APPENDIX 1: TABLE 1 - S.3 ACT 57 INVENTORY AND EVALUATION OF DOC AND DMH MENTAL HEALTH SERVICES

Service Type	**DOC Mental Health Service Provision – In State Contract** **To include:** ***Frequency*** ***Timeliness*** ***Male/Female*** **All of the information in this column pertains all VT facilities whether or not they are designated "male" or female" and the DOC ensures that social and racial equity issues were considered, including issues related to transgender and gender nonconforming persons.**	**DOC Mental Health Service Provision - Out of State (OOS) Contract** **To include:** ***Frequency*** ***Timeliness*** ***Male/Female*** **All of the information in this column pertains to the one Out of State contract in Mississippi which houses incarcerated individuals who identify as male and the DOC ensures that social and racial equity issues were considered, including issues related to transgender and gender nonconforming persons.**	**DMH per Master Service Agreements with DA's** **To include:** **Frequency** **Timeliness** ***Male/Female*** **DMH ensures that social and racial equity issues were considered, including issues related to transgender and gender nonconforming persons.**	**Comments:** ***DOC*** **DMH**
General Requirements	1. The Contractor shall act in good faith and comply with the Contract's terms, State and federal laws and professional standards. 2. The Contractor shall comply with: a) All state and federal law. b) The Prison Rape Elimination Act of 2003 (PREA), 42 U.S.C. §§15601–15609 and PREA Standards, 28 C.F.R. Part 115. c) The Americans with Disabilities Act (ADA), 42 U.S.C. §§12101–12213. d) All Vermont Department of Corrections' policies, directives, rules, interim memos, Memorandums of Understanding (MOUs), guidance documents, local procedures,	Except as otherwise provide herein, Contractor shall house the VTDOC ("State") inmates at Contractor's Tallahatchie County Correctional Facility ("Facility") located in Tutwiler, MS. Contractor shall house all State general population inmates together and Contractor shall keep all State general population inmates housed separate from other populations and jurisdictions to include recreation areas. State inmates may commingle with other populations and jurisdictions in programs or other common areas of the Facility.	DMH is responsible for the direction of publicly funded mental health services, the custody and care of individuals who require involuntary treatment, and the oversight of DA/SSA community mental health programs. The Agency of Human Services (AHS) as Vermont's Medicaid Single State Agency, stipulates that DMH administer Medicaid and other state and federal mental health programs, develop policies that assist Vermonters in accessing care and support health and wellness. DMH is authorized in Statute and charged with "planning a comprehensive mental health	***DOC contract requirements align and reference all pertinent state and federal law; stipulation; APA Rule and National Commission on Correctional Health Care standards (NCCHC). The American Medical Association (AMA) started the NCCHC because they recognized the need for correctional health standards. VT DOC has been NCCHC accredited for over the past 6 + years and accreditation maintenance are a contract requirement for both in state and out of state (Mississippi) contractors.***

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	intergovernmental agreements, and stipulated agreements. e) NCCHC Standards for Health Services in Prisons. 3. The Contractor shall: a) Be accountable to, and report to, the State through the Health Services Division (HSD) Health Services Director and designees. b) Provide health care services to maintain and/or acquire NCCHC accreditation at all Vermont correctional facilities. c) Employ QHCPs sufficient in type, number, location, and skills to meet all clinical, administrative, and performance-based requirements of this Contract. d) Maintain a provider network sufficient in size, location, and scope to meet all clinical requirements outlined in this Contract.	At the time of the signing of this Contract, Contractor shall certify in writing that the Facility is accredited by the American Correctional Association (ACA) and Contractor shall maintain such accreditation throughout the term of this Contract. Contractor shall obtain and/or be actively working towards NCCHC accreditation within one year of signing this Contract for the Facility and shall maintain accreditation, once obtained, throughout the term of this Contract. Contractor shall maintain staffing levels at the Facility in accordance with ACA standards and in sufficient numbers and rank to maintain the safety of the public, staff and inmates. The State shall be notified whenever the Contractor revises the staffing guidelines in inmate housing units holding State inmates during the term of the Contract. Contractor shall provide necessary care and treatment, to include food, clothing, appropriate housing, education, training, work programs, access to courts/Law Library and comprehensive healthcare services (routine, acute, chronic and emergency medical care	program."1 The law requires the Department to "… centralize and more efficiently establish the general policy and execute the programs and services of the State concerning mental health, and integrate and coordinate those programs and services … so as to provide a flexible comprehensive service to all citizens of the State in mental health and related problems."2 Finally, the law describes that "[t]he Department of Mental Health shall be responsible for coordinating efforts of all agencies and services, government and 1 18 V.S.A. § 7204 2 18 V.S.A. § 7201 12 | P a g e 12 | P a g e Updated: Jan 14, 2021 private, on a statewide basis in order to promote and improve the mental health of individuals through outreach, education, and other activities."3 Through a Medicaid Section 1115 Demonstration known as the Global Commitment to Health (GC), DMH oversight and operations are guided by Medicaid regulations for Managed Care (42 CFR §438). Under the Special Terms and Conditions (STCs) of the Demonstration and Medicaid Managed Care regulations, the State is allowed enhanced flexibility to serve Vermonters.	

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		consistent with the requirements of ACA standards, NCCHC standards, and constitutionally appropriate guidelines). The Contractor shall provide safe, supervised confinement in the form of direct supervision, and maintain proper discipline and control. The Contractor shall comply with applicable orders of the courts in the State of Vermont and otherwise comply with applicable laws. Contractor shall provide for inmate rights in accordance with ACA Fourth Edition Standards. The Contractor shall provide to each inmate upon arrival an Inmate Handbook (orientation guide) that includes, but is not limited to, information on rules and procedures, penalties and offenses, disciplinary procedures, access to courts, law library, attorney access, mail, visiting, telephone, grievances, PREA information, indigent criteria, medical care, religious programs, educational programs, work assignments and pay scale. This Inmate Handbook shall be updated annually, and a copy provided to the State.	Examples of this flexibility include use of alternative payment models; payment for healthcare and related services not traditionally reimbursable through Medicaid (e.g., pediatric psychiatry consultation) and investments in programmatic innovations (e.g., the Vermont Blueprint for Health). Vermont's GC Demonstration encourages inter-departmental collaboration and consistency across AHS programs. Under the authority of the GC Demonstration, DMH contracts for services on behalf of Medicaid beneficiaries and authorized GC Demonstration populations. Federal participation in the DMH program is achieved through a "Per Member, Per Month" capitation arrangement from the Department of Vermont Health Access (DVHA) to DMH. DMH, in turn, makes payments to DAs and SSAs. DMH provides additional State and federal funding (non-Medicaid) for services and MH program participants not eligible for coverage under the GC Demonstration.	

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		It is also important to note that the DOC uses a Mobility Code procedure to determine Out of State eligibility/ ineligibility. Any incarcerated individual who is designated as either M3 or M4 is not eligible for being sent out of state. M3 - Restrictions on Mobility This category includes patients who must have a notation in the "Medical Comments" section of OMS briefly describing the reason for M3 designation. PRIOR TO MOVEMENT, CONSULTATION SHALL OCCUR WITH A MEDICAL OR MENTAL HEALTH PROVIDER AND RECEIVING FACILITY SECURITY PERSONNEL AS NECESSARY. This category is used for patients who are: a. Under detox observation/ protocol. b. On methadone or scheduled for assessment or induction. c. Awaiting scheduled outside appointments. d. Pregnant. e. Designated as SFI and/or in a mental health unit.		

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		f. Inmates who are decompensating, suicidal and/or in acute mental health distress. g. 15-minute suicide precautions. h. In need of a one-level facility. i. Receiving an ADA accommodation. The accommodation shall be reviewed by the receiving facility (Superintendent or designated authority) to verify that the facility has the capacity to provide the accommodation. j. Using a mobility device (wheelchair, cane, crutches, walker) – the note shall indicate the device. <u>M4 – Limited Mobility</u> Patients in this category must have a notation in the "Medical Comments" section of OMS briefly describing the reason for M4 designation. Patients in this category are mobile ONLY to Infirmaries, Hospitals, Mental Health Units WITH MEDICAL OR MENTAL HEALTH APPROVAL. In cases where males are lodged at CRCF and classified as M4, the presumption is they will be transported to a male facility unless special situations dictate otherwise. In cases where		

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		females are lodged at a male facility and classified as M4, the presumption is they will be transported to CRCF unless special situations dictate otherwise. This category includes the following patients: a. Those with acute medical or mental health changes requiring constant observation. b. Patients in the infirmary or other special medical housing. c. Patients on dialysis. d. In a smock. h. Designated as a "Delayed Placement Person" (DPP).		
Facility Staffing, Mental Health	1. The Contractor shall provide 24/7 coverage of each facility by one or more Qualified Mental Health Professionals (QMHPs), with coverage of the first and second shifts provided on-site. 2. The Contractor shall provide on-call coverage at all other times. The on-call QMHP shall either (a) report to the facility in person within one hour, or (b) report immediately via telehealth, as approved by the DOC, when: a) A patient is placed in restraints. b) A patient is placed in a suicide smock.	Contractor shall maintain staffing levels at the Facility in accordance with ACA standards and in sufficient numbers and rank to maintain the safety of the public, staff and inmates. The State shall be notified whenever the Contractor revises the staffing guidelines in inmate housing units holding State inmates during the term of the Contract.	Providers eligible to receive child and/or adult mental health case rate payments are limited to DMH Commissioner-Designated Agencies (DA's) and other DMH Commissioner-designated entities such as 30 http://www.vtmedicaid.com/assets/manuals/VTMedicaidProviderManual.pdf 31 See exception for individuals receiving services through CRT at or above 185% of FPL at section 2.3 57 | P a g e 57 | P a g e Updated: Jan 14, 2021 Specialized Services Agencies (SSA's) that are established for the purpose of providing community based mental health care and are	***QMHP is a VT statutory designation. DMH provides both the training and the certification.*** DMH-QMHP_Manual_2006.pdf (vermont.gov). ***VT DOC maintains the same standards as in the community.*** ***VT DOC contracts for this staffing pattern to support immediate responses to emergent and urgent Mental health issues in order to both meet the community standards and not overburden community***

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	c) A patient with an SMI or SFI is placed in segregation or similar restricted environment. d) At the request of DOC.		Medicaid-enrolled providers. In order for a Commissioner-designated agency, specialized services agency, or entity to be eligible for participation under the Medicaid State Plan, it must agree to comply with appropriate federal regulations and to perform and bill for services, maintain records, and adhere to the supervision, regulations, standards, procedures, and this manual's requirements as set by the Commissioner of the Department of Mental Health.	***resources. A QMHP is the person who is certified to screen for the need for Emergency Evaluations.*** ***The least restrictive housing with persons designated SFI*** Vermont Laws ***is DOC Policy and also community standard.*** Vermont Laws ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.*** **DOC MH service appears to meet the standard of care in the community.**
Specialized Training for Mental Health Staff	The Contractor shall, at a minimum, provide training requirements for mental health staff that include: 1. In-depth orientation to familiarize the employee with the mental health services delivery system (see Appendix 2 – Mental Health and Co-occurring Workflow). 2. Continuing education to maintain employees' current licensure, accreditation, and clinical knowledge. 3. Best practices with regard to providing mental health care to	Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.	Initial clinical assessments must be completed by staff who meet one of the following qualifications • licensed physician certified in psychiatry by the American Board of Medical Specialties directly affiliated with the Designated Agency/Specialized Services Agency • licensed psychiatric nurse practitioner directly affiliated with the Designated Agency/Specialized Services Agency • for non-licensed Psychiatric Nurse Practitioners refer to	***DOC Mental Health Workflow frames the evidence-based practices and tools to be used in screening and assessing of incarcerated individuals. The Mental Health Workflow has been updated since the contract was signed as the contract permits.*** ***The contract requirements align with Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based practices (EBP) recommendations for***

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	patients including, but not limited to, motivational interviewing, cognitive behavioral therapy, risk-need responsivity (RNR) concepts, a SMART (Specific, Measurable, Attainable, Results oriented, and Timely) model for the development of Individualized Treatment Plans, and the standards for clinical documentation. 4. A process to become designated as a "Qualified Mental Health Professional" by the Commissioner of DMH. 5. Use of the Foundations of Clinical Supervision Model, utilizing Professional Development Plans (PDPs). 6. Training in any other evidence-based intervention as defined by the Health Services Director or designee.		Section 3.6 – Supervised Billing for Behavioral Health Services in the Vermont Medicaid General Billing and Forms Manual, located at http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.pdf; • a staff member of the Designated Agency/Specialized Services Agency who holds one of the following credentials: • Licensed Psychologist • Licensed Marriage and Family Therapist • Licensed Clinical Mental Health Counselor • Licensed Independent Clinical Social Worker • Licensed Alcohol and Drug Counselor • For Master's level, or BA level intern providing clinical services through a formal internship as part of a clinical Master's level program, non-licensed, rostered clinical staff, Supervised Billing rules apply– Supervised Billing for Behavioral Health Services in the Vermont Medicaid General Billing and Forms Manual, located at http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.pdf • any subcontractor must meet both of the following requirements	***Criminal Justice population when there is a recommendation and if not-aligns with SAMHSA community best practice standards.*** ***RNR is specific at this time to DOC approach and through JRI II recommendations and initiatives, community providers are being exposed to criminal justice (CJ) system needs to enhance CJ capabilities and capacities.*** ***QMHP is discussed above-meets community standard.*** ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.*** ***Staff providing MH services may only provide services that are within their scope of licensure or Certification.*** **DOC MH service appears to meet the standard of care in the community.**

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			• meet staff qualifications described above; and, • be authorized by the Designated Agency's/ Specialized Services Agency's Medical Director as competent to provide the service based on their education, training, or experience.	
Professional Development	1. Contractor shall ensure that all health care professionals will participate in annual continuing education appropriate for their positions. 2. For mental health staff, professional development should be guided by Professional Development Plans (PDPs). PDPs should be developed for each mental health professional at a minimum of once every six (6) months. Contractor shall train supervising mental health staff in the development and use of PDPs and shall utilize the Foundations of Clinical Supervision Model.	Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.	Designated Mental Health Agencies require staff to follow the qualifications needed per service. Those qualifications will be required to follow the licensing qualifications through Office of Public Regulations. The Mental Health Agency shall ensure that all health care professionals will participate in annual continuing education appropriate for their positions. The Designated Mental Health Agency will provide annual performance reviews as part of their performance improvement.	***These expectations represent Professional Development best practices and are commensurate with Community standards.*** ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.*** ***All staff including MH staff must adhere to the certification and licensure standards set by the regulating body- for example: VT Office of Professional Regulation or VT Medical Board*** **DOC MH service appears to meet the standard of care in the community.**
Psychiatric Services	1. The Contractor shall provide a range of evidence-based, trauma-informed, culturally sensitive, and	4.23.4 Emergency Services	Emergency Care and Assessment Services (Emergency Services, ES) are time-limited, intensive	***DOC requirements align with SAMHSA EBP and medical necessity.***

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	age- and gender-specific psychiatric services. Under the supervision of the Psychiatric Coordinator, the Contractor shall: a) Participate in emergency medication administration processes. b) Consult with a psychiatrist as required. c) Establish a process to obtain informed consent, review diagnosis, and discuss treatment options with the patient. d) Coordinate with DOC to create a system of supervision for psychiatric services providers. e) Provide for the prescription and management of medications in accordance with evidence-based standards and general best practices for correctional settings. Medication management shall include but not be limited to: i. Meeting with patients to assess their medication needs. ii. Scheduling patients for follow-up with psychiatric providers at clinically indicated intervals to monitor progress. iii. Obtaining release of information forms (ROIs) to consult with collateral sources. iv. Offering patients' education regarding the risks of non-compliance or the discontinuation of medications.	Contractor shall provide an immediate response to inmates with emergency health care needs. Contractor shall have twenty-four (24) hour physician coverage or telephone on- call coverage. Contractor shall have specific written policies and procedures to address emergency response and the emergency transfer of inmates. Contractor shall completely and accurately document all emergency responses in the inmate's medical record. Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply. NCCHC standards include provision of Psychiatric services.	supports intended to resolve or stabilize the immediate crisis through direct treatment, support services to significant others, or arrangement of other more appropriate resources13. Services may be initiated by, or on behalf of, a person experiencing an acute mental health crisis as evidenced by • a sudden change in behavior with negative consequences for well-being • a loss of effective coping mechanisms • presenting danger to self or others. The following Emergency Services shall be provided: CRISIS RESPONSE: A Designated Agency shall provide mental health crisis screening and assessment services to residents of any age in their catchment area who are in acute mental or emotional distress and need crisis support or stabilization. Services may also include in-office and outreach visits, emergency placement services, and resource information and referral.	***Emergency medication is within the scope of licensed medical professionals. DOC and DMH collaborated and drafted Policies and Procedures that are commensurate with community standard for the Correctional setting.*** ***Serious Functional Impairment designation (SFI) is unique to DOC facility population and is coded in statute*** Vermont Laws***.*** ***Administration and management of medication is in accordance with*** Vermont Laws Vermont Laws ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.*** **DOC MH service appears to meet the standard of care in the community.**

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	v. The timely completion of all documentation related to psychiatric services in the patients EHR. f) Review diagnostic assessments using Structured Clinical Interview for DSM-V (SCID5) or other tool specified by the Mental Health and Substance Abuse Systems Director or designee to aid in the assessment and diagnosis of mental illness. The SCID-5 shall be configured in the EHR. g) Establish process of clinical review to ensure the appropriate differential diagnosis and level of care. 2. The Contractor shall: a) Participate in planning and providing for the needs of patients with symptoms of acute mental health deterioration.			
	b) Participate in the identification and treatment of patients who are designated as having a serious functional impairment (SFI) or those with serious mental illness. c) Assure that all patients have provided informed consent for their treatment. d) Assure that individualized treatment plans incorporate interventions targeting at specific needs identified in assessment.			

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	e) Assure that interventions are evidenced based and delivered to the modality and intensity indicated in the assessment. f) Timely complete all documentation related to services (Refer to the Appendix 2 – Mental Health Workflow). g) Develop staff training for mental health providers and DOC staff as requested. h) Coordinate with DOC to create a system of supervision for mental health providers, including supervision for certification and licensure. i) Provide individual and group treatment at each facility. j) Collaborate in development of transitional support and/or continuing care plans. k) Provide for the treatment and needs of patients in segregation. l) Collaborate in developing support plans or discharge plans as required for the provision of services to patients. m) Collaborate with, and require that all psychiatric providers collaborate with, mental health professionals and DOC staff in the development of all plans for patient care, including safety plans, individualized treatment plans, discharge plans, and facility-			

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	based behavior management plans.			
Mental Health Services	1. The Contractor shall provide a variety of services and levels of mental health and cooccurring services and care to a patient with a mental condition, psychiatric disability or disorder, or SFI, up to but not including hospital level of care, consistent with the patient's treatment plan. 2. The Contractor shall use a level of care/placement criteria approved by the State, such as the LOCUS, when determining the appropriate level of mental health care. These services shall include, as appropriate, the following: a) Follow-up evaluations. b) 24/7 crisis intervention. c) Crisis beds. d) Residential care within a correctional institution, assisting in determining the size and location of designated units. e) Clinical services provided within the general population of the correctional facility f) Services provided in designated special units. g) other services that the DOC, the Vermont Department of Disabilities, Aging, and Independent Living, the Department of Vermont Health Access (DVHA), and the DMH	The contractor is NCCHC certified and as such adheres to the standards of care including the provision of mental health services. Additionally, current contract sections include: 4.12.3 Treatment: Contractor shall provide the following substance abuse treatment programs: 4.12.3.1 Substance Abuse 4.12.3.2 Alcoholics Anonymous 4.12.3.3 Narcotics Anonymous 4.12.3.4 Re-entry Program (Go Further Process) 4.19 NOTIFICATION OF INCIDENTS AND EMERGENCIES 4.19.1 Contractor shall notify State of the following events within one (1) hour, to include outside of normal business hours. 4.19.1.1 Death of a State inmate 4.19.1.2 Illness/medical condition (life threatening or high lethality)	The Designated agencies shall provide a variety of services. 1. The purpose of Community Rehabilitation and Treatment (CRT) is to provide comprehensive services, using a multi-disciplinary treatment team approach, for adults with severe mental illnesses. CRT offers a wide range of support options to help people remain integrated in their local communities in social, housing, school and work settings based on their preferences, while building strategies to live more interdependent and satisfying lives. 2. Individual Therapy is specialized, formal interaction between a mental health professional and a client in which a therapeutic relationship is established to help resolve symptoms, increase function, and facilitate emotional and psychological amelioration of a mental disorder, psychosocial stress, relationship problem/s, and difficulties in coping in the social environment. Individual therapy may be face-to-face or through Telemedicine.	***DOC requirements are commensurate with Community standards, and some are also unique to DOC. DOC, unlike some DA's provides all levels of care for mental health (MH) and substance use disorders (SUD) up to hospital level of care. Treatment is voluntary. Treatment becomes involuntary when a person meets statutory definition of a "person in need of treatment" and refuses treatment.*** **A "person in need of treatment" also only** ***pertains to those with a primary mental health diagnosis –behaviors for hospital level of care are not determined to be the result of SUD only.*** Vermont Laws ***Progressively higher levels of care up to hospital level of care, if an incarcerated individual wanted, could be obtained by participating in individual, groups, support groups, healthy activities of daily life, and technology***

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	jointly determine to be appropriate. 3. To the extent possible, Contractor shall develop and review mental health services collaboratively with the patient. The patient must give informed consent to any treatment, and Contractor shall honor a patient's refusal of treatment. Exceptions to this shall proceed in compliance with prevailing federal, state statute, case law, and state policy. 4. The Contractor shall provide 24/7 access to urgent and emergent on-call and on-site mental health services that include, but are not be limited to: a) Face-to-face encounters with patients. b) Assessments to determine if the patient requires a hospital level of care. c) Discussion of patients with urgent or emergent mental health needs as part of the facility's morning meeting. d) Those necessary to comply with Vermont's Act No. 78 (2017), related MOUs, and deliver care in mental health units which may be developed in DOC in compliance with NCCHC essential standard MH-G-02. See Appendix 3 – Act 78 An Act Relating to Offenders with Mental Illness, Inmate Records,	4.19.1.3 Suicide attempt (life threatening or high lethality) 4.19.1.4 Escape or attempted escape 4.19.1.5 Hostage situation 4.19.1.6 Disturbances involving four (4) or more inmates 4.19.1.7 Lockdown of any State inmate housing units 4.19.2 Contractor shall notify State of any of the following events within twenty-four (24) hours of occurrence: 4.19.2.1 Medical or mental health conditions that require transport to a hospital 4.19.2.2 Placement in the infirmary/medical/mental health observation 4.19.2.3 Assault/attempted with the use of a weapon 4.19.2.4 Evacuation 4.19.2.5 Use of any restraints for more than two (2) hours 4.19.2.6 Use of force in which there is an injury to a state inmate requiring medical treatment	3. Group therapy is an intervention strategy that treats individuals simultaneously for social maladjustment issues or emotional and behavioral disorders by emphasizing interactions and mutuality within a group dynamic. Group therapy shall focus on the individual's adaptive skills involving social interaction to facilitate emotional or psychological change and improved function to alleviate distress. Group therapy also includes multiple families or multiple couple's therapy. 4. Family Therapy is an intervention by a therapist with an individual and/or their family members considered to be a single unit of attention. Typically, the approach focuses on the whole family system of individuals and their interpersonal relationships and communication patterns. This method of treatment seeks to clarify roles and reciprocal obligations and to facilitate more adaptive emotional, psychological and behavioral changes among the family members, and includes couples' therapy. 5. Medication Management and Consultation Services include evaluating the need for	***assisted care (TAC) and medication.*** ***There are also Acute and Residential Mental Health Units for incarcerated individuals who meet criteria and who identify as male or female.*** ***Act 78 ACT078 As Enacted.pdf (vermont.gov) codified and operationalized DOC and DMH collaboration and consultation.*** ***DOC also collaborates with DVHA at the data and evaluation level, individual care level via Vermont Chronic Care Initiative (VCCI).*** Vermont Chronic Care Initiative | Department of Vermont Health Access ***Several DOC DVHA collaborations are memorialized in MOU's.*** ***DOC also collaborates Via MOU with VDH.*** ***The Columbia Suicide Severity Rating Scale (C-SSRS) has been developed for Corrections populations.***

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	and Inmate Services and Appendix 4 – Mental Health Units. e) Documentation of referral activity to inpatient psychiatric facilities, including but not limited to when the patient was initially referred; the outcome of the referral (accepted or denied); if denied, reasons for denial; date of placement; and latency between the initial referral and date of placement. f) Suicide prevention and intervention utilizing the Columbia Suicide Severity Rating Scale or other tool as indicated by the Mental Health and Substance Abuse Systems Director or designee. All patients shall be assessed by a QMHP using the Columbia Suicide Severity Rating Scale within one hour of any self-harming incident. The QMHP shall utilize all historical DOC or Contractor administered CSSRS responses. g) Consultation with local facility leadership regarding potential contraindications to the use of force with patients and recommending alternatives to the use of force. h) Evaluation of patients prior to segregation for potential contraindications to the use of	4.19.2.7 Alleged or known assault by an employee or civilian 4.19.2.8 Alleged or known PREA incident 4.19.2.9 Disturbance involving three (3) or more inmates which is not brought under control within fifteen (15) minutes 4.19.2.10 Property destruction rendering a living unit or support service area unusable 4.19.2.11 Use of chemical agents including hand-held OC units Contractor may make initial notification via phone or e-mail contact. Contractor shall provide State with electronic copies of the Facility's reports within seventy-two (72) hours of the event. 4.21 RECORDS AND REPORTS FROM CONTRACTOR Contractor shall provide the following information and reports to the State. All information and reports shall be uploaded to the Globalscape folder. 4.21.1	medication, prescribing and monitoring medication, and providing medical oversight, support and consultation for an individual's mental health care in coordination with other medical providers. Medication evaluation, management, and consultation services may be done in a group setting with client agreement to participate in this treatment forum. Separate notes must be written for each individual. 6. Service planning and coordination assists individuals and their families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and supports. Services and supports that are planned and coordinated may be formal (provided by the human services system) or informal (available through the strengths and resources of the family or community). Services and supports include discharge planning, advocacy and monitoring the well-being of individuals (and their families) and supporting them to make and assess their own decisions. 7. Community Supports are individualized and goal-oriented services to assist individuals and	***The VT DOC Suicide Prevention Directive was also independently reviewed by the Columbia Lighthouse Project, the developers of the C-SSRS and national suicidology researchers.*** **The Lighthouse Project The Columbia Lighthouse Project** ***The DOC has also completed an internal review of the VT DOC Clinical Suicide Pathways and interventions with an external 3rd party Quality Improvement Reviewer (VPQHC).*** **Vermont Program for Quality in Health Care, Inc. (vpqhc.org)** ***This review included all clinical, and security procedures and all security and clinical training materials.*** ***Treatment an placement of individuals designated as SFI adhere to APA Rule*** Code of Vermont Rules, Sub-Agency 130, Chapter 024 - THE USE OF ADMINISTRATIVE AND DISCIPLINARY SEGREGATION FOR INMATES WITH SERIOUS MENTAL ILLNESS | Code of Vermont Rules | Justia

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	segregation or consideration of less restrictive housing options. i) Patients who are housed in segregation will have a plan to assist them in transitioning from segregation to the general population as well as a plan to remain in general population. The Contractor is required to contribute, participate, and meet plan expectations as determined by the patient's needs. j) Critical incident debriefing for patients, staff DOC staff and/or visitors, as requested or otherwise required. k) QMHPs shall conduct regular mental health rounds, at least three (3) times per week, on all patients confined in segregation to ensure that the patients receive appropriate mental health services and that symptoms are detected and treated in a timely manner. l) Provide that any patient determined to be "a person in need of treatment" pursuant to 18 V.S.A. § 7504 is seen by a QMHP twice daily unless clinically contraindicated while waiting for hospitalization. 5. For patients with Serious Mental Illness (SMI) or Serious Functional Impairment (SFI), the Contractor shall: a) Provide that all	Any time a State inmate is placed in segregation, for any reason, a written report documenting the reason shall be uploaded to the Globalscape folder within twenty-four (24) hours. 4.21.2 Each Monday, a report shall be uploaded to the Globalscape folder, by 1100 hours (EST), that shows the number of State inmates in segregation by name, their admission date into segregation, the reason for their placement, and when they were released from segregation. 4.21.3 Contractor shall provide monthly reports to the State by the 5th of every month detailing information for the month prior. Monthly reports shall include: 4.21.3.1 Food Service - menu for the upcoming month, number of times the menu was changed last month, number of special and medical diets prepared. 4.21.3.2	their families with clearly documented psychosocial needs and diminished function. Services assist the individual to access community supports and develop social skills necessary to improve overall function and promote community connectedness and positive growth. These services may include support in accessing and effectively using community services and activities, advocacy and collateral contacts to build and sustain healthy personal and family relationships, supportive counseling, and assistance in managing and coping with daily living issues. 8. Supported employment services assist individuals with developing, achieving and sustaining work, educational, and career goals. Supported employment emphasizes an individual's strengths, capabilities, and preferences. Services are provided primarily in the community to increase positive relationships with community members and to offer service settings based on a person's preferences. 9. This service consists of group living arrangements owned and/or staffed full-time by employees of a provider agency. These arrangements are designed to	***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.*** **DOC MH service appears to meet the standard of care in the community.**

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	SFI patients have an Individualized Treatment Plan to address their functional impairment. b) Utilize mental health staff to perform self-harm watch and mental health evaluations on patients designated as SFI at least three (3) times per week. c) Utilize QMHPs to conduct periodic re-evaluation as required by law. d) Document all checks and encounters in the patient's EHR, to include, at least: i. The results and clinical impressions of a brief mental status exam. ii. Any observable elements of mental status. iii. Other observations (including those provided by DOC security staff) of patients' recent behavior such as social functioning, personal hygiene, and activities of daily living (ADL). iv. Administration of the Columbia Suicide Severity Rating Scale or another tool as approved by DOC. v. Indications that the patient is decompensating and may require a higher level of care (i.e., inpatient psychiatric hospitalization). vi. The development of an Individual Treatment Plan that is relevant to the patient's condition.	Disciplinaries - a report that reflects the inmate names, rule infractions, date of infraction, hearing date, hearing results, imposed sanctions and any appeals filed. 4.21.3.3 Grievances - a report that reflects the inmate names, the category of the complaint, the resolution, and dates throughout the process; including informal complaints, formal grievances and any appeals filed, narrative of trends or patterns identified through grievance reviews. 4.21.3.4 Urinalysis - name, date, random/cause, results, (positive for). 4.21.3.5 Searches - random and cause. 4.21.3.6 Contraband Log - what it was, where it was found, who found it, when it was found (date and time) and inmates(s) names if applicable. 4.21.3.7 Visitation - numbers of inmates receiving visits and the number of visitors, hours of visiting;	provide individualized, recovery-oriented treatment plan services in either transitional or longer-term residential rehabilitation settings. Group Living arrangements are licensed as residential treatment programs28; and individuals are afforded resident rights and protections before transitioning to more independent living arrangements in accordance with their treatment plan. 10. Facility-based Crisis Stabilization and Support Services provide short term services (hours to a few days) designed to stabilize people in an acute mental health crisis and to move to community-based supports as soon as possible with planned discharge and placement. Services are provided to individuals, their families, or their immediate support system that may be time-limited, but necessary to maintain stability or avert destabilization of an expected psychological, behavioral, or emotional crisis experiencing a mental health crisis as evidenced by: (1) a progressing change in behavior with negative consequences for well-being; (2) declining or loss of usual coping mechanisms; or, (3) increasing risk of danger to self or others. Crisis	

Type of Service	DOC in State	DOC OOS	DMH	Comments *DOC* DMH
	vii. Ensure a QMHP assess all patients with an SFI or SMI for contraindications prior to placement in disciplinary or administrative segregation. viii. Provide alternatives to segregation when contraindications exist. ix. Have a physician review and approve/deny administrative or disciplinary segregation placement based on medical judgment any patient with an SMI or SFI. A physician must review all disciplinary segregation placements regarding a patient with SMI or SFI prior to placement. SMI or SFI patients cannot be placed in disciplinary segregation without the approval of a physician. x. Ensure a QMHP determines if the behavior for which the patient received the disciplinary report proximately results from an SMI or SFI. The QMHP shall inform and recommend options for disposition to the Hearing Officer (DOC staff). xi. Ensure a Facility Psychiatrist or Advance Practice Nurse is available to the Hearing Officer during due process hearings when involving a patient with SMI or SFI. xii. Patients with an SMI or SFI that are housed in segregation shall	including contact and noncontact visits. 4.21.3.8 Religious Services - hours, participants, faith. 4.21.3.9 Recreation - indoor, outdoor, activities, participants. 4.21.3.10 Education - hours, participants, classes. 4.21.3.11 Work - hours, participants, jobs. 4.21.3.12 Law Library access - days and hours available by week, inmate sign in sheets evidencing individual inmate usage, services provided to inmates unable to access the law library (segregation, infirmary, special management units), equipment unavailability or failure (photocopiers, typewriter, terminals). 4.21.3.13 Lawsuits - current lawsuits by State inmates served on the Facility or Corporation. 4.21.3.14 Security Threat Group (STG) identification or validation. 4.21.3.15 Health Services Statistical and Monitoring Reports - including Chronic Illnesses, Mental Health	stabilization services are face-to-face services in an environment other than a person's home.	

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	receive daily visits from QHCPs or QMHPs to assess their status and initiate/refer for any needed changes in the treatment regimen. These assessments shall document physical observations, the patient's affect, any suicidal or self-harming ideation, and health complaints as per CVR 13-130-024. The needs of patients who are experiencing a current, severe psychiatric crisis, including but not limited to acute psychosis and suicidal depression, shall be addressed promptly, consistent with the patient's willingness to accept treatment. Alternative placements, consistent with their security, health and mental health needs, shall be considered.	Caseload Status and Treatment Planning, Off-site Services and others as determined by the VT DOC Health Services Division. 4.21.3.16 Updates on staffing levels at the Facility. Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.		
Services for Incapacitated Persons	Upon admission of the Incapacitated person (INCAP) to a DOC facility, the Contractor shall: a) Provide an initial medical screening, ongoing observation, and medically necessary services to the INCAP. b) If the results of the screening or observation indicate the INCAP has urgent needs which are beyond the capacity of the facility to provide, or is in danger of imminent self-harm, the Contractor shall immediately notify the Shift Supervisor to	N/A	N/A	***The provision of INCAP services is unique to DOC.*** Vermont Laws ***DOC INCAP services fill the community need for a broader statewide community based public inebriate program (PIP) which does not exist at this time.*** ***The Vermont Department of Health/ ADAP oversees the community-based PIP services that do exist, but do not***

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	arrange transportation for emergency medical care. c) Notify, as necessary, the ER that an INCAP will be arriving. d) Provide emergency medical care as necessary until emergency responders arrive and commence providing such care.			***provide the needed capacity statewide.*** ***There are typically over 1,000 annual DOC INCAP admissions. Most commonly, they are lodged at NWSCF and CRCF.***
Medication Assisted Treatment (MAT) Clinical Guidelines.	The Contractor shall follow the processes identified in Appendix 5 – VT DOC MAT	N/A	N/A	***DOC requirements for MAT provision meet the standards meet the standards set by Act 176 Vermont Laws.*** ***This law meets the community-based practice standards developed by the Vermont Department of Health /ADAP, associated VT Rules and DEA regulations.*** ***VT DOC is the largest "Spoke" office based Opioid Treatment provider (OBOT) of Buprenorphine in the state.***
Gender Dysphoria Services	In providing services to patients with gender dysphoria the Contractor shall: 1. Have mental health professionals assess and provide services, as needed, to patients who may have gender dysphoria. 2. Assist the DOC in providing necessary accommodations, including property, to meet the needs of a patient's gender identity.	Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply. Incarcerated individuals' treatment plans are monitored. If medically necessary to return to VT DOC for treatment; then they are returned.	Clinical assessment services evaluate individual and family strengths, needs, existence and severity of disability and functioning across environments. A clinical assessment is a service related to creating an accurate picture of an individual's needs and strengths. It may take a variety of forms and include multiple components, depending on the age and functioning of the	***The DOC requirements provide complete and comprehensive treatment of Gender Dysphoria which is in accordance with VT Medicaid and includes provision of sex reassignment.*** **DOC MH service appears to meet the standard of care in the community.**

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	3. Continue and/or initiate treatment, including but not limited to hormone therapy, as medically indicated and in accordance with law and DOC policy. 4. Provide gender-based care in accordance with the prevailing medical standard.		client, and the program the individual is being considered for. An assessment includes a review of relevant information from other sources, such as the family, health care provider, childcare provider, schools, other State agencies or programs, or others involved with the individual and their family.	
Enhanced Substance Abuse Treatment for Women	The Contractor will provide the following services for women who are currently placed at CRCF: 1. Develop and deliver, in collaboration with the State, evidence-based substance abuse and co-occurring treatment services for all incarcerated women regardless of criminal status. These services shall include early intervention/engagement as well as delivery of multiple group/individual/case management sessions each week. 2. Utilize the intake and mental health workflows as described in this Contract and appendices, in collaboration with the State, to conduct a screening and assessment for substance use and co-occurring disorders. Participate in multi-disciplinary treatment teams as designated by the State to assure a holistic, strength based, and gender responsive intervention approach.	N/A	N/A	***DOC requirements to provide enhanced SUD treatment is unique to DOC.*** ***These services align with BJA Residential Substance Abuse Treatment (RSAT) standards. CRCF, the facility that houses individuals who identify as female, receives (RSAT) grant funding*** FY 2021 Residential Substance Abuse Treatment (RSAT) for State Prisoners Program | Bureau of Justice Assistance (ojp.gov)

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	3. Utilize the DOC's risk assessment information as well as the DSM-5 (or its successors), TCU 5, SCID-5, TCU Opioid Supplemental and/or other State identified and approved tools in the development of enhanced programming at CRCF. 4. Identify, in collaboration with the State, evidence based, cognitive behavioral skill curriculums to be delivered within the facility (e.g., Seeking Safety, Criminal Conduct and Substance Abuse, Moving On, Thinking for a Change, Integrated Change Therapy). 5. Complete substance abuse assessments (TCU 5, SCID-5, TCU Opioid Supplemental) as per SUD and MAT workflow as approved by the State. 6. Conduct urinalysis and/or other proven reliable forms of drug and alcohol testing for program participants, including both periodic and random testing, while they are incarcerated. 7. Prior to release, develop comprehensive discharge plans. The discharge plans will be developed in coordination with community-based treatment resources including transition re-entry services, facility-based caseworkers, and field			

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	supervision. This care coordination at release is to ensure the appropriate level of treatment and continuing care. 8. Develop staffing and services based upon the scheduling needs of the facility, which may include evenings and weekends. 9. Recruit and retain designated credentialed staff of up to three (3) full-time clinical staff, inclusive of a Substance Abuse Treatment Program Manager who shall, at a minimum, possess a master's degree in a relevant field and certification in alcohol and drug abuse counseling. 10. Assure that all participants consent to release of information relevant to their program participation and case planning, to include transition and discharge planning. 11. Identify a supervision structure based on best practices which utilizes the existing administrative and clinical infrastructure at CRCF.			
Emergency Services	1. The Contractor shall: a) Maintain 24/7 on-site or on-call coverage by medical and mental health prescribers. b) Provide 24/7 access to emergency medical, mental health, and dental services. c) Adhere to DOC policies and procedures to address emergency	4.23.4 Emergency Services Contractor shall provide an immediate response to inmates with emergency health care needs. Contractor shall have twenty-four (24) hour physician coverage or telephone on- call	Emergency Care and Assessment Services (Emergency Services, ES) are time-limited, intensive supports intended to resolve or stabilize the immediate crisis through direct treatment, support services to significant others, or arrangement of other more appropriate resources. Services	***DOC requirements align with DMH's provision of QMHP's to provide emergency MH screening for potential involuntary or voluntary Psychiatric hospitalization.*** ***Both in state and out of state contractors are required to be***

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	response and the emergency transfer of patients at each facility. d) Provide emergency medical care necessary to stabilize any DOC staff, contractors, volunteers and visitors for assessment, stabilization, and referral. Any required follow up care will be the responsibility of the non-inmate. e) Provide staff with emergency response training in the following, but not limited to: i. Automated External Defibrillator (AED). ii. Bag valve masks (BVM). iii. Suction devices. iv. Other essential equipment for resuscitation and stabilization of patients pending the arrival of EMS. 2. Provide patients on work release with urgent and emergent medical care, regardless of patient's access to third-party coverage, including but not limited to referrals for necessary follow-up treatment. Care shall be provided at the most appropriate facility (community or DOC) based on the patient's health condition. 3. For patients injured while on work release whose injuries are covered under workers' compensation insurance, coordinate follow-up care with the	coverage. Contractor shall have specific written policies and procedures to address emergency response and the emergency transfer of inmates. Contractor shall completely and accurately document all emergency responses in the inmate's medical record. Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.	may be initiated by, or on behalf of, a person experiencing an acute mental health crisis as evidenced by • a sudden change in behavior with negative consequences for well-being • a loss of effective coping mechanisms • presenting danger to self or others The following Emergency Services shall be provided. CRISIS RESPONSE: A Designated Agency shall provide mental health crisis screening and assessment services to residents of any age in their catchment area who are in acute mental or emotional distress and need crisis support or stabilization. Services may also include in-office and outreach visits, emergency placement services, and resource information and referral. A Designated Agency shall have the capacity to provide 24/7 screening for the following mandated populations: • all potential admissions to involuntary inpatient care, • all individuals enrolled in Community Rehabilitation and Treatment (CRT) programs, • all voluntary youth (under 18 years) who have Medicaid as their primary pay source. All voluntary	***NCCHC accredited and maintain accreditation. NCCHC standards apply.*** ***Work release care is unique to DOC.*** **DOC MH service appears to meet the standard of care in the community.**

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	employer's workers' compensation insurer until 1) the patient's treating physician has released the patient to return to work, or 2) until the patient is discharged from the DOC facility, whichever occurs first. 4. Immediately report all serious or life-threatening injuries or deaths.		youth without Medicaid are approved by their insurance carrier and are not required to be assessed by a DA screener. Inpatient screening, as completed by a screener or reported by a reliable clinician, shall consist of a statement of the presenting problem and its history, a description of the community resources considered, risk assessment and a recommendation for disposition. All required information regarding patients admitted to hospitals for psychiatric treatment shall be communicated to the hospital at the time of admission. Screening for involuntary admissions shall be performed in accordance with the Qualified Mental Health Professional (QMHP) Manual. Crisis screeners must have 24-hour, seven-day a week access to psychiatry consultation by emergency screening staff. In addition to seeing people in the office, clinic and emergency departments, Emergency Services will have the capacity to be mobile and see people in the community. Mobile outreach shall participate actively with law enforcement as necessary. Mobile outreach shall demonstrate and track effective	

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			diversion of avoidable emergency room utilization.	
Informing Patients About Health Care Services	The Contractor shall provide each patient, at the time of initial intake, information on how to access health care services while in the facility, to include at minimum the following: 1. How to access routine health care services through the healthcare request (Sick Slip) process. 2. How to access health care services while in segregation. 3. How to request an accommodation pursuant to the ADA.	4.23.3 Sick Call Contractor shall provide a sick call system which provides inmates with access to health care services. Contractor's Health care staff shall collect, triage, and respond to all inmate requests daily. The frequency of sick call shall be consistent with NCCHC standards. If the inmate's custody status precludes attendance at sick call, appropriate measures shall be taken to provide access to health care services. Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.	General access standards for DA/SSA services: • The DA/SSA is responsible for making information available to individuals, family members, other service providers, and the general community about the array of services available. • The DA/SSA must offer an easy screening and intake process. • The DA/SSA will triage referrals based on the clinical assessment of acuity and the applicant's service needs. Routine care must be available in a timely manner consistent with the individualized treatment plan. • The DA/SSA should provide timely supports as necessary to manage urgent needs and/or to facilitate engagement as they work toward completing a comprehensive, person-centered clinical assessment. Services provided prior to the completion of the assessment, including support by non-MA level clinicians gathering information and supporting an individual's entrance into care may be documented as an encounter and submitted as a qualifying service. If a full assessment has not been completed, a provisional diagnosis	***DOC requirements align with EBP. Sick slips, including mental health related, must be triaged by a nurse in a face-to-face encounter within 24 hours.*** ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.*** **DOC MH service appears to meet the standard of care in the community.**

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			reporting the signs/symptoms may be used for these services only until the assessment is completed or the time maximum for assessment completion has lapsed, whichever comes first. • Waiting times for scheduled appointments must not exceed one hour. Exceptions to the one-hour standard must be justified and documented in writing if requested by DMH. Emergency Services Access Standards: • Emergency Services shall be available 24 hours a day, 7 days a week, with telephone availability within an average of five minutes. Face-to-face Emergency Services must be available within an average of thirty minutes of identified need. • Emergency Services shall be closely and routinely coordinated with all necessary community emergency resources, including medical and law enforcement support. The Community Mental Health Agency shall provide each client an overview of services that they are eligible for and an informed consent form to acknowledge their services.	
Patient Consent and Right to Refuse	Contractor shall:	4.23 COMPREHENSIVE HEALTHCARE SERVICES	General access standards for DA/SSA services:	***DOC requirements align with EBP/community standard of practice.***

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	1. Obtain a patient's informed consent prior to all examinations, treatments, and procedures. 2. Obtain informed consent from patients before reporting information about prior sexual victimization that did not occur in an institutional setting unless the patient is under the age of eighteen. 3. Respect a patient's right to refuse healthcare services. 4. Provide patients with education on the potential risks of refusing healthcare interventions. Provide the information in a format which is free of language, literacy, vision, hearing, or other barriers to comprehension. 5. Document all patient consent to, and refusal of, treatment in the patient's EHR. 6. Whenever possible or upon request, maintain consent and refusals forms for specific interventions.	Contractor's written policies and procedures shall describe health services, mental health service, and dental services to be provided. At a minimum, these must meet ACA standards, federal, state and local laws and regulations, and the following State policies and procedures. Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.	• The DA/SSA is responsible for making information available to individuals, family members, other service providers, and the general community about the array of services available. • The DA/SSA must offer an easy screening and intake process. • The DA/SSA will triage referrals based on the clinical assessment of acuity and the applicant's service needs. Routine care must be available in a timely manner consistent with the individualized treatment plan. • The DA/SSA should provide timely supports as necessary to manage urgent needs and/or to facilitate engagement as they work toward completing a comprehensive, person-centered clinical assessment. Services provided prior to the completion of the assessment, including support by non-MA level clinicians gathering information and supporting an individual's entrance into care may be documented as an encounter and submitted as a qualifying service Standards: The DA/SSA is responsible for evaluating all referrals for CRT enrollment. Referrals from inpatient, crisis beds, and ED should be considered priority referrals.	***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.*** **DOC MH service appears to meet the standard of care in the community.**

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			Those settings should make the referral to the DA as soon as is feasible during the patient/client stay (discharge planning). Those settings can make urgent requests for CRT eligibility when a patient is receptive to referral and early engagement and discharge from those settings would be delayed without a CRT eligibility determination. Urgent requests for eligibility shall be assessed within two business days. Other eligibility requests should be reviewed within 7 business days, or an alternative date that has been agreed to by the referring party. DAs should evaluate eligibility by having at minimum a master's-level clinician review relevant history, documentation, and have some face-to-face or telehealth contact with the client in order to complete the CRT eligibility form. Comprehensive clinical assessments may further inform this process and ongoing enrollment after initial eligibility has been determined. Non-urgent requests for assessment to determine CRT eligibility shall be completed within 30 days of referral, contingent on the individual's participation. The DA/SSA and its providers and subcontractors are prohibited	

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			from denying access to CRT for qualifying individuals who relocate to their catchment area. CRT enrollees have the right to move within Vermont and the DA/SSA shall make reasonable efforts to assist relocation. Assisting relocation does not require the receiving DA/SSA to provide housing. The receiving DA/SSA is responsible for working with the sending DA/SSA to support an individual's choice and goals, providing reasonable assistance in identifying resources for individuals choosing to relocate to their catchment area. The adult mental health case rate also covers adults of any age who are experiencing emotional or behavioral distress severe enough to disrupt their lives but do not meet coverage criteria for CRT services. The Agency shall address outpatient mental health needs of its communities to the extent that resources allow. To assist in efficient use of services the following shall be prioritized: • individuals admitted to involuntary inpatient care who are not eligible for CRT services, • individuals committed to the care and custody of the Commissioner of Mental Health in either inpatient or outpatient	

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			commitment who are not eligible for CRT services, and • individuals and/or families in or transitioning from other intensive/high priority services funded by AHS including individuals served by the Department of Corrections (DOC), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department for Children and Families (DCF)	
Initial Healthcare Receiving Screening Upon Admission to a Facility	1. The Contractor shall conduct an Initial Healthcare Receiving Screening (screening) **within four (4) hours of admission, unless extenuating circumstances exist,** for each patient admitted to a correctional facility. The screening shall be documented on a standardized Initial Healthcare Receiving Screening Form approved by the Health Services Director. At a minimum, the screening will include: a) Consent (or refusal) for treatment, signed by the patient. b) A release of information (or refusal), signed by the patient. c) An acknowledgement, signed by the patient, that information regarding the ADA has been provided verbally and in writing. d) Review of any current disabilities the patient has and	4.23 COMPREHENSIVE HEALTHCARE SERVICES Contractor's written policies and procedures shall describe health services, mental health service, and dental services to be provided. At a minimum, these must meet ACA standards, federal, state and local laws and regulations, and the following State policies and procedures. 4.23.1 Initial Healthcare Receiving Screening Contractor shall conduct a receiving screening on all newly admitted State inmates within twenty-four (24) hours of the inmate's arrival at the Facility. Contractor shall ensure that this screening is conducted by a qualified healthcare professional who is licensed in the State of	N/A	***DOC requirements are unique to its correctional setting, NCCHC standards and governing statutes. The braided workflows of nursing, medical providers and qualified mental health and psychiatric providers reflects this practice context.*** ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.*** ***DOC Requirements necessitate that a MH assessment (Part A) begins within 7 days of booking. And that the entire clinical assessment be completed within 28 days of booking if***

Type of Service	DOC in State	DOC OOS	DMH	Comments *DOC* DMH
	request or need for accommodations under the ADA. e) Provision of ADA accommodations to meet the immediate needs of the patient. f) Review of past and current health conditions, including but not limited to, allergies, infections, mental health conditions, communicable diseases, gynecological problems, special health (including dietary) requirements, and any hospitalizations. g) Screening and assessment for substance use disorders, including opioid use disorders. h) Opt-out testing for HIV/AIDS in accordance with Appendix 6, "MOU with VDH and DOC for HIV Testing." i) Opt-out testing for Hepatitis C. j) A urine pregnancy test, if applicable. k) A process to verify and track insurance enrollment status through discharge, including enrollment in Medicaid, as appropriate. l) Administration of a Tuberculin skin test and reading of the results within 48-72 hours. m) Verification of currently prescribed medications including buprenorphine, methadone, or other medication prescribed in the	Mississippi and shall include review of healthcare information for each inmate and provision of necessary services, including but not limited to: 4.23.1.1 Current and past medical, mental health, dental, pharmacological, and other problems. 4.23.1.2 A physical evaluation. 4.23.1.3 Observation of: 4.23.1.3.1 Behavior, which includes state of consciousness, mental status (including suicidal ideation), appearance, conduct, tremors and sweating. 4.23.1.3.2 Body deformities and ease of movement. 4.23.1.3.3 Persistent cough or lethargy; and 4.23.1.3.4 Condition of skin, including trauma markings, bruises, lesions, jaundice, rashes, infestations and needle marks or other indications of drug abuse. This should also include a Methicillin Resistant Staphylococcus Aurous (MRSA) check. 4.23.1.4		***clinically indicated and the individual participates. This is Commensurate and even exceeds community standards.*** **DOC MH service appears to meet the standard of care. DMH has no additional input.**

Type of Service	DOC in State	DOC OOS	DMH	Comments *DOC* DMH
	course of medication-assisted treatment. Medications shall be verified by the patient's pharmacy of record, primary care provider, other licensed care provider, the Vermont Prescription Monitoring System or other prescription monitoring or information system. n) Continuance of prescribed medication, or specific explanation of reason if prescribed medication is discontinued. o) Mental health screening to include, but not be limited to, information specified in NCCHC essential standard MH-E-04 and the following: i. Review of any mental health records from prior incarceration episode(s). ii. Determination if the patient had been previously designated as SFI. iii. Current diagnosis, as verified by community records. iv. Patient's report of any current mental health diagnoses. v. Mental Status Exam. vi. Relevant psychosocial history vii. Screening for traumatic brain injury (TBI) utilizing the "HELPS" Brain Injury Screening Tool (or another tool approved by the Health Services Director or designee), with referral to provider or services for patients that screen positive.	History of serious infectious or communicable diseases, and any treatment or symptoms (e.g., chronic cough, lethargy, weakness, weight loss, loss of appetite, fever, night sweats) suggestive of such illness. 4.23.1.5 Mental illness, including history of suicidal ideation. 4.23.1.6 Current and past medications. 4.23.1.7 Dietary requirements. 4.23.1.8 Use of alcohol and other drugs, and any history of associated withdrawal symptoms. 4.23.1.9 Screening and evaluation for other health problems. 4.23.1.10 Education and orientation regarding how to access healthcare services at the Facility, including: 4.23.1.10.1 Procedures for obtaining healthcare services (e.g., submission of "Healthcare Request Forms"). 4.23.1.10.2 Timeframes for sick call responses. 4.23.1.10.3 How various healthcare services are provided, including but not limited to chronic care,		

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	viii. The Columbia Suicide Severity Rating Scale or another tool as approved by the Mental Health and Substance Abuse Systems Director or designee to assist in determining the most appropriate and least restrictive placement for the patient. ix. Administration of the "NIDA Quick Screen," (or other screening tool approved by the Health Services Director or designee). p) Date and time that the screening was completed. q) Title and signature of the QHCP completing the screening. 2. As needed, the Contractor shall initiate referrals for follow-up and evaluation to the appropriate medical, mental health, substance use, or psychiatric provider, or to the emergency room. If any of a patient's responses indicate that referral for mental health or substance use treatment is needed, mental health staff shall conduct a mental health assessment within seven (7) days. See Section 4.6; Mental Health/Substance Use Assessment – Part A; and Appendix 2 – Mental Health Workflow. 3. The Contractor shall initiate routine referrals for medical, mental health or substance use treatment and complete, as	emergency services, pharmaceutical services, and infirmary services. 4.23.1.10.4 The behavior expected of inmates while in the health care services area. 4.23.1.10.5 Grievance procedures. 4.23.1.10.6 Procedure for obtaining copies of protected health information. 4.23.1.10.7 Orientation to the Prison Rape Elimination Act (PREA) to include the Contractor(s) local procedures on how to report sexual abuse or harassment. 4.23.1.10.8 Information regarding how to complete Advance Directive forms which are germane to the State of Mississippi. Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.		

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	appropriate, an Initial Comprehensive Health Assessment or Mental Health/Substance Use Assessment - Part A, within seven (7) days of screening. See Appendix 2 (Mental Health Workflow). 4. Urgent referrals to medical or mental health shall be seen within twenty-four (24) hours of the Initial Healthcare Receiving Screening. 5. Emergent referrals shall be seen immediately.			
Medical, Mental Health/ Substance Use Screening and Assessment for Transferred and Readmitted Patients	1. For patients transferred or readmitted to the facility who received an Initial Healthcare Receiving Screening no more than thirty (30) days immediately prior to their re-entry to the facility, the Contractor shall at a minimum: a) Review the last Initial Healthcare Receiving Screening. b) Review the last initial or comprehensive health assessment. c) Review pertinent laboratory results. d) Inquire whether there have been any significant changes to the patient's health status since the last admission. e) As needed, consult with the on-site or on-call provider to determine if a new Initial Healthcare Receiving Screening or	4.6 PRE-TRANSFER PACKETS At least two (2) weeks prior to the anticipated transfer date, State shall provide Contractor transfer packets electronically using the Globalscape folder. Transfer packets shall include. 4.6.1 Record of adjustment in VTDOC correctional facilities: 4.6.1.1 ID Face Sheet 4.6.1.2 Keep-a-parts (separations) 4.6.1.3 Current sentencing Mittimus, detainers and affidavits 4.6.1.4 Sentence computation 4.6.1.5	N/A	***DOC requirements are unique and are determined by NCCHC.*** ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.*** **DOC MH service appears to meet the standard of care. DMH has no additional input.**

Type of Service	DOC in State	DOC OOS	DMH	Comments *DOC* DMH
	Initial Comprehensive Healthcare Assessment may be necessary. 2. For patients transferred or readmitted to the facility who, within the past ninety (90) days, received a Mental Health/Substance Use Assessment, the QMHP shall at minimum: a) Review the prior assessment. b) Meet with the patient to determine if there have been significant changes or events since the prior assessment. c) Determine if patient's current mental health status requires a new Mental Health/Substance Use Assessment, referrals, or changes in treatment plan. 3. All medical and mental health reviews of transferred and re-admitted patients shall be documented in the patient's EHR and Individualized Treatment Plan updated as required.	Criminal Record Check 4.6.1.6 Drug Testing History 4.6.1.7 Sexual Violence Screening Tool (most recent) 4.6.1.8 Judicial and Administrative Rulings (stipulations/court orders) 4.6.1.9 Misconduct (ten-year disciplinary history) 4.6.1.10 Security Threat Group information 4.6.1.11 Contact notes (back one-year) 4.6.1.12 Current Vermont facility case plan 4.6.1.13 Approved Visitor List 4.6.2 Facility medical & mental health records including but not limited to: 4.6.2.1 Any current medical or mental health/ psychological condition requiring treatment, including suicide attempts. 4.6.2.2		

Type of Service	DOC in State	DOC OOS	DMH	Comments *DOC* DMH
		Any needs for follow-up specialty care for medical or mental health conditions. 4.6.2.3 Any medical admission testing performed and the results of those tests, including hepatitis, HIV/AIDS, hemophilia, multiple sclerosis, pulmonary arterial hypertension, tuberculosis, or other infectious disease testing. 4.6.2.4 Notice of current or previously administered medications. Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.		
Initial Comprehensive Health Assessment	The Contractor shall conduct an Initial Comprehensive Health Assessment of each patient within seven (7) days of the patient's admission to a facility. The assessment shall be documented on a standardized Initial Comprehensive Health Assessment Form approved by the Health Services Director. At a minimum, the assessment shall include: 1. Requests for consent for treatment and releases of information, if not already obtained.	Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.	N/A	***DOC requirements and workflow are unique and determined by NCCHC. But also meet community standard.*** ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.*** **DOC MH service appears to meet the standard of care in the community.**

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	2. Review of the receiving screening results. 3. Collection of additional data, as needed, to complete the medical, dental, and mental health histories. 4. Physical examination, including vital signs, weight and BMI assessment. 5. Screening for need for optical services. 6. RAST testing for allergies, if appropriate. 7. Ordering of laboratory and/or diagnostic tests, as clinically indicated. 8. Opportunity for HIV testing and brief counseling. 9. Immunization history and administration, when appropriate. 10. HELPS screening to determine if the patient has a traumatic brain injury. 11. For female patients, inquiry about: a) date of last pap smear. b) date of mammogram. c) past pregnancies. d) any other gynecological problems. 12. A plan of care and referrals for treatment to address each health concern. 13. Date and time of completion.			

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	14. Signature and title of individual completing the assessment.			
Mental Health/ Substance Use Assessment	1. The Contractor's mental health staff shall conduct a Mental Health/Substance Use Assessment and complete a Mental Health/Substance Use Assessment – Part A, see Appendix 2 (Mental Health Workflow) whenever: a) The patient's responses on any component of the Initial Healthcare Receiving Screening indicate that referral for mental health or substance use treatment is required. Nursing staff will determine whether an emergent, urgent, or routine referral is indicated. b) The patient requests to be seen by mental health via the "sick slip" process. c) DOC Security or DOC's Chief of Mental Health or designee requests it. 2. Mental Health Assessment – Part A shall include but not be limited to: a) Structured Clinical Interview for DSM-V (SCID-5; or its successor or as otherwise specified by the Mental Health and Substance Abuse Systems Director). Using the results of the SCID-5, the clinician will decide whether the patient meets the clinical criteria	Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.	Clinical assessment services evaluate individual and family strengths, needs, existence and severity of disability and functioning across environments. A clinical assessment is a service related to creating an accurate picture of an individual's needs and strengths. It may take a variety of forms and include multiple components, depending on the age and functioning of the client, and the program the individual is being considered for. An assessment includes a review of relevant information from other sources, such as the family, health care provider, childcare provider, schools, other State agencies or programs, or others involved with the individual and their family.	***DOC requirements align with EBP.*** ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.*** **DOC MH service appears to meet the standard of care in the community.**

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	for a mental health and/or substance use disorder consistent with the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). b) Adverse Childhood Experiences (ACE; or as otherwise specified by the Mental Health and Substance Abuse Systems Director or designee). c) Personality Inventory for DSM-5-Brief Form (PID-5-BF) or as otherwise specified by the Mental Health and Substance Abuse Systems Director or designee). d) The Corrections Modified Global Assessment of Functioning (CM-GAF), the results of which will be used to determine if the patient should be considered for SFI designation. e) Review of urine drug screen (UDS) results. f) Administration of the General Ability Measure for Adults (GAMA) (or other tool as specified by the Mental Health and Substance Abuse Systems Director or designee) for patients suspected of having low cognitive functioning. g) A pathway for referring patients to a psychiatric provider if the results of the assessment indicate that the patient may benefit from psycho-pharmacological			

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	treatment. The psychiatric provider shall evaluate the patient within thirty (30) days of the referral. 3. As a result of the completion of the Mental Health/Substance Use Assessment – Part A, the Contractor shall: a) Include all patients with a clinically verifiable diagnosis, for either a mental health condition or substance use disorder or both, and all patients prescribed a psychotropic medication on the Mental Health and Co-occurring Caseload. b) Enter diagnoses into the patient's problem list using DSM-V codes. c) Complete an Individualized Treatment Plan.			
Substance Abuse Screening, Assessment and Treatment	The Contractor shall screen all patients for substance use disorders upon intake using a tool that is approved by the Mental Health and Substance Abuse Systems Director or designee. If a patient screens positive, the Contractor shall conduct the Structured Clinical Interview for DSM-5, and shall refer a patient with a verified substance use disorder to receive the following continuum of services: 1. Development of an Individualized Treatment Plan.	Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.	N/A – services provided through Agency on Alcohol and Drug Program (ADAP)	***DOC requirements align with EBP.*** ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.*** **DOC MH service appears to meet the standard of care in the community**.

Type of Service	DOC in State	DOC OOS	DMH	Comments *DOC* **DMH**
	2. Substance abuse groups or individual treatment program. 3. Provide access to technology-enabled substance abuse treatment, if available. 4. Refer to Peer Recovery and Support Services, if available. 5. Encourage attendance at AA or NA.			
Continuation of Prescription Medication	1. Upon admission to a facility, the Contractor shall continue any patient who is under the medical care of a licensed physician, licensed physician assistant, or licensed advanced practice registered nurse, on a verified prescription medication, pending review and evaluation of the patient's health status and health care needs. The review and evaluation shall be conducted by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse. 2. Notwithstanding the above, the Contractor may discontinue a verified prescription medication that is not medically necessary. The decision to discontinue medication shall be based on the clinical judgment of a licensed physician, licensed physician assistant, or licensed advanced practice registered nurse, who shall document the reasons for	Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.	Medication Management and Consultation Services include evaluating the need for medication, prescribing and monitoring medication, and providing medical oversight, support and consultation for an individual's mental health care in coordination with other medical providers. Medication evaluation, management, and consultation services may be done in a group setting with client agreement to participate in this treatment forum. Separate notes must be written for each individual. There must be a face-to-face or telemedicine interaction that includes evaluation of the individual in terms of symptoms, diagnosis, and pharmacologic history; efficacy and management of the medication being prescribed or continued, and/or the monitoring of the individual's reaction (favorable or unfavorable) to the medication.	DOC requirements align with statute- Act 153 Draft Bill Template (vermont.gov) ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.*** **DOC MH service appears to meet the standard of care in the community.**

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	discontinuation in the patient's medical record. In addition, the Contractor shall provide written and oral explanation of the decision to discontinue to the patient, and an opportunity for the patient to authorize notification of the community-based prescriber.			
Individualized Treatment Plans for Mental Health & Substance Use	The Contractor shall develop Individual Treatment Plans that comply with NCCHC standard MH-G-03 and the following: 1. For the process of SFI designation, the DOC SFI interim memo (Appendix 7) should be followed. Additionally, ongoing SFI assessment, re-assessment and removal should be done according to Appendix 8 – SFI Identification). 2. For patients who have a mental health condition, substance use disorder, or psychiatric disability or disorder as defined by the DSM-V or its successor, develop and maintain Mental Health - Individualized Treatment Plans which are specific, measurable, attainable, realistic, and time-limited (SMART). The Individualized Treatment Plans will include, but not be limited to: a) The members of the multi-disciplinary treatment team, including local ADA coordinators and security staff as needed.	Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.	Person-centered planning is a way to assist individuals needing services and supports to construct and describe what they want and need to help facilitate good treatment and recovery. In mental health programs, a person-centered plan is required for treatment and must meet the requirements described below. The person-centered planning process must • be driven by the individual, and o include people chosen by the individual or family/guardian, o provide necessary information and support to ensure that the individual or family/guardian directs the process to the maximum extent possible, and is enabled to make informed choices and decisions; o be timely and occur at times and locations of convenience to the individual or family/guardian, o for home and community-based settings (HCBS) reflect that the setting in which	DOC requirements align with EBP, NCCHC and VT statute and federal law. ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.*** **DOC MH service appears to meet the standard of care in the community.**

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	b) Current, within the last 30 days, medications. c) Current SCID-5 results. d) Current CM-GAF results. e) Current diagnoses to be addressed. f) Collateral information including information from Community High School of Vermont, past community treatment providers, etc. g) Strengths relevant to the patient's successful completion of treatment goals. h) Problem statements relevant to current diagnosis and corresponding treatment goals. i) The specific goals of treatment. j) The objectives of treatment (what the patient will do to achieve the goals). k) The specific evidenced based interventions that the Behavioral Health Contractor and/or security staff will provide. l) The type, frequency and duration of all interventions. m) Duration of the plan, including the date that progress towards the goals will be reviewed. n) Patients' involvement in the treatment planning process. o) ADA accommodations needed. 3. Perform Utilization Review and update treatment plans every ninety (90) days or as clinically		the individual resides is chosen by the individual or family/guardian; o offer informed choices to the individual or family/guardian regarding the services and supports they receive and from whom, o be finalized and agreed to, with the informed consent of the individual or family/guardian in writing, and signed by all individuals and providers responsible for its implementation; • Be strengths-based, and o include individually identified goals and desired outcomes, or reflect the individual's strengths and preferences. • Be clear and understandable and reflect cultural considerations of the individual or family/guardian and be conducted by providing information in plain language. All services must also be accessible to individuals with disabilities and persons who have limited English proficiency; o be understandable to the individual receiving services and supports, as well as to the individuals important in supporting them (written in plain language and in a manner that is accessible to individuals with disabilities and persons who have limited English proficiency);	CM- GAF is a correctional Functionality scale developed in the Connecticut DOC. Development of an assessment of functioning scale for prison environments - PubMed (nih.gov) A pilot test of the CM-GAF among offenders with mental disorders - PubMed (nih.gov)

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	indicated, but in no event beyond their expiration. As part of this update, the patient shall be re-assessed for diagnostic impression. Review of Individualized Treatment Plans shall: i. Include all members of the multi-disciplinary treatment team, whenever possible. ii. Include a re-evaluation of the patient using the SCID-5 (or as otherwise specified by the Mental Health and Substance Abuse Systems Director) and CM-GAF. Changes from the prior SCID-5 and CM-GAF scores will be documented on the Individualized Treatment Plan. iii. Result in the re-formulation of the Individualized Treatment Plan as previously described in this section. 4. List patient's special needs and DSM-V diagnosis on the master problem list in the EHR and in the OMS, as appropriate. 5. Maintain an ongoing list of special needs patients, which shall be communicated to facility administration and custody staff via the OMS.		• Reflect the options explored, and o for HCBS, record the alternative home- and community-based settings that were considered by the individual, • Be proactive, and o include a method for the individual or family/guardian to request updates to the plan as needed, o reflect needs identified through functional assessments, or reflect the services and supports (both natural and professional) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports; o reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed; o identify the individual and/or entity responsible for monitoring the plan, o be distributed to the individual and other people involved in the implementation of the plan, and prevent the provision of unnecessary or inappropriate services and supports.	
Non-Emergent Care; Request for services	The Contractor shall: 1. Conduct daily, visual rounds to assess the patients' needs for health care services.	Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and	Noted above in general provisions of services.	***DOC requirements are unique and align with EBP and NCCHC.***

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	2. Implement a secure and efficient healthcare request (sick slip) process that enables all patients, including those in segregation, to report their health concerns and request healthcare services. 3. Triage each patient request for services within twenty-four (24) hours of the request. 4. Document the request, including the date and time received, in the patient's EHR via a Sick Slip Order that includes: i. Transcription of the patient's statement from the Healthcare Request Form. ii. Nursing staff triage and determination of priority (Priority 1 = Emergent, Priority 2= Urgent, Priority 3 = Routine). 5. Document sick slip responses in the patient's EHR. 6. Consult with the on-site or on-call provider if the patient's condition at the time of nursing triage or assessment requires emergency care beyond the established nursing protocols. 7. Regardless of whether the patient has requested services, under no circumstances defer or unnecessarily delay the care of any patient requiring urgent or emergent care pending discussion with management or supervisory	maintain accreditation. NCCHC standards apply.		***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.*** **DOC MH service appears to meet the standard of care in the community.**

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	staff. 8. Monitor sick slip responses as part of the CQI process.			
Procedure in the Event of Sexual Assault	In the event of a sexual assault, the Contractor shall: 1. Provide prompt and appropriate trauma-informed medical and psychological treatment services. 2. Refrain from providing services outside of those required to assess the patient for physical injuries that may potentially require immediate medical attention. At no time shall the Contractor provide what could be considered a "forensic" examination. 3. Assist DOC in coordinating transfer of the patient to a local ER where the patient shall be offered an examination by a Sexual Assault Nurse Examiner (SANE) or other QHCP. 4. When evaluating the extent of injuries or the need for outside medical services, avoid taking any actions, whether intentional or accidental, that may remove, dilute, or destroy evidence. 5. Provide medical care, including medication, follow-up treatment or referral, as directed by the SANE or ER provider.	4.3 PRISON RAPE ELIMINATION ACT Contractor shall comply with the Prison Rape Elimination Act (PREA) of 2003 (28 C.F.R. Part 115, Docket No. OAG-131. RIN 1005-Date May 17, 2012) and shall adopt all applicable PREA Standards for preventing, detecting, monitoring, investigating, and eradicating any form of sexual abuse within the Contractor's Facility that houses State inmates. The Contractor acknowledges that, in addition to "self-monitoring requirements", State of Vermont Staff shall conduct announced and/or unannounced, compliance monitoring to include "on-site" monitoring to ensure that Contractor is complying with PREA standards. Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.	N/A	DOC requirements are unique to the setting and align with EBP, federal Prison Rape Elimination law (PREA). Federal PREA audits occur as per the PREA requirements- currently once in every 3-year audit cycle. ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.*** **DOC MH service appears to meet the standard of care.** **DMH has no additional input.**
Use of Tobacco	The Contractor shall, as applicable:	Contractor must be NCCHC accredited within 1 year of	Designated agencies may offer smoking cessation groups.	***DOC requirements align with EBP and are supported with***

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	1. Provide a brief screening on tobacco use during the initial healthcare receiving screening or another health encounter. 2. Provide patients with self-reported use of tobacco products with: a) Information on the health impacts of continued use. b) Group interventions and support programs, written materials, and individual education. c) As part of release planning, information on community resources that can provide support with tobacco use cessation	initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.		***collaborative technical assistance with VT Department of Health.*** ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.*** **DOC MH service appears to meet the standard of care. DMH has no additional input.**
Mental Health Education and Self-Care	1. The Contractor shall provide mental health education and self-care education to patients with mental illness, substance abuse, and co-occurring disorders. Within six (6) months of contract initiation, the Statewide Director of Behavioral Health will create a calendar that describes the patient mental health activities planned for each month of the contract year. Thereafter, the calendar will be provided as an annual report, within fifteen (15) days of the close of the first contract year. Changes to the calendar will be made at the discretion of the Mental Health	Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.	Education, consultation and training services provided to family members, significant others, home providers, foster families and treatment teams to increase knowledge, skills and basic understanding necessary to promote positive change. This can include clinical consultation from a provider with a specific clinical specialty or with a provider from the private sector who has been working with the child or family.	***DOC requirements are unique to the setting and align with EBP.*** ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.*** **DOC MH service appears to meet the standard of care in the community.**

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	and Substance Abuse Systems Director or designee to address specific needs when identified. The calendar and proposed curricula will be reviewed and approved by the Mental Health and Substance Abuse Systems Director or designee prior to implementation. Additionally, the calendar should be coordinated with the facility and other DOC divisions to ensure that any competing activities or requirements that may affect scheduling are taken into account. 2. Programming, education, and interventions may include, but will not be limited to: a) Education on relapse prevention. b) Education on the appropriate and effective use of medications. c) Medication side effects. d) Development of coping skills for the self-management of stress, anxiety, anger, sleep disorders, depression, and thoughts of self-harm/suicidal ideation. e) Individual/group psychoeducation. f) Self-directed Cognitive Behavioral Therapy.			
Continuity of care	1. Continuity of care begins at admission and occurs at all transitions of care, including but not limited to intra-system	4.6 PRE-TRANSFER PACKETS At least two (2) weeks prior to the anticipated transfer date,	N/A	***DOC requirements are EBP and align with community practice standards. But since DOC functions as a "whole***

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	transfers, transfer to community-based facilities, discharges from custody, and re-admission to the DOC. The Contractor shall provide a Statewide Director of Care Coordination and Care Coordinator(s) to supervise the continuity of care practices upon admission, transfer, and discharge from DOC. 2. To facilitate continuity of care, the Contractor shall: a) Oversee the coordination of comprehensive health services as patients transfer between settings. b) Monitor care coordination activities at the facilities. c) Collaborate with DOC staff on care coordination activities. d) Verify and continue patients on medications on intake and on release as appropriate, and as required by law. e) Establish a process for identifying, tracking, notifying and referring individuals with chronic illnesses to appropriate health care services, while in custody and upon release to the community. f) Establish a process for identifying, tracking, notifying and referring individuals with mental health conditions to appropriate mental health care services, while	State shall provide Contractor transfer packets electronically using the Globalscape folder. Transfer packets shall include. 4.6.1 Record of adjustment in VTDOC correctional facilities: 4.6.1.1 ID Face Sheet 4.6.1.2 Keep-a-parts (separations) 4.6.1.3 Current sentencing Mittimus, detainers and affidavits 4.6.1.4 Sentence computation 4.6.1.5 Criminal Record Check 4.6.1.6 Drug Testing History 4.6.1.7 Sexual Violence Screening Tool (most recent) 4.6.1.8 Judicial and Administrative Rulings (stipulations/court orders) 4.6.1.9 Misconduct (ten-year disciplinary history) 4.6.1.10 Security Threat Group information 4.6.1.11 Contact notes (back one-year)		***health medical home," this means that DOC must also ensure that an individual's access to healthcare insurance and other entitlements are activated before release. DOC must also ensure that whole health needs- all continuing care appointments and medications are ordered and scheduled.*** ***These activities are also unique to the DOC setting as they must also be coordinated with Probation and Parole if they are sentenced to community supervision.*** ***Additionally, as of 7.2021, DOC refers individuals who, elect to participate and who meet criteria, to DVHA Vermont Chronic Care Initiative (VCCI) for Clinical case management services.*** Vermont Chronic Care Initiative | Department of Vermont Health Access ***Both in state and out of state contractors are required to be NCCHC accredited and***

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	in custody and upon release to the community. g) Collect and analyze data on care coordination activities for the purposes of CQI. h) Develop and implement processes (utilizing the EHR to the extent possible) to standardize and improve care coordination and continuity of care to community-based entities. i) Standardize processes so patients are initiated on MAT as required by law. j) Coordinate discharge plans for patients as requested by the DOC. 3. For patients with acute and/or chronic health conditions, the Contractor shall: a) Develop a comprehensive, multi-disciplinary treatment plan for the management and improvement of the patient's condition(s), in compliance with the security and safety requirements of the facility. b) Enroll patients in chronic care clinic. c) Obtain and review all relevant community-based treatment plans, especially those for individuals designated as SFI, and determine if the plan should be continued or modified in some manner during the patient's incarceration.	4.6.1.12 Current Vermont facility case plan 4.6.1.13 Approved Visitor List 4.6.2 Facility medical & mental health records including but not limited to: 4.6.2.1 Any current medical or mental health/ psychological condition requiring treatment, including suicide attempts. 4.6.2.2 Any needs for follow-up specialty care for medical or mental health conditions. 4.6.2.3 Any medical admission testing performed and the results of those tests, including hepatitis, HIV/AIDS, hemophilia, multiple sclerosis, pulmonary arterial hypertension, tuberculosis, or other infectious disease testing. 4.6.2.4 Notice of current or previously administered medications. 4.7.2.4 Both State and Contractor shall provide basic medical and mental health documentation to the transporting officers for continuity of care. This		***maintain accreditation. NCCHC standards apply.*** **DOC MH service appears to meet the standard of care in the community.**

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	d) Obtain a signed release that allows relevant information from any community-based organizations that provided treatment to the patient prior to admission to DOC to be obtained. e) Notify medical, mental health, psychiatric providers, nurses, and appropriate individuals at the DOC (e.g., Director of Nursing, Chief of Mental Health) when patients are sent to or returned to the facility following an emergency room encounter or inpatient hospital stay. f) Provide a timely follow-up encounter upon the patient's return to the facility from receiving off-site services. g) Transmit follow-up orders to the appropriate provider who shall review and approve or modify the orders, as required. h) Document that a review of all discharge orders from off-site providers was completed. i) Coordinate intra-system transfers, sharing all relevant information between the sending and receiving facilities regarding the patient's acute or chronic health conditions. j) Enter appropriate alerts or special needs into the OMS and the EHR.	information is in addition to the transfer of medical records. The basic information shall include. 4.7.2.4.1 Current problems list (medical and mental health) 4.7.2.4.2 Current chronic illness clinic (CIC) 4.7.2.4.3 Current medication administration record (MAR) The sending facility shall provide the transporting officers with seven (7) days' worth of medications. 4.7.2.5 Not more than seven (7) days prior to the transport, Contractor shall provide State with a Transportation Operations Plan for every transport conducted. The plan shall include, but not limited to, travel dates, assigned transport personnel, routes, inmate names, destinations, applicable security equipment, planned rest stops, emergency restroom protocols, meals, medication storage and delivery in route. The use of black security wrist restraint boxes shall be limited		

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	k) Schedule the patient to be seen by a psychiatric or other provider within seventy-two (72) hours or another timeframe as deemed appropriate by the QHCP. l) Document all follow-up encounters in the patient's EHR with the date, time, and signature/title of the QHCP. m) Provide the DOC Director of Nursing with weekly reports indicating patients with offsite appointments, including when and where the appointment is scheduled, the anticipated length of the appointment, and the reason for the appointment. 4. For patients designated as SFI or SMI, the Contractor shall: a) For patients designated as SFI during a previous incarceration, determine within thirty (30) days if the patient should be re-designated as SFI. For patients previously designated as SFI, there is no predetermination in advance of meeting the criteria whether through administrative review or clinical and functional impairment. b) Coordinate all intake and discharge planning with appropriate agencies, including but not limited to the DMH, Designated Agencies (DAs), Special Service Agencies (SSAs), and DAIL.	unless there is a verifiable security threat. 4.23.6 Hospitalization Contractor shall ensure that all inpatient hospital claims are processed through the Vermont Department of Vermont Health Access (Vermont's Medicaid program), since all State inmates may receive Medicaid benefits for inpatient hospital services, even if those services are provided out of state. The Contractor shall be financially responsible for all inpatient hospital services that are not remitted through Vermont's Medicaid program. Contractor shall ensure that an inmate's medical chart accurately and completely documents services provided by community health care providers. Under no circumstances shall Contractor limit or delay access to inpatient hospitalization for inmates identified as needing this level of care. State, at its discretion, may audit any case to ensure that there is no limit or delay access to inpatient hospitalization for inmates		***DOC release requirements regarding SFI are unique to DOC.*** ***The SFI release process is as follows:*** ***If an individual held an active community-based waiver prior to being incarcerated - then that person would need to be reconnected with the designated agency they were connected to (prior to being incarcerated) and before being released- to reinstate services.*** ***And if they were clinically and functionally designated as SFI by DOC, they would need to be evaluated for CRT or other waivered services (e.g., Choices for care; TBI/DAIL) by the designated agency in the county where they would be releasing to.***

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	c) Cause that QMHPs perform ongoing assessments of the patient's mental health and functional status, and when there is a concern that the patient's condition cannot be treated within the DOC setting, refer the patient for hospital level of care, if appropriate. d) Process all referrals for hospital-level care through the appropriate channels, including but not limited to the processes for Emergency Evaluation or voluntary admissions. See Appendix 3, Act 78 – An Act Relating to Offenders with Mental Illness, Inmate Records, and Inmate Services. 5. Upon notice of a patient's pending release from incarceration (to the community, the Contractor shall: a) Collaborate with DOC staff regarding release planning. b) Coordinate with the Facility Corrections Service Specialist on referrals, appointments, and the exchange of information with community-based organizations of the patient's choice, including but not limited to FQHCs, hubs/spokes, and DAs, with the intent of immediately connecting patients to appropriate health care services upon discharge. The	identified as needing this level of care. Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.		

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	Contractor shall make appointments and share the details with the Facility Corrections Service Specialist. c) Inform the patient of all pending appointments in the community, including the date, time, location, phone number, and name of the provider. d) Refer patients with communicable or other serious medical or mental health conditions to specialized clinics or a patient-centered medical home of the patient's choosing. e) Provide the patient with a list of community health professionals. f) Discuss with the patient the importance of appropriate follow-up and aftercare. g) Verify the patient's enrollment, and if necessary, enroll the patient, onto Medicaid or other health benefit plan. h) Provide patients with a discharge plan or Continuity of Care Document. i) Depending on the status of interface development, share the Continuity of Care Document and other specified information, via the EHR, with the Vermont Health Information Exchange. 6. Discharge Planning & Bridge Medications: The DOC wants as many individuals as possible to be			

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	enrolled onto Medicaid or other health benefit plan upon discharge from custody to ensure continuity of care. Because there are circumstances that prevent or delay enrollment, the Contractor shall: a) Provide patients with important and essential bridge medications. b) Determine the amount and category of medication provided at the time of release based on the patient's known history or risk profile for abuse, diversion, or accidental or intentional overdose. The Contractor shall provide patients with a sufficient supply of bridge medications as follows: i. All patients prescribed HIV medications shall be provided with a minimum of a 30-day supply of bridge medications. ii. Patients released to the community without active health insurance and whose next appointment date is unknown shall be provided with a 30-day supply of bridge medications. iii. All patients prescribed psychotropic medications shall be provided with a 30-day supply of bridge medications. If the patient is prescribed Clozapine, Lithium, or any other drug that requires close monitoring, the Contractor			

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	shall counsel the patient regarding their next mandatory lab draw. All patients will be advised of follow-up care needs including lab studies. iv. Patients enrolled or immediately eligible for Medicaid or other health benefit plan shall be provided with a known appointment date in the community and a sufficient supply of prescription medication(s) to last until the patient's next appointment. c) Pay for the costs of all bridge medications unless, within thirty (30) days of contract initiation, the Contractor verifies with DVHA that the costs of the medications can be processed through the patient's Medicaid or other health benefit plan.			
Patient Placement	Collaboration Between Staff and Facility Management Collaboration between DOC facility staff (e.g., Facility Management, correctional officers, living unit supervisors) and the Contractor's staff is vital for determining the most appropriate and least restrictive placement for patients and for maintaining a safe and secure correctional environment. The Contractor shall, in compliance with federal and state privacy and security requirements:	Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.	N/A	***DOC requirements are unique to DOC but align with EBP regarding multidisciplinary team approaches.*** ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.***

Type of Service	DOC in State	DOC OOS	DMH	Comments *DOC* DMH
	1. Coordinate meetings between DOC facility staff and the Contractor's staff as needed, but no less than weekly. Meeting topics may include, but are not limited to, placement of patients that are: a) "Delayed Placement Persons," or pending placement at an inpatient psychiatric hospital. b) Seriously functionally impaired (SFI) See Appendix 12, Act 26 (Seriously Functionally Impaired). c) Designated as potentially vulnerable to sexual victimization. d) Transgender, intersex, and gender non-conforming. e) Infected with serious communicable diseases. f) Receiving an ADA accommodation. g) risk of self-harm or suicide. h) Adolescents in adult facilities. i) On the mental health and co-occurring caseload. j) Chronically or terminally ill. k) Seriously mentally ill. l) Frail or elderly. m) In segregation. n) Hospitalized. o) Pregnant. p) Disabled. q) Receiving a special diet. 2. Inform DOC facility staff of any aspect of a patient's physical or mental health status that may			***Delayed Placement Persons (DPP) are unique to DOC and are in shared custody btw DOC and DMH. See Act 78*** ***MOU***

Type of Service	DOC in State	DOC OOS	DMH	Comments *DOC* DMH
	affect housing, work assignments, programming requirements, or pose a risk to the safe and orderly operation of the facility. 3. Immediately notify DOC Facility Management regarding patients that are acutely ill, decompensating, or whose physical or mental health is destabilized.			
Segregated Patients	For patients placed in segregation or other restrictive housing environment separate from the general population, the Contractor shall comply with the DOC Directive #410 (Responding to Inmate Behavior that Violates Facility Rules) and APA Rule #370.	Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.	N/A	***DOC requirements align with APA Rule #370.*** ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.***
Restraints	The Contactor shall comply with DOC Directive #413.08 (Use of Restraints and Roles of Security and Healthcare Professionals in Facilities).	Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.	N/A	***DOC restraint requirement is based on EBP.*** ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.***
Mental health treatment reporting	Concerning patient mental health treatment, the Contractor shall: a) Provide a daily written report to the DOC Chief of Mental Health or designee(s) which shall include, at a minimum, the status of patients that are: i. awaiting voluntary or involuntary hospitalization placement.	4.23.18 Mental Health Services Contractor shall provide individualized mental health services to meet the needs of State inmates, including assessment, evaluation, diagnosis, development of	Electronic documentation of services provided is required. Documentation must be of sufficient clarity (i.e., acronym free or clearly defined) and clinical content to ensure eligibility for payment. Auditors must be able to read documentation, especially any documentation kept in paper format. The DA/SSA and/or any	***DOC requirement is unique to setting, monitoring the population and contract, and EBP.*** ***Both in state and out of state contractors are required to be NCCHC accredited and maintain accreditation. NCCHC standards apply.***

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	ii. acutely decompensating. iii. self-injurious. iv. on suicide watch. v. on involuntary medication orders. vi. going to or returning from inpatient psychiatric hospitalization. vii. inducted on or tapered from MAT. b) Provide a weekly report which includes, at a minimum, a brief summary of each patient located in segregation or special MH housing units. c) Maintain a Mental Health and Co-occurring caseload (see Section 4.6). The data recorded via the Mental Health and Co-occurring Caseload should be created so that it is easily reviewed and analyzed and should contribute to a mental health classification system that should be developed according to a national model approved by the DOC.	treatment plans, evidence-based individual and group interventions, psychopharmacology, and periodic review by a multi-disciplinary treatment team. All mental health records shall be provided by the State to the Contractor for the purposes of continuity of care. The Contractor shall document all mental health services provided to inmates (including refusals of care) in the inmate's healthcare record. 4.23.19 Suicide Prevention and Crisis Intervention Contractor shall provide routine screening and evaluation of inmates to assess suicidal ideation or behavior. When an inmate is suspected of being at risk of harming self or others, Contractor: shall take all necessary measures and interventions to maintain the inmate's safety. Compliance with standards of professional practice shall be followed. When an inmate experiences psychiatric emergencies or crisis, the Contractor shall take	subcontractor must be able to produce specific encounter data from the EHR using MSR coding if requested by the State. All electronic records must be HIPAA compliant and retained for 10 years from the date of service. For individuals or families who require treatment intervention or support beyond consultation, education and population-based strategies, the following items must be present in the client file: • participant name & Medicaid ID, • referral & intake information, • screening tools or information, • evaluation tools & on-going assessment information (including assessment provider name and dates completed); • individual plan of care (including time frame of the plan, service type and frequency, responsible providers name, individual or parent/guardian and licensed clinician signature, dates completed); • progress notes, 39 which include o a summary of major content or intervention themes consistent with treatment goals; o a clear relationship to assessment data, o a description of services and interventions that reflect those listed in the treatment plan, o observations made of the individual or	**DOC MH service appears to meet the standard of care.**

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		all necessary measures to respond to the inmate's needs, place the inmate in an appropriate treatment setting (including but not limited to medical observation or a psychiatric hospital), and maintain the safety of the inmate and staff. Contractor must be NCCHC accredited within 1 year of initial contract (10.1.2018) and maintain accreditation. NCCHC standards apply.	responses to interventions, o an assessment of progress toward treatment goals, o signature by lead service coordinator, • ongoing needs for continued intervention and next steps, • performance goals/outcomes for individual clients served, • a log of services provided and dates (this log may be electronically available as part of the EHR and does not need to be duplicated as a separate document each month); and • a transition or discharge plan.	