as appropriate, and must be in a language the patient understands and at an appropriate level for their comprehension. Because many encounters do not require patient education, especially when they involve chronic conditions, the wholesale and/or rote inclusion of a statement such as "education provided" in EHR progress note entries, in the absence of meaningful education, generally would not satisfy the requirement of this provision.

8.18 Medication Services

8.18.1

Vendor shall conduct all pharmaceutical procurement, storage, handling, and medication administration in compliance with all federal, state, and local regulations and NCCHC and ACA accreditation standards.

8.18.2

Vendor shall use patient-specific medications that family members bring from home after verification of the medications prior to ordering medications de novo. Label this response: **8.18.2 Process for verifying medications family members bring from home.** *200-word limit.*

8.18.3

Prescription medications shall be administered or delivered to the patient only on the order of a licensed prescriber. However, if the patient arrives with medications in hand, or someone brings the patient's medications to Facility, and medical staff validate that the medication in the container matches the dispensing label, appropriately licensed medical staff shall administer the medication as indicated on the container and contact Facility prescriber for further instructions.

8.18.4

Prescribing and discontinuation of medications is the sole province of Vendor's licensed prescribers. Neither risk of diversion alone nor instruction from facility staff to discontinue a medication for security reasons can be a reason for discontinuing a medically necessary medication, though a prescriber may consider these and other factors on a case-by-case basis as they would in a community setting, to arrive at the most appropriate clinical decision. A patient's history of nonadherence may be considered as a factor in discontinuing a medication as long as the decision is a clinical one using the same criteria that would be applied in a community setting. Facility agrees to

defer to health care staff with regard to prescribing and discontinuation of medications and will not interfere with the decision to start or discontinue any medication, including controlled medications.

8.18.5

Administration of medication shall be by individuals properly trained and under the supervision of the health authority and Facility administrator or designee.

8.18.6

Prescribed medications intended for directly observed therapy (DOT) administration are administered as ordered or there is documentation of a valid reason for non-administration. Documentation includes the identity of the administrator. Valid reasons for failure to administer a medication as ordered include unavailability of the medication as long as the patient receives a clinically appropriate substitute; a declared emergency (e.g., natural disaster, weather emergency); a force majeure; a facility riot or lockdown; a sudden staff absence (e.g., a medication nurse taking ill during their shift); and patient refusal. Chronic understaffing or understaffing that was foreseeable or for which a contingency plan should have been in place are not valid reasons for non-administration.

For a patient newly admitted (e.g., transfer from another of the jurisdiction's facilities, return from a hospital stay, admission from a jail) and already on a medication in their previous venue, the first dose of a medication shall be administered DOT in time for their next regularly scheduled dose. For all other patients, the first dose of a newly ordered medication shall be or administered DOT within the time frame ordered or, if no time frame is specified, within a clinically appropriate time frame not to exceed 24 hours.

8.18.7

Medication administration is documented on a medication administration record.

8.18.8

Unavailability of the patient (e.g., "no-show") or of the medication (e.g., gap due to delayed refill or renewal) are not valid reasons for not administering the medication. Refusal is a valid reason, but only if the refusal is expressed face-to-face between the patient and the health care staff member and if the medication refusal policy is followed. A patient's refusal of a medication (or classes of medication), based on the specific medication or class and the number and pattern of refusals, shall trigger the medication administrator to escalate the case to a higher authority within a specified amount of time (which may differ by medication or class). The higher authority then shall be responsible for determining the reason for the refusal and securing the patient's adherence with the medication, or finding a clinically appropriate alternative treatment, or ensuring that the patient is making an informed refusal, or ensuring the execution of whatever clinically appropriate action is ordered by a prescriber.

8.18.9

To reduce stigma, medication lines shall not be disease specific, except – if necessary – for insulin and MOUD (for example, there shall not be separate medication administration processes or lines for HIV or psychotropic medications).

8.18.10

In locations where nurses are unable to easily transport the medication cart used for nurse-administered medications, nurses may pre-pour the medications as long as (a) the nurse who pre-pours is the same nurse who administers, (b) the medications are not out of the control of that nurse between these two activities, (c) the pre-poured medications are labeled with all information required by state law, and (d) the nurse documents on the medication administration record as soon as they return to the medication cart.

8.18.11

Vendor will develop and implement formulary with all prescribers (medical practitioner, mental health, and dental) and pharmacy and county.

8.18.12

Describe the process for a practitioner to prescribe a nonformulary medication. Label this response: **8.18.12 Process for a practitioner to prescribe a nonformulary medication.** *200-word limit.*

8.18.13

Describe your process for procuring DOT medications for use while patients are incarcerated. For example: Do you receive patient-specific medications from a pharmacy or do nurses administer medications from stock? For patient-specific medications, do you obtain them from a distant pharmacy, local pharmacy, or onsite pharmacists? If using a distant pharmacy, what is its turnaround time? Do you use a computerized order entry system or paper/faxed orders? How will you procure medications that are needed quickly? Label this response: **8.18.13 Process for procuring DOT medications.** *400-word limit.*

8.18.14

Describe your process for procuring medications in a timely manner, including MOUD if applicable, that must be provided to patients in hand upon release. Label this response: **8.18.14 Process for procuring medication to be provided to patients in hand upon release.** *400-word limit.*

8.19 Diet and Nutrition

8.19.1

Vendor shall order medical diets whenever clinically necessary. Vendor and Facility agree to work collaboratively to design an offering of medical diets that meets the clinical needs of patients but minimizes the number of distinct diets.

8.19.2

Vendor shall inform Facility if they identify a patient's nutritional need that is not addressable by a current facility diet and work with Facility to meet the patient's need.

8.20 Laboratory, Electrocardiogram, and Radiologic Testing

8.20.1

List the CLIA-waived tests Vendor will perform onsite. Label this response: **8.20.1 CLIA-waived tests Vendor will perform onsite.** *Response is limited to the requested list.*

8.20.2

List any CLIA moderate or high complexity tests Vendor will perform onsite. Label this response: **8.20.2 CLIA moderate or high complexity tests Vendor will perform onsite.** *Response is limited to the requested list.*

8.20.3

Vendor shall provide or arrange for, onsite or offsite, all medically necessary laboratory, imaging, and other diagnostic or disease management tests; clinical interventions; and consultations at Vendor's expense. For nonurgent plain X-rays and routine ultrasonography, Vendor shall arrange for mobile services to perform tests onsite. Vendor shall perform EKGs onsite and arrange for real-time electrocardiogram interpretation for nonroutine Electrocardiograms.

8.21 Digital Monitoring

8.21.1

Vendor may use remote (wired or wireless) digital patient monitoring (e.g., vital signs, respiratory movement, thermal imaging) as an adjunct to, but not as a replacement for, in-person assessments.

8.22 Use of Restraints

8.22.1

Vendor shall use clinical restraints or monitor restraints applied by custody staff for security reasons only in accordance with the current NCCHC standard on restraint and seclusion.

8.22.2

Clinical restraints shall be used only as a patient safety measure. They are applied only pursuant to an order by a medical or psychiatric practitioner, or by a psychologist or master's-level MH counselor with the approval of a practitioner. Every effort shall be made to minimize the restrictiveness and length of time in restraints. They shall not be used for more than four hours at a time unless renewed by a medical or psychiatric practitioner, and renewals must be at intervals no longer than four hours. The justification for continued use shall be documented in the patient's health record along with attempts and interventions provided to the patient in order to reduce behaviors and symptoms requiring clinical restraints. Patients shall be restrained only in settings that allow nurses sufficient access to perform wellness checks and provide necessary medical care. Nurses shall ensure that the restraints do not impair any essential health needs, such as breathing or circulation to the extremities. These checks shall be documented in the patient's health record. Patients in restraints shall be under direct observation at all times and shall be monitored in accordance with the NCCHC standard on restraint and seclusion. If an observer notes any ill effects of the restraints, every effort shall be made to remedy the ill effects, and a medical or psychiatric practitioner shall be notified immediately. Patients shall be removed from clinical restraints only by order of a medical practitioner (if the patient was placed in restraints for medical reasons) or a psychiatric practitioner, psychologist, or master's-level MH counselor (if the patient was placed in restraints for MH reasons).

In exceptional cases (e.g., a patient who is self-harming himself by opening the sutured closing of an abdominal incision when it is expected that healing of the wound requires the wound to be undisturbed for weeks), the renewal interval may be extended. Such extension requires the written approval of the facility medical director and includes appropriate monitoring of the patient to ensure patient safety.

Section 9: Ancillary Health Services

Section Content

9.1 Health Records and Requests

9.1.1

Vendor shall maintain an adequate health record consistent with the community standard, including, but not limited to, the following attributes:

a. The health record problem list shall be accurate, complete, and easily usable. “Easily usable” includes, but is not limited to, the following qualities: resolved or historical conditions or diagnoses are separated from current conditions; the date of onset or resolution of resolved or historical conditions or diagnoses is indicated, if known. Diagnoses of current conditions are listed only once; redundant diagnoses do not appear. For example, a problem list would not simultaneously list “heart disease,” “heart failure,” and “congestive heart failure, not otherwise specified.” The user of the record shall be able to easily view relevant background of listed conditions. For example, a diagnosis of congestive heart failure might be accompanied by such information as “Diagnosed by echocardiogram in 2014 with ejection fraction of 35%. Repeat echocardiogram 2019 shows ejection fraction of 25%.” A diagnosis of schizophrenia, multiple episodes, currently in partial remission, might be accompanied by such information as “Failed treatment with a variety of first- and second-generation antipsychotics. Started on clozapine 2022.”

b. For EHRs, imported or scanned documents (e.g., diagnostic test results, consultation reports, hospital discharge summaries) shall be filed in a clear and usable manner. For example: Documents shall be scanned into the health record within two business days of receipt, reviewed within four business days of receipt, scanned right side up, readable as a single file (for a multipage document), and accurately labeled with meaningful titles/file names. Fewer than 1% of files have titles/file names that begin with “Miscellaneous” or “Other.” Scanned documents shall be dated (and appear in any programmed or ad hoc list according to this date) based on the clinically relevant date of the document, not the date scanned. Examples of clinically relevant dates include the following: laboratory test – the

date the test was reported by the lab, discharge summary – the date of discharge, a prior health record – the date it was received, and an imaging study – the date of the study.

c. For paper health records, the records shall be maintained in a clear and usable manner. For example: All documents shall be legible with the printed name, title, and signature of its creator and the date and time of its creation; documents shall be filed in chronological order; external documents shall bear the date they were received at Facility, shall not be filed in the record until reviewed and initialed by a practitioner, and shall be filed in the record within four business days of receipt.

Clinically relevant, acute and chronic conditions shall include a clinically appropriate treatment plan.

9.1.2

Vendor shall provide patients with access to their health record. Upon written request from a patient, a patient may, once every six months, have a copy of any part of their health record that has not already been provided, without charge. Between these times, upon patient request (which is limited to no more often than once every thirty [30] days), Vendor shall provide a copy of any part of their health record that has not already been provided. Vendor may charge nonindigent patients a maximum of two cents ($0.02) per page if provided in paper (and retain these fees). If there is an EHR and patients can receive, store, and have a mechanism to retain health records electronically (e.g., with the use of tablets) after release, Vendor may provide requested health records electronically, but may not charge a fee.

9.1.3

Although Vendor shall be the custodian of patient health records, Facility is the owner of all patient health records. At the conclusion of the contract, Vendor shall return full control of all health records to Facility as described in Provision 9.1.7 and destroy all paper or electronic copies of health records in its possession. For the purposes of this RFP, “health records” includes clinical still, sound, and video recordings.

9.1.4

Vendor shall ensure that health records are maintained for a period of time consistent with federal and state law and regulations.

9.1.5

State which Vendor personnel will have access to health records and what level of access they will have (e.g., read only; read and write; read, write, and amend; authority to download/save data to a different location). Label this response: **9.1.5 Vendor personnel who will have access to health records and the level of access they will have.** *200-word limit.*

9.1.6

Vendor's proposed budget for the proposed EHR system or interface shall include all one-time implementation/installation costs and recurring costs, including staffing or consultants, as well as the cost of data conversions, billing requirements, intelligence/analytics, and reporting requirements.

9.1.7

If switching EHRs, Vendor shall migrate all existing clinical data to the EHR chosen by Vendor and shall be responsible for all costs associated with the migration. Please indicate whether you will switch to a different EHR and, if so, its name. Label this response: **9.1.7 Whether Vendor will switch to a different EHR, and if so, the EHR's name.** *20-word limit.*

Except where noted, Vendor shall be responsible for hardware, functionality, software, and corresponding costs including, but not limited to, the following:

Network Infrastructure, Integration, and Interfaces

a. Servers, laptop computers, desktop computers, tablets, and any other hardware and software required for operations, including operation of an EHR;

b. Interfaces between EHR system and Facility system;

c. Ensuring the security of data on servers, laptop computers, desktop computers, any other device that stores or handles patient data; and

d. Ensuring that the system can be securely accessed from any location with an Internet/broadband connection.

Maintenance of Hardware and Software

a. Secure Wi-Fi to ensure that the HIPAA and 42 CFR Part 2 data are managed and accessed only by medical Vendor's employees such as medical staff and Information Technology personnel;

b. Information Technology resources including, but not limited to, licenses, subscriptions, personnel, and hardware to manage the medical domain, systems, applications, email Internet access, data backups, antivirus and malware, OS and application patch management, and any user administration for the medical network and EHR system;

c. Ensuring that all Vendor medical equipment, including desktop computers, servers, and medical cart laptops, will be solely on the health network and domain;

d. Redundancy for the EHR system and data via alternative data site or other disaster recovery facility and procedures;

e. Routine backup of the EHR data in mirror image near real time 24/7 and cloned on a separate, independent system to ensure immediate access to data and prevent loss of data;

f. All data storage within the United States;

g. Provision and maintenance of all hardware and software including, but not limited to, network circuit infrastructure, all EHR software, servers, desktop computers, laptop computers, and tablets;

h. All other components of the EHR that are not explicitly identified as Facility responsibility herein;

i. A system that allows Vendor to continue to operate health services, provide care, and record such care in the event of temporary unavailability of the EHR;

j. Ensuring that the EHR meets all industry standards, including, but not limited to, HIPAA, HITECH, PHI, Health Level 7, and other industry standards;

k. A system that is premise or cloud based and meets HIPAA security and encryption standards;

l. An EHR system that includes comprehensive medical, dental, behavioral health, lab, and pharmacy services modules and the ability to interface to other services and providers;

m. Ensuring that all data interfaces and integration from the EHR system to other providers or services are supported and managed by the EHR or medical Vendor;

n. Ensuring that the EHR system can interface with appropriate external systems to ensure appropriate data exchange will be bidirectional and include, but not be limited to, incarcerated individuals' demographics, diets, special conditions, and supplies. The interfaces would be close to real time. The specific database information will be discussed with Vendor at the time of negotiations and contract execution;

o. Using the SAFER self-assessment guide to evaluate the readiness for safety and completion for use of an EHR system by Vendor;

p. Ensuring that the system employs industry-leading security to protect the records from unauthorized access by third parties; and

q. Ensuring that the EHR provides for pharmacy integration, lab services integration, and radiology integration and can accommodate custom program requests by Facility.

Vendor shall provide facility staff or agents full access (including remote access) to the EHR data and reports. Under no circumstances shall Vendor restrict access in special circumstances including, but not limited to, a patient death, an internal Vendor corporate inquiry or investigation, or an external inquiry or investigation. Vendor shall train Facility personnel on use of the EMR to run custom reports and conduct audits.

Transitions

a. Upon implementation of Vendor's EHR, Vendor agrees to fully support, at no further charge to Facility, the complete, accurate, and successful transfer of all patient information in the current EHR to Vendor's EHR. All individual data elements in the previous record must be mapped and transferred to the corresponding element in the new record. Regarding the generic titles of documents and files (e.g., intake medical screening form, cardiology consultation report), Vendor agrees to transfer these objects to meaningfully titled objects

within its own EHR; no more than 5% of said objects may be labeled or titled with a name that includes the word “miscellaneous” or similar meaning terminology. If any part of this data transition is not completed within one week of the contract start date, Facility will either arrange on its own to effectuate the transfer, deducting all reasonable costs from the next monthly payment(s) to Vendor, or, if Vendor must complete the work, will impose liquidated damages as described in Appendix A – Key Performance Indicators.

b. Upon termination of this contract, Vendor agrees to fully support, at no further charge to Facility, the complete, accurate, and successful transfer of all patient information in its EHR (“old EHR”) to the EHR that will replace it (“new EHR”). Such transfer must accommodate the transfer of all data into the new EHR such that it integrates with the same or comparable fields in the new EHR. This transfer must be completed within one week after the contract end date. Facility will withhold payment of Vendor’s last three monthly invoices until this transfer is satisfactorily completed. Facility will deduct from these three payments any reasonable costs incurred by Facility to complete work for which Vendor was responsible. If the costs incurred by Facility due to Vendor nonperformance or incomplete performance exceed the amount available to withhold, Vendor will be liable for these additional costs.

Facility will be responsible for the following:

a. Access to Facility applications necessary to support the EHR (e.g., incarcerated individual management system, canteen) and

b. Arranging, and paying for the cost of, the interface between the EHR and Facility applications necessary to support the EHR.

Explain how you will avoid catastrophic loss of data (e.g., via a ransomware attack). Label this response: **9.1.7 How Vendor will avoid catastrophic loss of data.** *400-word limit.*

Explain how you will ensure continued health care operations during periods when the EHR is inoperative (e.g., due to server malfunction). Label this response: **9.1.7 How Vendor will ensure continued health care operations during periods when the EHR is inoperative.** *400-word limit.*

9.1.8

Vendor shall share information from patient health records for research, quality assurance, and internal and external administrative reviews if such usage is requested by Facility, approved by Facility, or was ongoing at the time the contract begins.

9.2 Communication and Access to Interpretation Services

9.2.1

Vendor shall ensure equal access to interpreter services for all individuals with communication barriers that prevent understanding of oral or written language. Such services include the provision of oral interpretation, sign language, signs in braille for people with visual difficulties, and auxiliary aids and services for people who have hearing, visual, and other disabilities that impair communication.

9.2.2

Vendor shall inform incarcerated individuals by means of brochures, information posted in clinical areas, on its website, and orally that interpreter/translator/hearing impaired language assistance services are provided at no cost to the individual.

9.2.3

Vendor shall assess the English fluency of patients (including those who are deaf or hard of hearing) and, if not fluent, determine a language in which the patient is fluent, including during intake, upon request of the patient or others on behalf of the patient at any time, and whenever staff have a reason to believe a patient is not fluent in English. Explain how you will accomplish this requirement. Label this response: **9.2.3 How Vendor will assess English fluency and, if not fluent, determine a language in which the patient is fluent.** *200-word limit.*

9.2.4

Vendor shall ensure the following:

a. The patient's primary language shall be visible on all relevant screens of the patient's EHR, or the outside of the patient's health record if using a paper record.

b. In all individual and group health care encounters in all settings involving patients who are not fluent in English, interpretation shall be provided via health care staff named on a Vendor-maintained list of people who, pursuant to Vendor's written procedure, are proficient in the language understood by the patient, or via in-person or video interpretation service (for sign language) or audio language interpretation service. Such service shall be compliant with federal law and use licensed interpreters. This requirement for interpretation may be waived in an emergency.

c. The method of interpretation for all encounters is documented in the patient's health record.

d. All written materials given to patients are in a language the patient understands.

9.2.5

As noted in Provision 9.2.4, Vendor may use Vendor health care staff to interpret if the staff member is named on Vendor's list of people who are proficient in the language understood by the patient. Indicate whether you will ever use this method of interpretation and, if so, describe the procedure by which you will determine that a staff member is proficient in the language. Label this response: **9.2.5 Whether Vendor will ever use health care staff to provide interpretation and, if so, the procedure for determining language proficiency.** *200-word limit.*

9.3 Continuity of Operations During Lockdown

9.3.1

Vendor shall ensure continuity of clinical operations during facility lockdowns and other causes of reduced or arrested incarcerated individual movement. Describe how you plan to ensure provision of health care during times of limited movement that last for hours, days, or longer (e.g., count, partial or full lockdown). Label this response: **9.3.1 How Vendor plans to ensure provision of health care during times of limited movement that last for hours, days, or longer.** *200-word limit.*

9.3.2

When patient movement is restricted, Vendor shall travel to the patient's housing unit to deliver medically necessary care if such care can be safely and appropriately delivered in that venue. If care must be delivered in a clinical setting, Facility agrees to transport the patient to the clinical setting.

9.4 Disaster and Emergency Services Response Plan

9.4.1

Within sixty days of the contract start date, Vendor shall provide Facility with a written disaster plan.

9.5 Grievances

9.5.1

Vendor shall respond to emergency grievances from patients within four hours of receipt and other grievances within seven business days of receipt. An emergency grievance is one that is either labeled as such or that, in the opinion of facility staff, is an emergency. In general, Vendor staff shall meet in person with a patient who has submitted a grievance; if a meeting is unnecessary, that shall be documented in the grievance file. Vendor shall make a good faith attempt to resolve each grievance in a timely manner. Grievance responses shall be thorough, respectful, meaningful, and acknowledge when a program improvement should be made. All grievance responses shall include a

determination of “resolved” or “not resolved.” A practitioner (medical, MH, dental) shall be involved in addressing all grievance appeals.

9.6 Self-Improvement Program

9.6.1

Vendor shall evaluate errors, system problems, and possible system problems that come to its attention through a variety of sources, including, but not limited to, the near-miss and preventable adverse event reporting systems, mortality reviews, litigation, grievances, staff reports, continuous quality improvement, patient satisfaction surveys, staff meetings with incarcerated individuals, and joint custody/health care living unit meeting, and shall addresses them as appropriate. To prioritize analysis and remediation of errors and other system problems that it discovers, Vendor maintains an active log of all such errors and problems to assist it in deciding which issues to address and when, and to monitor progress in resolution. Based on this prioritization, root cause analysis is conducted as appropriate, from which an effective and sustainable remedial plan is implemented in a timely manner. A sustainable plan is one that outlives staff memory from a single training session after the review and outlives staff turnover. The remedial plan is monitored for effectiveness. Appropriate and timely modifications are made to the plan based on the monitoring.

9.6.2

Vendor shall operate a near-miss error reporting system with the following components. Only errors that caused no (or minimal) harm to the patient may be reported through this system.

a. Reporting is voluntary.

b. Anyone can report, including patients.

c. The reporter is immune from discipline, punishment, or retaliation related to the error unless the following are all true: the reporter is a staff member, the error is one they made themselves, and the error is one for which they have a current disciplinary or other performance improvement plan that addresses such errors.

d. Reporting is easy and fast for staff with a minimal amount of information required of the reporter initially, so that the reporting process itself is not a barrier to reporting.

e. Because minimal information is required initially, reports are confidential but not anonymous so that the reporter can be contacted to obtain richer detail if needed.

f. Reporters receive feedback about reports and their impact. Although individual feedback might be optimal, even feedback to the whole workforce about specific patient safety changes that resulted from reporting can be valuable.

9.6.3

Vendor shall operate a preventable adverse event error reporting system with the following components:

a. This system is for the reporting of errors that cause more than minimal harm to a patient.

b. Any such error is reported, not just medication-related errors.

c. Reporting is mandatory for staff.

9.6.4

Following a death or suicide attempt, Vendor shall identify all significant errors (near misses as well as preventable adverse events). Based on prioritization of all errors identified in facility, root cause analysis is conducted as appropriate, from which an effective and sustainable remedial plan is implemented in a timely manner. A sustainable plan is one that outlives staff memory from a training session after the review and outlives staff turnover. The remedial plan is monitored for effectiveness. Appropriate and timely modifications are made to the plan based on the monitoring. The sustainable plan is implemented within thirty calendar days of the death. The above is completed whether or not the medical examiner's report is available. If the medical examiner's report was unavailable, the above is revisited and modified, if necessary, within thirty days of receipt of the report.

9.6.5

Vendor shall implement a robust continuous quality improvement program to monitor the quality of clinical care. As part of this program, Vendor shall monitor the absolute value and trend of various parameters on a monthly basis. Where metrics or trends in metrics show room for improvement, Vendor shall make appropriate efforts to understand the underlying reason for deviation, take reasonable steps to effectuate improvement, evaluate the effectiveness of these steps in a reasonable time, and adjust its improvement efforts as needed. On a quarterly basis, beginning with the first full calendar quarter after the contract start date, and reporting by thirty days after the end of the quarter, Vendor shall report the above information. Provide examples of the reports you anticipate providing quarterly. Label this response: **9.6.5 Sample Vendor Reports to be provided on a quarterly basis.** *Response limited to reports.*

At a minimum, Vendor shall monitor the percentage of individuals:

a. Who released with a completed reentry linkage action plan;

b. Linked to a community health care provider within two weeks of release;

c. With a diagnosis of hypertension whose systolic blood pressure exceeds 140 mmHg or diastolic blood pressure exceeds 90 mmHg;

d. Who in the past 12 months have had a systolic blood pressure that exceeds 140 mmHg or diastolic blood pressure that exceeds 90 mmHg who do not have a diagnosis of hypertension and for whom there is no clinical explanation for not having a diagnosis;

e. With a diagnosis of diabetes, average hemoglobin A1C;

f. Taking ten or more prescribed medications;

g. Receiving timely breast cancer screening;

h. Receiving timely cancer screening;

i. Who have routine prenatal laboratory tests results as recommended in current national guidelines documented within one month of diagnosis of pregnancy;

j. With grievances that are appealed;

k. On antipsychotic medications receiving timely AIMS (Abnormal Involuntary Movement Scale) assessments;

l. On antipsychotic medications receiving appropriate and timely metabolic assessments;

m. Whose psychotropic medications were discontinued due to nonadherence without contact with a psychiatric provider;

n. For whom intake screening is completed more than four hours after arrival; and

o. Receiving medical restraints, the percentage which might have been avoidable, and recommendations for changes in policy, practice, or training that might reduce the use of restraints.

Vendor shall monitor other parameters as reasonably dictated by the other self-improvement activities described in the RFP.

9.6.6

Facility desires to avoid the inappropriate use of discipline for rule violations by incarcerated individuals with mental illness for whom a MH intervention would have been more appropriate. Vendor agrees to collaboratively review cases brought to its attention by Facility in which an incarcerated individual with a history of mental illness was disciplined for a rule violation and to provide feedback based on the professional expertise of its clinical staff regarding whether a MH intervention would have been more clinically appropriate than discipline. Vendor also agrees to advise Facility on how future interactions with such incarcerated individuals might be improved.

Section 10: Vendor Qualifications

Section Content

10.1 Vendor Requirements

10.1.1

The following factors will be considered in evaluating proposals:

a. Conformity with the terms, conditions, specifications and requirements of this Request for Proposals;
b. Pricing of services;
c. Relevant experience;
d. Performance capability, integrity, reliability, qualifications and responsibility of the vendor;
e. Merits of the proposed services in regard to meeting the above objectives of this RFP;
f. References; and
g. Advantageousness in regard to any other factors the County may deem relevant in reviewing proposals.

10.1.2

Vendor must meet professional licensing and credentialing requirements, adhere to the policies and procedures established by the Department of Corrections, and provide a comprehensive range of medical services to incarcerated individuals while complying with relevant state and federal laws regarding healthcare and correctional facilities.

10.1.3

In addition to the specific qualifications described in Provision 10.1.2 above, Facility will take the following vendor attributes into account when evaluating proposals: having a long track record of providing safe, humane, constitutionally adequate health care at the community level of care to incarcerated individuals at similar and other facilities; size; length of time in business; name changes, especially when associated with any restructuring; litigation history; history of adverse actions taken against the firm or its employees or agents by government entities or clients; financial stability; correctional experience; performance history and experience contracting with facilities similar to ours; key corporate and local personnel; professional histories of previous and current employees; ability to attract and retain employees; capability to fulfill the contract requirements now and for the duration of the contract; reputation; and feedback from previous and current clients.

10.2 Vendor History

10.2.1

How many years has your firm been providing correctional health services similar to those described in this RFP? Label this response: **10.2.1 Number of years Vendor has been providing correctional health services similar to those described in this RFP.** *20-word limit.*

10.2.2

List all correctional or detention entities with which you have contracted to provide services in the past ten years. Include average daily population, the contract manager's contact information, and whether the contract is active or has ended. Label this response: **10.2.2 All correctional or detention entities with which Vendor has contracted to provide services in the past ten years, average daily population, the contract manager's contact information, and whether the contract is still active.** *No word limit.*

10.2.3

Please provide a letter on your letterhead giving Facility permission to discuss your Vendor performance with any of the entities listed in your response to Provision 10.2.2. Label this response: **10.2.3 Letter giving Facility permission to discuss Vendor's performance with entities listed in response to Provision 10.2.2.** *1-page limit.*

10.2.4

For your three most recent contracts that started at least three months before issuance of this RFP, please provide, for each of the most recent twelve months (or as many months the contract has been in effect, if less than twelve [12] months): the number of hours of onsite service the contract required you to provide for each health care discipline and the number of hours actually provided, as shown in the sample table. Limit the information to the following disciplines:

Example	Month	Discipline	Contracted Service Hours	Service Hours Provided
Contract 1	Jan 20XX	Nurse	160	123
		Medical Practitioner	320	320
		MH Provider	30	22
	Feb 20XX	Nurse	160	123
		Medical Practitioner	320	320
		MH Provider	30	20

Contract 2	Dec 20XX	Nurse	160	123
		Medical Practitioner	80	76
		MH Provider	30	22

Label this response: **10.2.4 Number of hours of onsite service Vendor was required to provide for each health care discipline and number of hours actually provided**. *No word limit but must use the format shown in the sample.*

10.2.5

In the past ten years, has your firm, or a company that you were previously called, been assessed liquidated damages or penalties or been put on corrective action, including receipt of default letters or notices of corrective action for contract noncompliance, or other performance improvement plan while contracting with any correctional or detention entity? If yes, explain circumstances, including entity name, date(s) of action, cause for action, and outcome. Label this response: **10.2.5 In the past ten years, Vendor assessments of liquidated damages or penalties, or corrective action or other performance improvement plan while contracting with any correctional or detention entity; circumstances, including entity name, date(s) of action, cause for action, and outcome.** *No word limit.*

10.2.6

In the past ten years, has any contract between your firm, or a company that you were previously called, and a correctional or detention entity terminated (voluntarily or involuntarily) before the natural expiration of contract? If yes, explain circumstances, including entity name. Label this response: **10.2.6 In the past ten years, Vendor contracts with a correctional or detention entity that terminated before the natural expiration of contract and circumstances, including entity name.** *No word limit.*

10.2.7

List all claims or litigation initiated against your firm (bidding entity) and parent company if the parent company is also engaged in health care, a company that you were previously called, related corporate entities, or employees of your firm related to work performed under your contract with a correctional or detention entity in the past five years. This would include, but is not limited to, claims made by individuals, the U.S. Department of Justice, the U.S. Department of Homeland Security, a state regulatory agency, or a disability advocacy organization. If applicable, include the identity of the court and case number, nature of the claim and the outcome (e.g., trial, settlement, amount paid, pending). Label this response: **10.2.7 All claims or litigation initiated against Vendor, parent company, related entities, or Vendor employees related to work performed under a contract with a correctional or detention entity in the past five years.** *No word limit.*

10.2.8

List all state, federal, or grand jury investigations of your firm in the past ten years. Label this response: **10.2.8 All state, federal, or grand jury investigations of Vendor in the past ten years.** *No word limit.*

10.2.9

List all adverse actions taken by any licensing agency against anyone providing services for your firm where the action is related to those services. Label this response: **10.2.9 All adverse actions taken by any licensing agency against anyone providing services for Vendor where the action is related to those services.** *No word limit.*

10.2.10

Vendor acknowledges that Facility has the right, at the completion of the contract (whether or not it is renewed) to submit a post-contract evaluation to a national quality reporting system for correctional health care vendors, that describes Facility experience with Vendor, including, but not limited to, an evaluation of the quality of care Vendor provided and the quality of Vendor's communication and cooperation with Facility or other partners or stakeholders with whom Vendor interacted in relationship to the contract.

10.2.11

Provide a copy of your company's most recent bond capacity letter. Label this response: **10.2.11 Vendor's most recent bond capacity letter.** Response limited to a bond capacity letter from a surety agency.

Section 11: Insurance, Bonding, and Liability

Section Content

11.1 Insurance, Bonding, and Liability

11.1.1

Throughout the term of this Agreement and for all applicable statutes-of-limitation periods, Vendor shall maintain, in full force and effect, the insurance coverage set forth in this section.

11.1.2

All insurance policies shall be issued by companies that (a) are authorized to transact business in the State of Pennsylvania and (b) have a Best's rating of A–VI or better.

11.1.3

All insurance policies shall name and endorse the following as additional insureds: Crawford County Correctional Facility; the Board of Commissioners of Crawford County; and their officers, agents, employees, and commission members with an Additional Insured – Designated Person or Organization endorsement, or similar endorsement, to the liability policies. An additional insured is defended and indemnified for claims to the extent caused by the acts, actions, omissions, or negligence of Vendor, its employees, agents, subcontractors, and representatives, but is not defended or indemnified for the additional insured's own acts, actions, omissions, or negligence.

11.1.4

All insurance policies shall be endorsed to provide that (a) Vendor's insurance is primary to any other insurance available to the additional insureds with respect to claims covered under the policy and (b) Vendor's insurance applies separately to each insured against whom claims are made or suit is brought and that the inclusion of more than one insured shall not operate to increase the insurer's limit of liability.

11.1.5

Vendor shall provide Facility, prior to beginning the performance work under this contract (and at any time thereafter upon request), with a copy of the certificate of insurance or endorsements evidencing at least the following minimum types of insurance and coverages.

a. Comprehensive General Liability in the amount of $1,000,000 per occurrence and $2,000,000 in aggregate, listing Crawford County as an Additional Insured, with a Waiver of subrogation in favor of the County, and including Primary and Non-Contributory Coverage;

b. Professional Liability coverage for Vendor's work at Facility, its employees and its officers, for a minimum of $1,000,000 ($2,000,000 preferred) per occurrence and $3,000,000 in aggregate;

c. Commercial Auto Liability in the amount of $1,000,000 of Combined Single Limit Coverage, listing Crawford County as an Additional Insured, with a Waiver of subrogation in favor of the County, and including Primary and Non-Contributory Coverage;

d. Commercial Umbrella coverage in the amount of $2,000,000, with Underlying schedule for Umbrella/Excess coverage that includes CGL, Auto, Professional, Sexual Abuse and Molestation (SAM), and Employers Liability;

e. Workers Compensation insurance includes the following: Part One - Statutory (all PA employers required to have Worker's Compensation) and Part Two - Employer's liability coverage limits for each of the following categories: $100,000 bodily injury by accident (each accident), $500,000 bodily injury by disease (policy limit), and $100,000 bodily injury by disease (each employee), with a Waiver of subrogation in favor of the County;

f. Cyber Liability including as a minimum coverage and limits of third party liability and first party response expenses with limits of $1,000,000 per occurrence and $1,000,000 in aggregate; and

g. Improper Sexual Conduct (SAM) coverage of $1,000,000 per occurrence and $3,000,000 aggregate.

Vendor's insurance policies shall not be canceled, nonrenewed, restricted, reduced in coverages or limits, or otherwise materially altered without providing Facility at least thirty days prior written notice. Notice shall be sent to Stephanie Franz, Chief Financial Officer for Crawford County. If Vendor fails to submit the required insurance certificate in the manner prescribed, Vendor shall be in default and the contract shall be rescinded. Under such circumstances, Vendor may be prohibited from submitting future solicitations to Facility.

For each of the insurances described in paragraphs (a) through (d) above, state whether insurance will be provided by an insurance company or Vendor will be self-insured and, if the former, the dollar amount of the deductible. Label this response: **11.1.5 Source of insurance and dollar amount of deductible.** *4-line limit*

11.1.6

Vendor shall secure a performance and payment bond for the duration of the Agreement and any options to renew. The surety issuing the bond must be registered to do business in the State of Pennsylvania. The surety must be rated no less than “A” as to management and no less than Class “VI” as to financial strength. Vendor shall provide copies and evidence of said bond and its continued issuance within ten days of contract signing and any other request. Vendor agrees that the performance bond is not intended to, nor shall be deemed to, transfer liability of Vendor to Facility in the event of a material breach of any service agreement between Facility and Vendor.

Section 12: Post-RFP Issuance Process

Section Content

12.1 RFP Process Overview

12.1.1

In order to engage in a contract with a vendor to provide the best services at the most advantageous cost to Crawford County, Facility will use the process described herein. We will offer a tour of the facility to prospective vendors and an opportunity to pose questions in writing. Based on the written response to this solicitation and the strength of those responses using criteria described herein, Facility may select one or more vendors to make formal presentations to the selection committee. These presentations are not mandatory, but the selection committee will consider information provided during the presentation in its final selection decision. The selection committee may use experts and others to inform, advise, and assist the committee at any stage of the RFP process. Using the criteria below, the committee expects to select a single vendor with which to enter into final negotiations and with which to contract. However, Facility reserves the right to make no selection.

12.2 RFP Timeline

12.2.1

Facility will adhere to the following schedule. Where action is required of a vendor by a certain date, failure to complete that action may result in elimination of the vendor from further consideration. Dates marked as "anticipated" are an estimated date and subject to change at the sole discretion of Facility. The deadline for all events described as "deadlines" is 4:00 PM EST on the date shown.

a. 08/01/25 RFP release date

b. 08/01/25 Beginning date for submitting written questions. Submit questions to Theresa Chimiak, Procurement Specialist, 903 Diamond Park – Meadville, PA 16335 or tmchimiak@co.crawford.pa.us.

c. 08/12/25 4:00 PM EST Deadline to notify Facility of interest to participate in a Bidders' Conference and submit information about visitors. Participation in the conference is voluntary. Facility tours are available upon request. All Conference and Tour Requests should be submitted in writing to Theresa Chimiak, Procurement Specialist, 903 Diamond Park – Meadville, PA 16335 or tmchimiak@co.crawford.pa.us. Each vendor is limited to four representatives participating in the conference. When submitting your notice of interest to participate, for each proposed visitor, include their name, date of birth, social security number. Be advised that Facility may bar a visitor based on the results of a background check and/or late submission.

d. 08/14/25 Anticipated date Facility will make all notifications of approval (or denial) of proposed visitors. Notification will include more specific information about where to report, screening procedures, and allowable personal items.

e. 08/15/25 9:00 to 10:00 AM EST Bidders' Conference. We will provide details about location and how to access the facility after receipt of your list of proposed participants. Individual Facility Tours will be scheduled as requested.

f. 08/22/25 4:00 PM EST Deadline for Facility Tours and submitting written questions. All questions should be submitted in writing to Theresa Chimiak, Procurement Specialist, 903 Diamond Park – Meadville, PA 16335 or tmchimiak@co.crawford.pa.us.

g. 09/10/25 Anticipated date Facility will complete responses to questions. Responses will be posted at www.crawfordcountypa.net/RFP. Facility reserves the right to group questions and provide a single response.

h. 09/26/25 4:00 PM EST Deadline for submitting proposals.

i. 10/17/25 Anticipated date Facility will notify vendor(s) that have been selected to make presentations and to notify vendor(s) of the date and time of their presentation.

j. 10/24/25 Anticipated date of vendor presentations. Once selected vendors have been notified of their presentation date, this date cannot be changed. If a vendor is unable to present at the designated time and date, Facility may, at its sole discretion, reschedule the presentation. If Facility does not reschedule, vendor forfeits that opportunity. However, Facility will still consider vendor's written proposal.

k. 10/31/25 Anticipated date to notify vendors of selection committee's selected vendor.

l. 11/21/25 Anticipated date of Intent to Award Letter.

m. 12/1/25 Anticipated date to finalize the contract with the successful vendor.

n. 1/1/26 12:01 AM EST Anticipated date vendor will begin providing services.

12.3 How to Respond to the RFP

12.3.1

Bidders' proposals should contain the following sections, labeled as such and arranged in the following order:

Section 1: Cover letter

The cover letter should include the proposed cost to provide the services described in the RFP; a list identifying any proposed subcontractors and their roles; a list of all materials and enclosures being forwarded in the proposal; and any introductory comments you wish to make. Finally, your cover letter must include the name, title, phone number, email address and dated signature of your authorized representative.

Section 2. Company and Program Description

Provide an overview of your company and your work plan that you believe will be helpful in evaluating your proposal. This section may include your type of business, years in existence, location, range of services, size and type of customer base, number of employees, professional memberships or other distinctions, specific experience and capability related to the RFP services, and description and qualifications of any proposed subcontractors.

Section 3: Responses to Questions and Requests for Information

A number of RFP provisions request specific responses from you. Follow these instructions when responding:

a. Place all such responses within this section of the proposal.

b. Label each response with the bolded text that appears in the instruction to submit the response.

c. Place the responses in the same order as the requests for responses appear in the RFP.

d. Do not exceed the word or page limit for each response, if one is indicated. If Vendor exceeds the word or page limits, any part of the response exceeding these limits will not be considered in evaluating or scoring the submission.

e. Do not include graphics such as pictures, drawings, diagrams, logos, and artwork in the responses unless requested to do so. Bullet lists and tables are allowed, but their word count or length are subject to any stated limits.

f. All information required for a complete response to the request must be contained within the written response as described above. The response should not reference nor rely upon material/information (a) in another part of your submission, (b) provided orally, (c) provided in another specific response, or (d) conveyed during a presentation to the selection committee. Any information that appears in other parts of the submission will not be considered in evaluating responses to questions and requests for information.

Section 4. Pricing Structure

Under this heading, attach a full description and explanation of how you would price incarcerated individual health-care services for the Crawford County Correctional Facility. Use or adapt the form in Appendix B as a guide to your price response. Include information that responds to the following items.

a. For budgetary reasons, Facility seeks a fixed price as much as possible for incarcerated individual health-care services. Accordingly, the table indicates certain categories under which the contractor shall be expected to pay for all costs out of the base price. The table identifies those categories with a "YES" in the applicable column of contractor cost responsibility. If you seek any exceptions to those categories, you must list them in your proposal as "variances."

b. So that vendors can better predict their potential contract liabilities, Facility will consider participating in costs in certain other categories. Those categories give options. You may propose all costs in the base price; propose that Facility share in costs that exceed specified limits; or propose (unless not allowed as an option) that the County pay the costs fully. With regard to any proposed cost sharing, you must specify what would be your limits of responsibility and what would be Facility's payable share on a reimbursement or other basis. Notwithstanding, keep in mind that Facility desires proposals that offer as much cost coverage as possible in the base pricing.

c. For any costs that the proposal does not specify otherwise, Vendor shall be assumed responsible for paying them in full.

d. The scope of services you provide under each cost category must be made clear. Identify the extent of services in each category by way of a brief summary to accompany the form in Appendix B. If you propose sharing or shifting of costs in any category, indicate how you would seek to contain those health-care expenses overall and especially any payment responsibility that Facility would have.

Section 5. Agreement Exceptions

List any RFP provisions that you cannot agree to along with a brief explanation. Be advised that stating any Agreement Exception does not constitute an agreement to accept your exception.

Section 6. Sample Contract

Under this heading, attach a sample contact for the incarcerated individual health-care services you offer. The County reserves the right to negotiate any final contact. The executed contract will incorporate the contract; terms and conditions in the RFP document, including addendums; and the proposal submitted by the Vendor.

Section 7. Non-Collusion Statement

Under this heading, attach Vendor non-collusion statement.

Section 8. Business Associate Agreement

Under this heading, attach completed and signed Agreement from Appendix C.

12.3.2

Bidders' should submit their proposals as follows:

Preparation

Proposals must be prepared in accordance with all specifications and requirements contained or referenced herein regarding the desired services. Proposals also must conform to the specified format, content, signatures and dates for submitting responses. The County is not responsible for any costs incurred by vendors in preparing proposals or responding otherwise to the RFP process.

Proprietary Information

The County will consider keeping in confidence any trade secrets or other proprietary information that the vendor does not wish disclosed for public review. Vendor must label any such information as "Confidential," in boldface, at the top and bottom of where the specific content appears in the proposal. Vendor may not represent the entire or majority of the proposal content to be proprietary. For any procurement subject to competitive sealed bidding, the County shall *not* deem price or cost information to be confidential prior to (or after) contract award and execution. Despite what a vendor may label as confidential, the County's determination of whether to consider and treat it as such shall be based on Pennsylvania laws and regulations regarding open records.

Signature

The proposal must be signed by a representative authorized to make a firm offer. By signing, Vendor certifies that the proposal is bound to the terms, conditions, specifications and requirements of the RFP, except for any variances that the County might deem acceptable. Proposals shall remain valid for 90 calendar days from the date due. The County shall have this time to evaluate proposals and make any contract award.

Number of Copies

Submit one original and two hard copies of the complete proposal.

Deadline

Proposals must be received by the County no later than 4:00 pm EST on Friday, September 26, 2025. Official time of receipt shall be as recorded in the Commissioners' Office. Any submission not on time for any reason shall receive no consideration. The County is not responsible for lateness of mail or carrier services, or for any associated delivery costs.

Means of Submission

Proposals must be submitted by postal or express mail, or hand delivery. Proposals submitted outside of these options shall receive no consideration.

Sealed and/or Marked

Proposals delivered in person or via mail must be sealed in an envelope or other packaging. The outside must be marked "Incarcerated individual Health Care Proposal," and must bear Vendor business name and address.

Receiving Location

Proposals must be addressed and submitted to:

Procurement Department
Crawford County Courthouse
903 Diamond Park
Meadville, PA 16335
Attention: Theresa Chimiak
(814) 333-7400, extension #7420

12.4 Question Submission and Response

12.4.1

Except for receiving general tour information from the above facility representative, vendors shall direct any inquiries, questions or other communication regarding the Request for Proposals, in writing, to tmchimiak@co.crawford.pa.us no later than 4:00 pm EST Friday, August 22, 2025. Questions will be answered by the date noted in Provision 12.2.1.

12.5 Scoring Factors/Model

12.5.1

A selection committee, chosen by the Crawford County Commissioners, will review all vendor proposals that meet the minimal requirements of the RFP. The committee will consider the following factors when reviewing proposals:

a. Vendor qualifications, history, and present resources as described in Section 10, including, but not limited to, having a long track record of providing safe, humane, constitutionally adequate health care at the community level of care to incarcerated individuals at similar and other facilities;
b. Cost of the proposal;
c. Quality of the proposal and the degree to which it is likely to produce the results required by Facility;
d. Vendor's performance on other contracts;
e. Quality of vendor's presentation; and
f. Agreement Exceptions stated by vendor.

The committee will confidentially discuss each vendor proposal, and then each member will assign a global score between 0 and 100, with 100 being the optimal score. The scores will be averaged to determine the committee's choice.

Facility reserves the right to reject all proposals if none meet its needs.

Appendix A – Key Performance Indicators (KPIs)

The following information pertains to Facility's auditing of the KPIs in this appendix and the calculation of liquidated damages.

1. Liquidated Damages will be determined and agreed upon by the selected Vendor and the County prior to contract signature.
2. Liquidated Damages are calculated and assessed/awarded no more often than once a quarter and are based only on events occurring during the quarter under review (i.e., the audit may not look at events from previous quarters).
3. An individual patient record may be used in the audit of more than one KPI.
4. Multiple events in an individual patient record may be used in the audit of a single KPI. For example, if a patient were sent to the ER on two occasions, the visits may be counted individually in the audit.
5. The size of the sample upon which KPIs are measured and liquidated damages are calculated depends on specific KPI.
    a. For some KPIs, no sample of cases will be drawn because liquidated damages are levied for all events that fail the KPI.
    b. Some KPIs relate to events that are easily measured without the need for professional judgment
    c. For all other KPIs with a performance threshold of 90% or 100%, Facility will use a minimum sample size of 10. If 2 or more cases fail the KPI, Facility will increase the sample size to 20. All samples will be random samples drawn from a relevant subset of individuals.

KPIs fall into 10 categories:

Code	Key Performance Area	Page
I	Intake	89
M	Medications	90
AC	Access to care	91
CD	Practitioner and nursing care and documentation	88
CC	Care continuity	89
R	Refusals	89
SU	Substance use disorder treatment	89
A	Administration	93
P	Personnel	93
HR	Health records	94

*Liquidated Damages will be determined and agreed upon between the two parties, during the contract award process, prior to contract signature.

Intake

	Performance Indicator	Threshold Value	*Liquidated Damages
I–1	Intake health and behavioral health screenings described in Provision 8.2.2 are completed within four hours of arrival at Facility.	95%	TBD
I–2	Focused assessments are completed within the time frame specified in the contract.	90%	TBD
I–3	Focused assessments are completed in the manner specified in the contract.	95%	TBD
I–4	Health records are requested immediately upon arrival when clinically appropriate. Where there is a reasonable suspicion that the patient may have a health condition and/or be taking medications, but no records have been received, a practitioner is contacted in a clinically appropriate time frame, but no later than 24 hours, to determine appropriate care.	95%	TBD

Medications

	Performance Indicator	Threshold Value	*Liquidated Damages
M–1	New medications are administered within the time frame ordered by the medical practitioner or, if none were specified, within a clinically appropriate time frame not to exceed 24 hours.	95%	TBD
M–2	Ongoing medications are administered without gap across refill and renewal junctures.	95%	TBD

Access to Care

	Performance Indicator	Threshold Value	*Liquidated Damages
AC–1	Following submission of a request for care expressing a clinical symptom or problem (e.g., excludes requests for an administrative service such as a copy of records, the date of a future service, refill of a medication), the patient is seen at a visit within 24 hours.	95%	TBD
AC–2	Patients discharged from suicide watch are evaluated by a licensed clinician between the 2nd and 4th day after discharge and between the 12th and 16th day after discharge.	100%	TBD

Practitioner / Nursing Care Documentation for Medical, Mental, and Dental Care

	Performance Indicator	Threshold Value	*Liquidated Damages
CD–1	All care and documentation of care is consistent with the requirements of Provision 8.1.3.	95%	TBD

Care Continuity

	Performance Indicator	Threshold Value	*Liquidated Damages
CC–1	All health care that is planned or ordered is completed within the time frame designated at the time of planning or ordering. “All health care” includes, but is not limited to, onsite and offsite diagnostic tests, interventions, referrals, and care prescribed in a medical, MH, or dental treatment plan.	95%	TBD
CC–2	Upon return from an ER or urgent care center visit, procedure, hospitalization, or any other consultation resulting in immediate recommendations, if a nurse conducts the evaluation, the nurse discusses the case with a practitioner.	95%	TBD
CC–3	Recommendations received from an ER or urgent care center visit, procedure, hospitalization, or any other consultation are followed by Vendor unless the reason for not following them is obvious or an appropriate rationale is documented.	95%	TBD

Refusals

	Performance Indicator	Threshold Value	*Liquidated Damages
R–1	All refusals for medications, clinical encounters, and interventions are received in person by health care staff and in accordance with the requirements in Provision 8.3.4.	95%	TBD

Substance Use Disorder Treatment

	Performance Indicator	Threshold Value	*Liquidated Damages
SU–1	All cases of intoxication, withdrawal, or risk of withdrawal are managed in accordance with the requirements in Section 8.13.	100%	TBD

Administration

	Performance Indicator	Threshold Value	*Liquidated Damages
A–1	All grievances are addressed appropriately, timely, and respectfully and in accordance with policy, and include face-to-face encounters when appropriate. Emergency grievances are, at a minimum, assessed as soon as they are received. If the assessment reveals that there is no clinical emergency, the grievance may be resolved as would a nonemergency grievance.	90%	TBD
A–2	All reports are submitted as required by the contract.	100%	TBD

Personnel

	Performance Indicator	Threshold Value	*Liquidated Damages
P–1	For each category of positions below, Vendor must maintain staff in those positions at a minimum of the threshold value listed for the number of hours required:		TBD
	• 2.0 FTE Nurses present during day shift	100%	
	• 2.0 FTE Nurses present during evening shift	100%	
	• 1.0 FTE Nurse present during night shift	100%	
	• 1.5 FTE MH provider available during business hours	100%	
	• 1.0 FTE Medical Practitioner present one day a week	100%	
	For the purposes of this KPI, position is considered filled only if the staff member is legally qualified to perform the functions of that position, as described in Provision 3.3.3.		

Health Records

	Performance Indicator	Threshold Value	*Liquidated Damages
HR–1	Upon implementation of Vendor EHR, Vendor agrees to fully support, at no further charge to Facility, the complete, accurate, and successful transfer of all patient information in the current EHR to Vendor's EHR. Regarding the generic titles of documents and files (e.g., intake medical screening form, cardiology consultation report), Vendor agrees to transfer these objects to meaningfully titled objects within its own EHR; no more than 5% of said objects may be titled with a name that includes the word "miscellaneous" or a similar meaning term. If any part of this data transition is not completed within one week of the contract start date, Facility will either arrange on its own to effectuate the transfer and deduct all reasonable costs from the next monthly payment(s) to Vendor or, if Vendor must complete the work, will impose liquidated damages.	100%	TBD

Appendix B – Pricing Structure

Enter a base price for each year. Years one and two must remain firm. Also, enter the maximum price escalation proposed (if any) in years three through five. The percentage and amount of increase refers to the escalation over the base price from the prior year.

	BASE PRICE	MAXIMUM PRICE ESCALATION (if any)	
		Percentage increase	Amount of increase
Year 1		0.0 %	$0.00
Year 2		0.0 %	$0.00
Year 3			
Year 4			
Year 5			

COST CATEGORY	ALL COSTS	SHARED COSTS	ALL COSTS
In each category that permits options, enter a response to indicate which party — Vendor, County, or both — would have cost responsibility under your proposal.	**Vendor has full responsibility**	**Vendor & County share responsibility**	**County has full responsibility**
	Base price includes all costs	*Base price has cost limits (specify Vendor and County share):*	*Base price excludes all costs*
Medical Practitioner services, on site and on call	YES		
Nursing services, 24/7 coverage	YES		
Psychiatric/ psychological services: on site	YES		
Psychiatric/psychological services: off site			
Dental services: on site			
Dental services: off site			
Administrative support, case management	YES		
Pharmaceuticals: over-the-counter	YES		
Pharmaceuticals: prescriptions			
Ancillary services: laboratory, on site			
Ancillary services: X-ray, on site			
Ancillary services: other, on site			
Ancillary services: off site			
Office equipment and supplies	YES		
Medical equipment and supplies	YES		
Billing and payment management	YES		

Appendix C – Business Associate Agreement

MODEL BUSINESS ASSOCIATE AGREEMENT

This BUSINESS ASSOCIATE AGREEMENT (the "BAA") is made and entered into as of by and between , a organized under the laws of the ("Covered Entity") and , a or ganized under the laws of ("Business Associate", in accordance with the meaning given to those terms at 45 CFR §164.501). In this BAA, Covered Entity and Business Associate are each a "Party" and, collectively, are the "Parties".

BACKGROUND

I. Covered Entity is either a "covered entity" or "business associate" of a covered entity as each are defined under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended by the HITECH Act (as defined below) and the related regulations promulgated by HHS (as defined below) (collectively, "HIPAA") and, as such, is required to comply with HIPAA's provisions regarding the confidentiality and privacy of Protected Health Information (as defined below);

II. The Parties have entered into or will enter into one or more agreements under which Business Associate provides or will provide certain specified services to Covered Entity (collectively, the "Agreement");

III. In providing services pursuant to the Agreement, Business Associate will have access to Protected Health Information;

IV. By providing the services pursuant to the Agreement, Business Associate will become a "business associate" of the Covered Entity as such term is defined under HIPAA;

V. Both Parties are committed to complying with all federal and state laws governing the confidentiality and privacy of health information, including, but not limited to, the Standards for Privacy of Individually Identifiable Health Information found at 45 CFR Part 160 and Part 164, Subparts A and E (collectively, the "Privacy Rule"); and

VI. Both Parties intend to protect the privacy and provide for the security of Protected Health Information disclosed to Business Associate pursuant to the terms of this Agreement, HIPAA and other applicable laws.

AGREEMENT

NOW, THEREFORE, in consideration of the mutual covenants and conditions contained herein and the continued provision of PHI by Covered Entity to Business Associate under the Agreement in reliance on this BAA, the Parties agree as follows:

1. **Definitions**. For purposes of this BAA, the Parties give the following meaning to each of the terms in this Section 1 below. Any capitalized term used in this BAA, but not otherwise defined, has the meaning given to that term in the Privacy Rule or pertinent law.

A. "Affiliate" means a subsidiary or affiliate of Covered Entity that is, or has been, considered a covered entity, as defined by HIPAA.

B. "Breach" means the acquisition, access, use, or disclosure of PHI in a manner not permitted under the Privacy Rule which compromises the security or privacy of the PHI, as defined in 45 CFR §164.402.

C. "Breach Notification Rule" means the portion of HIPAA set forth in Subpart D of 45 CFR Part 164.

D. "Data Aggregation" means, with respect to PHI created or received by Business Associate in its capacity as the "business associate" under HIPAA of Covered Entity, the combining of such PHI by Business Associate with the PHI received by Business Associate in its capacity as a business associate of one or more other "covered entity" under HIPAA, to permit data analyses that relate to the Health Care Operations (defined below) of the respective covered entities. The meaning of "data aggregation" in this BAA shall be consistent with the meaning given to that term in the Privacy Rule.

E. "Designated Record Set" has the meaning given to such term under the Privacy Rule, including 45 CFR §164.501.B.

F. "De-Identify" means to alter the PHI such that the resulting information meets the requirements described in 45 CFR §§164.514(a) and (b).

G. "Electronic PHI" means any PHI maintained in or transmitted by electronic media as defined in 45 CFR §160.103.

H. "Health Care Operations" has the meaning given to that term in 45 CFR §164.501.

I. "HHS**"** means the U.S. Department of Health and Human Services.

J. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, Public Law 111-005.

K. "Individual" has the same meaning given to that term i in 45 CFR §§164.501 and 160.130 and includes a person who qualifies as a personal representative in accordance with 45 CFR §164.502(g).

L. "Privacy Rule" means that portion of HIPAA set forth in 45 CFR Part 160 and Part 164, Subparts A and E.

M. "Protected Health Information" or "PHI" has the meaning given to the term "protected health information" in 45 CFR §§164.501 and 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

N. ‘‘Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

O. "Security Rule" means the Security Standards for the Protection of Electronic Health Information provided in 45 CFR Part 160 & Part 164, Subparts A and C.

P. "Unsecured Protected Health Information" or "Unsecured PHI" means any "protected health information" as defined in 45 CFR §§164.501 and 160.103 that is not rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the HHS Secretary in the guidance issued pursuant to the HITECH Act and codified at 42 USC §17932(h).

2. Use and Disclosure of PHI.

A. Except as otherwise provided in this BAA, Business Associate may use or disclose PHI as reasonably necessary to provide the services described in the Agreement to Covered Entity, and to undertake other activities of Business Associate permitted or required of Business Associate by this BAA or as required by law.

B. Except as otherwise limited by this BAA or federal or state law, Covered Entity authorizes Business Associate to use the PHI in its possession for the proper management and administration of Business Associate's business and to carry out its legal responsibilities. Business Associate may disclose PHI for its proper management and administration, provided that (i) the disclosures are required by law; or (ii) Business Associate obtains, in writing, prior to making any disclosure to a third party (a) reasonable assurances from this third party that the PHI will be held confidential as provided under this BAA and used or further disclosed only as required by law or for the purpose for which it was disclosed to this third party and (b) an agreement from this third party to notify Business Associate immediately of any breaches of the confidentiality of the PHI, to the extent it has knowledge of the breach.

C. Business Associate will not use or disclose PHI in a manner other than as provided in this BAA, as permitted under the Privacy Rule, or as required by law. Business Associate will use or disclose PHI, to the extent practicable, as a limited data set or limited to the minimum necessary amount of PHI to carry out the intended purpose of the use or disclosure, in accordance with Section 13405(b) of the HITECH Act (codified at 42 USC §17935(b)) and any of the act's implementing regulations adopted by HHS, for each use or disclosure of PHI.

D. Upon request, Business Associate will make available to Covered Entity any of Covered Entity's PHI that Business Associate or any of its agents or subcontractors have in their possession.

E. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR §164.502(j)(1).

3. **Safeguards Against Misuse of PHI**. Business Associate will use appropriate safeguards to prevent the use or disclosure of PHI other than as provided by the Agreement or this BAA and Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate agrees to take reasonable steps, including providing adequate training to its employees to ensure compliance with this BAA and to ensure that the actions or omissions of its employees or agents do not cause Business Associate to breach the terms of this BAA.

4. **Reporting Disclosures of PHI and Security Incidents**. Business Associate will report to Covered Entity in writing any use or disclosure of PHI not provided for by this BAA of which it becomes aware and Business Associate agrees to report to Covered Entity any Security Incident affecting Electronic PHI of Covered Entity of which it becomes aware. Business Associate agrees to report any such event within five business days of becoming aware of the event.

5. **Reporting Breaches of Unsecured PHI**. Business Associate will notify Covered Entity in writing promptly upon the discovery of any Breach of Unsecured PHI in accordance with the requirements set forth in 45 CFR §164.410, but in no case later than 30 calendar days after discovery of a Breach. Business Associate will reimburse Covered Entity for any costs incurred by it in complying with the requirements of Subpart D of 45 CFR §164 that are imposed on Covered Entity as a result of a Breach committed by Business Associate.

6. **Mitigation of Disclosures of PHI**. Business Associate will take reasonable measures to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of any use or disclosure of PHI by Business Associate or its agents or subcontractors in violation of the requirements of this BAA.

7. **Agreements with Agents or Subcontractors**. Business Associate will ensure that any of its agents or subcontractors that have access to, or to which Business Associate provides, PHI agree in writing to the restrictions and conditions concerning uses and disclosures of PHI contained in this BAA and agree to implement reasonable and appropriate safeguards to protect any Electronic PHI that it creates, receives, maintains or transmits on behalf of Business Associate or, through the Business Associate, Covered Entity. Business Associate shall notify Covered Entity, or upstream Business Associate, of all subcontracts and agreements relating to the Agreement, where the subcontractor or agent receives PHI as described in section 1.M. of this BAA. Such notification shall occur within 30 (thirty) calendar days of the execution of the subcontract by placement of such notice on the Business Associate's primary website. Business Associate shall ensure that all subcontracts and agreements provide the same level of privacy and security as this BAA.

8. **Audit Report.** Upon request, Business Associate will provide Covered Entity, or upstream Business Associate, with a copy of its most recent independent HIPAA compliance report (AT-C 315), HITRUST certification or other mutually agreed upon independent standards based third party audit report. Covered entity agrees not to re-disclose Business Associate's audit report.

9. Access to PHI by Individuals.

A. Upon request, Business Associate agrees to furnish Covered Entity with copies of the PHI maintained by Business Associate in a Designated Record Set in the time and manner designated by Covered Entity to enable Covered Entity to respond to an Individual's request for access to PHI under 45 CFR §164.524.

B. In the event any Individual or personal representative requests access to the Individual's PHI directly from Business Associate, Business Associate within ten business days, will forward that request to Covered Entity. Any disclosure of, or decision not to disclose, the PHI requested by an Individual or a personal representative and compliance with the requirements applicable to an Individual's right to obtain access to PHI shall be the sole responsibility of Covered Entity.

10. Amendment of PHI.

A. Upon request and instruction from Covered Entity, Business Associate will amend PHI or a record about an Individual in a Designated Record Set that is maintained by, or otherwise within the possession of, Business Associate as directed by Covered Entity in accordance with procedures established by 45 CFR §164.526. Any request by Covered Entity to amend such information will be completed by Business Associate within 15 business days of Covered Entity's request.

B. In the event that any Individual requests that Business Associate amend such Individual's PHI or record in a Designated Record Set, Business Associate within ten business days will forward this request to Covered Entity. Any amendment of, or decision not to amend, the PHI or record as requested by an Individual and compliance with the requirements applicable to an Individual's right to request an amendment of PHI will be the sole responsibility of Covered Entity.

11. Accounting of Disclosures.

A. Business Associate will document any disclosures of PHI made by it to account for such disclosures as required by 45 CFR §164.528(a). Business Associate also will make available information related to such disclosures as would be required for Covered Entity to respond to a request for an accounting of disclosures in accordance with 45 CFR §164.528. At a minimum, Business Associate will furnish Covered Entity the following with respect to any covered disclosures by Business Associate: (i) the date of disclosure of PHI; (ii) the name of the entity or person who received PHI, and, if known, the address of such entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of the disclosure which includes the basis for such disclosure.

B. Business Associate will furnish to Covered Entity information collected in accordance with this Section 10, within ten business days after written request by Covered Entity, to permit Covered Entity to make an accounting of disclosures as required by 45 CFR §164.528, or in the event that Covered Entity elects to provide an Individual with a list of its business associates, Business Associate will provide an accounting of its disclosures of PHI upon request of the Individual, if and to the extent that such accounting is required under the HITECH Act or

under HHS regulations adopted in connection with the HITECH Act.

C. In the event an Individual delivers the initial request for an accounting directly to Business Associate, Business Associate will within ten business days forward such request to Covered Entity.

12. **Availability of Books and Records**. Business Associate will make available its internal practices, books, agreements, records, and policies and procedures relating to the use and disclosure of PHI, upon request, to the Secretary of HHS for purposes of determining Covered Entity's and Business Associate's compliance with HIPAA, and this BAA.

13. **Responsibilities of Covered Entity**. With regard to the use and/or disclosure of Protected Health Information by Business Associate, Covered Entity agrees to:

A. Notify Business Associate of any limitation(s) in its notice of privacy practices in accordance with 45 CFR §164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

B. Notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

C. Notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR §164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

D. Except for data aggregation or management and administrative activities of Business Associate, Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA if done by Covered Entity.

14. **Data Ownership.** Business Associate's data stewardship does not confer data ownership rights on Business Associate with respect to any data shared with it under the Agreement, including any and all forms thereof.

15. **Data Ownership.** Business Associate's data stewardship does not confer data ownership rights on Business Associate with respect to any data shared with it under the Agreement, including any and all forms thereof.

16. **Term and Termination.**

A. This BAA will become effective on the date first written above, and will continue in effect until all obligations of the Parties have been met under the Agreement and under this BAA.

B. Covered Entity may terminate immediately this BAA, the Agreement, and any other related agreements if Covered Entity makes a determination that Business Associate has breached a material term of this BAA and Business Associate has failed to cure that material breach, to Covered Entity's reasonable satisfaction, within 30 days after written notice from Covered Entity. Covered Entity may report the problem to the Secretary of HHS if termination is

not feasible.

C. If Business Associate determines that Covered Entity has breached a material term of this BAA, then Business Associate will provide Covered Entity with written notice of the existence of the breach and shall provide Covered Entity with 30 days to cure the breach. Covered Entity's failure to cure the breach within the 30-day period will be grounds for immediate termination of the Agreement and this BAA by Business Associate. Business Associate may report the breach to HHS.

D. Upon termination of the Agreement or this BAA for any reason, all PHI maintained by Business Associate will be returned to Covered Entity or destroyed by Business Associate. Business Associate will not retain any copies of such information. This provision will apply to PHI in the possession of Business Associate's agents and subcontractors. If return or destruction of the PHI is not feasible, in Business Associate's reasonable judgment, Business Associate will furnish Covered Entity with notification, in writing, of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of the PHI is infeasible, Business Associate will extend the protections of this BAA to such information for as long as Business Associate retains such information and will limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible. The Parties understand that this Section 14.D. will survive any termination of this BAA.

17. Effect of BAA.

A. This BAA is a part of and subject to the terms of the Agreement, except that to the extent any terms of this BAA conflict with any term of the Agreement, the terms of this BAA will govern.

B. Except as expressly stated in this BAA or as provided by law, this BAA will not create any rights in favor of any third party.

18. Regulatory References. A reference in this BAA to a section in HIPAA means the section as in effect or as amended at the time.

19. Notices. All notices, requests and demands or other communications to be given under this BAA to a Party will be made via either first class mail, registered or certified or express courier, or electronic mail to the Party's address given below:

A. If to Covered Entity, to:

Attn:
T:
E:

B. If to Business Associate, to:

Attn:
T:
E:

20. **Amendments and Waiver**. This BAA may not be modified, nor will any provision be waived or amended, except in writing duly signed by authorized representatives of the Parties. A waiver with respect to one event shall not be construed as continuing, or as a bar to or waiver of any right or remedy as to subsequent events.

21. **HITECH Act Compliance**. The Parties acknowledge that the HITECH Act includes significant changes to the Privacy Rule and the Security Rule. The privacy subtitle of the HITECH Act sets forth provisions that significantly change the requirements for business associates and the agreements between business associates and covered entities under HIPAA and these changes may be further clarified in forthcoming regulations and guidance. Each Party agrees to comply with the applicable provisions of the HITECH Act and any HHS regulations issued with respect to the HITECH Act. The Parties also agree to negotiate in good faith to modify this BAA as reasonably necessary to comply with the HITECH Act and its regulations as they become effective but, in the event that the Parties are unable to reach agreement on such a modification, either Party will have the right to terminate this BAA upon 30-days' prior written notice to the other Party.

In light of the mutual agreement and understanding described above, the Parties execute this BAA as of the date first written above.

By: _____
Name:
Title:

By: _____
Name:
Title:

Appendix D – Definitions and Abbreviations

D.1 Glossary of Definitions

Bidder: An entity that is proposing to contract for the services described herein.

Facility: When capitalized, this refers to the Crawford County Correctional Facility. When set lowercase, it refers to other correctional facilities or facilities generically.

Health care: All physical and MH care, including, but not limited to, emergent; urgent; nonurgent episodic; chronic; palliative; scheduled; inpatient; residential; outpatient; referrals to other onsite professionals; offsite specialty referrals; modifications of specialty referral requests; and action taken on posthospital, post-emergency room, or specialist recommendations.

Health records: For the purposes of this RFP, this term refers to all health-related documentation, including clinical still, sound, and video recordings.

Medical Practitioner: A physician, nurse practitioner, or physician assistant.

Patient: An incarcerated individual, including pretrial detainees, when the context is the individual in relationship to the provision of health care.

Proposal, submission: The sole written document that bidders submit to Crawford County in response to the RFP.

Psychiatric practitioner: A psychiatrist, MH-trained nurse practitioner, or MH-trained physician assistant.

Incarcerated individual: A person in custody of Facility, including a pretrial detainee, when the context is the individual generally and not related to the provision of health care.

Suicide watch: Heightened observation of an incarcerated individual by health care and custody staff due to concern that the individual may attempt suicide or other self-harm. The intensity of observation depends on the level of risk of suicide or other self-harm.

Vendor: The contracted provider of health care to Facility. When referring to an individual, "Vendor" refers not only to employees of the entity, but also individuals or companies that work as Vendor's agents, including temporary staff and medical providers that are hired or retained. Occasionally, a contractor may be another government agency or a nonprofit entity; this will be obvious from the context. In the contract language, "Vendor" is capitalized when it refers to the entity that will submit the bid and/or enter into the contract. When the word is used to refer to other vendors (e.g., Information Technology vendor) or vendors generically, it is set in lowercase.

D.2 Glossary of Abbreviations

The following are abbreviations used more than once in the RFP:

ACA: American Correctional Association

ADA: Americans with Disabilities Act of 1990

CLIA: Clinical Laboratory Improvement Amendments

DOT: Directly Observed Therapy (medication administration where a staff member watches the patient take the prescribed medication)

EHR: Electronic Health Record

ER: Emergency Room

FTE: Full-Time Equivalent

HIPAA: Health Insurance Portability and Accountability Act of 1996, including all updates and revisions

KPI: Key Performance Indicator

MH: Mental Health

MOUD: Medications for Opioid Use Disorder

NCCHC: National Commission on Correctional Health Care

P&Ps: Policies and Procedures

PCP: Primary Care Provider (a medical practitioner who is assigned primary responsibility for a patient's physical health care)

RFP: Request For Proposal (document issued by a jurisdiction describing the contracted services it is seeking to procure and soliciting proposals from interested vendors; some jurisdictions use terms such as request for information, request for quote)