PROFESSIONAL SERVICES AGREEMENT
for
BEHAVIORAL HEALTHCARE SERVICES
Contract No. DOC23025-BHVRHEALTH

This Professional Services Agreement ("Agreement") is entered into as of May 1, 2023 (Effective Date) and will end on June 30, 2026, by and between the State of Delaware, Department of Correction ("Delaware" or "DDOC" as appropriate), and VitalCore Health Strategies, LLC ("Provider").

WHEREAS, Delaware desires to obtain certain services to provide behavioral healthcare services and an integrated, evidence-based, recovery-oriented system of care for incarcerated individuals (pretrial and sentenced) housed in a correctional system; and

WHEREAS, DDOC issued Request for Proposal No. DOC23025-BHVRHEALTH on or about December 23, 2022 and selected Provider as the winning bidder; and

WHEREAS, Provider acknowledges, accepts, and will comply with all terms and conditions of said RFP as outlined in the RFP specifications; and

WHEREAS, the Commissioner of the DDOC has legal authority to enter into any and all contracts, 29 *Del. C.* § 8903(5); and

WHEREAS, the Commissioner possesses the legal authority to "do any and all things necessary to carry out and to fulfill the purposes of this chapter," 11 *Del. C.* § 6517(11); and

WHEREAS, the Commissioner possesses the legal authority to administer a "medical/ treatment services contract," 11 *Del. C.* § 6517(12); and

WHEREAS, among the Commissioner's duties, he "shall establish reasonable health, medical and dental services," 11 *Del. C.* § 6536(a); and

WHEREAS, Provider desires to provide such services to Delaware on the terms set forth below; and

WHEREAS, Delaware and Provider represent and warrant that each party has full right, power and authority to enter into and perform under this Agreement;

FOR AND IN CONSIDERATION OF the promises and mutual agreements herein, Delaware and Provider agree as follows:

1. **Services.**

1.1. Provider shall perform for Delaware the services specified in the Appendices to this Agreement, attached hereto and made a part hereof. Provider shall comply with all DDOC policies and other laws and regulations in performing the services.

1.2. Delaware may, at any time, in writing, make changes in the scope of this Agreement and in the services or work to be performed. No services for which additional compensation may be charged by Provider shall be furnished, without the written

authorization of Delaware. When Delaware desires any addition or deletion to the deliverables or a change in the services to be provided under this Agreement, it shall notify Provider, who shall then submit to Delaware a "Change Order" for approval authorizing said change. The Change Order shall state whether the change shall cause an alteration in the price or the time required by Provider for any aspect of its performance under this Agreement.

1.3. Provider will not be required to make changes to its scope of work that result in Provider's costs exceeding the current unencumbered budgeted appropriations for the services. Any claim of either party for an adjustment under Section 1 of this Agreement shall be asserted in the manner specified in the writing that authorizes the adjustment.

2. **Payment for Services and Expenses.**

2.1. The term of the initial Agreement shall be from May 1, 2023 through April 30, 2026. The Agreement may be renewed for two (2) optional extensions for a period of two (2) years for each extension through negotiation and mutual written agreement between the Provider and Delaware. Should the Agreement be extended, the Agreement amount may be adjusted based upon the current Philadelphia All Urban Consumers Price Index (CPI-U), U.S. City Average. The CPI-U used shall reflect the percentage change during the previous published twelve (12) month period. Should the percentage change be greater than 3%, the annual adjustment shall be capped at 3%.

2.2. Delaware will pay Provider for the performance of services as described in Appendix-1. The fee will be paid in accordance with this Agreement and the invoice instructions provided in Appendix-1.

2.3. Delaware's obligation to pay Provider for the performance of services will not exceed the total amount set forth in Appendix-1. It is expressly understood that the services defined in Appendix-1 to this Agreement must be completed by the Provider and it shall be Provider's responsibility to ensure that hours and tasks are properly budgeted so that all services are completed for the agreed upon fixed fee. Delaware's total liability for all charges for services that may become due under this Agreement is limited to the total maximum expenditure(s) authorized in Delaware's purchase order(s) to Provider.

2.4. Delaware will make payment to the Provider by Automated Clearing House (ACH).

2.5. Provider shall submit invoices to Delaware in sufficient detail to support the services provided during the previous month. Delaware agrees to pay those invoices within thirty (30) days of receipt. In the event Delaware disputes a portion of an invoice, Delaware agrees to pay the undisputed portion of the invoice within thirty (30) days of receipt and to send the Provider a detailed statement of Delaware's position on the disputed portion of the invoice within thirty (30) days of receipt. Delaware's failure to pay any amount of an invoice that is not the subject of a good-faith dispute within thirty (30) days of receipt may be charged interest on the overdue portion at no more than 1.0% per month. All payments should be sent to the Provider's identified address on record with the State of Delaware's Division of Accounting as identified in the completion of the electronic W-9.

2.6. Unless provided otherwise in this Agreement, all expenses incurred in the performance of the services are to be paid by Provider.

2.7. Delaware is a sovereign entity and shall not be liable for the payment of federal, state and local sales, use and excise taxes, including any interest and penalties from any related deficiency, which may become due and payable as a consequence of this Agreement.

2.8. Delaware shall subtract from any payment made to Provider all damages, costs and expenses caused by Provider's breach of contract, resulting from or arising out of errors or omissions in Provider's work products, which have not been previously paid to Provider.

2.9. Provider agrees to certify in writing, under penalty of perjury, that it has timely paid all valid subcontractor invoices received by Provider excluding invoices which may be pending corrections or disputes. Such written certification shall be attached to each monthly invoice submitted to Delaware and shall include an explanation for any pending disputes which exceed $100,000.00 in aggregate. DDOC recognizes and understands that for outside provider invoices, there is a lag time between the date the provider services are rendered and the invoices are submitted to Provider ("Claims Lag"). Provider's monthly affidavit will not include invoices that are a part of this Claims Lag.

3. **Responsibilities of Provider.**

3.1. Provider shall be responsible for ensuring that all services, products and deliverables furnished pursuant to this Agreement comply with standards promulgated by the Delaware Department of Technology and Information ("DTI") published at https://dti.delaware.gov/, and as modified from time to time by DTI during the term of this Agreement. If any service, product or deliverable furnished pursuant to this Agreement does not conform to DTI standards, Provider shall, at its expense and option either (1) replace it with a conforming equivalent or (2) modify it to conform to DTI standards. Provider shall be and remain liable in accordance with the terms of this Agreement and applicable law for all damages to Delaware caused by Provider's failure to ensure compliance with DTI standards.

3.2. It shall be the duty of the Provider to assure that all services and products of its effort are technically sound and in conformance with all pertinent Federal, State and Local statutes, codes, ordinances, resolutions and other regulations including DDOC policies. Provider will not produce a work product that violates or infringes on any copyright or patent rights. Provider shall, without additional compensation, correct or revise any errors or omissions in its work products.

3.3. Permitted or required approval by Delaware of any products or services furnished by Provider shall not in any way relieve Provider of responsibility for the professional and technical accuracy and adequacy of its work. Delaware's review, approval, acceptance, or payment for any of Provider's services herein shall not be construed to operate as a waiver of any rights under this Agreement or of any cause of action arising out of the performance of this Agreement, and Provider shall be and remain liable in accordance with the terms of this Agreement and applicable law for all

damages to Delaware caused by Provider's performance or failure to perform under this Agreement.

3.4. All of the services specified by this Agreement shall be performed by the Provider or by Provider's employees or agents under the personal supervision of the Provider. Prior to performing any work under this Agreement, Provider and Provider's employees and agents shall submit to any criminal history or other background checks that may be requested by Delaware and shall comply with all DDOC policies. DDOC may refuse access to any Delaware facility or to any sensitive information possessed or controlled by Delaware for any person not conforming to DDOC policy or whose criminal history or background check results are not acceptable to DDOC, in its sole and absolute discretion.

3.5. In accordance with the Federal Prison Rape Elimination Act of 2003 and DDOC Policy 8.60, the Provider agrees to report allegations of sexual misconduct promptly, fully cooperate with investigation inquiries and participate in training as directed by the DDOC, within thirty (30) days of entering into contract. Provider and Provider staff's (including volunteers and subcontractors) agree to abide by DDOC Policy 8.60. The Provider acknowledges that all allegations of staff sexual misconduct and/or harassment will be investigated and, if substantiated, will result in discipline up to and including termination. All substantiated cases will be referred to the Delaware Department of Justice for prosecution. Failure to report such misconduct, delays in reporting, or material omissions shall be grounds for termination. If DDOC Policy is modified, the Provider will be notified and shall comply.

3.6. In accordance with DDOC Policy 16.1 and its Annual Training Plan, as established by the Stephen R Floyd Jr. Training Academy, the Provider's employees and agents will be required to complete the Contractual Staff Orientation prior to job assignment and any other mandatory training as may be required in the annual plan. Those employees who are retained by Provider from the prior behavioral healthcare vendor ("Incumbent Staff") and who have already satisfactorily completed this training are not required to retake it until their annual updated training is due.

3.7. Upon receipt of written notice from Delaware that an employee or agent of Provider is unsuitable to Delaware for good cause, including, without limitation, violation of DDOC policies, or a criminal history or background check that yield results that are not acceptable to DDOC, in its sole and absolute discretion, Provider shall remove such employee from the performance of services and substitute in his/her place a suitable employee or agent.

3.8. Provider shall furnish to Delaware's designated representative copies of all correspondence to regulatory agencies for review prior to mailing such correspondence.

3.9. Provider agrees that its officers and employees will cooperate with Delaware in the performance of services under this Agreement and will be available for consultation with Delaware at such reasonable times with advance notice as to not conflict with their other responsibilities.

3.10. Provider has or will retain such employees as it may need to perform the services required by this Agreement. Such employees shall not be simultaneously employed by Delaware or any other political subdivision of Delaware.

3.11. Provider will not use Delaware's name, either express or implied, in any of its advertising or sales materials without Delaware's express written consent.

3.12. The rights and remedies of Delaware provided for in this Agreement are in addition to any other rights and remedies provided by law.

4. **State Responsibilities.**

4.1. In connection with Provider's provision of the services, Delaware shall perform those tasks and fulfill those responsibilities specified in Appendix-1.

4.2. Delaware agrees that its officers and employees will cooperate with Provider in the performance of services under this Agreement and will be available for consultation with Provider at such reasonable times with advance notice as to not conflict with their other responsibilities.

4.3. The services performed by Provider under this Agreement shall be subject to review for compliance with the terms of this Agreement by Delaware's designated representatives. Delaware representatives may delegate any or all responsibilities under the Agreement to appropriate staff members and shall inform Provider by written notice before the effective date of each such delegation.

4.4. The review comments of Delaware's designated representatives may be reported in writing as needed to Provider. It is understood that Delaware's representatives' review comments do not relieve Provider from the responsibility for the professional and technical accuracy of all work delivered under this Agreement.

4.5. Provider will not be responsible for accuracy of information or data supplied by Delaware or other sources to the extent such information or data would be relied upon by a reasonably prudent contractor.

4.6. Delaware agrees not to use Provider's name, either express or implied, in any of its advertising or sales materials. Provider reserves the right to reuse the nonproprietary data and the analysis of industry-related information in its continuing analysis of the industries covered.

5. **Work Product.**

5.1. All materials, information, documents, and reports, whether finished, unfinished, or draft, developed, prepared, completed, or acquired by Provider on behalf of Delaware ("Work for Hire"), which are not otherwise protected by copyright, trademark or other registration, relating to the Services to be performed hereunder shall become the property of Delaware and shall be delivered to Delaware's designated representative upon completion or termination of this Agreement, whichever comes first. Work for Hire specifically does not include any materials, information, documents, policies, programs, etc. developed by Provider not on behalf of Delaware or pre-existing but modified for use by Delaware. Provider shall not be liable for damages, claims, and

losses arising out of any reuse of any Work for Hire on any other project conducted by Delaware. Delaware shall have the right to reproduce all Work for Hire as allowed by law.

5.2. Provider retains all title and interest to the data created pursuant to, or necessary for, this Agreement. Retention of such title and interest does not conflict with Delaware's rights to the Work for Hire materials, information and documents developed in performing the project. The Parties will cooperate with each other and execute such other documents as may be reasonably deemed necessary to achieve the objectives of this section.

5.3. In no event shall Provider be precluded from developing for itself, or for others, materials that are competitive with the Work for Hire, irrespective of their similarity to the Work for Hire. Additionally, Provider shall be free to use its general knowledge, skills and experience, and any ideas, concepts, know-how, and techniques within the scope of its consulting practice that are used in the course of providing the services.

5.4. Notwithstanding anything to the contrary contained herein or in any attachment hereto, any and all intellectual property or other proprietary data owned by Provider prior to the effective date of this Agreement ("Preexisting Information") shall remain the exclusive property of Provider even if such Preexisting Information is embedded or otherwise incorporated the Work for Hire first produced as a result of this Agreement or used to develop such materials or products. Delaware's rights under this section shall not apply to any Preexisting Information or any component thereof regardless of form or media.

6. **Confidential Information.**

To the extent permissible under 29 *Del. C.* § 10001, et seq., the parties to this Agreement shall preserve in strict confidence any information, reports or documents obtained, assembled, or prepared in connection with the performance of this Agreement.

7. **Warranty.**

7.1. Provider warrants that its services will be performed in a manner consistent with applicable professional standards. Provider agrees to re-perform any work not in compliance with this warranty brought to its attention within a reasonable time after that work is performed.

7.2. Third-party products within the scope of this Agreement are warranted solely under the terms and conditions of the licenses or other agreements by which such products are governed. With respect to all third-party products and services purchased by Provider for Delaware in connection with the provision of the services, Provider shall pass through or assign to Delaware the rights Provider obtains from the manufacturers and/or suppliers of such products and services (including warranty and indemnification rights), all to the extent that such rights are assignable.

8. **Indemnification; Limitation of Liability.**

8.1. Provider shall indemnify and hold harmless the State of Delaware, its agents and employees, from any and all liability, suits, actions or claims, together with all reasonable costs and expenses (including attorneys' fees) directly arising out of:

a. the negligence or other wrongful conduct of the Provider, its agents or employees, or

b. Provider's breach of any material provision of this Agreement not cured after due notice and opportunity to cure, provided Provider shall have been notified promptly in writing by Delaware of any notice of such claim.

8.2. If Delaware promptly notifies Provider in writing of a third-party claim against Delaware that any services infringe a copyright or a trade secret of any third party, Provider will defend such claim at its expense and will pay any costs or damages that may be finally awarded against Delaware. Provider will not indemnify Delaware, however, if the claim of infringement is caused by:

a. Delaware's misuse or modification of the Deliverable, or

b. Delaware's failure to use corrections or enhancements made available by Provider, or

c. Delaware's use of the Deliverable in combination with any product or information not owned or developed by Provider, or

d. Delaware's distribution, marketing or use for the benefit of third parties of the Deliverable, or

e. Information, direction, specification or materials provided by Client or any third party. If any Deliverable is, or in Provider's opinion is likely to be, held to be infringing, Provider shall at its expense and option either:

i. Procure the right for Delaware to continue using it, or
ii. Replace it with a non-infringing equivalent, or
iii. Modify it to make it non-infringing.

The foregoing remedies constitute Delaware's sole and exclusive remedies and Provider's entire liability with respect to infringement.

9. **Employees.**

9.1. Except as provided herein with respect to removal of employees for good cause, and subject to the DDOC's sole and absolute right to maintain safety and security and otherwise manage the operations of its facilities, Provider has and shall retain the right to exercise full control over the employment, direction, compensation and discharge of all persons employed by Provider ("Personnel") in the performance of the services hereunder; provided, however, that it will, subject to scheduling and staffing considerations, attempt to honor Delaware's request for specific individuals.

9.2. Except as the other party expressly authorizes in writing in advance, neither party shall solicit, offer work to, employ, or contract with, whether as a partner, employee or independent contractor, directly or indirectly, any of the other party's Personnel during their participation in the services or during the twelve (12) months thereafter. For purposes of this Section, Personnel includes any individual a party employs as a partner, employee or independent contractor and with which a party comes into direct contact in the course of the services.

9.3. Possession of a Security Clearance, as issued by the DDOC, is required of any employee of Provider who will be assigned to this Agreement.

10. **Independent Contractor.**

10.1. It is understood that in the performance of the services herein, Provider shall be, and is, an independent contractor, and is not an agent or employee of Delaware and shall furnish such services in its own manner and method except as required by this Agreement. Provider shall be solely responsible for, and shall indemnify, defend and save Delaware harmless from all matters relating to the payment of its employees, including compliance with social security, withholding and all other wages, salaries, benefits, taxes, exactions, and regulations of any nature whatsoever.

10.2. Provider acknowledges that Provider and any subcontractors, agents or employees employed by Provider shall not, under any circumstances, be considered employees of Delaware, and that they shall not be entitled to any of the benefits or rights afforded employees of Delaware, including, but not limited to, sick leave, vacation leave, holiday pay, Public Employees Retirement System benefits, or health, life, dental, long-term disability or workers' compensation insurance benefits. Delaware will not provide or pay for any liability or medical insurance, retirement contributions or any other benefits for or on behalf of Delaware or any of its officers, employees or other agents.

10.3. Provider shall be responsible for providing liability insurance for its personnel.

10.4. As an independent contractor, Provider has no authority to bind or commit Delaware. Nothing herein shall be deemed or construed to create a joint venture, partnership, fiduciary, or agency relationship between the parties for any purpose.

11. **Dispute Resolution.**

11.1. At the option of the parties, they shall attempt in good faith to resolve any dispute arising out of or relating to this Agreement promptly by negotiation between executives who have authority to settle the controversy and who are at a higher level of management than the persons with direct responsibility for administration of this Agreement. All offers, promises, conduct and statements, whether oral or written, made in the course of the negotiation by any of the parties, their agents, employees, experts and attorneys are confidential, privileged and inadmissible for any purpose, including impeachment, in arbitration or other proceeding involving the parties, provided evidence that is otherwise admissible or discoverable shall not be rendered inadmissible.

11.2. If the matter is not resolved by negotiation, as outlined above, or, alternatively, the parties elect to proceed directly to mediation, then the matter will proceed to mediation as set forth below. Any disputes, claims or controversies arising out of or relating to this Agreement shall be submitted to a mediator selected by the parties. If the matter is not resolved through mediation, it may be submitted for arbitration or litigation. The DDOC reserves the right to proceed directly to arbitration or litigation without negotiation or mediation. Any such proceedings held pursuant to this provision shall be governed by Delaware law, and jurisdiction and venue shall be in the State of Delaware. Each party shall bear its own costs of mediation, arbitration, or litigation, including attorneys' fees.

12. **Remedies.**

Except as otherwise provided in this Agreement, including but not limited to Section 11 above, all claims, counterclaims, disputes, and other matters in question between the State of Delaware and the Provider arising out of, or relating to, this Agreement, or a breach of it may be decided by arbitration if the parties mutually agree, or in a court of competent jurisdiction within the State of Delaware.

13. **Suspension.**

13.1. Delaware may suspend performance by Provider under this Agreement for such period of time as Delaware, at its sole discretion, may prescribe by providing written notice to Provider at least 30 calendar days prior to the date on which Delaware wishes to suspend. Upon such suspension, Delaware shall pay Provider its compensation, based on the percentage of the project completed and earned until the effective date of suspension, less all previous payments. Provider shall not perform further work under this Agreement after the effective date of suspension until receipt of written notice from Delaware to resume performance.

13.2. In the event Delaware suspends performance by Provider for any cause other than the error or omission of the Provider, for an aggregate period in excess of 30 days, Provider shall be entitled to an equitable adjustment of the compensation payable to Provider under this Agreement to reimburse Provider for additional costs occasioned as a result of such suspension of performance by Delaware based on appropriated funds and approval by Delaware.

14. **Termination.**

14.1. This Agreement may be terminated in whole or in part by either party in the event of substantial failure of the other party to fulfill its obligations under this Agreement through no fault of the terminating party, but only after the other party is given:

a. Not less than 90 calendar days written notice of intent to terminate, and

b. An opportunity for consultation with the terminating party prior to termination.

14.2. This Agreement may be terminated in whole or in part by Delaware for its convenience, but only after Provider is given:

a. Not less than 180 calendar days written notice of intent to terminate, and

b. An opportunity for consultation with Delaware prior to termination.

14.3. If Delaware terminates the Agreement for default, Delaware will pay Provider that portion of the compensation which has been earned as of the effective date of termination, but:

a. No amount shall be allowed for anticipated profit on performed or unperformed services or other work, and

b. Any payment due to Provider at the time of termination may be adjusted to the extent of any additional costs occasioned to Delaware by reason of Provider's default.

c. Upon termination for default, Delaware may take over the work and prosecute the same to completion by agreement with another party or otherwise. In the event Provider shall cease conducting business, Delaware shall have the right to make an unsolicited offer of employment to any employees of Provider assigned to the performance of the Agreement, notwithstanding the provisions of Section 9.2.

14.4. If after termination for failure of Provider to fulfill contractual obligations, it is determined that Provider has not so failed, the termination shall be deemed to have been affected for the convenience of Delaware.

14.5. The rights and remedies of Delaware and Provider provided in this section are in addition to any other rights and remedies provided by law or under this Agreement.

14.6. Gratuities.

a. Delaware may, by written notice to Provider, terminate this Agreement if it is found after notice and hearing by Delaware that gratuities (in the form of entertainment, gifts, or otherwise) were offered or given by Provider or any agent or representative of Provider to any officer or employee of Delaware with a view toward securing a contract or securing favorable treatment with respect to the awarding or amending or making of any determinations with respect to the performance of this Agreement.

b. In the event this Agreement is terminated as provided in 14.6.a hereof, Delaware shall be entitled to pursue the same remedies against Provider it could pursue in the event of a breach of this Agreement by Provider.

c. The rights and remedies of Delaware provided herein shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

15. **Severability.**

If any term or provision of this Agreement is found by a court of competent jurisdiction to be invalid, illegal or otherwise unenforceable, the same shall not affect the other terms or provisions hereof or the whole of this Agreement, but such term or provision shall be deemed

modified to the extent necessary in the court's opinion to render such term or provision enforceable, and the rights and obligations of the parties shall be construed and enforced accordingly, preserving to the fullest permissible extent the intent and agreements of the parties herein set forth.

16. **Assignment; Subcontracts.**

16.1. Any attempt by Provider to assign or otherwise transfer any interest in this Agreement without the prior written consent of Delaware shall be void. Such consent shall not be unreasonably withheld.

16.2. Services specified by this Agreement, other than those listed by Provider in its RFP response, shall not be subcontracted by Provider, without prior written approval of Delaware.

16.3. Approval by Delaware of Provider's request to subcontract or acceptance of or payment for subcontracted work by Delaware shall not in any way relieve Provider of responsibility for the professional and technical accuracy and adequacy of the work. All subcontractors shall adhere to all applicable provisions of this Agreement, including but not limited to the insurance and indemnification requirements.

16.4. Provider shall be and remain liable for all damages to Delaware caused by negligent performance or non-performance of work under this Agreement by Provider, its subcontractor or its sub-subcontractor. Provider shall not be liable to any third-party for a breach of contract claim under this provision, including but not limited to DDOC offenders or their family members or heirs.

16.5. The compensation due shall not be affected by Delaware's approval of the Provider's request to subcontract.

17. **Force Majeure; Applicability.**

Neither the Provider nor Delaware shall be held liable for non-performance under the terms and conditions of this Agreement due, but not limited to:

17.1. Acts of God, labor disturbances, accidents, failure of a governmental entity to issue a permit or approval required for performance when the Provider has filed proper and timely application with the appropriate government entity, civil disorders, acts of aggression, changes in any law or regulation adopted or issued by a governmental entity after the date of this Agreement, a court order, explosions, failure of utilities, or material shortages, or

17.2. Diseases, plagues, quarantine, epidemics, pandemics, or

17.3. Federal, state, or local work or travel restrictions to control, mitigate, or reduce transmission of diseases, plagues, epidemics, pandemics, or

17.4. Delaware's need to occupy, utilize, or repurpose an active or prospective work area due to diseases, plagues, quarantine, epidemics, pandemics, work or travel restrictions, and the need to control, mitigate, or reduce transmission of diseases, plagues, epidemics, or pandemics.

Each party shall notify the other in writing of any situation that may prevent performance under the terms and conditions of this Agreement within two (2) business days of the party's knowledge of significant non-performance risk.

18. **Non-Appropriation of Funds.**

18.1. Validity and enforcement of this Agreement is subject to appropriations by the General Assembly of the specific funds necessary for contract performance. Should such funds not be so appropriated, Delaware may immediately terminate this Agreement in writing, and absent such action this Agreement shall be terminated as to any obligation of the State requiring the expenditure of money for which no specific appropriation is available, at the end of the last fiscal year for which no appropriation is available or upon the exhaustion of funds.

18.2. Notwithstanding any other provisions of this Agreement, this Agreement shall terminate and Delaware's obligations under it shall be extinguished at the end of the fiscal year in which Delaware fails to appropriate monies for the ensuing fiscal year sufficient for the payment of all amounts which will then become due.

19. **State of Delaware Business License.**

Provider and all subcontractors represent that they are properly licensed and authorized to transact business in the State of Delaware as provided in 30 *Del. C.* § 2502.

20. **Complete Agreement.**

20.1. This Agreement shall constitute the entire agreement between Delaware and Provider with respect to the subject matter of this Agreement and shall not be modified or changed without the express written consent of the parties. The provisions of this Agreement supersede all prior oral and written quotations, communications, agreements, and understandings of the parties with respect to the subject matter of this Agreement.

20.2. If the scope of any provision of this Agreement is too broad in any respect whatsoever to permit enforcement to its full extent, then such provision shall be enforced to the maximum extent permitted by law, and the parties hereto consent and agree that such scope may be judicially modified accordingly and that the whole of such provisions of the Agreement shall not thereby fail, but the scope of such provision shall be curtailed only to the extent necessary to conform to the law.

21. **Miscellaneous Provisions.**

21.1. In performance of this Agreement, Provider shall comply with all applicable federal, state and local laws, ordinances, codes and regulations. Provider shall solely bear the costs of permits and other relevant costs required in the performance of this Agreement.

21.2. This Agreement may only be modified by the mutual written agreement of the parties. No waiver of any provision of this Agreement shall be effective unless it is in writing and signed by the party against which it is sought to be enforced.

21.3. The delay or failure by either party to exercise or enforce any of its rights under this Agreement shall not constitute or be deemed a waiver of that party's right thereafter to enforce those rights, nor shall any single or partial exercise of any such right preclude any other or further exercise thereof or the exercise of any other right.

21.4. Provider covenants that it presently has no interest and that it will not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of services required to be performed under this Agreement. Provider further covenants, to its knowledge and ability, that in the performance of said services no person having any such interest shall be employed.

21.5. Provider acknowledges that Delaware has an obligation to ensure that public funds are not used to subsidize private discrimination. Provider recognizes that if, in performing the services, it refuses to hire or do business with an individual or company due to reasons of race, color, gender, ethnicity, disability, national origin, age, or any other protected status, Delaware may declare Provider in breach of the Agreement, terminate the Agreement, and designate Provider as non-responsible.

21.6. Provider warrants that no person or selling agency has been employed or retained to solicit or secure this Agreement upon an agreement or understanding for a commission, or a percentage, brokerage, or contingent fee. For breach or violation of this warranty, Delaware shall have the right to annul this Agreement without liability or at its discretion deduct from the contract price or otherwise recover the full amount of such commission, percentage, brokerage, or contingent fee.

21.7. This Agreement was drafted with the joint participation of both parties and shall be construed neither against nor in favor of either, but rather in accordance with the fair meaning thereof.

21.8. Provider shall maintain all public records, as defined by 29 *Del. C*. § 502(8), relating to this Agreement and its deliverables for the time and in the manner specified by the Delaware Division of Archives, pursuant to the Delaware Public Records Law, 29 *Del. C.* Ch. 5. During the term of this Agreement, authorized representatives of Delaware may inspect or audit Provider’s performance and records pertaining to this Agreement at the Provider business office during normal business hours.

21.9. Funds received and expended under the Agreement must be recorded so as to permit the DDOC to audit and account for all expenditures in conformity with the terms, conditions, and provisions of this Agreement, and with all pertinent federal and state laws and regulations.

21.10. The Provider recognizes that no extra contractual services are approved unless specifically authorized in writing by the Department. Further, the Provider recognizes that any and all services performed outside the scope of this Agreement and attached budgets will be deemed by the DDOC to be gratuitous and not subject to any financial reimbursement.

21.11. The Provider agrees that, upon termination, all equipment purchased with DDOC funds will be returned to the DDOC immediately upon termination.

21.12. No Third-Party Beneficiaries. This Agreement inures to the benefit of DDOC and Provider. There are no third-party beneficiaries to this Agreement and no obligations of either party inure to the benefit of any third-party for a breach of contract claims, including but not limited to Inmates, their families, heirs and assigns.

21.13. The State reserves the right to advertise a supplemental solicitation during the term of the Agreement if deemed in the best interest of the State.

21.14. Provider's employees carrying out any work related to this Agreement within a State facility shall have those employees comply with any health mandate or policy issued by the State related to a pandemic or other State of Emergency issued by any State authority during the term of this Agreement, including those that apply directly to State employees.

22. **Insurance.**

As a part of the Agreement requirements, the Provider must obtain at its own cost and expense and keep in force and effect during the term of this Agreement, including all extensions, the minimum coverage limits specified below with a carrier satisfactory to the State. All Providers must carry the following coverage depending on the type of service or product being delivered

a. Worker's Compensation and Employer's Liability Insurance in accordance with applicable law.

b. Commercial General Liability - $1,000,000 per occurrence/$3,000,000 per aggregate.

c. Automotive Liability Insurance covering all automotive units used in the work (including all units leased from and/or provided by the State to Provider pursuant to this Agreement as well as all units used by Provider, regardless of the identity of the registered owner, used by Provider for completing the work required by this Agreement to include but not limited to transporting Delaware clients or staff), providing coverage on a primary non-contributory basis with limits of not less than:

I. $1,000,000 combined single limit each accident, for bodily injury;
II. $250,000 for property damage to others;
III. $25,000 per person per accident Uninsured/Underinsured Motorists coverage;
IV. $25,000 per person, $300,000 per accident Personal Injury Protection (PIP) benefits as provided for in 21 *Del. C.* § 2118; and
V. Comprehensive coverage for all leased vehicles, which shall cover the replacement cost of the vehicle in the event of collision, damage or other loss.

The Provider must carry at least one of the following depending on the scope of work being performed.

a. Medical/Professional Liability - $1,000,000 per occurrence/$3,000,000 per aggregate

b. Miscellaneous Errors and Omissions - $1,000,000 per occurrence/$3,000,000 per aggregate

c. Product Liability - $1,000,000 per occurrence/$3,000,000 aggregate

Should any of the above-described policies be cancelled before expiration date thereof, notice will be delivered in accordance with the policy provisions.

Before any work is done pursuant to this Agreement, the Certificate of Insurance and/or copies of the insurance policies, referencing the contract number stated herein, shall be filed with the DDOC. The certificate holder is as follows:

Delaware Department of Correction
Contract No: DOC23025-BHVRHEALTH
CBO Purchasing
245 McKee Road
Dover, DE 19904

Nothing contained herein shall restrict or limit the Provider's right to procure insurance coverage in amounts higher than those required by this Agreement. To the extent that the Provider procures insurance coverage in amounts higher than the amounts required by this Agreement, all said additionally procured coverages will be applicable to any loss or claim and shall replace the insurance obligations contained herein.

To the extent that Provider has complied with the terms of this Agreement and has procured insurance coverage for all vehicles Leased and/or operated by Provider as part of this Agreement, the State of Delaware's self-insured insurance program shall not provide any coverage whether coverage is sought as primary, co-primary, excess or umbrella insurer or coverage for any loss of any nature.

In no event shall the State of Delaware be named as an additional insured on any policy required under this Agreement.

23. **Performance Requirements.**

The Provider will warrant that it possesses, or has arranged through subcontractors, all capital and other equipment, labor, materials, and licenses necessary to carry out and complete the work hereunder in compliance with any and all Federal and State laws, and County and local ordinances, regulations and codes.

24. **Performance Bond.**

Effective July 1, 2023, the Provider is required to annually furnish a Performance Bond equal to 100% of the annual price to the State of Delaware for the benefit of the Delaware Department of Correction. Said bonds shall be conditioned upon the faithful performance of the Agreement. This guarantee shall be submitted in the form of good and sufficient bond drawn upon an Insurance or Bonding Company authorized to do business in the State of Delaware.

25. **Assignment of Antitrust Claims.**

As consideration for the award and execution of this Agreement by the State, the Provider hereby grants, conveys, sells, assigns, and transfers to the State of Delaware all its right, title and interest in and to all known or unknown causes of action it presently has or may now or hereafter acquire under the antitrust laws of the United States and the State of Delaware,

regarding the specific goods or services purchased or acquired for the State pursuant to this Agreement. Upon either the State's or the Provider's notice of the filing of or reasonable likelihood of filing of an action under the antitrust laws of the United States or the State of Delaware, the State and Provider shall meet and confer about coordination of representation in such action.

26. **Governing Law.**

This Agreement shall be governed by and construed in accordance with the laws of the State of Delaware, except where Federal law has precedence. Provider consents to jurisdiction and venue in the State of Delaware.

27. **Notices.**

Any and all notices required by the provisions of this Agreement shall be in writing and shall be mailed, certified or registered mail, return receipt requested. All notices shall be sent to the following addresses:

DELAWARE:
Manager, Support Services
Department of Correction
245 McKee Road
Dover, DE 19904

PROVIDER:
VitalCore Health Strategies, LLC
719 S.W. Van Buren St., Suite 100
Topeka, KS 66603

[SIGNATURE PAGE TO FOLLOW]

IN WITNESS THEREOF, the Parties hereto have caused this Agreement to be duly executed as of the date and year first above written.

For the Provider:

Viola Riggin 5/1/2023
Viola Riggin Date
Chief Executive Officer
VitalCore Health Strategies, LLC

For the Department:

Monroe B. Hudson, Jr. 5/1/23
Monroe B. Hudson, Jr. Date
Commissioner

5/1/23
Christine Dunning, Chief Date
Bureau of Administrative Services

5/1/23
Mike Records, Chief Date
Bureau of Healthcare, Substance Abuse,
and Mental Health Services

Craig Fetzer 5/1/2023
Craig Fetzer Date
Manager, Support Services

APPENDIX-1
SCOPE OF SERVICES AND BUDGET DESCRIPTION

Provider: VitalCore Health Strategies, LLC ("Provider")
Address: 719 S.W. Van Buren St., Suite 100
Topeka, KS 66603

Primary Contact: Viola Riggin, CEO
Phone: (785) 246-6840
Email: VRiggin@VitalCoreHS.com

Department: Delaware Department of Correction ("DDOC")
Address: 245 McKee Road
Dover, DE 19904

Primary Contact: Michael Records, Bureau Chief
Bureau of Healthcare, Substance Abuse, and Mental Health Services (BHSAMH)
Phone: (302) 857-5389
Email: michael.records@delaware.gov

Contract ID#: DOC23025-BHVRHEALTH

Contract Title: Behavioral Health Services

Contract Amount:

Period	Annual Amount	Monthly Amount
May 1, 2023 – June 30, 2023 *(Transition Period)*	$192,958.00	One-time payment
July 1, 2023 – June 30, 2024 *(Year One)*	$25,260,021.19	$2,105,001.77
July 1, 2024 – June 30, 2025 *(Year Two)*	$25,260,021.19	$2,105,001.77
July 1, 2025 – June 30, 2026 *(Year Three)*	$25,260,021.19	$2,105,001.77
Three Year Total	$75,973,021.57	

I. OVERVIEW

A. **Purpose**. This Agreement is to provide behavioral healthcare services and an integrated, evidence-based, recovery-oriented system of care for incarcerated individuals (pretrial and sentenced) and vulnerable at risk populations under DDOC custody. There are currently eight (8) correctional facilities in operation in the state, of which, four are Level-V facilities (prisons/jails) and four are Level-IV facilities (community corrections centers). Outpatient substance use disorder (SUD) treatment may occur post release while offenders are placed under community supervision. The DDOC may, at its discretion repurpose any of its facilities as a Level-IV or Level-V facility. As long as this does not impact the census above or below contracted allowances, the Provider will adapt and reconfigure staff accordingly (Refer to Appendix-2 – Staffing Matrix).

The Provider shall manage and deliver an integrated, recovery-oriented system of care that will provide constitutionally required behavioral healthcare services to incarcerated men and women in the State of Delaware's Level-IV and Level-V correctional facilities who have been identified as having behavioral healthcare needs. Behavioral healthcare services include a full range of psychiatric and psychological treatments, procedures, short term CBT, programs for substance users, sexual offenders, DUI, and offenders diagnosed with mental health disorders. These services shall include random drug testing for offenders participating in substance use disorder treatment. The Provider shall also provide interpretation services for offenders participating in behavioral healthcare services or programs who require such services.

The Agreement will be managed by the Bureau of Healthcare, Substance Abuse, and Mental Health Services (BHSAMH), which is responsible for quality assurance monitoring and measuring compliance within the provisions of the Contract, including, but not limited to the following areas:

- Compliance with safety and security guidelines of the facility
- Quality of treatment services (e.g., timely assessments and evaluations, appropriate treatment planning and evidence-based programming for the identified level of care, responsive to the risk and needs of offenders, continuity of follow-up services, etc.)
- Fidelity to evidence-based practices
- Staffing levels
- Responsiveness to complaints and grievances
- Continuity of integrated care across the correctional continuum
- Effectiveness of programming as determined by agreed upon outcome measures.
- Matching clinical hours of treatment aligned with designated level of care treatment dosage as determined by the DDOC's Risk-Needs-Responsivity (RNR) tool
- Compliance with national correctional standards, DDOC policies and procedures and professionally accepted best practices in correctional behavioral healthcare.
- Compliance with DDOC data reporting requirements

The Provider shall practice quality, evidence-based, and trauma informed behavioral healthcare in all of the identified service areas: conduct screenings and assessments, deliver evidence-based programs to the offender population, present and implement a continuum of care model, work in tandem with the provider of medical services, deliver comprehensive discharge and reentry services, and control costs. The Provider shall work collaboratively with the DDOC in order to increase access to substance use disorder treatment, addiction treatment medications, and psychosocial support services in the State's correctional system as well as appropriate screening, assessment, relapse prevention, and reentry services to help identify individuals with addiction involving opioids or other substances and ensure they have the tools to sustain treatment, remission, and recovery when they return to the community after release.

As part of the DDOC's approach to providing integrated, holistic healthcare services, the Provider must work collaboratively with the medical and pharmaceutical providers on all aspects of service delivery such as sick call, intake, routine healthcare visits, OTP, etc. to ensure adequate healthcare is provided to each offender requiring services.

The Provider shall implement programs designed around RNR principles and will align its services in a manner consistent with the spirit expressed by the American Correctional Association (ACA) and the American Society of Addiction Medicine (ASAM) "Joint Public Correctional Policy on the Treatment of Opioid Use Disorders for Justice Involved Individuals".

B. **DDOC Population.**

The incarcerated population in Delaware varies from most other jurisdictions in that Delaware operates a "unified system" similar to a small number of other states that contains both pre-trial detainees and sentenced offenders in the same facilities.

The terms "DDOC clients", "inmates", "offenders", and/or "clients" all refer to individuals who are committed in Level-IV and Level-V facilities, and the term "patients" refers to the subset of that population that is receiving or in need of healthcare services.

The combined average daily population (ADP) for Level-IV and Level-V is 5000 including interstate compact offenders. If the combined ADP falls below 4000 or exceeds 6000 over two quarters, the parties will meet and discuss the need for staffing and/or compensation adjustment.

Provider costs of medical care for interstate compact inmates is capped at $50,000/inmate per medical event and is subject to Provider's medical necessity review. Any costs exceeding this amount are the responsibility of DDOC.

C. **DDOC Accreditations.**

The Provider shall maintain a thorough knowledge of the National Commission on Correctional Health Care (NCCHC), the American Correctional Association (ACA), and the Prison Rape Elimination Act (PREA) standards, especially the differences between the prison and jail populations. All appropriate standards of NCCHC, ACA, and PREA must be met at a minimum. The DDOC sees those standards as the baseline of care and expects those standards, whenever possible, to be exceeded. The Provider is responsible to meet all NCCHC, ACA, and PREA standards as well as all DDOC current and future policies and procedures.

All DDOC facilities are ACA accredited, and the Provider is required to assist the DDOC in the process of ACA accreditation and adhere to all ACA standards in preparation of any ACA audits. The DDOC is responsible for the costs of ACA accreditation.

All DDOC facilities are PREA accredited, and the Provider is required to assist the DDOC in the process of maintaining PREA accreditation and adhere to all PREA standards. The DDOC is responsible for the costs of PREA accreditation.

The Provider shall be cognizant of the unique issues associated with serving the jail and prison populations, including the separate NCCHC requirements for jails and prisons and ACA performance based expected practices for jails, prisons, and community corrections centers for medical healthcare, mental health care, and opioid treatment programs. The Provider will be required to meet all applicable standards for NCCHC, ACA, and PREA. The Provider shall cover the costs of obtaining and/or maintaining accreditation through NCCHC for Mental Health operations at all Level-IV and Level-V facilities. The Provider is also responsible for meeting all federal and state laws applicable to mental health care and correctional settings as well as all DDOC policies.

D. **Behavioral Healthcare.**

Behavioral Healthcare includes treatment services to offenders with psychiatric disorders, including but not limited to serious (and persistent) mental illness, sex offenses, offenders with substance use, and co-occurring disorders.

Assessment Driven Placement

Substance Use Disorder (SUD) services may be in one of three tracks: Outpatient (OP), Intensive Outpatient (IOP), and Residential Treatment Unit (RTU) Services. The Provider shall work with BHSAMH to develop and maintain a broad continuum of care for SUD treatment throughout the course of the contract to align with the Department's overarching assessment process as outlined in DDOC policies. The DDOC may choose to redesign and re-appropriate various services as needed to meet the needs of the population. Additionally, program placement decisions and program design shall align with graduations of intensity (treatment dosage) congruent with various American Society of Addiction Medicine (ASAM) levels of care. As such, the provider is also expected to match services with that of the Department's use of the Level of Service/Risk-Needs-Responsivity (LS/RNR) and George Mason University's RNR or "Assess an Individual" Tool whereby people are assessed and matched by DDOC staff according to "best fit" for risk and need factors with an aim for behavioral healthcare service provisions to be customized to the individual and as to reduce symptomology and increase functionality during incarceration and increase potential for post release community assimilation. The Provider shall incorporate the use of LS/RNR and RNR assessments into its behavioral healthcare assessment process and plan for coordination with DDOC staff for level of care determination.

The RNR tool categorizes risk and need into the following groupings:

Group A: Dependence on "Hard Drugs"	Treatment focuses on addressing severe dependence on drugs statistically associated with criminogenic behavior patterns (hard drugs), but also includes cognitive restructuring techniques for criminal thinking to strengthen cognitive processing and decision making, as well as interpersonal and social skills interventions to target group B and C issues. Targets predominately high- and moderate-risk individuals, with dosage of approximately 300 hours.

Group B: Criminal Thinking/Cognitive Restructuring	Programs focus on criminal thinking using cognitive restructuring techniques but also include interpersonal and social skills interventions. May include group C & D components, especially if criminal behavior patterns involve substance abuse. Targets predominately high-risk individuals, with dosage of approximately 300 hours.
Group C: Self Improvement and Management	Programs focus on self-improvement and self-management, especially problem solving, and self-control related to mental health disorders and substance abuse. It also includes some cognitive restructuring work to address developing criminal thinking patterns. Targets predominately moderate-risk individuals with dosage of about 200 hours.
Group D: Interpersonal skills	Programs focus on social skills and interpersonal skills targeting multiple destabilizing issues. Targets moderate- and low-risk individuals, with dosage under 200 hours.
Group E: Life skills	These programs focus on life skills such as financial stability, occupational training, or education. Targets predominately low risk individuals, with dosage of about 100 hours.

For additional information on the RNR tool see: https://www.gmuace.org/tools/

Treatment programs shall follow ASAM levels of care as well as the Association for the Treatment and Prevention of Sexual Abuse (ATSA) practice guidelines for sex offenders.

The Provider will use the University of Cincinnati Correctional Program Checklist (CPC) which is a tool for increasing program effectiveness and ensuring that programs are evidenced based when implementing SUD, Sex Offender (SO), CBT, and other programming within the DDOC.

The Provider's approach shall incorporate ASAM placement criteria into the:

- LS/RNR and RNR assessment process currently in use by the DDOC;
- Provider program design;
- Selection of specific interventions, manualized curricula; and
- Use of risk and need factors into treatment planning.

In the event DDOC determines an operational need to relocate current SUD treatment programs at any facility to a different facility, the Provider should be prepared to accommodate the relocation of services in the event SUD treatment beds are relocated.

E. **Definitions of Technical Terms.**

Evidence-based practice refers to the conscientious use of the best evidence currently available, to inform decisions about the supervision of individual offenders, as well as the design and delivery of policies and practices, to achieve the maximum, measurable reduction in recidivism. The explicit and unbiased use of current best research results in making clinical (individual) and health policy (population) decisions.

Treatment refers to a broad range of services responsive to multidimensional instability (symptomology). It encompasses services that can target a client's criminogenic (crime-producing) risk and need factors as determined by actuarial risk assessment including addiction, co-occurring disorders with an aim to improve functionality during incarceration and/or potential for successful reentry.

Criminogenic risk factors: Research has identified both changeable (dynamic) and unchangeable (static) risk factors directly related to criminal behavior. Studies revealed eight dynamic criminogenic (crime producing) risk factors closely associated with criminal conduct that can be assessed and altered through effective interventions (see J. Bonta & D. Andrews, Risk-Need-Responsivity Model for Offender Assessment and Rehabilitation, 2007).

Risk-Need-Responsivity-Fidelity principles:

- Risk principle (who to target) Moderate to high-risk offender
- Need principle (what to target) Static vs. dynamic risk factor
- Responsivity principle – (how to target specific interventions
  - *General* - use cognitive-behavioral techniques and social learning
  - *Specific* - attend to client abilities, motivation, gender, learning style
- Fidelity principle – (fidelity) evaluate and measure feedback (see J. Bonta, et al., 2010)

F. **Standards of Care and Evidence Based Medicine.**
The Provider will provide behavioral healthcare that is consistent with the best available evidence-based practices for offenders' specific conditions. The list below reflects professional regulations and guidelines and is intended to be indicative of the generally accepted professional standard of care and, therefore, is not all-inclusive:

- DDOC healthcare policies
- ACA standards and expected practices
- NCCHC standards for Opioid Treatment Programs and Mental Health Services
- Substance Abuse and Mental Health Services Administration (SAMHSA) https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines
- Division of Substance Abuse and Mental Health (DSAMH) https://dhss.delaware.gov/dhss/dsamh/regs.html
- Drug Enforcement Agency (DEA) https://www.deadiversion.usdoj.gov/Resources.html

- Centers for Disease Control Protocols and guidelines for self-directed violence https://www.cdc.gov/violenceprevention/pdf/self-directed-violence-a.pdf
- Programs and Practices: What Works in Criminal Justice https://www.crimesolutions.gov/
- National Institute of Corrections Evidence Based Practices in Criminal Justice System: Annotated Biography https://nicic.gov/evidence-based-practices-criminal-justice-system-annotated-bibliography
- National Institute of Drug Abuse Principles of Drug Abuse Treatment for Criminal Justice Populations - A Research-Based Guide https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations/principles
- Substance Abuse and Mental Health Services Administration Evidence-Based Practices Resource Center https://www.samhsa.gov/ebp-resource-center

Any deviation from accepted standards of practice must be approved by the BHSAMH Medical Director and BHSAMH Bureau Chief prior to use by the Provider. DDOC also recognizes that all clinical situations and the need for future program design and/or service elements may not be covered in existing standards or within the current solicitation and, in such cases, the Provider will work in partnership with DDOC to determine proper course of action. Once a course of action is determined the Provider must adhere.

Behavioral healthcare staff conducting groups shall utilize facilitator guides and other appropriate teaching tools to facilitate programming. For example, if using the CBI/Change Company Journal Curriculum the group facilitator shall utilize the facilitator guide that is provided by the Change Company.

The DDOC has made major steps in transitioning to an integrated healthcare division by expanding and emphasizing a multidisciplinary approach to the intake screening process, incorporating use of an electronic health record encompassing medical, behavioral health, reentry readiness, discharge planning, and developing a case management reentry process as highlighted in the Department's use of the Transition Accountability Plan (see DDOC policy 3.12 Reentry Planning). The Provider shall be responsible to produce outcome-based interventions which control and manage costs while prioritizing safety and security.

G. **Research.**

No research projects involving offenders will be conducted without the prior written consent of the Commissioner of Correction in accordance with DDOC Policy 6.9 Research Activities. The conditions under which the research will be conducted will be governed by written guidelines mutually agreeable to the Provider and the DDOC. In every case, the written informed consent of each offender who is a subject of the research project will be obtained prior to the offender's participation. All Federal and State regulations applicable to such research will be fully and strictly followed, including but not limited to HIPAA regulations and Federal Office of Human Resource Protections. Research must be approved by a Human Subjects Review Board and approved by the Bureau Chief of BHSAMH and the Chief of Planning, Research, and Reentry or their

designees and must be in accordance with DDOC Policy G-06 "Medical and Other Outreach.

H. **Drug Free Workplace.**
The Provider shall support DDOC's drug-free workplace with sufficient policies to comply with Federal and State regulations and DDOC policies. State of Delaware regulations can be found at:
https://regulations.delaware.gov/AdminCode/title19/4000/4100/4104.shtml

The Provider shall develop and maintain (at the Provider's expense) a urine drug screening program for all new hires, subcontractors, and employees, (comparable to the DDOC's random urine drug screen program) in which at least 5% of the institution's personnel are randomly selected for screening each month. The Provider must develop a procedure for drug screening and procedures in the event of a positive screen and have these approved by BHSAMH. The Provider agrees to comply with any current or future drug detection initiative that the DDOC may implement applicable to Provider employees, trainees, visitors, and consultants. Furthermore, the Provider must submit to the Department a monthly list depicting the number, names, and positions of individuals who received drug screens, along with the results.

I. **Transition Plan between Existing and New Provider.**
The transition period will commence upon the date of contract signing (May 1, 2023) and be completed by June 30, 2023. July 1, 2023 is the go-live date that the Provider shall take over all services from the incumbent healthcare provider. The transition plan must be presented in writing to the BHSAMH Bureau Chief and BHSAMH Medical Director within 14 days of the contract approval and will address an orderly and efficient start-up, including at a minimum:

- Recruitment of new staff and retention of current staff
- Screening and selection sub-contractors and specialists, where applicable
- Identification of and process for assuming current behavioral healthcare cases
- Equipment and inventory
- Client records management
- Orientation of new staff
- Coordination of transition with current Provider
- Plan to provide the DDOC with weekly progress reports detailing any challenges encountered and response to any potential interruption in a seamless transition between Providers

The Provider must outline timelines and personnel that will be assigned to supervise and monitor the transition. If the Provider plans to integrate the current Provider's employees and/or subcontractors, the Provider must specify how it intends to integrate them and obtain BHSAMH approval to continue each employee's access to DDOC facilities prior to making a job offer. As part of this process, the Provider and BHSAMH shall meet to discuss incumbent leadership staff for the statewide office and facilities.

The Provider must provide resumes for the management staff expected to be hired by the Provider at the statewide level and facility level and these must be approved

by BHSAMH for access to DDOC facilities prior to Provider making offers of employment. The DDOC/BHSAMH reserves the right to withdraw any Provider staff's access to DDOC facilities at any time during the contract at the discretion of DDOC/BHSAMH. Note that the Provider must provide credentials for all medical Providers (physicians, dentists, physician assistants, advanced practice registered nurses, dieticians, physical therapists) and submit these to BHSAMH for review, approval and credentialing prior to finalizing job offers in accordance with DDOC Policy C-01 Credentials.

The transition plan must also summarize problems anticipated during the course of transferring the contract and include proposed solutions for each. The Provider will provide a similar transition plan at the end of the contractual period for transition to a new contract or a new Provider and include the relevant documentation required by NCCHC and ACA audits pertaining to the time the Agreement is in effect.

II. SCOPE OF WORK

A. **Introduction.**

This section outlines the requirements for each area of behavioral healthcare, including the services to be delivered, and the tasks necessary to meet the Bureau's requirements. The primary objectives include:

- Delivering high quality, evidenced-based practices with demonstrated outcomes
- Providing offender integrated healthcare
- Providing Trauma Informed care
- Utilizing an array of community resources
- Providing cost efficient behavioral healthcare services
- Reducing recidivism

The Provider's behavioral healthcare provided must be consistent and standardized across all Level-IV and Level-V facilities to the extent possible. The Provider will work closely with the facility Wardens and security staff to ensure that the offenders' behavioral healthcare needs are met. These populations may include, and are not limited to, the following subsets: the pretrial population, sentenced offenders, including those offenders sentenced for driving under the influence, pregnant women diagnosed with substance use disorders, and sex offenders. The Provider is responsible to provide access and availability of treatment services to meet the needs of offenders with behavioral healthcare needs on-site with a coordinated network and warm hand-off to off-site community resources across the state. The Provider shall be familiar with the public behavioral resources from DSAMH. Additionally, the Provider must be able to offer behavioral healthcare utilizing trauma informed approaches while supporting pro-social values and decreasing pro-criminal behaviors.

DDOC requires staffing that will provide adequate levels of coverage and care in each facility to meet the needs of the offenders. It is not recommended to have shared staffing to meet the needs in both Level-IV and Level-V facilities ratios. The Provider will be expected to maximize the continuity of care between facilities with

various levels of program services. As such, it is expected that the Provider shall collaborate with other Providers to ensure integrated care for all offenders. In the event a need arises requiring shared staffing, the Bureau Chief of BHSAMH shall be notified in writing within 24 hours along with the expected duration of the plan and strategies to end the sharing of staff.

The Provider is responsible for delivering behavioral healthcare services 24 hours per day, seven days per week, regardless of weather, emergency security conditions, and/or work stoppages in all facilities. The Provider must have a designated staff of behavioral healthcare professionals trained to offer both mental health and substance use treatment, assigned to each listed facility, and must notify BHSAMH immediately if circumstances negatively impact the ability to provide such service. The Provider must demonstrate successful staff recruitment and retention to substantiate no delay or break in service delivery. The Provider shall have an on-call service for each facility with the expectation that the individual will be ready, willing, and able to be on-site in each facility upon receiving an emergency call requiring on-site consultation.

The below table provides a summary of programs currently in place at designated facilities and new/expanded programs that are required to be provided. The programs are further described in Part III.

Program Name	Current/Proposed	BWCI	HRYCI	JTVCC	SCI	HDP	CCTC	PCCC	SCCC
Road to Recovery (R2R) Track 1- Residential	Current	X	X			X	X		
Road to Recovery (R2R) Track 2 – Intensive Outpatient (IOP)	Current	X			X	X	X		
Road to Recovery (R2R) Track 3 – Outpatient (OP)	Current	X			X	X	X		
Road to Recovery (R2R) Track 4 DUI Program AKA Reflections	Current	X			X		X		
6 for 1 Program	Current	X	X		X				
Cognitive Behavioral Therapy (CBT) Group - Low Dose	Current	X	X	X	X	X	X	X	X
Cognitive Behavioral Therapy (CBT) Group - Moderate Dose	Current	X	X	X	X	X		X	X
Cognitive Behavioral Therapy (CBT) Group - High Dose	Current	X	X	X	X				
Commitment to Change (C2C)	Current					X	X		
SUD Aftercare	Current	Done in all three counties post release							
Thinking for a Change (T4C)	Current	X		X	X	X	X	X	X
Transitions (Sex Offender Treatment Program)	Current	X		X	X	X	X	X	X
Mental Health BH5 Residential Treatment Unit (RTU)	Current	X		X					
Mental Health BH4 Intensive Outpatient Services (IOP)	Current	X	X	X	X	X	X	X	X
Mental Health BH3 Outpatient Services (OP)	Current	X	X	X	X	X	X	X	X
Cognitive Behavioral Therapy (CBT) Group - SHU	New			X					
Additional SUD program	New	X	X	X	X				
Behavior Management Unit (BMU)	New			X					
Transition Unit	New	X	X	X	X				
Detentioner Mental Health Unit	New		X						
Incarcerated Veterans Group	New		X		X				

B. **Qualifications of Provider.**

Provider must have a minimum of three (3) years previous experience with proven effectiveness in administering a correctional behavioral healthcare program in a prison system with multiple facilities.

Provider shall maintain current experience in providing a standard of care that is in compliance with the NCCHC and the ACA standards for adult correctional and community residential facilities. Provider shall possess an internal structure that provides a system of technical, administrative, information technology, quality assurance, financial reporting, legal counsel, and clinical support, as well as professional staff development, to their organization. This entails a corporate structure that includes physician, nursing and behavioral health leadership, clinical development, technical resource support services, and individual peer review. The Provider shall possess recruiting and retention capabilities for all levels of professional and support personnel on a local and national level.

The Provider shall maintain expertise in the delivery of a full range of behavioral healthcare services and programs conducted within a correctional environment. The Provider shall ensure all workers employed are either citizens of the United States or have legal immigration status authorizing them to be employed for pay in the United States.

C. **Governance And Administration.**

1. **Contract management expectations.**
The Provider will be accountable to the DDOC's Commissioner, Bureau Chief of BHSAMH, and designees. The Provider shall be responsible for managing the completion of all contract deliverables utilizing current project management methodologies and contract administration activities. All staff and subcontractors proposed to be used by the Provider shall be required to follow a consistent methodology for all contract activities.

The Provider is required to have at the minimum one (1) full time Senior Level Contract Administrator/Project Manager (CA/PM) dedicated to this contract and located in Delaware. The CA/PM shall coordinate all the tasks necessary to successfully implement the contract. These tasks will include but not be limited to assigning staff, scheduling meetings, preparing, reviewing, and submitting status reports, addressing project issues, providing administrative oversight for clinical services, and preparing presentations for state stakeholders.

The CA/PM shall have overall responsibility for the contract deliverables, schedule, and successful implementation of the Provider's resources to fulfill the requirements of the contract. The CA/PM shall have daily contact with BHSAMH as necessary. The CA/PM shall schedule and facilitate (at the minimum) monthly project team status meetings with the Bureau Chief of BHSAMH or their designee(s). These meetings shall be held either on-site in DDOC's Central Administrative office or via tele-conference.

The Provider's CA/PM shall provide a written "Monthly Status Report" to BHSAMH which shall include, at a minimum:

- Contractual and project tasks accomplished, incomplete, or behind schedule in the previous month (with reasons given for those tasks behind schedule and plans for completion).
- Contract deliverables (including staffing levels and other performance metrics) per executed contract.
- Tasks planned for the coming month.
- Status of any corrective action plans.
- Current status of the contract's/project's technical progress, contractual financial obligations (e.g., status of payment of hospital bills, outpatient and specialty care bills, achievements to date, risk management activities, unresolved issues and the requirements needed to resolve them, action items, identified problems, and any significant changes to the Provider's organization or method of operation).

- Notice to the DDOC/BHSAMH if required deliverables will not be completed on time.
- DDOC/BHSAMH and the Provider's CA/PM will agree on the exact format of the "Contract/Project Plan" and the "Monthly Status Reports" at or before the contract/project kickoff meeting.
- The CA/PM will be responsible for oversight and accountability for all the Provider's continuous quality assurance efforts.
- Information on new staff hires, terminations, resignations, vacancies, significant disciplinary action (including reasons), significant incidents, contact with law enforcement and reports made to Delaware Division of Professional Regulation and law enforcement agencies on any staff.
- The BHSAMH reserves the right to conduct exit interviews with contract staff upon termination or resignation.

2. **General requirements.**
The Provider shall maintain and cover the costs of NCCHC mental health accreditation and provide needed efforts in support of the maintenance of NCCHC medical accreditation, ACA accreditation, and PREA accreditation at all DDOC sites. Additionally, the Provider shall be responsible for passing any audits as it relates to the DEA and Substance Abuse and Mental Health Services (SAMHSA)/Delaware Division of Substance Abuse and Mental Health (DSAMH).

If the Provider fails to attain or maintain certifications and/or accreditation, DDOC may assess liquidated damages as follows:

For NCCHC surveys, the following will apply:

- If a facility receives an accreditation decision of accredited, no penalty is assessed.
- If a facility receives an accreditation decision of accredited with verification, a corrective action plan will be issued. A penalty of $25,000 shall be assessed if the corrective action is not successfully implemented within the timeframes outlined by NCCHC and BHSAMH.
- If a facility receives an accreditation decision of deferred, a penalty of $50,000 shall be assessed. A corrective action plan will be implemented, and an additional penalty of $25,000 shall be assessed if the corrective action is not successfully implemented within the timeframes outlined by NCCHC and BHSAMH.
- If a facility receives an accreditation decision of denied accreditation, there may be a discussion involving termination of the contract for cause.

For ACA and PREA audits, each individual institution is audited on a schedule issued by the ACA and PREA. These audits measure certain criteria relative to specific standards in all areas of the operation of an institution including behavioral healthcare. This audit results in accreditation, re-accreditation or loss of accreditation. The Provider shall be responsible for ensuring that all behavioral healthcare practices meet the applicable behavioral healthcare accreditation standards of these audits and will create corrective action plans for any standards found non-compliant by the ACA and/or PREA. Any failure

to meet behavioral healthcare standards by the ACA and/or PREA shall result in liquidated damages as follows:

- If the result of the non-compliance results in loss of accreditation - $25,000 penalty.
- If a specific standard is found to be non-compliant, but the facility still receives accreditations - $1,000 penalty per occurrence

For DEA audits, each individual institution is subject to audits and inspections on an unannounced schedule by the DEA. These audits measure certain criteria relative to specific standards in all areas of the operation of an institution relative to medication storage, dispensing, administration, and documentation. The results of these inspections and/or audits may result in adverse action(s) if issues or deficiencies are noted. In the event this occurs liquidated damages shall be assessed as follows:

- If the result of the non-compliance results in loss of DEA license - $50,000 penalty.
- If a specific standard or regulation is found to be non-compliant, the facility may receive a memorandum of understanding (MOU), memorandum of agreement (MOA), or other corrective action deemed appropriate by the DEA, but the facility still maintains the license - $10,000 penalty per identified issue

For SAMHSA/DSAMH audits, each individual institution is subject to audits and inspections on an unannounced, or announced schedule established by the SAMHSA/DSAMH. These audits measure certain criteria relative to specific standards in all areas of the operation of an institution relative to medication assisted treatment (MAT). The results of these inspections and/or audits may result in adverse action(s) if issues or deficiencies are noted. In the event this occurs liquidated damages shall be assessed as follows:

- If the result of the non-compliance results in loss of SAMHSA/DSAMH license - $50,000 penalty.
- If a specific standard or regulation is found to be non-compliant, the facility may receive a memorandum of understanding (MOU), memorandum of agreement (MOA), or other corrective action deemed appropriate by the SAMHSA/DSAMH, but the facility still maintains the license - $5,000 penalty per identified issue

In the event that any of the above occurs relative to NCCHC, ACA, PREA, DEA, and/or SAMHSA/DSAMH audits, the DDOC may exercise its ability to execute a claim against the Provider’s performance bond. Any liquidated damages (as outlined above) shall not be the exclusive remedy for failure to achieve and/or maintain accreditation.

The Provider shall also:

- Deliver qualified behavioral healthcare and re-entry professionals in sufficient number, location, and skillset to meet all clinical, administrative,

and performance-based requirements outlined in this RFP. Behavioral healthcare professionals must be qualified consistent with NCCHC and ACA standards and applicable state laws governing licensure, credentialing, and scope of practice requirements.

- Participate in applicable quality assurance meetings, activities and quality improvement projects as directed by DDOC. This includes participating in and reporting at monthly meetings of the Adult Correctional Healthcare Review Committee (ACHRC) at the request of BHSAMH or ACHRC and participation in a statewide continuous quality improvement program.
- Coordinate all related activities in collaboration with BHSAMH.
- Be subject to outside party review beyond current accreditation bodies as deemed necessary by DDOC (e.g., DSAMH)

3. **Regulation Compliance.**
The Provider shall ensure compliance with the following:

- Americans with Disabilities Act (ADA). Provider shall work closely with DDOC to provide accommodations to offenders in compliance with the ADA. In the event of a dispute between the Provider and the DDOC on matters related to accommodations. The DDOC shall have final decision-making authority. Refer to DDOC Policy 11 F-01 Patients with Chronic Disease and Other Special Needs.
- Prison Rape Elimination Act (PREA). Provider shall comply with the Prison Rape Elimination Act of 2003, all applicable Federal PREA standards, and all DDOC policies, directives, rules, interim memos, and guidance documents, related to PREA for preventing, detecting, monitoring, investigating, and responding to any form of sexual abuse. The Provider shall provide all necessary documentation to show compliance with the PREA standards and reporting requirements as part of ongoing quality assurance. The Provider's documentation related to PREA compliance and reporting requirements shall be readily available to the DDOC's PREA Coordinator. Refer to DDOC Policy 8.60 Prison Rape Elimination Act (PREA) and DDOC Policy 11-B-05 Procedure in the Event of Sexual Abuse.
- Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2. The Provider shall comply with HIPAA and 42 CRF Part 2 and shall adhere to all state and federal statutes, laws, regulations, DDOC policies, directives, rules, and guidance documents regarding the confidentiality of "Protected Health Information" (PHI), including the transmittal of information by any verbal, written, electronic, or other means. Refer to DDOC Policy 11.A-08 Health Record
- Delaware Department of Correction – BHSAMH policies: The Provider shall comply with all policies of the BHSAMH Chapter 11 Medical Services. The Provider is responsible to develop site specific procedures in compliance with the DDOC policies and ACA/NCCHC standards for each facility. The Provider will ensure timely updates to reflect changes in policy and accreditation standards.
- Security and Other Violations: The Provider shall immediately report to law enforcement any allegations, plans or reports of illegal or potentially criminal activity by its staff of which the Provider becomes aware. In

addition, the Provider shall adhere to the DDOC policies as it relates to the investigation of misconduct and/or security breaches by the Provider, the Provider staff, or others. The Provider shall adhere to DDOCs policies and administrative directives as they relate to the introduction into facilities of contraband such as cell phones, weapons, illicit substances, tobacco products, etc. Refer to DDOC Policy 11 G-04 Therapeutic Relationship, Forensic Information, and Disciplinary Actions.

- All applicable State and Federal rules and regulations.

D. **Liquidated Damages/Penalties – Operations Audits.**
The BHSAMH Quality Assurance Matrix is a tool used to measure compliance with the contract. There will be a list of evaluation tools and a monitoring calendar which can be adjusted as needed and approved. The overall standard is a threshold of 85% compliance in the first year of the contract and 90% in subsequent years. The Provider may be assessed liquidated damages as described below if it fails to meet the compliance threshold.

- BHSAMH Monitoring and Evaluation Audits with overall scores at threshold or greater in each category:
  - No liquidated damages will be assessed
- BHSAMH Monitoring and Evaluation Audits with overall scores at threshold or greater but with certain areas with less than threshold scores:
  - No liquidated damages will be assessed.
  - Corrective action plans will be required for areas coming in under the threshold.
- BHSAMH Monitoring and Evaluation Audits with overall scores less than threshold show a failure in compliance with DDOC policies and directives. A liquidated damages phase is assessed as follows:
  - Initial audit scores less than DDOC established threshold. Corrective action plans are created by DDOC and implemented by the Provider – $0.00 penalty assessed.
  - Re-audit to be conducted the following quarter (approximately 90 days from the initial audit). If the re-audit still has an overall score below the threshold, corrective action plans are reviewed/revised as needed - $25,000 penalty is assessed for each audit below compliance.
  - Subsequent re-audit conducted the following month (approximately 30 days from the re-audit). If the re-audit still has an overall score below threshold, corrective action plans are reviewed/revised as needed - $50,000 penalty is assessed for each audit below compliance.
  - Subsequent re-audit conducted the following month (approximately 30 days from the most recent re-audit). If the audit has an overall score of less than threshold, corrective action plans are reviewed/revised as needed - $75,000 penalty assessed for each audit below compliance.
  - Repeat audits will continue each month until compliance is met. If the subsequent re-audit score is below the threshold - $100,000 penalty will be assessed for each audit below compliance until a satisfactory score at or above is obtained for that audit.

At any time during the audit process, if the overall score is at threshold or greater, no penalty will apply for the audit period.

Although the Operations Audit above is used to measure the Providers compliance with the Agreement, DDOC reserves the right to apply liquidated damages in those instances when the Providers' manner of operation poses an immediate or significant threat to patient safety contrary to the terms of this Agreement and/or generally accepted standard of behavioral healthcare. This includes acts of negligence that impact (or pose a risk for) patient safety. Liquidated damages will be assessed using the same phased timeline and penalty amounts listed above.

E. **Liquidated Damages/Penalties - Staffing levels.**
Effective January 1, 2024, in addition to the money withheld as a result of vacant positions, if at any time, staffing levels fall below specific thresholds for a given month, liquidated damages shall be assessed as follows:

- Psychiatrists
  - 95%-100% - no liquidated damages assessed
  - 85%-95% - $5,000.00 deducted from monthly invoice
  - 75% - 85% - $10,000 deducted from monthly invoice
  - 50% - 75% - $25,000 deducted from monthly invoice
  - Below 50% - $50,000 deducted from monthly invoice
- Psychologists
  - 95%-100% - no liquidated damages assessed
  - 85%-95% - $5,000.00 deducted from monthly invoice
  - 75% - 85% - $10,000 deducted from monthly invoice
  - 50% - 75% - $25,000 deducted from monthly invoice
  - Below 50% - $50,000 deducted from monthly invoice
- Nurse Practitioners
  - 95%-100% - no liquidated damages assessed
  - 85%-95% - $5,000.00 deducted from monthly invoice
  - 75% - 85% - $10,000 deducted from monthly invoice
  - 50% - 75% - $25,000 deducted from monthly invoice
  - Below 50% - $50,000 deducted from monthly invoice
- Site Mental Health Clinicians
  - 95%-100% - no liquidated damages assessed
  - 85%-95% - $5,000.00 deducted from monthly invoice
  - 75% - 85% - $10,000 deducted from monthly invoice
  - 50% - 75% - $25,000 deducted from monthly invoice
  - Below 50% - $50,000 deducted from monthly invoice
- Site SUD Counselors
  - 95%-100% - no liquidated damages assessed
  - 85%-95% - $5,000.00 deducted from monthly invoice
  - 75% - 85% - $10,000 deducted from monthly invoice
  - 50% - 75% - $25,000 deducted from monthly invoice
  - Below 50% - $50,000 deducted from monthly invoice
- Site Mental Health Directors/Clinical Supervisors
  - Vacant more than 45 days - $10,000 deducted from monthly invoice
  - Vacant more than 60 days - $15,000 deducted from monthly invoice
  - Vacant more than 90 days - $20,000 deducted from monthly invoice
- Site SUD Program Directors/Clinical Supervisors
  - Vacant more than 45 days - $10,000 deducted from monthly invoice
  - Vacant more than 60 days - $15,000 deducted from monthly invoice

- Vacant more than 90 days - $20,000 deducted from monthly invoice

F. **Assessment and Classification to Treatment.**
The SUD programs implemented by the Provider will serve offenders who have been identified as candidates for the programs from many of DDOC's institutions across the state. The DDOC classification staff will refer the candidates to these programs based on information provided during the assessment process and based on sentencing orders. As indicated elsewhere in this solicitation the Provider will also be responsible for providing substance use disorder screening to all offenders referred by mental health, medical, DDOC or through self-referral. Offenders will be referred to the SUD programs so that their community correction eligibility coincides with their estimated program completion date. In many instances those who successfully complete the Level-V SUD program will be rewarded for their successful program participation with opportunities to transition into Level-IV-SUD programs located in community corrections centers as part of an integrated continuum of care designed to provide optimal treatment dosage to reduce risk to recidivate.

Although the DDOC's classification staff will refer candidates for program participation based on their assessment scores, substance use history and/or sentencing orders, the Provider must communicate with classification and security staff to coordinate transferring offenders who meet the admission criteria into the programs.

III. COMPREHENSIVE SERVICES

Provider is responsible to provide comprehensive services for all service components listed below that will achieve an integrated delivery system for offenders with behavioral health, substance use and co-occurring disorders.

Service Component
• Intake Screening and Assessment - (Refer to subsection III. A.)
• Emergency Services - (Refer to subsection III. B.)
• Suicide Prevention and Intervention - (Refer to subsection III. C.)
• Psychiatric Close Observation (PCO) - (Refer to subsection III. D.)
• Non-emergency healthcare requests - (Refer to subsection III. E.)
• Behavioral Healthcare Services - (Refer to subsection III. F.)
• Substance Use Disorder Services - (Refer to subsection III. G.)
• Special Populations - (Refer to subsection III. H.)
• DUI Services - (Refer to subsection III. I.)
• Additional SUD Treatment Programming - (Refer to subsection III. J.)
• Peer Support Program - (Refer to subsection III. K.)
• Discharge Planning and Reentry - (Refer to subsection III. L.)

A. **Intake Screening and Assessment.**

Initial Behavioral Health Screening

Each offender shall receive an initial behavioral health screening as part of the initial intake screening using the screening tools identified by BHSAMH and within the timeframes outlined in DDOC Policy E-05 Mental Health Screening and Evaluation. This screening will be performed by a qualified mental health professional, or by a healthcare professional who has received approved and documented training on the behavioral health aspects of the screening. The screening results will be documented in the DOC's Electronic Health Record System, iCHRT. Based on this screening the healthcare professional will determine if a referral to mental health is required for the completion of a comprehensive behavioral health evaluation. This evaluation shall be completed within 24 hours.

Individuals with the following will be referred for a comprehensive behavioral health evaluation:

- Individuals with cognitive or developmental disabilities.
- Individuals who were receiving behavioral health treatment (psychosocial treatment, medication, or both) in the community prior to detainment.
- Individuals recently (within last 2 years) hospitalized for a behavioral health condition or have multiple prior hospitalizations for behavioral health conditions.
- Individuals who have a history of mental health or substance use (as indicated by self-report, drug test, historical information from DDOC records or other sources of information) and report any current symptoms on screening).
- Individuals who endorse symptoms on screening of mental health, substance use or both.
- Individuals who present with signs of psychological distress and/or signs of a behavioral health problem independent of screening results.
- Individuals with a history of self-directed violence.
- Individuals who identify as transgender.

Comprehensive Mental Health Evaluation (CMHE)

Individuals referred for a comprehensive evaluation should receive an evaluation using a biopsychosocial evaluation tool approved by BHSAMH. The evaluation must be completed as outlined in DDOC Policy E-05 Mental Health Screening and Evaluation. This evaluation will be utilized to determine if an individual meets criterion for a mental health and/or substance use diagnosis and will be used along with other available information to determine a clinical classification (not mentally ill, mentally ill, seriously mentally ill, co-occurring mental health and substance use disorders) and what level of care is appropriate to address the current behavioral health symptoms (outpatient, intensive outpatient, residential). Individuals who are identified as requiring behavioral healthcare services during incarceration will have an individualized treatment plan developed as outlined in DDOC Policy G-02 Special Needs Treatment Plan and DDOC Policy G-02.1 Mental Health Treatment Plan.

PREA Assessment

In the event of a sexual assault, the Behavioral Healthcare Provider shall comply with the Prison Rape Elimination Act of 2003 (Federal Law 42 U.S.C. 15601 et. seq.), all applicable Federal PREA standards, and all DDOC policies, directives, rules, interim memos, MOUs, intergovernmental agreements, and guidance documents, related to PREA for preventing, detecting, monitoring, investigating, responding, and eradicating any form of sexual abuse.

The Provider shall follow the DDOC Policy 8.60 Prison Rape Elimination Act (PREA) which allows a victim of sexual abuse the opportunity to receive appropriate intervention.

Upon return from the outside community facility, an evaluation by a licensed qualified mental health professional (QMHP) for crisis intervention counseling and follow up must be completed with the victim. A mental health clinician shall attempt to conduct a CMHE on all known offender-on-offender abusers within 15 days. The clinical presentation of the offender may require an immediate assessment.

The Provider shall maintain written policies and procedures to comply with PREA. All written policies shall be approved by the DDOC's PREA Coordinator and the bureau chief of BHSAMH.

Suicide Risk Assessment: BHSAMH has adopted the Centers for Disease Control and Prevention Self-Directed Violence Framework regarding suicidal and non-suicidal self-injury (ref: https://www.cdc.gov/violenceprevention/pdf/self-directed-violence-a.pdf). Requirements for suicide risk assessment are outlined in DDOC Policy B-05 Suicide Prevention and Intervention.

Segregation review: Upon notification that an individual has been placed in segregation, a qualified mental health staff member shall review the mental health record to determine if the individual has a mental health condition that requires an accommodation. If so, the mental health staff member shall notify security of the need.

Qualified mental health staff shall conduct a face-to-face segregation assessment within 24 hours of placement in segregation.

All individuals placed in segregation will be monitored during their time in segregation by mental health staff conducting segregation rounds a minimum of once per week or more often as required in the individual's individual treatment plan (ITP). Segregation rounds must take place during hours when the offender population is generally awake. These rounds and any significant findings must be documented in the EHR. Treatment as prescribed in an ITP shall be continued in segregation until the ITP is updated accordingly. Reference DDOC Policy G-02 Segregated Offenders.

B. **Emergency Services.**

All staff must collaborate and fully participate in disaster plans and drills as required by the DDOC. The Provider must show how they will staff and utilize a behavioral health team to respond and to address emergency services.

Additionally, and in accordance with NCCHC essential standard D-07 and MH-A-07, and DDOC Policy D-07 Emergency Services and Response Plan the Provider shall:

1. Provide immediate response to offenders in facility-based emergency situations.

    a. Participate in critical incident debriefs related to facility-based emergency situations.
    b. Provide 24-hour on-call coverage by mental health providers (psychiatrist or APRN).
    c. Provide written policies and procedures to address emergency response procedures and the emergent transfer of offenders at each facility, in coordination with the DDOC Facility Management
    d. Provide 24-hour emergency healthcare for staff and offenders within the correctional facilities.
    e. Cooperate with any investigating agents from the state government or a law enforcement agency.

2. Provide for a coordinated emergency response with DDOC custody staff to include:

    a. Man-down drills for staff requiring immediate medical intervention.
    b. A mass disaster drill involving multiple casualties that require triage by health and mental staff.
        i. minimum of one per year and drill must occur on all three shifts at least once in three years.
        ii. one drill must occur during MAT med pass.
    c. Any emergency incident.
    d. Responses to incidents or allegations which are sexual in nature.
    e. Establishment of an emergency medical triage area inside a correctional facility at the direction of the incident commander.
    f. Procurement and maintenance of emergency medical equipment in a secure location, determined by DDOC.
    g. Ensuring equipment and Emergency Medical Services are onsite to allow for moving infirmary, non-ambulatory, and critically ill offenders during an evacuation or other emergency.
    h. Participating in post-drill debriefs that will review the responses of participants, response times of participants, and include a written summary to the DDOC Health Services Administrator or designee to improve future responses.

C. **Suicide Prevention and Intervention.**
The Provider shall assist the DDOC with the establishment and annual review of the system-wide written suicide prevention plan in accordance with DDOC Policy B-05 Suicide Prevention and Intervention. The DDOC's current suicide prevention plan consists of the following:

1. Training (NOTE: the Provider will provide training to all DDOC and Provider staff members on how to recognize verbal and behavioral cues that indicate

potential suicidal and non-suicidal self-injury thoughts or intent and how to respond appropriately.)
2. Identification
3. Referral
4. Evaluation
5. Treatment
6. Housing
7. Monitoring
8. Communication
9. Intervention
10. Notification
11. Reporting
12. Review
13. Debriefing

If an offender exhibits behavior that poses an imminent threat to self or others, the Provider must work directly with correctional personnel to transfer the offender to a safe location in the infirmary or in any other designated location identified by the DDOC. All urgent referrals require a visual assessment and evaluation in accordance with BHSAMH policies (See DDOC Policy E-02 Intake Screening; DDOC Policy E-09 Continuity, Coordination, and Quality of Care During Incarceration); DDOC Policy B-05 Suicide Prevention and Intervention) All offenders identified or suspected of being at-risk for suicide or self-injury at the initial screening or at any other time in custody, will remain under constant supervision by a staff member (DDOC staff, medical staff, psychiatric technicians, or other behavioral healthcare staff) in a safe cell while an order for placement on psychiatric observation is obtained from appropriate personnel. A licensed qualified mental health professional (QMHP) or certified screener shall evaluate the offender as soon as possible after a notification of placement on psychiatric observation. If a QMHP, or certified screener is not on site at the time of placement, the offender must be evaluated by a QMHP or certified screener within 24 hours of the placement.

In the event of an offender death the Provider is responsible for various reporting and documentation as outlined in DDOC Policy A-09 Procedure in the Event of an Offender Death and DDOC Policy B-05 Suicide Prevention and Intervention. There are also timelines for completion of various reports and activities outlined in the policy. The Provider is responsible for meeting these deadline requirements. The submission of signed documents at the request of BHSAMH staff shall be completed within seven days of the request.

D. **Psychiatric Close Observation (PCO).**
PCO is considered an observational status reserved for those offenders deemed to be at risk of suicide or who are experiencing extreme decompensation requiring increased management. Offenders will be placed on one of two observation levels.

PCO Level 1 - For offenders who are deemed acutely or actively suicidal.
These offenders are monitored by Provider staff (psychiatric technicians) via direct and constant visual observation.

1. The monitoring is documented at least every 15 minutes on a PCO Observation Log for all three shifts.

2. Copies of this daily monitoring log shall be provided to the site mental health director, the shift commander, and a copy placed in the EHR.

3. Offenders on PCO Level 1 shall receive a daily assessment by a QMHP at least once per day that must be documented on a Daily PCO Contact Sheet. In addition to this visit, a Mental Health Clinician shall conduct a wellness check at least once per day at a different time than the daily assessment. Both encounters must be documented in the offender's EHR.

PCO Level 2 - for offenders who are deemed non-acutely suicidal or not actively suicidal, but expresses suicidal ideation (i.e., expressing a wish to die without a specific threat or plan) and/or has a recent episode of self-destructive behavior. PCO Level 2 can also be for offenders who deny suicidal ideation or do not threaten suicide but demonstrate other behaviors suspicious for potential self-injury as noted by the offender's actions, current circumstances, or recent history. This level of observation is also used for offenders who due to psychiatric decompensation, are at risk of injury to self or others.

1. These offenders are monitored by Provider staff (psychiatric technicians) at variable and unpredictable intervals not to exceed 15 minutes.

2. The monitoring is documented at least every 15 minutes on a PCO Observation Log for all three shifts.

3. Copies of this daily monitoring log shall be provided to the site mental health director, the shift commander, and a copy placed in the HER.

4. Offenders on PCO Level 2 shall receive a daily assessment by a QMHP at least once per day that must be documented on a Daily PCO Contact Sheet. The Daily PCO Contact From must be placed in the offender's EHR. Additional daily visits shall occur as clinically indicated.

The Provider must provide an adequate number of psychiatric technicians at each Level-V facility (PCOs at Level-IV are sent to a Level-V facility for monitoring) to effectively observe offenders placed on PCO. The Provider must adhere to the DDOC policies outlining PCO levels and procedures for placement. See DDOC Policy B-05 Suicide Prevention and Intervention.

Behavioral Healthcare staff must be ready, willing, and able to address and treat significant psychological distress or signs for the potential of decompensation. The Provider must discuss how staff is or will be trained for recognizing the signs and symptoms of behavioral health illnesses, decompensation, and emergency interventions. The Behavioral Healthcare staff must be ready, willing, and able to respond to all referrals, sick call requests, and provide brief intervention to a comprehensive evaluation as clinically indicated.

The Provider will support the system-wide written suicide prevention plan by conducting the above listed activities as outlined in current or future DDOC policies.

E. **Non-Emergency Healthcare Requests.**
The Provider shall establish appropriate triage mechanisms to be utilized for daily offender care in accordance with DDOC Policy E-07 Non-Emergent Healthcare Requests and Services. The Provider shall assure that each facility has procedures in place that enable all offenders (including those in segregation and/or closed custody units) to submit requests for mental health services daily including weekends and holidays.

Offender non-emergency healthcare request forms (sick call request) shall be deposited in locked boxes at a designated location at each facility. The Provider shall collect them daily. Offender non-emergency healthcare request forms shall be reviewed, signed, and time and date stamped and entered into the EHR. At the current time, the medical Provider is responsible for the daily collection and triage of non-emergency healthcare request forms.

All patients submitting non-emergency mental healthcare request forms shall be seen by a qualified healthcare professional within 24 hours of the form being collected by healthcare staff (i.e., the nurse picking them up daily). Referrals for appropriate treatment will be made at that time and appropriate information entered into the EHR. All medication matters shall be seen by the appropriate healthcare provider.

The Provider shall conduct sick call at all facilities consistent with DDOC Policy E-07 Non-Emergency Healthcare Requests and Services, DDOC Policy A-01 Access to Care, and other NCCHC or ACA standards as appropriate.

If a written mental healthcare request is of an emergent/urgent nature, and if the mental health staff is not on duty at the time of receipt of the emergent/urgent request, the on-call psychologist or psychiatrist will be contacted for instructions on what actions should be taken. The on-call psychologist or psychiatrist shall enter their orders in the EHR and inform the triage nurse of the orders.

All documentation of the triage, examination, and subsequent treatment will be entered into the EHR, and any paper documents shall be scanned into the EHR.

To facilitate all healthcare requests being seen within 24 hours of receipt of the request, a qualified mental health professional must be onsite seven days per week.

If an offender's housing status precludes attendance at sick call, arrangements shall be made to provide sick call services at the place of the offender's confinement (i.e. offenders housed in segregated housing including disciplinary detention, administrative segregation, etc.).

F. **Behavioral Healthcare Services.**
The DDOC requires a wide array of behavioral healthcare services in each of the Level-IV and Level-V facilities to meet the needs of the offenders. The Provider

shall be responsible for providing clinically appropriate, efficient, and cost-effective behavioral healthcare services inclusive of substance use disorder, mental health, sex offender, and behavior management treatments. The Provider shall provide a continuum of behavioral healthcare services including the provision of integrated care for individuals with co-occurring disorders.

Treatment activities will include those which are linked to a written individualized treatment plan, derived from assessments, individualized to each offender's risk, and needs, and inclusive of those services which are provided on an as needed basis. The Provider shall provide a description of their behavioral healthcare treatment philosophy for incarcerated individuals, a comprehensive list of evidence-based interventions (to include dosage and length of treatment) that would be used, list of any curricula that would be provided, and information regarding treatment strategies, schedules for each program, and how it will address each of the following service types.

The Provider must meet the minimum requirements listed below, to include but not limited to the specific tasks and program services described in the RFP. The Providers may provide any additional or creative programming and activities to complete the assigned tasks but would be required to explain in detail the purpose and the strategy to achieve the program objectives.

Trauma-Informed Care

BHSAMH recognizes that incarcerated individuals often have experienced lifetime exposure to traumatic events, often beginning in childhood and continuing into adulthood. BHSAMH also recognizes that the experience of incarceration may in and of itself be a traumatic event. The Provider is expected to provide services in a manner that are trauma-informed, responsive to the prevalence of trauma avoiding the use of any methodology that risks re-traumatization. Available data suggests that as many as two-thirds of incarcerated individuals report lifetime history of physical and/or sexual abuse and on average more than one-third report post-traumatic stress disorder (PTSD) symptoms at intake (with some facilities having two-thirds report PTSD symptoms). Providing individualized, evidenced based practice for the treatment of PTSD (prolonged exposure, EMDR etc.) can be highly challenging in a correctional setting, however, in the absence of treatment individuals with trauma exposure may struggle within the correctional environment. The Provider shall include services for individuals with trauma exposure and current symptoms of post-traumatic stress (with and without a formal diagnosis of PTSD) along with innovative solutions for creating a trauma-informed treatment environment as applicable.

The Provider should have a trauma informed specialist as part of its clinical team to assist in the provision of trauma informed care and services. The trauma informed specialist will work with the DDOC to ensure that all behavioral healthcare services utilize this methodology in the delivery of behavioral healthcare groups and services at all DDOC facilities. The Provider shall offer a trauma informed group at all Level-V facilities to assist those individuals dealing with psychological trauma.

Routine Behavioral Healthcare

Individuals may be identified as having mental health and/or substance use disorders that require routine behavioral healthcare services. These services shall be provided in accordance with the following DDOC policies:

1. F-03 Mental Health Services
2. F-03.1 Sex Offender Treatment Services
3. F-04 Medically Supervised Withdrawal and Treatment
4. F-05 Counseling and Care of the Pregnant Offender
5. F-08 Substance Use Treatment Programs
6. All other applicable healthcare policies.

Routine behavioral healthcare services shall include a continuum of evidence-based cognitive behavioral psychosocial interventions (individual and group) as well as the use of psychotropic medication. This continuum should be structured in such a way as to support an individual clinically moving up and down the continuum based on clinical need and to support the offender.

Behavioral Healthcare Categories and Behavioral Healthcare Levels of Care

BHSAMH has established a system of behavioral healthcare categories and behavioral healthcare levels of care.

The Provider shall designate offenders into one of the following behavioral healthcare categories:

1. Not Mentally Ill (NMI)
2. Mentally Ill (MI)
3. Seriously Mental Ill (SMI)
4. Substance Use Disorder (SUD)
5. Co-Occurring Disorder (COD)
    a. COD patients will be categorized into one of two categories:
    b. COD/SMI
    c. COD/MI

The Provider shall utilize a behavioral healthcare level of care model to match the appropriate intervention to the offenders' needs. The levels of care (LOC) in use within the DDOC are as follows:

1. BH1 Level of Care: No history and no current need
    a. The offender has no known behavioral healthcare treatment history and has been assessed to have no current behavioral healthcare condition.

2. BH2 Level of Care: Only history and no current need
    a. The offender has a history of behavioral healthcare treatment but has been assessed to have no current need for services.

3. BH3 Levels of Care: Outpatient Services
    a. The offender has been assessed and meets the following criteria:
        i. The offender has a history of behavioral healthcare treatment, and

ii. The offender has experienced or may be at risk to experience mild psychological distress or transient psychiatric disorder(s) that can be treated with outpatient psychological interventions.

b. Treatment at this level generally involves 1-4 contacts per month typically occurring Monday through Friday

c. Patients at this level generally reside in the general population at Level-IV and Level-V facilities.

i. Times for provision of service will need to consider that individuals at Level-IV facilities may leave the facility for work during the day.

4. BH4 Level of Care: Intensive Outpatient Services

a. The offender has been assessed and meets the following criteria:

i. The offender meets the criteria of BH3, and

ii. The offender requires increased hours of highly structured outpatient therapy to include group therapy and individual therapy on a weekly basis.

iii. BH4 may be utilized as an intervention targeted to prevent worsening of a psychiatric condition, which would result in residential treatment. It may also be utilized as a step-down from residential treatment prior to transition to outpatient level of care.

b. Treatment at this level generally involves multiple contacts per week and may be offered 7 days per week

c. Patients at this level generally reside in the general population at Level-IV and Level-V facilities.

i. Times for provision of service will need to consider that individuals at Level-IV facilities may leave the facility for work during the day.

5. BH5 Level of Care: Residential Treatment

a. There is a designated Mental Health Residential Treatment Unit (RTU) available for those offenders with impairment in behavioral functioning associated with serious mental illness and/or impairment in cognitive functioning. The severity of the impairment does not require an inpatient level of care, but the offender demonstrates a historical and current inability to function adequately in the general population.

i. The DDOC currently has an RTU in operation at JTVCC and BWCI.

ii. The RTU may house offenders of varying security levels and sentencing statuses. They may be housed on different tiers within the RTU housing unit or all together on the same tier based on security requirements.

b. The offender has been assessed and meets the following criteria:

i. The offender meets criteria for BH4, and

ii. The offender has been assessed to have significant functional impairment requiring placement in a residential care unit.

iii. The unit will provide a safe and therapeutic environment focused on symptom stabilization, improving activities of daily living, and programming with comprehensive wrap-a-round services from a multidisciplinary team consisting of psychiatric providers, psychologists, medical personnel, clinicians, and other behavioral healthcare professionals.

iv. Patients in this setting shall receive a minimum of ten hours of therapeutic, structured activity delivered by a MH professional.

a) The amount of structured activity required shall be outlined in the individual's ITP and must be at minimum ten hours or more.
b) all structured activity must be tracked in the appropriate module in the EHR.

v. Patients in this setting shall also receive a minimum of 10 hours of unstructured activity out of their cells.
a) Unstructured activity is generally run by security staff in the form of recreation, showers, phone privileges, etc. However, the Provider may be asked to assist with some of the unstructured activities in the RTU.

c. This program shall run seven days per week
i. structured groups shall run Monday through Friday
ii. other program activities may occur on the weekends

d. Patients at this level should be housed in the RTU at designated Level-V facilities.
i. There are no RTU's at Level-IV facilities.

e. The Provider will be required to manage (in partnership with security) the entire RTU to include admissions, treatment, and discharges. The ultimate goal of treatment is to assist in stabilizing the patients and assist them in being able to function at their highest level of functioning resulting in them being able to be eventually stepped down to a lower level of care and security. The Provider shall provide specialized evidenced-based treatment and programming for patients in the RTU as well as a proposed program schedule.

6. BH6 Level of Care - Inpatient Hospitalization
a. The offender has been assessed and meets the following criteria:
i. The offender meets the criteria for BH5, and
ii. The offender requires treatment beyond that available within the DDOC.
a) If the offender were residing in the community, they should meet the criteria for a civil commitment, as defined by state law.
iii. When an offender meets this criteria, he/she will be referred to the Treatment Review Committee (TRC) in accordance with BHSAMH Policy G-03.1 Non-Emergency Involuntary Medication Administration for consideration for inpatient hospitalization outside the correctional facility or placement at the Jane E. Mitchell (JEM) Building at the Delaware Psychiatric Center.

7. All offenders designated as SMI and BH5, regardless of housing location, must be offered a minimum of ten hours of therapeutic, structured activity and ten hours of unstructured activity per week.

8. Provider is required to track movement between levels of care for each offender.

<u>Behavior Management Unit</u>
Provider will work with BHSAMH and Bureau of Prisons (BOP) to determine the feasibility of establishing a specialized residential level of care unit at JTVCC that is designed to address offender behaviors proven to be aggressive, violent, and life-threatening towards staff, other offenders, or self. The offenders identified for

admission include individuals with a primary diagnosis of personality disorder. The unit will be supervised by a licensed psychologist and include an interdisciplinary group consisting of, but not limited to, psychiatry, psychologist, qualified mental health professionals, activity therapists, and nursing staff. The Provider will collaborate with the BOP to ensure correctional staff are trained and included as members of the interdisciplinary group. The provider will establish admission procedures to include utilization of an evidence-based assessment before admission to determine need. Offenders admitted to the program will have an individualized treatment plan and a discharge plan that outlines goals upon their transition from the current level of care. The specialized residential LOC will deliver cognitive-behavioral based treatment interventions designed in a phase system that reflects the offender's progress through the program. The BMU will provide treatment interventions that include but are not limited to crisis intervention, individual therapy, group therapy, daily medical rounds. Structured and unstructured treatment services will be provided daily with a minimum of 30 hours of programming per week.

Transition Unit

Provider will establish an intensive level of care unit at all Level-V facilities for offenders who do not meet criteria for outpatient treatment and do not meet criteria for traditional residential services. The offenders identified will have a primary mental health diagnosis. The unit will be supervised by a licensed clinician and include an interdisciplinary treatment group consisting of but not limited to psychiatry, psychologist, qualified mental health professionals, activity therapists, and nursing staff. The provider will establish admission procedures to include utilization of an evidence-based assessment before admission to determine need. Offenders admitted to the program will have an individualized treatment plan and a discharge plan that outlines goals to address their transition from the current level of care. The specialized residential LOC will deliver cognitive-behavioral based treatment interventions designed in a phase system that reflects the offender's progress through the program. The BMU will provide treatment interventions that include but are not limited to crisis intervention, individual therapy, group therapy, daily medical rounds. Structured and unstructured treatment services will be provided daily with a minimum of 20 hours of programming per week.

Detentioner Mental Health Unit

The DDOC wishes to establish a dedicated Mental Health Unit for detentioners at the Howard R. Young Correctional Institution (HRYCI). This unit would house up to 40 offenders. The Provider would provide 2-4 hours of structured therapeutic activity, 7 days per week. If a dedicated unit cannot be appropriated for this purpose, the Provider shall still be required to provide mental health groups for this population as outlined above. The curriculum used must be evidence-based and reviewed and approved by DDOC prior to implementation.

Incarcerated Veterans Group

The Provider shall offer an incarcerated veterans' group at two Level-V facilities (Sussex Correctional Institution (SCI) and HRYCI). This group would run 1-2 times per week for up to 15 offenders per group. The group shall be focused on issues faced by veterans with mental illness (PTSD, trauma, etc.). The curriculum used

must be evidenced-based and reviewed and approved by DDOC prior to implementation.

Continuity of Care

Individuals being served in Level-V facilities may transfer to another Level-V facility, step-down to a Level-IV facility, or be released directly to the community. The behavioral healthcare treatment staff shall work with the offender and other individuals supporting re-entry (including medical staff, re-entry staff funded through this contract, DDOC in-reach coordinators, case managers through managed care organizations) to develop a plan for continued behavioral healthcare treatment in the receiving facility or in the community. (See DDOC Policy E-09 Continuity, Coordination, and Quality of Care During Incarceration) Refer to Section G below for more information on discharge and reentry services for those being released directly to the community.

Documentation of services delivered

All Provider staff (including sub-contractor staff) are required to document all clinical contacts in the appropriate sections of the EHR in accordance with DDOC policies.

G. **Substance Use Disorder Services.**

The purpose of substance use disorder (SUD) treatment is to ensure that incarcerated men and women with substance use disorders and those with substance use and co-occurring mental health disorders are promptly identified, and that timely, clinically appropriate, and effective treatment interventions tailored to the correctional client are provided. The DDOC recognizes a strong relationship between substance use and a history of exposure to trauma. Programs providing substance use services strive to incorporate trauma informed principles into practice to promote recovery and avoid re-traumatization of service recipients. The DDOC also recognizes the need to apply principles of evidence-based practices responsive to the criminogenic risks and needs of justice involved clients into their SUD treatment programs.

All SUD programs must follow and align with ASAM levels of care by offering a variety of levels of care called tracks, within designated Level-IV and Level-V facilities. Some of these tracks are housed and program together and some are completely separated in certain locations. All Level-V and Level-IV SUD programming follows the Therapeutic Community (TC) model.

In 2020 the DDOC began a redesign of their flagship SUD programs to incorporate the latest proven evidence-based treatment practices in collaboration with its medical and behavioral healthcare provider. Planning and approval for the redesigned SUD programs, renamed Road to Recovery (R2R), was completed in September 2020. Inmate and stakeholder education was completed, and R2R launched Department-wide on November 1, 2020

R2R retains the TC model, an industry best practice which has proven to be effective. Key features include:

1. The need for treatment and placement in the program will be identified through DDOC's classification process and will include a comprehensive assessment, drug screen, and multidisciplinary clinical review.

2. Each participant will be guided by an individualized treatment plan based upon his or her specific needs that are identified through the assessment process. R2R employs the Texas Christian University (TCU) Comprehensive Assessment tool as well as the Addiction Severity Index (ASI), widely used in criminal justice and community treatment settings across the nation.

Additional "electives" shall be offered to participants, including Trauma, Co-Occurring Disorders, and Healthy Relationships, in addition to continuing to offer the existing anger management elective. Progression through treatment is determined by achieving treatment benchmarks and demonstrating progress through ongoing assessments.

R2R is offered at Level-V facilities HRYCI, SCI, and Baylor Women's Correctional Institution (BWCI) and Level-IV facilities Community Corrections Treatment Center (CCTC) and Hazel D. Plant Treatment Center (HDP). Participants may be moved among these facilities to complete the recommended program.

Participants will be assigned a track of treatment described below:

<u>Level-V Treatment Program Tracks</u>
R2R Track 1 is currently offered at Level-V at HRYCI and BWCI. It uses the Modified Therapeutic Community (MTC) as a therapeutic level of care. This program requires 30-35 hours of structured, staff facilitated treatment programming each week. The current core curriculum is CBI-CA and CBI-SA, while the phase curriculum uses The Change Companies RDAP Journal Series, and the Collegiate Model curriculum utilizes The Change Companies MEE Series for treatment programming. Approximate length of stay is 9-12 months.

R2R Track 2 is currently offered at Level-V at SCI and BWCI. It uses the Intensive Outpatient (IOP) as a therapeutic level of care. This program requires 9-15 hours of structured, staff facilitated treatment programming each week. The current core curriculum uses The Change Companies Breaking the Cycle curriculum while the Collegiate Model curriculum utilizes The Change Companies MEE Series for treatment programming. Approximate length of stay is 4-6 months.

R2R Track 3 is currently offered at Level-V at SCI and BWCI. It uses the Outpatient (OP) as a therapeutic level of care. This program requires less than nine hours of structured, staff facilitated treatment programming each week. This program track uses the Collegiate Model curriculum - The Change Companies MEE Series for treatment programming. Approximate length of stay is 3-6 months.

Provider shall also develop and facilitate a short-term, out-patient style treatment program for LV offenders with an SUD but do not meet admission criteria for LV residential SUD treatment.

Provider shall develop and facilitate appropriate programming within the Level-V R2R programs for offenders with a dual diagnosis to ensure they receive

appropriate behavioral healthcare services. This programming shall be facilitated by a licensed, masters level clinician.

Level-IV Treatment Program Tracks

R2R Track 1 is currently offered at Level-IV at CCTC and HDP. It uses the Modified Therapeutic Community (MTC) as a therapeutic level of care. This program requires 25-30 hours of structured, staff facilitated treatment programming each week. The current core curriculum is the TCU Mapping Interventions, while the phase curriculum uses the CBI-EMP, and the Collegiate Model curriculum utilizes The Change Companies MEE Series for treatment programming. Approximate length of stay is 6-9 months.

R2R Track 2 is currently offered at Level-IV at CCTC and HDP. It uses Intensive Outpatient (IOP) as a therapeutic level of care. This program requires 9-15 hours of structured, staff facilitated treatment programming each week. The current core curriculum is the CBI-EMP, and the Collegiate Model curriculum utilizes The Change Companies MEE Series for treatment programming. Approximate length of stay is 4-6 months.

R2R Track 3 is currently offered at Level-IV at CCTC and HDP. It uses Outpatient (OP) as a therapeutic level of care. This program requires less than 9 hours of structured, staff facilitated treatment programming each week. The current curriculum utilizes The Change Companies MEE Series for treatment programming. Approximate length of stay is 3-6 months.

The Provider is required to purchase and provide all Level-IV and Level-V participants a copy of program materials in accordance with their assigned individualized treatment plan (i.e., workbooks) upon placement in a track of treatment.

Coordination of Care

DDOC is committed to increasing the success of offenders who are transitioning from incarceration back to the community. Some offenders who are eligible for release in less than six months shall be provided transitional services to facilitate their reentry into the community. The Provider must coordinate the transition of offenders who complete Level-V SUD programs to a Level-IV SUD program in a community corrections facility or to SUD programming in the community with probation and parole staff.

Community Corrections SUD programs must also include treatment for offenders diagnosed with co-occurring mental health and SUD diagnoses as well as make accommodations for offenders with serious medical conditions. This programming shall be facilitated by a licensed, masters level clinician. Additionally, the Provider will develop referrals for sober housing, medical assistance, continued MAT, and other relevant reentry needs aimed at reducing risk to recidivate. The Provider must provide additional reentry support through Aftercare services located in probation and parole offices.

Aftercare

Consistent with empirical findings, DDOC believes that released offenders with strong community support and accountability systems are less likely to reoffend. Furthermore, it is expected that community based, follow up SUD treatment will lower recidivism and make Delaware a safer place to live. SUD Aftercare is the third and last step in Delaware's substance use disorder continuum. Offenders who complete either the Level-IV or Level-V programs are expected to participate in a six-month Aftercare program. The Provider will be required to work in collaboration with probation/parole officers and other organizations such as the Treatment Access Center (TASC) as needed toward reducing risk for returning to prison.

The Provider shall be responsible for obtaining and maintaining space for aftercare service staff to complete their administrative duties relative to service delivery.

H. **Special Populations.**

The DDOC has several special populations throughout the Level-IV and Level-V facilities. These programs are described below.

Six for One

6 for 1 Programs – a voluntary "pre-treatment" program based on the essential elements of a modified therapeutic community, with the programming running up to 90 days. The program is currently offered at several Level-V facilities (HRYCI, SCI, and BWCI). The program targets pre-trial detainees who have been screened to have an alcohol and/or drug problem. Programming is to follow a condensed version of the Level-V SUD treatment content, topics and curriculum identified in this document. The clinical focus of 6 for 1 is on early treatment engagement and interventions targeting intrinsic motivation to change along with other relevant criminogenic risk factors as determined through the assessment process.

Sex Offender Treatment Program

Provider will provide sex offender treatment services for offenders in all Level-IV and Level-V facilities. The provider will utilize an evidence-based risk assessment to determine level of care and to measure progress throughout the course of treatment. All clinical staff providing SOTP services must meet the criteria as outlined in Delaware Administrative Code, Title 1, section 1100.

1. There shall be a designated SOTP Director who must be a Credentialed Sex Offense Service Provider (CSOSP) as outlined in Delaware Administrative Code, Title 1, section 1100, 3.0. This director shall also be credentialed by the DDOC credentialing committee as a SOMB Program Director.

2. All clinicians who provide SOTP services must be a licensed, Masters level clinician. They may have either the CSOSP or they may be an Associate Sex Offense Service Provider (ASOSP) who is working on obtaining CSOSP certification.

The Provider will utilize the DDOC approved evidence-based sex offender curricula designed for high-risk and low-risk offenders. The Provider will utilize behavior management strategies such as contingency management to reinforce behavior change. The Provider will establish methods to track offender's progress in treatment as well as support management of their relapse prevention plan.

Clients are classified and assessed using psychosexual risk assessments including Static 99R, ISORA, Stable 2007, Hanson Sex Attitude Questionnaire, ACEs Questionnaire and PCL-R (Hare Psychopathy Checklist) prior to starting the program to determine placement in either high or moderate/low risk group.

The Initial psycho-sexual evaluation shall consist of the following:

1. Clinical interview
2. Clinical mental health status exam
3. Observational assessment
4. History or functioning
5. Case file/document review
6. Collateral information/ contact/interview

Sex offense-specific evaluation shall address the following areas:

1. Cognitive-Functioning
2. Mental Health
3. Medical/Psychiatric Health
4. Drug/Alcohol Use
5. Stability of Function
6. Development History
7. Sexual Evaluation
8. Risk using the Static-99R, Stable and Acute 2007
9. Motivation and Amenability to treatment

The LS/RNR and RNR score and offense related aggravating factors can be considered for overrides to a high-risk group. The scores for individuals classified to treatment and their group placement shall be tracked on a shared Excel sheet that SOTP staff and DDOC correctional counselors will monitor and update. Risk Assessments for those identified for the high-risk group are completed prior to the start of the program. Assessments for those identified for the low-risk group will be completed either prior to or within three months of starting the low-risk group.

The SOTP general program/community model will fall into one of two risk categories, have a set number of participants, and use a curriculum as follows:

1. High-risk: Closed CBT-based intensive outpatient therapy model with 5-10 clients per group using the CBI-SO as the core curriculum.

2. Low-risk: Open CBT-based outpatient therapy model with 8-14 clients per group utilizing the Preparing to Change journals and Maintaining Positive Change journal.

The SOTP Program will utilize phases of treatment, with duration of treatment, dosage, and targets criteria for phase advancement as follows:

Level-V Facilities - Sex Offender Programming

High Risk group: Three Phases of Treatment with two 2-hour groups held weekly for a total of 12-13 months. Cognitive Behavioral Interventions for Sexual Offending (CBI-SO) is broken into three phases lasting approximately 12-13 months.

1. Phase 1 (approximately nine weeks): Pre-Treatment Module and Module 1 - Motivational Engagement. Motivational engagement involves increasing motivation and interest, developing trust, setting personal goals, introducing social skill building and developing emergency strategies to cope with urges in the short term.

2. Phase 2 (approximately 40 weeks): Phase two includes modules 2-6. These modules are an introduction to basic CBT concepts, cognitive restructuring, emotional regulation, social skills, and problem solving.

3. Phase 3 (approximately 4-7 weeks): Success planning. Success planning involves re-exploring personal history and lifestyle, reinventing their life, identifying, and engaging a social support network and rehearsing and presenting their success plans.

Advancement criteria for each phase involves regular attendance, participation in group, completion of practice work, basic understanding of material presented, limited number of sanctions and meaningful (as opposed to disruptive) participation.

Low risk group: 2 phases of treatment with a two-hour group held once a week for a total of 11-12 months.

1. Phase 1 (approximately 9-10 months): Change Companies Preparing to Change Model. This consists of five treatment journals. The topics of the journals are Pretreatment, Self-Reflection, Guiding Principles, Challenging Distorted Thinking, Understanding Victim Impact and My Readiness Statement.

2. Phase 2: Maintaining Positive Change Journal from Getting it Right Reentry Series of Journals. This phase involves release planning. Approximately 2 months.

Level-IV Facilities - Sex Offender Programming

Maintaining Positive Change Journal to be completed by all those who completed the high-risk group at Level-V and by those who did not complete either the high risk or low risk groups at Level-V. For those who did complete the low-risk group at Level-V, they will review and update their Maintaining Positive Change Journals, while in the SOTP at Level-IV.

For high-risk groups, progression in the program is measured by their Stable 2007 score. If the score shows they are regressing, or their score shows their risk level has grown higher, they will not progress to the next phase or may be asked to repeat a phase. The Stable 2007 score is updated six months into the program and again upon completion or discharge for the high-risk group.

For the low-risk group, the Stable is done at the time of the assessment and updated upon completion.

Cognitive Behavioral Therapy (CBT) Groups

The Provider should describe its plan for continuing to provide existing, short-term CBT groups. Offender participation in these groups is determined through the Department's assessment and classification process and provides access to offenders who may not otherwise be eligible due to limitations of classification parameters and/or the limited space within the correctional facilities where other programs are housed. There are three tiers of CBT programming the Provider should be prepared to offer:

Three Tiers of CBT:

1. Low Dose CBT: This tier of treatment shall be offered at all Level-IV and Level-V facilities on a weekly basis. Offenders eligible for this tier of treatment would be RNR Group B. It shall comprise of up to 20 hours of staff facilitated, manualized treatment interventions (dependent upon number of topics offered) tailored to the criminogenic needs of the incarcerated person as determined by actuarial risk assessment and/or court ordered treatments. Based on Texas Christian University's Mapping Enhanced Counseling (TMEC) and Brief and Intermediate Interventions, each session can be offered as a stand-alone intervention or offered sequentially in advance of other more intensive interventions.
   a. Facilitated as open enrollment or modified open enrollment sessions.
   b. Designed for groups but can be delivered to individuals.
   c. Training requirements are minimal, and use of curriculum is at no cost with permission of authors.
   d. Mapping is an NRREP registered evidence-based practice.

   Commitment to Change (C2C): As part of probation and parole's use of graduated sanctions, C2C takes place on the weekends at the following community corrections centers: HDP and CCTC. As an administrative commitment lasting up to ten calendar days in one year (typically weekends), probationers are provided C2C as an intervention in lieu of a VOP and in response to behavioral non-compliance while on probation – often related to drug use. During the weekend, the Provider is expected to deliver four sessions totaling 4-8 hours of CBT using the Texas Christian University Curriculum, Mapping Enhanced Counseling session called, Getting Motivated to Change or other TCU brief interventions. More about the curriculum is available at: https://ibr.tcu.edu/manuals/description-getting-motivated-to-change/

2. Moderate Dose CBT: This tier of treatment shall be offered at all Level-IV and Level-V (excluding CCTC) facilities on a weekly basis. Offenders eligible for this tier of treatment would be RNR Group B. Approximately 37 hours of intervention using Thinking for a Change, a National Institute of Corrections Thinking for a Change 4.0 (T4C) is an integrated cognitive behavioral change program authored by Jack Bush, Ph.D., Barry Glick, Ph.D., and Juliana Taymans, Ph.D., under a cooperative agreement with the National Institute of

Corrections (NIC). T4C incorporates research from cognitive restructuring theory, social skills development, and the learning and use of problem-solving skills. T4C comprises 25 lessons that build upon each other and contains appendices that can be used to craft an aftercare program to meet ongoing cognitive behavioral needs of your group. Not all lessons can be completed in one session, so a typical delivery cycle may take 30 sessions. Sessions should last between one and two hours. Ideally, the curriculum is delivered two times per week, with a minimum recommended dosage of once per week and a maximum of three times per week. Participants must be granted time to complete mandatory homework between each lesson.

a. Facilitated as closed enrollment groups with open sessions allowable within the first 5 sessions
b. Requires specialized training that is contracted through NIC at a cost.

3. High Dose CBT: This tier of treatment shall be offered at all Level-V facilities on a weekly basis. Offenders eligible for this tier of treatment would be RNR Group B. Approximately 84 hours of intervention using University of Cincinnati's Cognitive Behavioral Interventions Core Curriculum (CBI-CC) that broadly targets all criminogenic (crime-producing) needs. As the name suggests, this intervention relies on a cognitive-behavioral approach to teach participants strategies to manage risk factors. The program places heavy emphasis on skill building activities to assist with cognitive, social, emotional, and coping skill development. The curriculum provides modifications so that individuals with mental illness can participate, though it is not dedicated exclusively to this population. Using a modified closed group format with multiple entry points, the curriculum is designed to allow for flexibility across various service settings and intervention lengths.
   a. Facilitated as modified open enrollment groups with multiple points of entry.
   b. Requires specialized training through University of Cincinnati.
   c. Each curriculum session includes a modified version of the material for the mental health population.
   d. Shorter versions of the curriculum, CBI-EMP and CBI-SA, blend CBT strategies with sessions focusing on employment and substance misuse.

4. SHU CBT Groups - The DDOC would like to offer CBT groups to high-risk offenders housed in the SHU at JTVCC. These groups would be directed at inmates that have been placed in the SHU as a result of having displayed a history of staff or inmate assaults, gang activity, and chronic disruptive behavior and/or have been identified as a threat to the correctional system in general. A goal of this program is to provide inmates with the skills to prepare them for their return to the general population and participation in more intensive programs. The group consists of an evidenced-based curriculum, delivered 1-3 days a week, 1.5-2 hours per day, for 6-9 months, by a person trained on the model, and this may be supplemented with workbook or other interactive journal assignments. Moral Reconation Therapy and Reasoning and Rehabilitation are two evidence-based curriculums in use with criminal justice populations in the United States and abroad. The Provider will select one of those two curriculums or may recommend another evidenced-based curriculum for the DDOC to evaluate and consider.

The Provider should also propose a wide array of other CBT based programming across all facilities to include Post-Traumatic Stress Disorder (PTSD) treatment and groups.

I. **DUI Services.**
The Provider will be responsible for providing programming based on 21 *Del. C.* § 4177(d)(9) for individuals incarcerated for DUI. Programming shall include intensive treatment, group processes, and drug and alcohol programming. Individuals who are convicted of a third or subsequent Driving Under the Influence (DUI) offense are currently enrolled in a 90-day treatment program at BWCI and SCI called Reflections.

This program is also referred to as Track 4 and is embedded in the R2R program currently offered at Level-V at SCI and BWCI as well as at Level-IV at CCTC. It uses the Outpatient (OP) model as a therapeutic level of care. This program follows the IOP therapeutic level of care and requires 9-15 hours of structured, staff facilitated treatment programming each week. This program track uses the CBI-CA as its core curriculum and for the DUI concentration, it uses The Change Companies Responsible Decisions: Impaired Driving Program for treatment programming. Approximate length of stay is 90 days.

J. **Additional SUD Treatment Programming.**
The Provider shall provide a 1-2 hour SUD group at least once per week at each facility for those offenders who are assessed and require SUD treatment but do not score High/Medium Risk on the LS/RNR and RNR tools (and therefore would not be placed into the sentenced SUD Program/R2R) but were determined as needing SUD specific treatment by the L/-RNR and RNR. There is a group of offenders who do not score high/medium for criminogenic risk/need TCU screens but will have SUD treatment needs.

K. **Peer Support Program.**
In addition to coordination with community peer support services, the Provider shall work with DDOC to establish the operation of a certified behavioral healthcare peer support program in conjunction with BOP and Bureau of Community Corrections (BCC). The program will select, train, supervise and support current offenders who elect to work as peers supporting incarcerated individuals with mental health and/or substance use disorders.

L. **Discharge Planning and Reentry.**
Offenders are released from Delaware Correctional facilities every day. Approximately 90% of all offenders entering DDOC custody will eventually be released –approximately 13,500 releases statewide per year. As such, supportive services are needed to promote successful reintegration upon release. The Behavioral Healthcare Provider will be responsible for discharge/reentry efforts with support from the Medical Provider.

The DDOC recognizes that a significant number of individuals who are incarcerated and returning to the community have chronic health, substance use and mental health disorders and need treatment in addition to employment, housing, and other services. Therefore, the goal of discharge planning, reentry, and transitional support is to support successful reintegration, reduce recidivism,

and promote public safety through the implementation of evidenced based practices that help offenders to develop healthy and meaningful lives in the community.

The Provider shall work with the DDOC's contracted medical Provider to develop and maintain a continuous collaborative case management approach to reentry planning and continuity of care for offenders having high risk/high need challenges in accordance with DDOC Policy 11-E-10 Discharge Planning and DDOC Policy 3.12 Reentry Planning. Comprising discharge planning nurses, reentry- coaches, DOC staff, and clinicians, this multidisciplinary approach is an integral part of the overall approach to reentry services.

The DDOC is committed to providing comprehensive discharge planning. The provider shall provide a dedicated reentry team to coordinate reentry services across all DDOC facilities. The reentry team shall consist of one (1) Director of Reentry Services, one (1) Supervisor of Reentry Services one (1) administrative assistant, and a minimum of eight (8) reentry coaches spread across all Level-IV and Level-V facilities to meet the needs of the offender population.

These reentry coaches provide access to community programs, ensure continuity of care following release into the community, advocate for patient needs, and act as liaisons between the multiple systems impacting the lives of offenders with mental health illnesses, co-occurring substance use disorders, and chronic medical illnesses.

The Provider will be expected to implement a discharge planning case management system pursuant to DDOC Policy 11-E-10 Discharge Planning which reflects BHSAMH's mission, and is established on well-defined operating principles, clear discharge service objectives, site specific-written policies and procedures, performance standards and measurements that guide discharge and reentry activities for chronic care, behavioral health, and high-risk special needs. The Provider must adhere to, but not be limited to, the following service requirements:

1. Arrange for continuity of care if receiving psychotropic medication.

2. Ensure the offender is enrolled in the public insurance system (Medicaid or Medicare as appropriate) prior to reentry.

3. Assist with applications for Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and/or General Assistance (GA).

4. Submit applications and/or assist with appropriate housing post-release as it relates to management of their medical or behavioral healthcare condition. This must include making arrangements in accordance with available resources for continuity of care for offenders determined by the mental health or medical staff who need involuntary inpatient commitment.

5. For offenders identified as having opiate use disorder and who are on MAT, ensure appropriate follow up appointments are scheduled including arranging transportation if necessary.

6. Attend meetings with Reentry staff and other personnel within the facilities (DOC, medical, mental health, substance abuse staff).

7. Arrange for transportation services for offenders upon release.

8. Referrals to the Eligibility Enrollment Unit (EEU) for involuntary hospitalization and/or Promise services as appropriate.

9. Referrals for Long Term Care (LTC) with follow up based on level of care for which offender is approved.

10. Referrals to Division of Developmental Disabilities Services (DDDS).

11. Referrals for general case management services.

12. Assist with Social Security Disability (SSDI) and Social Security Insurance (SSI) applications.

13. Respond to requests from other agencies such as the Courts, Attorney General's Office and Public Defender's Office to assist in connecting offenders to the appropriate level of care in the community.

14. Collaboration with Mental Health Court as appropriate.

15. Referrals for hospice care.

16. Referrals for behavioral healthcare services will be made via the Delaware Treatment Referral Network (DTRN) as early as possible but at least 30 days prior to release, whenever possible or as appropriate for the referral type.

17. For planned discharges to the community for any offender receiving Medication Assisted Treatment (MAT), healthcare staff must arrange for enrollment of the offender in a community-based MAT program so that therapies started while incarcerated will continue upon discharge to the community. This will require close coordination between discharging and the receiving community-based clinic.

18. Provide the offender with a list of available community resources.

19. Make arrangements or referrals for follow-up services with community mental health providers, including the exchange of clinically relevant information. This includes, but is not limited to, the following:

    a. Establishing formal linkages to community-based mental health providers and community-based resources.
    b. Providing contact information on community mental health professionals to ensure ongoing care to the patient following discharge.

c. Making appointments with community provider(s) who can see the patient in a timely manner to prevent treatment interruption.
d. For planned discharges, healthcare staff shall arrange or make appointments for offenders with community-based services as clinically indicated.

IV. MEDICAL EQUIPMENT AND SUPPLIES

The Provider is responsible to provide, maintain, and replace, as needed, all the medical equipment and supplies necessary to carry out the terms of the contract. Provider shall bear the cost of all office supplies, patient use supplies, patient-specific durable medical equipment, medical equipment, and other equipment needed to provide behavioral healthcare services. The DDOC shall be responsible for desks, office chairs, and computers. All equipment and supplies purchased for during the contract shall become the property of the DDOC.

A. Equipment and supplies needed for patient care shall be procured for the patient in a timely fashion.

    1. For example, durable medical equipment such as C-Pap's, walkers, cam boots, etc. should be acquired within three business days of determination of need.

    2. Equipment that requires customization should be acquired as quickly as possible without undue delay. If this equipment delivery will be longer than 30 days, the BHSAMH Director of Community Health shall be notified immediately.

    3. That all durable medical equipment shall be reviewed and approved by security.

B. Inventory and perform a maintenance check as necessary to maintain all supplies and equipment in good working order at least once a quarter or with frequency defined by the manufacturer (whichever is shorter).

V. COLLABORATION BETWEEN TREATMENT PROVIDER AND SECUIRTY STAFF

While security is the primary concern of any Delaware correctional facility, a healthy and effective treatment system ultimately enhances security. DDOC is committed to providing treatment opportunities to offenders to enhance their ability to benefit from their treatment during incarceration and to help reduce recidivism. New Provider staff will receive training on basic security measures from the DDOC staff. Provider staff will keep the DDOC staff apprised of all treatment activities. An open line of communication between correctional and treatment staff is imperative. Security staff will be accessible to the treatment staff to discuss planning, schedules, special program events, the movement of prisoners into and out of the treatment programs, the recruitment of program participants and issues pertaining to security.

VI. TREATMENT STAFF DESCRIPTION, QUALIFICATIONS, SUPERVISION, AND WORK SHIFTS

The DDOC requires personnel who will provide adequate levels of coverage and care in each facility. It is not recommended to have shared personnel between facility levels. Any shared staffing must include a detailed plan outlining how staff will be shared, offender-to-staff ratios to be maintained, and immediate coverage when staff is not present. The DDOC expects the Provider to demonstrate in writing how it will maintain staff retention and its formula for determining staff retention rates. The proposed formula is subject to approval by BHSAMH.

The Provider's staffing plan (Appendix-2) must include how many of each type of staff will be assigned to each facility. The staffing plan must be sufficient to meet the needs of the population. The regional office must include a full-time Contract Administrator/Program Manager, Statewide Behavioral Health Director, Statewide Director of Substance Use Disorder Programs, Chief Psychiatrist, Chief Psychologist, Substance Use Disorder Treatment Program Trainer, Statewide Director of Reentry Services, and Statewide Director of Quality Assurance. There must be a senior behavioral health leader designee to be available 24/7 who will work closely with BHSAMH.

Each Level-V facility must have a designated behavioral health director. Each Level-V behavioral health director will also be responsible for one Level-IV facility. The behavioral health directors will be responsible to coordinate all on-site clinical operations with BHSAMH Behavioral Health Treatment Services Director and serve as the liaison with DDOC security personnel.

Each Level-IV facility must have a designated clinical supervisor who reports to a Behavioral Health Director at the associated Level-V facility, and other staff as needed to meet the behavioral healthcare needs of the facility.

The Provider must assure that all behavioral staff will be capable of utilizing the DDOC's electronic health record (iCHRT) and offender management system (DACS) (as permitted). The DDOC staff will conduct the initial training and the Provider will conduct all follow-up training. The DDOC will continue to provide IT technical assistance regarding its electronic health record throughout the length of the contract.

A. **Licensure and Credentialing.**

The Provider shall have a system for credentialing and privileging staff that is approved by the Bureau Chief of BHSAMH. Each off-site service requiring licensure and certification in the State of Delaware used by any Contracted Provider shall have the licensure or certification on file and be in good standing without practice restrictions.

All healthcare service staff and subcontractors who provide clinical services must be licensed, certified, and registered in accordance with state and/or federal requirements and in accordance with DDOC Policy C-01 Credentials. A restricted license that limits practice to correctional institutions is not in compliance with this section. The Provider shall:

1. Verify that all personnel are duly licensed, certified, and/or registered in accordance with Delaware laws and regulatory requirements.

2. Within three months of contract initiation, develop and deliver a plan for the ongoing education and clinical supervision of staff. This plan shall detail how contracted staff shall access ongoing education necessary to maintain licensure, credentials, and knowledge of current best practices. The plan shall be provided to the DDOC Director of Standards and Compliance and BHSAMH Behavioral Health Director. Quarterly reports on progress toward maintaining licensure and credentials shall be provided to DDOC by the Provider.

3. Be aware that all new hires are subject to, and must pass a background check performed by DDOC, and have their credentials reviewed prior to being allowed to work in a facility.

4. Ensure contracted employees complete required paperwork for renewal of background clearances when requested in a timely manner.

5. Provide personnel information as requested to the bureau chief of BHSAMH or designee.

6. Report any internal disciplinary infractions (including termination decisions) and resulting actions to BHSAMH.

7. Ensure that all reports/complaints against professional staff filed with the Division of Professional Regulation shall also be reported to the bureau chief of BHSAMH or designee.

8. Maintain documentation in a readily available location of current licensure and credentials for all behavioral healthcare staff employed under this contract.

9. Require that once hired, behavioral healthcare staff are responsible for bringing to the attention of the responsible health authority any changes to their credentials.

10. Require that the credential verification process includes inquiry regarding sanctions or disciplinary actions of state boards, employers, and the National Practitioner Data Bank (NPDB).

11. Require that behavioral healthcare staff do not perform tasks beyond those permitted by their credentials, licensure, and training.

Behavioral Healthcare providers will receive privileges to practice in the DDOC healthcare system in accordance with BHSAMH policy C-01 Credentialing. Providers may have privileges revoked at any time due to failure to correct performance deficiencies identified through peer review or other means or due to egregious breaches of conduct or clinical performance as solely determined by BHSAMH. All providers must have and maintain security clearance.

B. **Statewide Staffing.**
The Provider is required to have the following statewide positions dedicated to this Agreement and located within Delaware:

- Contract Administrator/Program Manager (CA/PM)
- Statewide Behavioral Health Director
- Chief Psychiatrist
- Chief Psychologist
- Statewide Director of Substance Use Disorder Programs
- Substance Use Disorder Treatment Program Trainer
- Statewide Director of Reentry Services
- Statewide Quality Assurance Manager

C. **Staffing Positions and Qualifications.**
The Provider should have experience working with offenders in the criminal justice system in a residential treatment setting comparable to the scope of work described herein. The staff hired to work under this Agreement shall be as follows and must meet the criteria listed for each position:

Contract Administrator/ Program Manager - The Provider is required to have at the minimum one (1) full time senior level Contract Administrator/Project Manager (CA/PM) dedicated to this contract and located in Delaware.

- Minimum bachelor's degree (master's degree preferred) in Health Sciences, Social Science, Program Management, Public Administration, Business Administration, or related field.
- Possession, at the time of execution of the contract, certification in project management by either the Project Management Institute, or by Six Sigma (green belt or higher) or other demonstration of project management/contract management training and skill.
- Minimum of five years of experience (bachelor's degree holder) or two years' experience (Graduate degree holder) in managing complex projects.
- At least two years leadership experience overseeing/coordinating the work of a multidisciplinary team.

The CA/PM shall be responsible for both the medical and behavioral health Agreements.

Statewide Behavioral Health Director - the Provider must ensure there is a Statewide Behavioral Health Director who is licensed in the State of Delaware. (Preference is for a licensed Psychologist in Delaware).

- Master's degree in social work, counseling psychology, or other similar degree that leads to a clinical license.
- Must hold a Delaware clinical license - i.e., LCSW or LPC. (Note - a LMSW is not considered a clinical license).
- The candidate must demonstrate that they have a minimum of five years' experience leading a large behavioral health unit/program that encompasses both mental health and substance use disorder services. This experience must include administrative duties and direct responsibility for oversight of the

program. Additional experience with serious mental illness and sex offender treatment is preferred.

Chief Psychiatrist - the Provider must ensure that one of the licensed psychiatrists assigned to the contract is designated as the chief psychiatrist for the contract. The chief psychiatrist is expected to maintain a caseload and perform administrative duties. These duties should not exceed 50% of their overall schedule. These duties may include but are not limited to the following: peer review, clinical supervision, administrative meetings, and other administrative functions.

Chief Psychologist - the Provider must ensure that one of the licensed psychologists assigned to the contract is designated as the chief psychologist for the contract. The chief psychologist is expected to maintain a caseload and perform administrative duties. These duties should not exceed 50% of their overall schedule. These duties may include but are not limited to the following: peer review, clinical supervision, administrative meetings, and other administrative functions.

Statewide Director of SUD Programs - The Provider shall provide a Statewide Director of SUD Programs to oversee all SUD programs statewide.

- Master's degree in social work, counseling psychology, or other similar degree that leads to a clinical license.
- Must hold a Delaware clinical license - i.e., LCSW, LPC, and/or LCDP. (Note - a LMSW is not considered a clinical license).
- Preference for a certification in chemical dependency (i.e., Certified Alcohol & Drug Counselor - CADC).
- The candidate must demonstrate that they have a minimum of five years' experience leading a substance use disorder treatment program. This experience must include administrative duties and direct responsibility for oversight of the program.
- Preference for a candidate with at least two years' experience working in a Therapeutic Community (TC) environment.

Substance Use Disorder Treatment Program Trainer - The Provider shall provide a Statewide SUD Treatment Program Trainer that will be responsible for training all SUD treatment staff in the proper way to run a Therapeutic Community (TC) SUD program.

- Bachelor's degree in social work, counseling psychology, or other similar degree.
- Must have a substance use certification (i.e., CADC, CAADC), or must be actively working towards attaining a substance use certification and must obtain the certification within two years of hire. The Provider shall include monthly updates on each individual's progress towards certification as part of the monthly training and credentialing log.
- Individuals who are not certified must be under the direct supervision of a certified clinical supervisor with written documentation of supervision.

- Candidate must have two years' experience working in a TC environment. Candidates without two years' experience working in a Therapeutic Community (TC) environment may be considered on a case-by-case basis.

Statewide Director of Reentry Services

- Bachelor's degree in human services, social work, or related field.
- Experience working in a human service program that assists clients with connecting with various community-based services and benefits.
- Experience working with staff from multiple disciplines as a coordinated effort to provide reentry services (e.g., medical, mental health, SUD/OUD service providers, etc.)

Statewide Quality Assurance Director - The Quality Assurance Director shall implement and oversee all quality assurance activities by collecting and analyzing data through audits, interviews, and other activities to monitor the quality and appropriateness of service delivery. The QAD shall also possess the ability to provide leadership, problem-solve and communicate effectively.

- Possession of a bachelor's degree or higher in Health Sciences, Social Science, Program Management, Public Administration, or related field.
- Five years' experience in quality improvement and quality assurance which includes evaluating the quality of services, identifying problems and needs and recommending corrective action and improvements to ensure optimum service delivery, the meeting of goals and objectives and ensuring compliance with applicable laws, policies, procedures, and standards
- Five years' experience in ensuring compliance with regulatory and accreditation standards for healthcare delivery. Experience in developing policies or procedures.
- At least two years leadership experience overseeing/coordinating the work of a multidisciplinary team
- Must be certified by a healthcare quality organization such as Institute for Healthcare Improvement (IHI), Agency for Healthcare Research and Quality (AHRQ), National Association for Healthcare Quality (NAHQ) or possess Six Sigma certification. If not in place at time of hire, must be obtained within six months.
- At the minimum, (in the absence of maintaining current certification in healthcare quality), the Quality Assurance Director shall complete 20 hrs. of continuing education in healthcare quality and patient safety each year and shall provide proof of completion of said training to BHSAMH Compliance Director on an annual basis, starting six months after the execution of the contract.

Site Mental Health Director - The Provider shall provide a Mental Health Director for each Level-V facility. The Site Mental Health Director will be responsible for overseeing mental health services and collaborating with the SUD directors at their assigned Level-V facility to ensure integrated care occurs.

- Master's degree in social work, counseling psychology, or other similar degree that leads to a clinical license.

- Must hold a Delaware clinical license - i.e., LCSW or LPC. (Note - a LMSW is not considered a clinical license). Please note - an incumbent that does meet these qualifications at the time of contract start up shall obtain the required license within one year of contract start up.
- Experience - the candidate must demonstrate that they have a minimum of five years' experience leading a large behavioral health unit/program that encompasses both mental health and substance use disorder services. This experience must include administrative duties and direct responsibility for oversight of the program. Prefer additional experience with serious mental illness and sex offender treatment.
- Site MH Directors must work collaboratively with the Health Services Administrator (HSA) to establish a relationship between medical and mental health.

SUD Program Director - The Provider shall provide an SUD Program Director for each SUD program at each Level-IV and Level-V facility. The SUD director must meet the following criteria.

- Master's degree in social work, counseling psychology, or other similar degree that leads to a clinical license.
- Must hold a Delaware clinical license - i.e., LCSW, LPC, and/or LCDP. (Note - a LMSW is not considered a clinical license).
- Preference for a certification in chemical dependency (i.e., Certified Alcohol & Drug Counselor - CADC) or certified co-occurring disorder professional (CCDP).
- Experience - the candidate must demonstrate that they have a minimum of five years' experience leading a substance use disorder treatment program. This experience must include administrative duties and direct responsibility for oversight of the program.
- Preference for a candidate with at least two years' experience working in a Therapeutic Community (TC) environment.
- Site SUD Directors must work collaboratively with the site BH Director and the Health Services Administrator (HSA) to establish a relationship between medical, SUD treatment, and mental health.

Mental Health Clinical Supervisor - the Mental Health Clinical Supervisor will be responsible for day-to-day operations. Minimum qualifications are as follows:

- Master's degree in social work, counseling psychology, or other similar degree.
- Must be licensed - i.e., LCSW or LPC.
- Must have at least 2 years' experience leading a mental health program.

SUD Clinical Supervisor - each SUD program shall have a clinical supervisor assigned to it. that supervisor shall meet the following criteria:

- Master's degree in social work, counseling psychology, or other similar degree.
- Must hold a substance use certification (CADC, CAADC, licensed chemical dependency professional, or CCDP).
- prefer to be licensed - i.e., LCSW, LPC, and/or LCDP.
- Must have at least 2 years' experience in an SUD treatment program.

Mental Health Clinician

- Must have a graduate degree in psychology, social work, counseling, or a related field, and
- preferred to be licensed (i.e., LCSW, LPCMH). Note - a LMSW is not considered a clinical license.
- Individuals who are not licensed must be under the direct supervision of a licensed clinician with written documentation of supervision. A non-licensed clinician shall be actively working towards licensure. The Provider shall include monthly updates on each individual's progress towards licensure as part of the monthly training and credentialing log.

SUD Counselor

- Bachelor's degree in social work, counseling psychology, or other similar degree.
- Must have a substance use certification (i.e., CADC, CAADC) or must be actively working towards attaining a substance use certification and must obtain the certification within two years of hire. The Provider shall include monthly updates on each individual's progress towards certification as part of the monthly training and credentialing log.
- Individuals who are not certified must be under the direct supervision of a certified clinical supervisor with written documentation of supervision.

Peer Support Staff - Individuals with lived experience may provide peer support services to support and enhance the treatment process.

Psychiatric Technicians - The Provider must provide an adequate supply of psychiatric technicians who will be responsible for providing visual monitoring of individuals who have been assessed to be at risk of self-directed violence (otherwise known as Psychiatric Close Observation). Psychiatric technicians shall meet the following criteria:

- High School Diploma (preference for an associate degree in human services, or working towards a degree in human services)

D. **Staffing.**

To temporarily fill a vacancy, a position must be filled by a person who is equally or more qualified in the same field. That person shall not be cross covering another position to the point that their contribution in both positions adds up to more than one (1) FTE. In positions requiring licensure, the replacement candidate's license must be of an equal or higher level and must fall under an equal or higher liquidated damages hourly rate.

DDOC will not pay staffing costs for positions that are vacant more than 30 days. DDOC will actively monitor Provider staffing levels on an ongoing basis. The Provider's monthly invoice shall summarize the number of total filled FTEs in each category for each week of the month and include a time and attendance report to support the FTEs invoiced for the billing month. Vacant FTE's shall be subtracted on the Provider's monthly invoice each month based upon the staff billing rate chart shown below. The BHSAMH reserves the right to conduct random quality assurance audits of time sheets against facility schedules.

PROVIDER'S STAFF BILLING RATE

Behavioral Health Staff Positions	**Hourly Bill Rate** ***(Includes Fringe)***
Statewide Behavioral Health Director	$84.00
Statewide Director of Substance Use Disorder	$51.00
Chief Psychiatrist	$227.00
Chief Psychologist	$84.00
HR Recruiter	$52.00
Substance Use Disorder Treatment Program Trainer	$45.00
Statewide Director of Reentry Services	$55.00
Statewide SOTP Director	$58.00
Supervisor of Reentry Services	$49.00
Reentry Administrative Assistant	$29.00
Reentry Specialist (Minimum of 8 required)	$47.00
Statewide Director of Aftercare Services	$45.00
Aftercare Counselor	$39.00
Administrative Assistant	$35.00
Site Mental Health Director	$75.00
Site SUD Program Director	$48.00
Site Mental Health Clinical Supervisor	$57.00
Site SUD Program Clinical Supervisor	$45.00
Psychiatrist	$228.00
Nurse Practitioner	$115.00
Psychologist	$81.00
Psychiatric RN	$56.00
SOTP Clinician	$53.00
Mental Health Clinician	$53.00
SUD Counselor	$36.00
Peer Support Staff	$24.00
Reentry Specialist	$45.00
SUD Assessment Specialist	$26.00
Group Intervention Specialist	$46.00
BH Activity Technician	$36.00
Psychiatric Technicians (PCO Observation)	$25.00
Administrative Assistant	$29.00

E. **Position Control.**
Maintaining acceptable staffing levels is a critical element of providing effective behavioral healthcare services. The Provider shall assign a unique identifier number for each contracted position. Each week, the Provider shall submit a weekly position control report in an excel spreadsheet template provided by the DDOC to the Director of Policy and Standards Compliance that summarizes the previous week. This weekly report shall include the following:

- Unique position identification number
- Employee Name

- Employee Title
- Education Level
- Licenses/Certifications held
- Facility assigned
- Hours worked
- Hourly rate for that employee
- Employee's start date
- Date position became vacant if position is vacant
- Number of days vacant

F. **Provider Staffing and Work Shifts.**
Provider is expected to schedule staff to work in a manner that provides adequate coverage across all Level-IV and Level-V facilities to meet the behavioral healthcare needs of the offender population such as, but not limited to the following: conduct screenings, assessments, comprehensive mental health evaluations, suicide risk assessments, sick calls, and other routine and crisis calls as needed.

G. For SUD programs at Level-IV and Level-V facilities, counselor staff shall be on site 8:00 AM to 8:00 PM. Monday through Friday and 8:00 AM to 4:30 PM on weekends and holidays.
- At all Level-V facilities, MH clinicians shall be on site 8:00 AM to 8:00 PM Monday through Friday and 8:00 AM to 4:30 PM on weekends and holidays.
- At all Level-IV facilities, MH clinicians shall be on site 8:00 AM to 4:30 PM at least three days per week.

Preference is for the clinical staff to be licensed. If the Provider uses non-licensed staff, non-licensed staff must have access to an on-call licensed clinician for consultation. Provider shall ensure its staff interacts, collaborates, and partners with the DDOC staff and other Providers. Provider shall maintain work schedules for each position, including any position working weekends or evenings. Provider's staff must be approved by the DDOC through the DDOC Human Resource background check process.

H. **Changes to the Position Control Report.**
If at any time the Provider needs to make a permanent change to the approved staffing plan, it must do so through a contract amendment itemizing each staffing change. This includes moving positions between facilities, combining positions into a single position, or splitting a position into multiple positions. The amendment must reference each unique position identifier and what is happening with that position. To create a new position using existing staffing positions the amendment must show what positions (and unique identifier) is being combined, and so on.

I. **Supervision.**
Structured and documented clinical supervision shall be provided by a licensed/credentialed behavioral healthcare professional.

- Licensed mental health professionals and credentialed substance use counselors will receive monthly individual supervision for a minimum of one hour.

- Unlicensed/uncredentialed clinicians/counselors will receive weekly individual supervision for a minimum of one hour.
- Supervision will be documented in writing and will be reviewed periodically by the Statewide Behavioral Health Director. This review shall be documented.
- The Statewide Behavioral Health Director will provide clinical direction to the site Mental Health Director and SUD Program Director based on the results of these reviews, particularly in complex cases.

The Provider shall describe its approach to ensure consistent clinical supervision that is inclusive of detailed case reviews.

J. **Peer Review.**
In accordance with DDOC Policy C-02 Clinical Performance Enhancement, the Provider shall require and conduct a formal annual peer-review of clinical performance of the facility's licensed staff, including but not limited to, psychiatrists, psychologists, nurse practitioners, directors, clinicians, and counselors.

A peer is defined as another provider in the same discipline (e.g., psychiatrist, psychologist, nurse practitioner, or clinician) who has firsthand knowledge of the provider's clinical performance. The peer review should evaluate the professional care the provider has given using a sample of the provider's primary patient case load and comment on specific aspects of the provider's knowledge and skills, such as actual clinical performance, judgment, and technical skills. The Provider shall maintain a record of these peer reviews. See 24 *Del. C.* § 1768 regarding the State of Delaware's statutory peer review privilege.

Peer review must be done within the same discipline. For example, a psychiatrist must conduct a peer review for a psychiatrist, a psychologist for a psychologist, etc.

In the event of an unsatisfactory review or termination, the bureau chief of BHSAMH or designee shall be informed and when applicable, shall receive a copy of the employee's corrective action plan. The Provider's administrative team will ensure that clinical staff complete any corrective action plan developed to correct deficiencies identified by the peer review process, random or scheduled audits, or other processes. Providers shall discuss peer reviewed processes that they have utilized in other correctional and/or behavioral healthcare systems.

K. **Orientation and Training.**
All newly hired Provider staff and contractors (FT, PT, PRN, agency, temporary, etc.) must attend New Employee Orientation (NEO). They must also receive a security briefing from a member of the facility security staff (designated by the warden or designee) at their assigned facility. Attending NEO shall occur prior to the first day on the job at a facility. The security briefing must occur on the first day working at the facility.

All healthcare staff working in a DDOC facility must complete all DDOC mandated training in accordance with the DDOC's Annual Training Plan in accordance with DDOC policy C-03 Professional Development.

The Provider shall coordinate with the DDOC to provide and cover the cost of mental health and suicide training by a qualified mental health professional (QMHP) for all DDOC employees attending initial training at the Stephen R Floyd Jr. Training Academy (Correctional Employee Initial Training (CEIT), Basic Officer Training Course (BOTC), and Non-Security Basic Training).

The Provider shall provide and cover the cost of training on a regular basis by a QMHP to correctional staff assigned to receiving, screening, and mental health areas, including mental health programs, residential units, or segregated housing areas, on mental health topics specific to those areas to fulfill their specific duties.

All SUD and MH staff shall receive formal training within 90 days of hire, on any curriculum in use by the program they are assigned to facilitate. As part of the initial orientation, all newly hired clinical staff should be assigned to another staff member to acclimate to their position and the correctional environment.

The Provider shall utilize a Train-the-Trainer program to facilitate training for all MH and SUD staff.

The Provider shall perform other in-house training as required by the DDOC.

The Provider shall develop and utilize an orientation checklist for all employee categories. This checklist shall contain all required items an employee must complete for basic orientation and in-depth orientation. A copy of this checklist shall be maintained in each employee's file and must be shared with BHSAMH upon request.

VII. ADMINISTRATIVE MEETINGS AND REPORTS

The Provider is required to participate in a variety of meetings to ensure there is appropriate and effective collaboration between facility administration, the Bureau of Healthcare, Substance Abuse & Mental Health Services, and the various healthcare contracted providers. The Provider shall ensure that all required participants among their staff are invited to each meeting and actively participate. The Provider shall be responsible for compiling meeting records and notes for meetings they facilitate and disseminating them to all participants.

Provider must participate in all administrative meetings as outlined in current and future NCCHC Standards and ACA Expected Practices for Jails and Prisons. Details on the daily, weekly, monthly and quarterly meetings the Provider is required to convene, attend and/or contribute to and the Provider's role in these meetings is as outlined in DDOC Policy A-04 Administrative Meetings and Reports. Brief information on quarterly meetings is also provided below.

A. Quarterly Meetings.

Healthcare Advisory Committee: Each facility is required to conduct a quarterly Healthcare Advisory Committee (HAC) meeting in accordance with DDOC Policy A-04 Administrative Meetings and Reports. The Provider is required to attend and participate in the HAC meeting. These and other meetings should be coordinated with the Healthcare Contractor's meetings.

Continuous Quality Improvement Meeting (Statewide): The bureau chief of BHSAMH or designee convenes and facilitates the state level Continuous Quality Improvement (CQI) meetings in accordance with DDOC Policy A-06 Continuous Quality Improvement Program. The state level CQI Committee meets at least once per quarter or more often as needed. The Provider shall attend the CQI Meeting as outlined in the policy. The DDOC reserves the right to request additional or different reporting information from the Provider throughout the term of the contract, on either an ad hoc or regular basis. Contracted behavioral staff required to attend this meeting are:

- Contract Administrator/Project Manager
- Statewide Director of Quality Assurance
- Statewide Behavioral Health Director
- Statewide SUD Director
- Chief Psychiatrist
- Chief Psychologist
- Other staff members as deemed necessary by the bureau chief of BHSAMH and/or BHSAMH Medical Director

Continuous Quality Improvement Meeting (Facility level): In addition to #2 above, each site is required to have a site level CQI Committee that shall meet at least once per quarter in accordance with DDOC Policy A-06 Continuous Quality Improvement Program. The Provider shall participate in this meeting which is facilitated by the medical contractor.

Joint Provider meeting: The DDOC will facilitate a Joint Provider Meeting at least once per quarter, or more often as needed in accordance with DDOC Policy A-04 Administrative Meetings and Reports. The Joint Provider Meeting is conducted to ensure that effective collaboration exists among the various contracted providers. The Provider must attend these meetings as outlined in the policy. The DDOC will lead this meeting.

Pharmacy and Therapeutics Committee: The Pharmacy and Therapeutics (P&T) Committee meets at least quarterly and is facilitated by the Pharmacy Provider. The Statewide Behavioral Health Director may be requested to attend this meeting. (See DDOC Policy D-01 Pharmaceutical Operations)

B. **Quality Assurance.**
The DOC/BHSAMH has a quality assurance plan (QAP) to monitor contracted services for compliance and quality. The Provider shall work with BHSAMH to provide any requested program materials/records in support of the QAP. BHSAMH will conduct regular and ad hoc chart reviews to verify the delivery of services provided by the Provider. These reviews may be scheduled in advance or may be unannounced. The Provider and the DDOC/BHSAMH shall review the results, and when deficiencies are identified, the Provider shall perform all remediation as requested by the DDOC/BHSAMH within thirty days or within an agreed-upon time-period.

1. **Reports and Notifications.**
   The Provider shall make available detailed personnel records (including hours worked, hourly rate of pay, and demographic information), attendance data, staff vacancy reports, clinical documentation, and other relevant information (including financial data related to the contract) as requested by the DDOC/BHSAMH. The Provider and the State shall review the results, and when deficiencies are identified, the Provider shall perform all remediation as requested by the DDOC/BHSAMH within an agreed-upon time-period.

   The DDOC may request any reports on data points maintained in the EHR related to services or other data. The Provider shall produce all such reports utilizing data from the DDOC's EHR. All reports shall be provided in the format requested by the DDOC/BHSAMH. The Provider shall supply DDOC with any requested reports within 30 days of request.

   The Provider shall provide required monthly reports within 15 days of the close of the previous month. Required monthly reports are outlined in numerous DDOC Policies. Quarterly reports on certain programs identified by DDOC/BHSAMH may also be required by the DDOC's Strategic Partnership Oversight Committee (SPOC). This multi-disciplinary DDOC group reviews utilization metrics, client demographics, and program outcome data utilizing provider reports. Upon contract award, DDOC will make a determination of which provider-administered programs will need to complete SPOC quarterly reports and will work with the provider to customize portions of the SPOC template to capture program outcome results.

   Numerous DDOC policies require notifications of events such as deaths, emergency codes, emergency department transports, etc. The Provider must adhere to these required notifications and the timelines assigned.

2. **Policies, Procedures, and Forms.**

   - The Provider shall adhere to all current and future DDOC policies, directives, rules, interim memos, MOUs, intergovernmental agreements, and guidance documents.
   - The Provider may be asked to participate in policy development.
   - All forms utilized by the Provider for the provision of healthcare services or data collection relative to healthcare services must be reviewed and approved by the DDOC before being put into use.
   - The Provider shall use all forms provided, or created, by the DDOC.

   Additionally, the Provider shall:

   - Develop site-specific procedures from each BHSAMH policy. These site-specific procedures shall have sufficient detail to educate a reader on how to perform all associated tasks. All site-specific procedures shall be reviewed and approved by DDOC. All site-specific procedures shall be reviewed annually by the Provider and by the DDOC.

- Participate in the process of developing, reviewing, editing, and finalizing new versions of policies and procedures relative to offender health and offender healthcare.
- Review and discuss policies and procedures as a component of staff new-hire orientation and in-service training.
- Ensure that all staff are oriented to all policies and procedures
- Verify that site-specific procedures comply with all current and future federal and state laws and regulations, NCCHC standards, ACA Expected Practices, DDOC policies, directives, rules, interim memos, MOUs, intergovernmental agreements, and guidance documents.
- Cooperate with DDOC or any independent agency, organization, entity, or person chosen for the purposes of scheduled or unscheduled audits.
- As part of the CQI process, monitor compliance with DDOC policies, directives, rules, interim memos, MOUs, intergovernmental agreements, and guidance documents, and resolve discrepancies in collaboration with the DDOC.

C. **Continuous Quality Improvement Program.**
The Provider shall implement a site level Continuous Quality Improvement (CQI) program at each site in accordance with DDOC Policy A-06 Continuous Quality Improvement Program. 30 days or more prior to the start of service delivery under this contract, the Provider shall provide a written plan outlining how they will implement the site level CQI Program and provide any associated CQI manuals or audit tools they plan to utilize.

The CQI program shall monitor and study all major service areas. These major services areas include but are not limited to:

- Behavioral Health Screening during the Intake Processing.
- Psychiatric Medication Services.
- Medication Assisted Treatment (MAT).
- As Needed Behavioral Healthcare Services (e.g., PCO, segregation, sick call, crisis, etc.).
- Routine Behavioral Healthcare Services (e.g., Outpatient, Intensive Outpatient Residential).
- Intra-system Transfers services.
- Re-entry/Discharge Planning Services.

The site level CQI program shall occur quarterly and will be overseen by a multi-disciplinary CQI Committee as outlined in DDOC Policy A-06 Continuous Quality Improvement Program. The primary purpose of the CQI Committee is to identify problems and opportunities for improvement, based upon the collection and assessment of relevant data. The CQI Committee will meet at least quarterly and follow the format outlined in DDOC Policy A-06 Continuous Quality Improvement Program.

The Provider's CQI program shall include such audits, narrative reports, and executive summaries necessary to identify and remedy any quality issues identified in the Provider's operations and consistent with those required by the DDOC. Reports of activity from the quarterly meetings that are distributed at CQI

meetings that affect services provided pursuant to this contract must be submitted to the bureau chief of BHSAMH or designee on a quarterly basis. Any reports provided under contractual obligation will remain confidential unless otherwise authorized by BHSAMH; however, all documents related to offender care and quality improvement activities must always remain available to the DDOC.

All reports, data compilations, and other information submissions required by the contract shall be certified by the Provider's appropriate supervisory employee.

It is expected that the Provider will provide any Quality Assurance Metrics to aid BHSAMH in the monitoring of the healthcare system as stipulated by BHSAMH. The QA Metrics will include clinical, fiscal, operational, and other data to facilitate comprehensive monitoring of the healthcare system. Failure to meet the standards set forth in the QA matrix may result in a contract warning, liquidated damages, and potential termination of the contract with due notice.

VIII. MEDICAL RECORDS

A. **Electronic Health Record (EHR).**
The DDOC currently uses an EHR system called iCHRT. The Provider shall adhere to DDOC Policy A-08 Health Record relative to the EHR. The EHR is the official health record for a patient. Specifically, the Provider shall:

1. Utilize the DDOC's current and any future EHR/ EHR extensions to their full capacity.

2. Maintain up to date medical records within the EHR.

3. Submit help desk tickets in a timely manner for any issues with the EHR.

4. Provide all services related to the EHR in a manner that minimizes disruptions to facility operations.

5. Recognize that healthcare records are, and will remain, the property of the DDOC.

6. Conform to all State rules regarding DDOC ownership of patient's health records.

7. Upon request, provide the state with full and unrestricted access to copies of health records.

8. Provide a Training Facilitator at each facility who will ensure that the Provider's EHR users are adequately trained in the use of the EHR. If the contract for medical and behavioral healthcare is operated by the same Provider, this position may be combined.

9. Ensure that Provider's staff have valid user IDs within the EHR. Provider must inform DDOC of new users within three days of start (usually as part of the New Employee Orientation (NEO) process) as well as user accounts to be

deactivated (must notify the DDOC within three business days of the employee's last day of work).

10. Adhere to DDOC's and the Delaware Department of Technology and Information (DTI) Acceptable Use Policy and may be required to execute Delaware's Data Usage Terms and Conditions Agreement.

11. Maintain sufficient numbers of medical records staff to allow for timely and efficient medical record management and retrieval.

12. Work in close collaboration with the Medical Contractor to ensure completeness of patient records upon request from BHSAMH, patients, attorneys, and other stakeholders and upon release of the patient.

13. All subcontracted employees must document in the EHR where appropriate.

B. **Confidentiality and Completeness of Medical and Mental Health Records and Information.**
In compliance with DDOC policy, the Provider shall:

1. Maintain the privacy and security of all current and former patients' Protected Health Information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA). The Provider may be required to enter into a Business Associate Agreement with DDOC to comply with the requirements of HIPAA.

2. Understand and adhere to the rules regarding the sharing of information with DDOC personnel that includes but may not be limited to that which is necessary for the classification, security, and control of patients.

3. Retain the health records of discharged patients in accordance with federal and state law, and in accordance with applicable state retention policies.

4. Incorporate external healthcare records into the EHR. This includes information obtained from the Delaware Healthcare Information Network (DHIN), records from healthcare providers outside of DDOC and results/reports from diagnostic and therapeutic studies conducted during patients' incarceration.

5. Promptly make all records available to DDOC's legal/defense staff and the Delaware Attorney General's Office as needed and as requested.

6. Promptly make all records available to a patient's legal, fiduciary, or other representative in accordance with a properly completed, and signed, Release of Information (ROI) Form.

7. Respond to DDOC's request for medical information within the timeframes specified in such requests.

C. **Access to Custody and Information.**
The Provider staff may request access to the Delaware Automated Correction System (DACS) information regarding the patient's custody information if it is determined that such information is relevant to the patient's course of treatment and/or programming within the DDOC.

IX. INVOICING PROCEDURES

A. Provider shall submit monthly invoices within five (5) days following the end of each month unless DDOC requests an alternate due date.

B. Invoices shall be submitted to DDOC via email to:
DOC_Medical.BusinessOffice@delaware.gov

C. At a minimum, the Providers invoice shall contain the following information:

- Provider's name and address
- Billing point of contact name, number, and email address
- Invoice date, Invoice number
- Description and period covered
- Invoice calculations (credits, subtractions, or other adjustments)
- Total amount due
- Subcontractor payment status certification

D. Payment(s) will be made within 30 days after presentation of invoice(s) submitted with supporting documentation that verifies the completed, acceptable deliverable(s).

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CONTRACTOR : **VitalCore Health Strategies, LLC**
PROGRAM NAME: **Behavioral Health Services**

Appendix 2 - Staffing

Staff Roster

Staff Name	Agency Title	Certification Standards Title	Total Agency Salary			Program Eligible Salary		
			Hrs Per Week	Annual Salary	OEC's	Hrs Per Week	Annual Salary	OEC'S
Administrative Staff								
Contract Administrator/Program Manager	Vice-President of Operations	n/a	40	$197,600.00	$58,884.80	40	$197,600.00	$58,884.80
Statewide Behavioral Health Director	Statewide Behavioral Health Director	LCSW	40	$135,200.00	$40,289.60	40	$135,200.00	$40,289.60
Statewide Director of Substance Use Disorder Programs	Statewide Director of Substance Use Disorder Programs	LCSW, LPC, or LCDP	40	$81,120.00	$24,173.76	40	$81,120.00	$24,173.76
Chief Psychiatrist	Chief Psychiatrist	Licensed Psychiatrist	40	$364,000.00	$108,472.00	40	$364,000.00	$108,472.00
Chief Psychologist	Chief Psychologist	Licensed Psychologist	40	$135,200.00	$40,289.60	40	$135,200.00	$40,289.60
HR Recruiter	HR Recruiter	n/a	40	$83,200.00	$24,793.60	40	$83,200.00	$24,793.60
Substance Use Disorder Treatment Program Trainer	Substance Use Disorder Treatment Program Trainer	CADC or CAADC	40	$72,800.00	$21,694.40	40	$72,800.00	$21,694.40
Statewide Director of Reentry Services	Statewide Director of Reentry Services	na	40	$87,360.00	$26,033.28	40	$87,360.00	$26,033.28
Statewide SOTP Director	Statewide SOTP Director	LCSW	40	$93,600.00	$27,892.80	40	$93,600.00	$27,892.80
Statewide Director of Quality Assurance	Statewide Director of Quality Assurance	RN	40	$101,920.00	$30,372.16	40	$101,920.00	$30,372.16
Supervisor of Reentry Services	Supervisor of Reentry Services	RN	40	$79,040.00	$23,353.92	40	$79,040.00	$23,353.92
Reentry Administrative Assistan	Reentry Administrative Assistan	n/a	40	$45,760.00	$13,636.48	40	$45,760.00	$13,636.48
Statewide Director of Aftercare Services	Statewide Director of Aftercare Services	LCSW, LPC, or LCDP	40	$72,800.00	$21,694.40	40	$72,800.00	$21,694.40
Aftercare Counselor	Aftercare Counselor	CADC or CAADC	40	$62,400.00	$18,595.20	40	$62,400.00	$18,595.20
Administrative Assistant	Administrative Assistant	n/a	40	$56,160.00	$16,735.68	40	$56,160.00	$16,735.68
Site Mental Health Director	Site Mental Health Director	LCSW or LPC	160	$482,560.00	$143,802.88	160	$482,560.00	$143,802.88
Site SUD Program Director	Site SUD Program Director	LCSW, LPC, or LCDP	220	$423,280.00	$126,137.44	220	$423,280.00	$126,137.44

Site Mental Health Clinical Supervisor	Site Mental Health Clinical Supervisor	LCSW	440	$1,006,720.00	$300,002.56	440	$1,006,720.00	$300,002.56
Site SUD Program Clinical Supervisor	Site SUD Program Clinical Supervisor	LCSW, LPC, or LCDP	320	$582,400.00	$173,555.52	320	$582,400.00	$173,555.52
Administrative Assistant	Administrative Assistant	n/a	284	$324,896.00	$96,819.01	284	$324,896.00	$96,819.01
Total Administrative Staff			2,024	$4,488,016.00	$1,337,229.09	2024.00	$4,488,016.00	$1,337,229.09
					FTE's	50.60		

Program Staff	**Agency Title**	**Certification Standards Title**						
Reentry Specialist (minimum of eight (8) required)	Reentry Specialist (minimum of eight (8) required)	n/a	320	$599,040.00	$178,513.92	320	$599,040.00	$178,513.92
Psychiatrist	Psychiatrist	Licensed Psychiatrist	54	$505,440.00	$135,710.64	54	$505,440.00	$135,710.64
Nurse Practitioner	Nurse Practitioner	Psych APRN or APRN	176	$823,680.00	$221.158.08	176	$823,680.00	$221.158.08
Psychologist	Psychologist	Master's or Licensed	160	$532,480.00	$142,970.88	160	$532,480.00	$142,970.88
Psychiatric RN	Psychiatric RN	RN	48	$112,320.00	$30,157.92	48	$112,320.00	$30,157.92
SOTP Clinician	SOTP Clinician	LCSW preferred	620	$1,321,840.00	$377,985.40	620	$1,321,840.00	$377,985.40
MH Clinician	MH Clinician	LCSW preferred	1,480	$3,155,360.00	$889,920.72	1,480	$3,155,360.00	$889,920.72
SUD Counselor	SUD Counselor	CADC or CAADC	1,648	$2,399,488.00	$691,877.68	1,648	$2,399,488.00	$691,877.68
Peer Support Staff	Peer Support Staff	n/a	400	$416,000.00	$82,243.20	400	$416,000.00	$82,243.20
Reentry Specialists	Reentry Specialists	Bachelor's Mental Health	480	$873,600.00	$239,470.40	480	$873,600.00	$239,470.40
SUD Assessment Specialist	SUD Assessment Specialist	CADC or CAADC	240	$274,560.00	$49,420.80	240	$274,560.00	$49,420.80
Group Intervention Specialist	Group Intervention Specialist	LCSW preferred	40	$74,800.00	$20,105.28	40	$74,800.00	$20,105.28
BH Activity Technicians	BH Activity Technicians	n/a	360	$524,160.00	$154,481.60	360	$524,160.00	$154,481.60
Psychiatric Technicians (PCO Observation)	Psychiatric Technicians (PCO Observation)	n/a	2,312	$2,284,256.00	$695,790.68	2,312	$2,284,256.00	$695,790.68
Employee 15								
Employee 16								
Employee 17								
Employee 18								
Employee 19								
TOTAL Program Staff			8,338	$13,897,024.00	$3,688,649.12	8338.00	$13,897,024.00	$3,688,649.12
					FTE's	208.45		
TOTAL Staff			**10,362**	**$18,385,040.00**	**FTE's**	**259.05**	**$18,385,040.00**	