Confidential
Proponent Response

to

Request for Proposals
Number: ON-001946

HEALTH CARE SERVICES
FOR INMATES INCARCERATED IN
BRITISH COLUMBIA
PROVINCIAL CORRECTIONAL CENTRES

Ministry of Public Safety & Solicitor General
Corrections Branch

Submitted by:

Calibre Health Services Inc.

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Calibre Health is committed to promoting the health and wellness of persons in custody. We believe in creating an environment that fosters integrity and quality of care.

PROPOSAL SUMMARY

Calibre Health Services Inc. (CHS)[1] has enjoyed a twenty-five year relationship with BC Corrections. First proving themselves through a number of years at Vancouver Island Regional Correctional Centre (VIRCC), CHS then assumed the role of providing multidisciplinary health care services to the ten correctional centres around the Province in 2003.

In this proposal we will address CHS' approach to the general service delivery outlining services from admission to discharge and post release planning. We will show how effectively the team will work in a collaborative manner to provide care.

We will offer details of past experiences that will exemplify the utilization of teamwork, continuous quality improvement, and the advancement of current health systems. In consultation with the Ministry, CHS has worked with patients who are marginalized, often addicted and withdrawing, and/or suffering from mental disorders.

CHS has built a senior management team whose members have extensive experience in correctional nursing, business and labour relations within the public and private sector, and are specialized in communicable disease and quality improvement management within a provincial Health Authority. CHS' middle management have held their positions for a number of years and bring a wealth of experience from a variety of clinical settings. An experienced team of medical and other allied health professionals are in place throughout the Centres and work collaboratively with correctional and health care staff.

[1] Firstly as a Nursing Consultant operating under a proprietorship, then as Joye Morris Health Services Inc.

The addition of addictions counselling and treatment to the portfolio is an exciting new clinical area and we look forward to including this in our service package.

CHS has studied the proposal and has identified areas for potential enhancement and these have been addressed. CHS believes this will significantly improve care delivery for BC Corrections within the structure of services requested.

The delivery of health services in Corrections is a highly specialized area of care and yet demands a competency that encompasses every field of medicine.

PROPONENT RESPONSE

APPROACH (4.1)

GENERAL SERVICE DELIVERY (4.1.1)

1. Contact Person

Name a contact person for the proposal, and include this person's address, phone and fax numbers, and email address. This information will not be evaluated, but may be used to contact the Proponent.

The contact person for this proposal is:

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President
Calibre Health Services Inc.
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Victoria, BC, V9A 7N7
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Fax: 250-388-7068
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2. Performance of Responsibilities

Provide an overview of how the Contractor's responsibilities listed as items (a) through (i) above will be performed, including the titles of the personnel who will be responsible for each.

The Contractor will assume the responsibility for:

a) providing appropriate triage, treatment and referral of inmates:

- The initial triage will occur when a Registered Nurse (RN/RPN) assigned to admissions will complete an Initial Health Assessment (IHA) on intake to the centre. A history and modified physical will be completed for each inmate. As appropriate, Alerts will be entered into CORNET in a manner that does not contravene medical confidentiality.

- During incarceration nursing staff (including LPNs) will review and triage all Health Care Service Requests (HSRs). These will be entered into PAC and appropriate follow-up appointments will be created based on the urgency of the request.

- The mental health screener will conduct a face-to-face Jail Screening and Assessment Tool (JSAT) screening triage on each inmate being admitted to the centre and will confer with the nurse and the Classifications Officer as needed regarding placement.

- Mental Health Program Coordinators (MHPC) will review all JSAT screenings completed by the mental health screeners and will schedule appointments for those requiring their follow-up.

- Initial referral to appropriate health care professionals will occur, as required, following the IHA. The nurse will create an appointment in the electronic health record (Patient Assessment and Care (PAC) system).

- All staff will be responsible to book appointments for ongoing care in the PAC system for subsequent medical, dental, mental health and addictions services appointments. (PAC will require the addition of Addiction Services to the appointment drop down.)

- Clerks and nurses will establish time lines of urgency and book (internal and external) specialist appointments as deemed necessary by the physician.

- Psychologists will receive referrals from the MHPC and the physician, assess the urgency of need, see and treat inmates accordingly.

- Psychiatrist appointments will be scheduled on specific order by the physician.

- New inmates will be instructed on self-referral through the HSR (Health Care Service Request) during the intake process.

- Ongoing treatment will be provided in physician's and nurse's clinics

- Dentists will see, assess and treat as required all inmates who have been referred to them by the centre physician.

- Emergency treatment will be provided when required. For example, the Registered Nurse (RN and RPN) and other designated members of the health care team will respond to all Code Blue calls and take charge of all medically indicated needs.

- The duty nurse will complete transfer notes in PAC when an inmate is transferring from centre to centre. This will provide the relevant information to assist the receiving centre regarding the continuity of treatment and care of the patient.

- To ensure the continuity of treatment and care, the duty nurse will review all transfer notes when receiving an inmate from another centre verifying

information with the patient. The nurse will document their assessment and any interventions required. Appointments are made on the basis of urgency.

b) ongoing assessment and monitoring of inmates:

- All health care professionals will chart all encounters and assessments into PAC.
- Nurses, MHPC and clerks will initiate Frequent Monitoring (FM) for those who meet the criteria per CHS policy. They will document for every inmate with acute or evolving care needs.
- Nurses will continue to complete ongoing assessments when responding to FM. This is a mandatory assessment completed at regular intervals and recorded in PAC.
- When monitoring patients in Isolation for communicable disease concerns, the nurse will ensure adherence to the use of personal protective equipment and appropriate notification (e.g. cell signage).
- Medical, mental health and addictions professionals will work closely with correctional staff. Assessment of behavioural, cognitive and physical changes may be first noticed and reported by the Correctional Officers who are working in the units with the inmates. Health care staff will be open to input provided by correctional staff on an inmate's medical or mental health condition. and The nurse will asses the patient accordingly..
- Nurses administer medications at set times throughout the day and although the interval of face-to-face contact is short, essential assessments and observations will be made and appropriate action taken and documented.
- Nurses and clerks will book follow-up treatments and appointments.

c) participating in the case management of inmates:

- Case management will begin at the time of intake. CHS nurses and mental health screeners will confer with each other and will maintain a close working relationship with the Classification Officer.
- Correctional Officers are often the first to notice changes or problems with the inmates. Nurses will work in conjunction with the Correctional staff to manage the care required by inmates.

- Health Care Managers (HCM) will communicate with the Deputy Warden of Programs (DWP) to provide ongoing integrated care.

- CHS on-site multidisciplinary staff will work together with the Communicable Disease Lead and the Discharge Planning Lead to coordinate case management where appropriate.

- MHPCs will work in alliance with the Mental Health Liaison Officers (MHLOs) to coordinate multidisciplinary care.

- Assigned health care staff will participate in weekly meetings for Mentally Disordered Offenders (MDO).

- Case management of patients with complex health care needs will be assigned to FM review per CHS policy - see attached Frequent Monitoring Policy at TAB 7. At the beginning of each shift the duty nurse will review and act on the FM Report in PAC. This will alert them to all patients having acute or evolving health needs. This list will be reviewed by the HCM on a daily basis to ensure Policy compliance.

d) individualized treatment:

- Using a standardized approach the nursing, mental health and addictions staff will individualize a care plan for each inmate starting from the time of admission. At this time the individual's existing community supports will be identified with a view to discharge planning and reintegration.

- Using the Episode function of PAC a "problem list" will be created by any member of the team and the continuity of care will be enhanced during incarceration, on transfer and on subsequent intake(s).

- Medical and mental health and addictions issues will be identified and documented. Appointments will be requested by the physician, nurse or MHPC for follow-up with the appropriate health care professional.

- Nursing staff will respond to individual inmate's health service requests.

- Using Medinet the nurse will access the provincial pharmacy records via Pharmanet to obtain personal prescription information.

- Physicians will be notified of medical, mental health and addictions issues that require intervention prior to the next clinic visit.

- The physician will refer a patient to the psychiatrist when required.

- Referrals to specialists will be ordered by the doctor or dentist and booked by the clerk if required.

- A multidisciplinary approach, coordinated by HCM/MHPC, to plan for discharge will occur for individuals as appropriate. Other team members will be included based on the patient's individual health care needs.

e) supervising, scheduling, and training of the Contractor's Health Care Personnel:

- CHS has an established an extensive orientation and training program for new employees. S21

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- Checklists, outlining job functions, duties and policies have been created and will be used to ensure that staff is taught the necessary elements during orientation.

- Working with the DWP the HCM will arrange a security training session for each new employee.

- HCM will organize CORNET training which will be provided by a corrections' trainer.

- Occupational Health and Safety orientation, as required by the *WorkSafe BC Act* and *Regulations* will be conducted by the HCM, utilizing the electronic on-line program, as part of the initial orientation. S21

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- The HCM will arrange Occupational First Aid (OFA) training for the designated employee. Once completed there will be a multilevel approach for the maintenance of OFA certification. The employee will

maintain an awareness of required date of renewal. S21

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- PAC training will be arranged and completed prior to commencing independent work. This is an entire day of instruction. The HCM will schedule a date with the PAC Lead at the CHS office in Victoria. Training will be conducted either face-to-face or by webinar, depending on the circumstances. Learning is reinforced by the completion of the PAC skills list.

- Ongoing training using, a variety resources, will occur throughout the term of employment. This will be overseen by the HCM

- Scheduling of personnel and shifts will be the ultimate responsibility of the HCM but they may be assisted by the clerical staff on site. S21 S21 will be posted for staff in accordance with the BC Nurses' Union (BCNU) Collective Agreement.

- Supervision of the Health Care staff will be the responsibility of the HCM with assistance and guidance from the labour relations consultant at the CHS head office in Victoria.

- Performance appraisals for health care staff will be completed annually by the HCM.

f) liaising with community health services and outreach programs for release planning:

- The HCM and the MHPC will maintain an awareness of the ongoing needs of the patients identified as requiring discharge release planning.

- Doctors, nurses, the mental health and addictions team, working together with corrections case management, will identify persons who are at high risk of reintegration failure. The team at the centre will create new links to community support and re-establish existing links. Assisted by the Discharge Planning Lead the multidisciplinary team will plan for the patient's re-entry to the community.

- CHS doctors will contact specialists and community doctors as required.

- MHPC and psychologists will liaise with community mental health programs and forensics as needs are identified.

- Methadone pharmacies, methadone prescribing physicians, and the College of Physicians and Surgeons will be notified of release of patients on the methadone maintenance program.

- The HCM in conjunction with the Communicable Disease Lead under the direction of Medical Director, BC Corrections will contact Public Health if the patient has a condition that warrants follow-up.

- In some centres the Outreach Street Nurses attend and provide care and discharge planning for inmates. The HCM will work in collaboration with this agency.

g) addressing inmate complaints, including verbal complaints:

- Where possible the complaint will be resolved immediately. Where that is not possible, the staff member receiving the complaint will assure the complainant that his/her concern will be documented and referred to the HCM for investigation and follow-up.

- Complaints will be received via a number of means. They may be written or verbal, and may come directly from the inmate or channelled through Inspections and Standards, a lawyer, the Ombudsperson, an MLA, family, or relayed through a Correctional Officer.

- CHS HCMs and Operations Lead will receive and respond promptly to all inmate complaints.

- The HCM will investigate the complaint. A review of the PAC documentation will be done. Interviews with the inmate, relevant CHS staff members will be done if required. Relevant information will be sought from Correctional Officers. As needed physicians, dentists, mental health and addictions professionals will be consulted.

- All attempts will be made to discern an inmate's need from a want. Where a complaint is received and identified as a need CHS will work to reach a resolution. Where a want is identified and does not meet the criteria of health care delivery, an explanation will be provided to the inmate.

- The Investigations and Standards Office (ISO) has a legislated right to all information regarding a specific complaint made by an inmate. All members of CHS staff will be responsible to respond to ISO queries. CHS staff may not be familiar with the inspectors at ISO, and rather than release information inadvertently to someone who is not entitled to the information, staff will consult with HCM or senior CHS management.

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h) gender and culturally relevant program content and delivery:

- Ongoing development of a quality program will be based on health care innovations in other jurisdictions. Quality initiatives implemented at one centre will be shared with all other centres. S21

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- MHPC will work in conjunction with the native liaison workers to offer culturally relevant services.

- When access is available to the appropriate translators other services will be offered to foreign speaking inmates. Enhanced explanation of the health procedures will be addressed.

- Facilitating access to community support groups for racial/cultural groups will be supported through discussions with CHS head office and Federal Translation services.

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- It is acknowledged that the female population arrive to Corrections with complex medical conditions and concerns of a higher acuity that the general male population. HC staff to patient ratio will reflect this.

i) review developments in the health care field:

- Ongoing development of a quality program will be based on health care innovations in other jurisdictions. Quality initiatives implemented at one centre will be shared with all other centres. The Quality Improvement Lead will review developments, in public health and acute care settings to assess the suitability and the ability to transfer the learning to the correctional centres.

- CHS will continue to support the development and improvement of PAC according to internationally recognised electronic health care record standards.

- CHS will use internal and provincial expert resources to respond in a timely way to new information S21

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- All CHS staff will review new developments for the care delivered at the centres. S21

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- We will continue to work with BCCDC and other provincial groups to remain current and informed. Auto messaging will be used to alert these health care partners. Pertinent information will be passed to staff.
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DELIVERY OF MEDICAL SERVICES (4.1.1.1)

3. Physician's Clinics

Provide an overview of how the Contractor will provide Physician's clinics according to schedules established with each Centre. Explain reasons for the proposed approach.

- Regularly scheduled physician clinics will be arranged at each centre with predetermined times based on each centre's inmate population and acuity of the population. This level of service will be clearly communicated in the contract between the physician and CHS.
- To enhance the efficiency of physicians' clinics, support will be provided by any combination of clerical staff, nurses and mental health and addictions professionals.
- Correctional staff will attend each physician's clinic conducted to provide security.

- To optimize the physician's time, clinic lists will be triaged by a nurse. Clinic lists are prepared as 2 separate lists for the physician that include the following:
  - Clients requiring assessment.
  - Chart review of clients' files where their attendance is not required.

- PAC contains a priority mechanism that will assist the nurse to assign the appropriate level of urgency to each appointment. This essential triaging by the nurse will maximize the efficient use of the physician's time.

- Physician assessments and treatments of clients will be charted in PAC in compliance with documentation standards set out by the BC College of Physicians and Surgeons.

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- During absences of the centre physician, alternate coverage will be pre-arranged to ensure continuity of physicians' clinics.

DELIVERY OF MENTAL HEALTH SERVICES (4.1.1.2)

4. Delivery of Mental Health Services

Describe how the Mental Health Services in (a)-(c) above will be delivered including the titles of the personnel who will be responsible for each and explain why this approach is appropriate.

The CHS mental health service will consist of the following integrated programs:

1. Supervision and Delivery of Mental Health Programs

2. Diagnostic and Functional Assessments

3. Suicide Prevention and Management strategies

Supervision and Delivery of Mental Health Programs

Primary Mental Health Personnel:

- Mental Health (and substance use) Screener (MHS)

- Mental Health Program Coordinator (MHPC)
- Psychologist
- Psychiatrist
- Addictions Counsellor
- Mental Health and Addictions Lead

Secondary Health Care:

- Pharmtech
- Nurse
- Physician

Additional Staff:

- Mental Health Liaison Officer (MHLO)
- Chaplain
- Corrections Staff/Supervisors

a) diagnostic and functional assessments where indicated, which can be augmented with external assessment tools if approved by the Ministry;

The delivery of mental health services will follow an integrated model of service delivery. The population within the BC Correctional Service contains persons who are addicted, marginalized, experiencing acute withdrawal symptoms, experiencing significant mental and/or physical disorders (including concurrent disorders), displaying non-compliant, aggressive, manipulative and drug-seeking behaviours. Inmates thus vary in their level of insight, treatment readiness, motivation, and severity of condition. As well, inmates differ in the balance of mental health, substance use, and social disabilities they present. In addition to the complex individual presentations, and the acute and chronic difficulties they suffer from, there is also variation in the role and function between the nine correctional centres within the province responsible for managing these persons (e.g. size of centres, remanded vs. sentenced). S21

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Provincial Inmates include:

- convicted offenders sentenced to terms of custody from one day to two years less a day;
- accused persons that have been remanded to custody awaiting trial or sentencing;

- individuals detained under the Immigration Act; and
- Federal Inmates who are in provincial custody to address parole violations or other court matters.

On intake, each person will undergo mental health screening using the Jail Screening Assessment Tool (JSAT), conducted by a Mental Health Screener (MHS). Where possible MHSs will be graduate students in Clinical Psychology, with coursework in assessment, psychopathology and ethics.

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S21 All Mental Health screenings will be completed within 24 ours. Completed JSAT forms will be reviewed the following day by the MHPC, who will have administrative oversight of the MHSs. This screening will provide basic identifier information and an understanding of the person's legal situation.

Significant areas covered during this initial screen include:

- violence issues
- history of mental health treatment
- suicide/self-harm issues
- social background
- substance use
- mental health status information
- management recommendations – an important part of the process.

The task of this initial mental health assessment is not simply to gather information. S21

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S21 The MHPC will review

the electronic health record (PAC) based (JSAT) mental health screening forms and referrals generated from the intake assessments completed by the MHS. Based on a review of this information, the MHPC will provide subsequent in-person follow-up to the inmate and/or coordinate additional services for discharge planning or contact with outside agencies (e.g. transferring individual to Forensic services) and/or refer this person to a more qualified health or mental health professional for subsequent assessment and treatment (e.g. psychologist, physician). S21

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Centre psychologists will provide psychological assessment and treatment services based primarily on referrals received from the MHS and the MHPC (although other sources of referral will also be reviewed, e.g. unit staff concerns about an inmate's adjustment). Psychological services will provide functional and, where possible, diagnostic understanding of an inmate's mental and behavioural functioning. A plan will then be developed to address identified needs. Treatment efforts will be directed toward the resolution of acute issues, stabilizing an individual's mental status, or to providing further consultation, support, and referrals as directed by the mental health needs of an individual client. Psychologists will be involved in assessing all individuals placed on special (suicide) observation protocols. Psychologists will consult with the MHPC to obtain further information or to request further coordination with community services. As well, the psychologist will refer and consult with the Centre physician (and psychiatrist as indicated) to ensure medication needs for inmates with mental health issues can be addressed and appropriate cases may be referred for consultation with the Centre psychiatrist.

As a medical specialty, psychiatrists will see all individuals referred for consultation by the Centre physician. Working in accordance with the Most Responsible Physician model, psychiatrists will provide diagnostic and functional assessments of inmates, and provide written consultation reports to the Centre physicians, detailing the results of their assessment, diagnostic indications, and medication recommendations as appropriate.

All professionals involved in the assessment and care of individuals with known or suspected mental health issues will document their contacts, information, and assessment results in the appropriate paper or electronic health record (e.g. PAC).

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Diagnostic and Functional Assessments:

Centre psychologists, physicians and psychiatrists will perform diagnostic assessments by using information from in-person assessments, as well as integrating collateral sources of information based on file review and community data, where available. Diagnostic assessments, following a

framework such as that outlined in the *Diagnostic and Statistical Manual for Mental Disorder* (Fourth Edition Text Revision), provide a focus for treatment planning. However, because of the complex nature of inmate problems, which often represent a blend of situational stresses, substance use, acute or chronic mental health issues, and adjustment difficulties it will not always be possible to obtain a clearly articulated diagnostic formulation. Nevertheless, on-going management and case planning services will be required. Functional assessments provide a dynamic means to measure a person's ongoing mental health needs and adjustment without necessarily providing a fixed diagnosis. Many individuals entering the Corrections environment have psychosocial needs that impact their mental status, or serve as legitimate areas of concern requiring response from the mental health team. Literacy needs, employment skills, housing and social supports all serve as contributors to an individual's ability to benefit from treatment services or maintain gains made through mental health programs. In addition, it is important to understand the difficulties an individual may have with the correctional setting. A functional assessment of social skills and coping abilities will serve to provide an understanding of what other skills or programs an individual may require, both for their time in the correctional setting, and for discharge planning services. Coordination of this process will be the responsibility of the MHPC, and will involve team case management meetings to assist in case management.

b) suicide prevention/management;

Suicide Prevention/Management

Suicide prevention and management is a collective responsibility. Effective risk management and prevention requires not only the identification of potential suicidal concerns, but also action and communication to effectively address such concerns. Every inmate will be provided an initial screen for possible suicidal ideation and history by the MHS. If an individual identifies suicidal ideation, or in the judgment of the screener is thought to present a suicide risk, that individual will be identified to Corrections staff as requiring special (suicide) observations and management (in accordance with Correction's policy). It should be noted that any Health Care or Correction's staff member that has reason to believe an inmate may be suicidal can initiate the person's placement on suicide watch. S21

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c) supervision and delivery of mental health programs throughout the Centres to those Inmates assessed as needing these services;

Supervision and Delivery of Mental Health Programs

Generally speaking, supervision and clinical oversight of mental health programs can be partitioned into administrative and clinical divisions.

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S21 The Mental Health and Addictions Lead will consult with centre staff to ensure consistent service standards are met at a provincial level. The Mental Health and Addictions Lead with track trends and service requirements and consult with the Director, Mental Health Services, BC Corrections to discuss relevant planning needs, issues, or problems.

Clinical supervision and oversight will be provided by the Centre psychologist. S21

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S21 On-going clinical supervision of the Mental Health Screeners by the Centre psychologists will occur in accordance with the requirements set by the Director, Mental Health Services, BC Corrections.

5. Existing Special Programs

Describe any of the Proponent's existing special programs that may be incorporated into the Services for mentally disordered Inmates that are included in the Proponent's pricing.

Current existing special programs for mentally disordered inmates include:

1. Weekly round to mentally disordered offender (MDO) units by Mental Health Program Coordinator. The purpose of these visits is to monitor for specific mental health issues and discuss concerns with the Corrections staff, MHLO and to refer patients as appropriate.

2.

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3. Support for volunteer programs as needed

DELIVERY OF ADDICTION SERVICES (4.1.1.3)

6. Delivery of Service and Responsible Personnel

Describe how the addictions and concurrent disorder services in (a)-(e) above will be delivered including the titles of the personnel who will be responsible for each and explain why this approach is appropriate.

Program Considerations:

Calibre Health Services (CHS) recognizes the importance of providing dedicated addictions treatment that integrates with mental health services. This model will assist not only in providing inmates with a high level of service across a continuum of care, but will also provide greater consistency with the organization of mental health and addictions services within the community, allowing for seamless transition planning. The Mental Health and Addictions program needs to be tailor made to suit the diverse needs of clientele with typically short, but variable, lengths of stay, different stages of withdrawal and treatment readiness, and who may present with concurrent mental health issues.

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ADDICTIONS

It is recognized that correctional populations have a consistently higher prevalence of substance use problems than the general population. As identified by the Ministry for Public Safety, approximately 56% of individuals incarcerated in BC Corrections have some form of mental health and/or substance use disorder. In hard numbers, this figure translates into approximately 1428 individuals incarcerated on any given day that are experiencing substance use and/or mental health issues.

a) withdrawal management

To address substance use issues, addictions and concurrent disorder services will be provided by a team of health, mental health, and addictions professionals. Given that concurrent disorders present a range of psychological, physiological, and psychosocial rehabilitative needs, an integrated model of service delivery, with systemic support and communication, will be used to ensure that a continuum of care is provided to inmates in need. This approach will ensure that an individual's changing needs (e.g. from acute withdrawal through to post-release planning) can be monitored and responded to appropriately.

Given the range of withdrawal phase acuity, and the impact of these on the physical and mental health of inmate, the withdrawal management process requires a matched level of response by health care, mental health, and addictions services; ranging from acute physiological withdrawal to requests for community based treatment and recovery programs. Individuals with substance withdrawal related concerns (mental and physical) will be identified at intake through the Mental Health Screens (Mental Health Screeners) and Initial Health Assessments (Registered Nursing staff). Depending on the level of needs identified through these initial screens, the inmate will be referred to the appropriate professional.

For individuals with physical/physiological withdrawal symptoms, the centre physician will not only follow-up on general health issues, but will also

continue individuals on the Methadone Maintenance Program as indicated, prescribe medication to assist individuals through the acute withdrawal phases (e.g. valium to reduce seizures and tremors in alcohol withdrawal) or to address emergent mental health issues (e.g. Drug Induced Psychotic Episodes). Inmates with concurrent or suspected mental health issues will be referred for follow-up assessment to the Mental Health Program Coordinator and/or centre psychologist. Through coordination with medical and mental health services, the Addictions Counsellor will begin to engage with inmates to plan for addictions treatment services and link to community mental health and addictions services as appropriate (MHPC/Addictions Counsellor.)

b) addiction assessment tools (note: prior to their use, all addiction tools will require Ministry approval);

The process of assessing and treating inmates with addictions and concurrent disorders will begin when an individual is first admitted into a BC Correctional Centre. Every new admission will undergo both a health and mental health screening. These screenings will be conducted by an Intake Nurse and Mental Health Screener, respectively.

Initial Health Assessment: Along with identifying general health issues which often accompany chronic substance use and abuse (e.g. Hep C, HIV, liver problems), the health assessment will help identify issues associated with drug use and withdrawal that may require more urgent attention (e.g. malnutrition, seizures, tremors). Based on the results of the Initial Health Assessment, routine or urgent referrals will be made to the centre physician for follow-up.

Mental Health Screen: Mental Health Screeners will be trained to administer the Jail Screening Assessment Tool (JSAT). The JSAT uses a semi-structured interview format to guide the mental health screening of inmates being admitted to jail. This interview helps to determine the individual's level of functioning, psychological adjustment and possible needs for mental health and/or substance abuse treatment. It should be noted that it is not always possible during an intake screening to identify whether an individual is experiencing a primary mental health problem, primary substance use problem or some combination of both. It will thus be important that follow up and communication between professionals occurs. Nevertheless, specific sections of the intake interview focus on patterns of substance use that will identify whether an individual is appropriate for subsequent referral to the addiction's counsellor, mental health program coordinator, psychologist, nurse, or physician. The results of the mental health screening will be recorded in PAC and the appropriate appointments booked for follow with Addictions, Mental Health, and/or Medical professionals. Note: PAC will require a cost free addition of the option

"Addictions Counsellor" to assist with ease of booking appointments for addictions follow up.

Addictions Assessment Tools: The Addictions Counsellor will provide follow up assessment to individuals referred from intake to further assess the individual's level of readiness and prioritize the need for addictions services. Currently multiple and varied assessment tools are used by the different agencies supporting Addictions care throughout BC Corrections. The selection of specialized addictions assessment tools will occur upon notification of Contract award success and prior to commencing the new program. Choice of consistent assessment tools will be made in conjunction with Provincial Addictions experts and as approved by the Ministry.

It is expected that some individuals referred to the Addictions Counsellor may require further assessment by health and/or mental health services to assess for dependency related disorders and/or mental health/psychological difficulties. In such instances, the inmates will be seen by the centre psychologist for further diagnostic assessment. In some cases, particularly where medication needs may require attention, the individual may be further assessed by the Centre physician, and possibly referred for consultation to a psychiatrist. If it is determined that the inmate does have a drug dependency problem, the inmate will be referred back to the Addictions Counsellor for follow-up treatment and transitional services.

It is also expected that there will be instances where an individual may be referred to the MHPC or psychologist for follow up from intake, but the primary need identified is for addictions treatment. In such cases, the psychologist will refer the individual to the Addictions Counsellor for further assessment and treatment.

Recommended modifications to the electronic health record (PAC) to accommodate inclusion of services by Addictions Counsellors include:

- Add "Addictions" to appointment types
- Add "Addictions" to referral types
- Add "Addictions" to Episodes – Problem List
- Add "Professional Status" of "Addictions Counsellor" to PAC
- Add "Treatment Plan-Addictions" in Episodes-Problem List (currently under review by HCC)
- Incorporate a screening tool into PAC for the Addictions Counsellor's use once an approved assessment tool has been identified

c) counselling interventions;
AND
d) relapse prevention;

Because of the complex needs and changing presentation of persons with substance use and mental health disorders, an integrated clinical framework will be utilized to ensure that communication and referral occur to appropriately monitor and respond to inmates in need. S21

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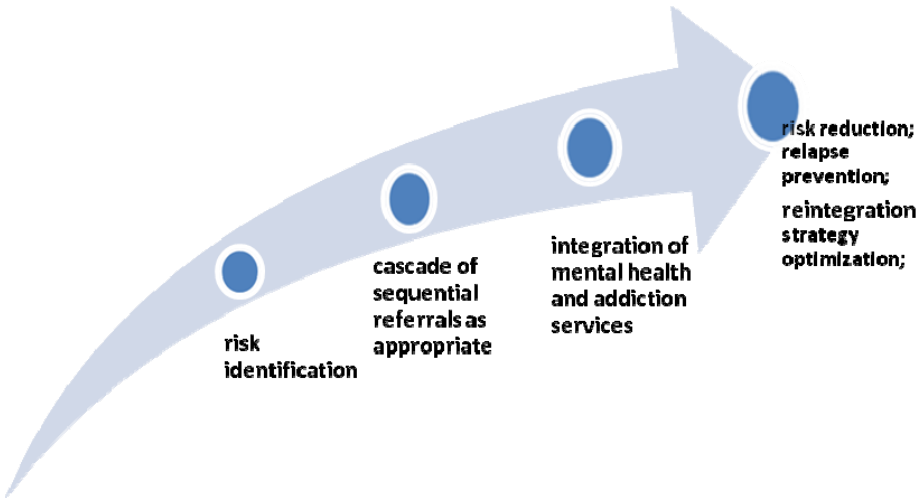
Alcohol and Drug services will be available to all inmates. However, it is anticipated that due to differences in the length of stay, institutional counts, availability of programs, and fluctuating levels of clinical acuity in Centre populations, the relative emphasis of service provision will need to be tailored to meet the demand of each institution. However, all institutions will have a combination of Addictions services including education and relapse prevention planning groups facilitated by the Addictions Counsellor (co-facilitated by corrections staff, as appropriate and if negotiated), individual counselling, group programming (e.g. Substance Abuse Management program), and transition/release planning. Inmates identified as having the most complex needs will receive priority for addictions treatment services.



Counselling interventions will be based on accepted and evidence-based practice standards. Individual counselling will be responsive to the client's needs. This may involve helping the inmate gain a more realistic understanding of addiction; matching community treatment options to inmate presentations; providing self-directed work in treatment and relapse prevention planning; understand the relationship between mental health issues and addictions (with referral to appropriate mental health services), or other supportive and planning activities as may be appropriate.

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Although relapse prevention work may form a part of individual counselling (e.g. identifying a specific trigger or risk factors), it is believed that group sessions in relapse prevention planning with be more effective and efficient, and the majority of relapse prevention work will occur in a group format.

On average, inmates are in custody for brief durations, relative to the length of their substance abuse and dependency disorders. Accordingly, an integral part of the Addictions Services program will be assisting inmates with a transition plan and follow up with community treatment resources. The transition planning process will involve the Addictions Counsellor identifying community support groups (e.g. Narcotics Anonymous, Alcoholics Anonymous), Recovery Houses, or Drug Treatment Programs as an individual case may require. S21

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S21 In cases where concurrent disorder programming may be most appropriate (e.g. Burnaby Mental Health and Addictions), the inmate will benefit from the joint efforts of the MHPC and Addictions Counsellor. Other agencies and correctional staff (e.g. Mental Health Liaison Officers (MHLOs)) may also participate in the transition/release planning sessions.

e) counselling, with an emphasis on group work

As indicated, individual counselling will be necessary to establish an understanding of addictions service needs and transition/treatment program planning. However, a group counselling format will be offered to assist a greater number of inmates with relapse prevention as well as with understanding addictions issues. The group format not only offers the advantage of more inmates receiving service, but also the group format has been shown to be effective in overcoming treatment resistances and denial. Group processes are supportive and help inmates to recognize that they share common problems for which they can identify solutions.

It is expected that as the Addictions Service is established with Provincial oversight by the Mental Health and Addictions Lead, improvements in coordinated services to inmates will be realized, leading to some differences where most group programs are offered. S21

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7. Counsellors' Hours & Numbers of Patients Served

Identify the proposed number of Addictions Counsellors' hours that will be provided per week in each Centre, and the average number of Inmates that they will serve in each Centre per week. Include a description of why the average number of Inmates is reasonable and achievable.

Proposal Rationale:

1. Currently there are no consistent hours of services across the nine centres.

2. RFP requires no less than 35 hours per week at each of nine centres.

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Rationale for Numbers:

The average number of inmates Addictions Counsellors will see is based on the following rationale:

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8. Outcome Measures

Describe the outcome measures proposed and how the Proponent intends to assess the effectiveness of their addiction services through this series of measures.

Outcome measurements of the addictions services will vary according to the service provided. S21

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Outcome measurements will have two purposes:

1. On an individual patient level – to measure the effectiveness of the service for this particular individual. This will inform how future addictions services will be provided by CHS staff for this patient.
2. In aggregate – which services appear to be most effective for the greatest number of patients.

Working with the CHS QI Lead, some proposed measurements would include:

1. Withdrawal Management

    - Adherence to Methadone Maintenance Program (MMP) requirements

    - Success of MMP – measured by reducing dosage

2. Assessment tools

    - Completion of intake assessment tool (JSAT) within 24 hours of admission

    - Appropriateness of JSAT referrals– conducted random audits to ensure JSAT assessments are reflective of the patient's condition at intake. Audit to be performed by a knowledgeable individual such as the Addictions Counsellor/Mental Health and Addictions Lead.

    - Planned targeted audits of the use of assessment tools and the appropriateness of the tool for the patient. Audit to be performed by a

knowledgeable individual as designated by the Mental Health and Addictions Lead

3. Counselling Interventions

   - Number of counselling sessions attended by the patient
   - Hours of counselling received by the patient
   - Number of Individual versus group sessions conducted and number of clients served in each modality
   - Patient satisfaction. This measurement will be developed by the Addictions Counsellors team under the guidance of the Mental Health and Addictions Lead. Typical patient surveys may not be appropriate for this population.

4. Relapse Prevention

   Relapse will most often occur after the patient has left the centre. Measurement will be outside the scope of the CHS Addictions Services. Recidivism as a proxy measure is too imprecise, as many factors may contribute to a return to incarceration.

   The strategy most likely to have an impact on relapse prevention working with the Discharge Planning Lead to have community support in place before the patient leaves the centre. CHS proposes measurements of discharge planning as an indicator of relapse prevention:

   - The number of discharge plans in place for Addictions Services clients. To be measured quarterly and expressed as a percentage of all Addictions Services clients due to be discharged in the same quarter.
   - The number of discharge plans in place in the timeframe criteria set by Addictions Services (e.g. all discharge plans should be in place 5 business days before Expected Date of Discharge (EDD).Population would include sentenced patients only.)
   - A periodic random audit to assess completeness and appropriateness of discharge plans in place. Audit performed by a knowledgeable individual such as Addictions Transitions Coordinator.

Note: These monitoring outcomes measure whether services are provided. Additionally, the Mental Health and Addictions team is open to working with community resources to expand the area of outcome measurement where alternate options exist.

INTAKE PROCESS (4.1.2)

9. Recommendation for Safe Housing of Inmates

Provide specific examples where the Proponent would inform the Warden that an Inmate's physical and/or mental health may affect the Centre's ability to safely house that Inmate

Calibre Health Services (CHS) will inform the Warden, or designate, that an inmate's physical and/or mental health may affect the centre's ability to safely house that inmate in the following situations:

- On admission, if an inmate is assessed and deemed to be unfit for transfer into the institution, the Warden or delegate will be informed. Reasons the inmate cannot be safely housed may include an illness or injury that can be better managed with the increased resources available at a community hospital/facility. As an example, an inmate on intake who has sustained head injuries and has a diminished level of consciousness. As a result, the patient will be immediately transferred to hospital.

- In centres where there is not 24-hour nursing coverage the Warden or designate would be notified of the need to transfer patients requiring this coverage.

- The warden or designate will be notified of all inmates who are certified under the *Mental Health Act.* These patients will be monitored closely and health care staff will work collaboratively with Corrections, Sheriffs and the outside agency accepting the patient.

- Certain communicable diseases will require that the Warden, or designate be notified. All cases requiring personal protective measures beyond routine practices (standard precautions) will be reported. Other inmates exposed to infectious cases will be managed in conjunction with information from correctional staff

- An entry made in the Client Log (CLog) of CORNET for inmates placed on Frequent Monitoring (FM). Health Care will alert the Warden or designate of anyone placed on any atypical frequency of monitoring by the Officers.

- Potentially suicidal or self injurious patients will be identified to the Warden, or delegate.

- The Warden or designate will be notified of any situation that may present a risk to the Branch, the centre or patient safety e.g. unpredictable or violent behaviour.

- All loss, theft or discrepancies of controlled substances raises the concern of potential overdose. These occurrences will all be reported to the Deputy Warden of Programs, who is a designate of the Warden.

- Although not necessarily related to a health issue it is the responsibility of CHS staff members to report any incident which may pose a threat to the good order of the institution. Examples are rumours of illegal drug stashes or of potential riots.

- The Warden or designate will be notified of deaths of all inmates assigned to that centre.

PRIORITIZING HEALTH CARE SERVICES REQUESTS (4.1.3)

10. Prioritizing Delivery of Medical Services

Describe the proposed process and considerations for prioritizing Health Care Services requests for referrals and treatment that are specific to all of the Services (Medical, Dental, Mental Health & Addiction).

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CASE MANAGEMENT AND RELEASE PLANNING (4.1.4)

11. Links to Community Programs

Describe how the Proponent plans to establish and maintain linkages with appropriate community programs and agencies in order to facilitate the continuity of care between custody and the community.

Planning of social reintegration into the community is achieved during incarceration through early identification of risk factors and linkage to resources specific to these risks. The Discharge Planning Lead will work with centre HCMs to encourage admitting nurses and mental health screeners, (while working within admission time constraints), identify reintegration obstacles. Consideration of status (i.e. remanded or sentenced) will influence the extent of motivation on the part of both the staff and the inmate, to commit to focusing on discharge planning. Once inmates are sentenced, early identification of mental health status, addiction issues, homelessness, increasing age and loss of personal community supports permits more rapid linkage to existing community resources.

As risks are identified, staff under the guidance of the Health Care Manager will work with CHS Lead roles to access appropriate community resources. For example, if the person is a TB case or contact, the CHS Communicable Disease Lead can communicate information and receive recommendations from the local TB clinic staff to ensure care and follow up for that client continues following discharge.

Identification of discharge barriers during routine care and through inmate's self or physician referral will be the prime triggers for discharge planning follow-up.

When discharge risks are identified in a timely way, this will create the opportunity to encourage therapeutic group participation specific to the identified risk(s) during sentenced incarceration. The Discharge Planning Lead will work with health care and corrections staff, as well as community stakeholder groups and individuals, to ensure that everyone shares a commitment to reintegration and is familiar with available community resources specific to that region.

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12. Information Sharing/Complying with FOIPPA

Provide a plan for the provision of an Inmate-specific integrated case management approach with community professionals and resources, which ensures the sharing of appropriate information while maintaining the protection of privacy consistent with the Freedom of Information and Protection of Privacy Act (see Appendix Q).

CHS Discharge Planning Lead will establish and build on existing policies and processes ensuring that patients' information is only accessed appropriately for use within the Health Care context intended, and that all sharing of information complies with established policies as covered in the *Freedom of Information and Protection of Privacy Act*. As a leader in this area, the Discharge Planning Lead will provide clearly documented policies for staff reference and educate Managers and staff regarding the principles and details of information access.

On intake, competent patients[1] will be required to sign a release of information form prior to access of Pharmanet information access. In addition, a release of information form will also be used to ensure that all requests for personal health information for Probation and other community services are granted with the patient's full knowledge of the extent of the information to be shared and the intended purpose.

The Discharge Planning Lead will work with CHS Senior Management and BC Corrections personnel to ensure that existing and future patient care policies clearly document that external requests for information comply with the Freedom of Information and Protection of Privacy Act of BC and provide complete accurate health information in a timely manner. Policies will ensure that external requests are forwarded to the Provincial Representative within five (business) days, unless otherwise requested by the Province. Personal information required for expert health care consultation that is moved between sites (and cannot be performed digitally) will occur in an encrypted and secured format. The CHS Management Team will ensure that all patient and company information is stored on secure Government websites within Canada.

SERVICE DELIVERY TEAM (4.1.5)

13. Organization Chart/Roles & Responsibilities/Additional Roles

Provide an organization chart of the proposed team delivering Services that includes all Health Care Personnel, organized by Centre and type of position, and that outlines all reporting relationships. Include all the roles listed in section 3.7.2 as well as any additional roles required for corporate capability functions such as human resources, labour relations, finance & administration, contract and operations management, etc. If more than one organization is proposed to deliver the Services, identify which organization is responsible for each position named in the organizational chart. If any team members are in roles not defined in the RFP, include a description of their role(s) and responsibilities.

See our Calibre Health Services organizational chart in TAB 10.

S21

[1] Discharge Planning Lead will be an available resource person to assist staff to work with Corrections to establish a patient representative for patients deemed incompetent to provide informed consent.

Following are roles and responsibilities for team members that are not defined in the RFP.

OPERATIONS LEAD

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QUALITY IMPROVEMENT LEAD

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MEDICAL LEAD

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RADIOLOGY LEAD

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S21

BUSINESS & FINANCE LEAD

S21

S21

LABOUR RELATIONS LEAD

S21

S21

HUMAN RESOURCES MANAGER

S21

S21

14. Local and Provincial Integration of Services

Describe how you intend to ensure both local and provincial integration of Services, addressing all of the bullets above. Include how this integration works for Inmates moving from one Centre to another.

The key to ensure both local and provincial integration of services is communication.

The health care team on a local site must have a consistent flow of communication from one discipline to another and this will extend within the web of inter institutional transfers. Continuity of care is enhanced through easy access and use of communal shared policies, a close working relationship between the nine (CHS) Health Care Managers (HCMs) and use of the structured provincial health record system (PAC).

- o CHS will provide a seamless experience for inmates receiving services, from one discipline to another.

Locally:

- The electronic health record in the form of PAC is the key to consistent information flow. (Refer to APPENDIX D Project at TAB 3)
- Back up will be done nightly at each Health Care Centre to preserve the data in the event of system failure
- A designated computer will be available at each centre on which the back up information can be accessed in the event of system failure.
- Starting from the first contact between health care and the inmate, information will be charted.
- The need for the intervention by other disciplines (physician, dental, mental health or addictions) will be determined and documented.
- Appointments will be arranged as appropriate for the patient and created in PAC.
- All of the professionals will have access to this complete charting providing a flow of current information.
- The integration of new processes in the management of addictions counselling and discharge planning will promote seamless patient services.
- Team meetings will allow discussion on overall development of collaboration.
- Specific case conferencing will be held as required.
- HCMs will have a key lead role to ensure a cohesive approach to patient care.
- HCMs will ensure consistent compliance by staff to CHS and Correctional policies.
- The MHPC will work to coordinate the mental health and addictions work and will ensure that this is clearly communicated to the HCM at the site. This will prevent duplication of effort.

Provincially:

- On transfer of the inmate, the electronic health record will be the pivotal key to information flow which will provide a seamless transition throughout the province.
- Key to the success of the standard use of the health care record will be the provision of a structured PAC orientation, including skill review sheet completed by each new employees and subcontractors.
- The chart will be reviewed by a nurse at the centre initiating the transfer out.
- Care will be taken to note if there are ongoing specialist appointments or other factors that may need to be considered by Corrections prior to transfer.
- Notations will be made detailing specific issues that will require follow up at the receiving centre.

- The nurse will review all entries, but with sufficient advance notice a review and summary will be provided by mental health and addictions as well.
- Medications will be prepared and sent along with the patient at the time of transfer.
- The electronic health record will be automatically available to the receiving centre avoiding the risk of loss.
- On receipt of the patient at a new centre a nurse will do a transfer review. Medication administration will be organized by the transferring and receiving centres to ensure continuity of drug therapy. Medications will be arranged with the premise that no doses are to be missed.
- Appointments with the physician, mental health and addictions will be scheduled as required.
- The availability of planning tools through the Discharge Planning Lead (at CHS head office) will enhance provincial reintegration strategies.

o Strong communication among the different roles and services.

Locally:

S21

- Team meetings of nursing, medical, mental health and addictions staff will occur at each centre at regular intervals.
- Health care staff will have access to all areas of charting within PAC for patients in their centre.

Provincially:

- Conference calls for each discipline will occur. HCMs will meet monthly with the Operations, Communicable Disease and the QI Leads from CHS headquarters.
- MHPCs will meet with the Mental Health and Addictions Lead by teleconference at least once a month.
- Addictions Counsellors will meet with the Mental Health and Addictions Lead by teleconference.
- Dentists will meet with the Medical Services Lead by teleconference.
- Physicians will meet with the Medical Services Lead by teleconference.
- Psychologists will meet with the Mental Health and Addictions Lead by teleconference.
- It will be encouraged that the individual groups (all HCMs, MHPCs and Addictions Counsellors) have an opportunity to meet face to face for a

minimum two-day session with their respective Leads to discuss health care strategies

S21

o Consistency of service delivery across the province

Locally and Provincially:

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- The Health Care Service Manual and the Adult Custody Manual are posted so all staff will have access to the information.

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- The EHR (PAC) demands a format that requires a consistency in approach to making appointments, charting and structuring information. Orientation and QI reviews will reinforce this standard use.

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- It will be encouraged that the individual groups (all HCMs, MHPCs and Addictions Counsellors) have an opportunity to meet face to face for a minimum two-day session with their respective Leads to consolidate the consistency of approach.
- CHS Medical Services Lead, Mental Health & Addictions Lead and Operations Lead will provide a provincial overview in the consistency of services delivered.

o A structure that functions as a multi disciplinary team, each stream commanding equal importance.

Locally:

- CHS has long recognized that each patient or inmate is an individual entity with unique needs.

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- In service training and staff meetings will be multidisciplinary and all disciplines will be encouraged to attend.
- Medical, mental health and addictions professionals will refer patients as appropriate to each other. They will network and share resources in the case management of patients.

- There will be multidisciplinary charting in PAC which will be available to all health care professionals. Additions to the EHR will be recommended to the PAC management team to include documentation fields for addictions services.
- The addition of the addictions component to the health care team will be seen as an important role.
- Team meetings will support the multidisciplinary structure.
- The HCM will act as the coordinator of all resources.

Provincially:

S21

- Outbreak control will occur through the Communicable Disease Lead who will provide one link to the Medical Director, BC Corrections and BCCDC, preventing communication duplication and standardizing the approach.
- The Mental Health and Addictions Lead will create a team with common approach and goals.
- Addictions counsellors in conjunction with the Mental Health and Addictions Lead will develop a provincially coordinated approach to case management.

S21

RECRUITING, HIRING AND RETAINING STAFF (4.1.6)

15. Recruiting and Hiring Processes

Explain the Proponent's approach to recruiting and hiring new staff, including all steps in the process and estimated timelines for completion.

Recruitment and Hiring Procedure:

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Timelines will be as follows:

- Once staffing request received, position will be posted internally for 14 calendar days in accordance with *C.A. Art. 17.01 Postings, A) The Employer shall post notice of all vacancies describing the position, classification, date of commencement, a summary of the job description, the required qualifications, and the site of the vacancy."* And *B) "The Employer agrees to post notices at least fourteen (14) days in advance of the selection."*

- External postings and advertising can be carried out simultaneously as well, unless appropriate internal applicant is known to be interested.

- Position can be filled immediately following the 14 day posting period by internal applicant who has proved fit for position by formal interview and/or assessment.

- If position needs to be filled externally timelines will depend on the availability of suitable external candidates.

16. Recruitment and Retention Incentives

Describe what incentives will be offered (excluding the hourly bonuses specified in section 4.4.3) to recruit and retain the employees and/or sub-contractors required for the delivery of these Services.

Recruitment and Retention Incentives:

- CHS has found that the most successful method for recruiting nurses is by word of mouth in the local nursing community as many of our current staff work in hospitals and will vigorously continue this approach.

- CHS will offer a $1000 finder's fee to staff and non-staff on the completion of a successful recruitment. This will provide incentive during times of personnel shortage or recruitment challenges.

- Staff retention strategy will be encouraged by the potential opportunity for promotion into supervisory positions, e.g. Assistant Health Care Manager (AHCM).

- CHS will endeavour to give preference to internal candidates and give opportunities to demonstrate their capabilities in temporary supervisory positions.

- In order to provide a welcoming workplace, HCMs and staff will be educated on respectful workplace policies. These policies will be enforced with zero tolerance for lack of respect in the workplace.

- In order to provide a safe workplace CHS will comply with all WorkSafe Regulations. HCMs and staff will perform an annual risk assessment in conjunction with Occupational Health and Safety Program.

S21

- CHS will review requests for educational funding and will grant funding when appropriate as defined by *C.A. Art. 34.03 General Education Programs (*see TAB 27*)* as negotiated by CHS with unionized staff.

- CHS will provide competitive wages and benefits to all health care staff to attract suitable applicants.

- A long service bonus of $1,000 after 10 years of service with CHS will be instituted.

- Sub-contractors will be recruited through professional networking and retention will be promoted through peer support groups.

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17. Service Delivery Levels/Personnel Shortages

Describe how Proponents will ensure service delivery levels are met in the event of personnel shortages (i.e. due to geography, limited local resources, etc.)

To ensure service delivery levels are met in the event of personnel shortages, CHS will do the following:

- The use of outside personnel is limited because of security requirements. The exception is when a shortage of Occupational First Aid Attendant (OFA) trained personnel occurs. In this case, if no OFA trained personnel is available from another centre, an outside agencies will be used. In the event of a shortage of staff holding current certification, local First Aid providers will be engaged to attend in the non-secure area of the centre (e.g. the lobby) for the duration of the shift to attend to occupational injuries as needed.

S21

- Review other centre staffing availability, especially casual pool and import staff as required, i.e. Lower Mainland Centres and Vancouver Island Centres will support each other during staff shortages.

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CONTINUITY OF SERVICE DELIVERY (4.1.7)

18. Staffing Levels During Unforeseen Disruption

Describe the Proponent's plan, both short term (up to 48 hours of disruption) and longer term (more than 48 hours) to ensure appropriate staffing levels during unforeseen circumstances.

Calibre Health Services (CHS) employs a team of over three hundred staff who are experienced in providing health care in a correctional setting. CHS recognizes that emergency situations may impact the ability of CHS staff to attend the workplace for their scheduled shift. A plan for the continuity of service has been developed to ensure that the health care needs of its clients are met. The plan addresses unforeseen labour disruptions as a separate issue because a different response is required.

Staffing levels in the first 48 hours

- In the hours immediately following an emergency, it may not be possible for staff scheduled for work to travel to the centre. The HCM or the AHCM in consultation with the CHS' senior management may request staff currently on duty to remain at the centre.

- CHS will assess the availability of personnel to staff the centre. The HCM/AHCM and senior CHS staff will contact staff by phone and request information regarding their availability and ability to attend the work place.

- CHS will maintain critical job functions in the first 48 hours. Other tasks will be performed as staffing levels allow.

Critical Job Functions

Critical job functions will include:

- Continuing to manage acute onset illness.

- Continue to manage chronic illness/conditions, (diabetes, cardiac conditions, Hepatitis C and HIV treatments, respiratory conditions) psychiatric and mental health issues and dental conditions.

- Attending all Code Blue calls.

- Provide emergency care including chest pain, hemorrhage, diabetic crisis, seizures, overdose, accidents with injury or trauma, suicide risk and self harm, unpredictable psychiatric events, extensive infections and fractures.

- Administer priority medications.

- Documentation of assessments and interventions in the Health Care Record

Staffing levels after the first 48 hours

Service levels may be impacted depending on the number of staff available. The following table provides a planned reduction of service that will be introduced if staffing remains at a reduced level. Not all services are available at all sites.

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Labour Disruptions

In the event of labour disruption by unionised staff the immediate essential service levels will be based on the Essential Service order from the Labour Relations Board of British Columbia date Aug 14, 2006. A full copy of the order will be with CHS' Labour Relations department.
It is anticipated that an application would be made to the Labour Relations Board as soon as possible to request a new order.

Staffing in the first 48 hours

2006 Critical job functions and essential service levels will be in force.

Critical Job Functions

- Screening of inmates, medication rounds, physicians clinics and OFA cover are essential services.

- Mental Health Program Coordinators are not essential for first 3-4 days but after that would likely be essential. In this event a ruling would be sought from the Labour Relations Board

- The following summary provides service hours to be delivered by Union and Excluded Staff:

Service Levels

Centre	Excluded Staff Hrs/ Provider	Shift Times	Days of week	Union Hours/ Provider	Day	Evening	Night
ACCW	45 / RN	0630-1745	Wed/Th/Fri/ Sat	28 / LPN	1x2x7	1x2x7	
FMCC	15 / RN	0730-1530	Mon/Tues	0			
FRCC	60 / RN	0630-1830	Mon - Fri	15 / LPN 54 / RN	1x4x5 (M-F) Remainder of shift on-call 1X2x2 (Sat-Sun) 0900-1100hrs 1x2x2 (Sat-Sun) 1600-1800hrs	1x3x5 1x4x5 (M-F) Remainder of shift on-call 1x3x2 (Sat-Sun) 1900-2200hrs	
KRCC	60 / RN	0630-1830	Mon - Fri	10 / LPN 10 / PT* 10 / MHS 41 / RN	1x2x5 1x4x2 Intake on supper runs (Th,Fr) Remainder of shift on-call On call M/W/Fr	1x2x5 1x2x5 1x3x5 (M-F) 1800-2100hrs) 1x5x2	

Centre	Excluded Staff Hrs/ Provider	Shift Times	Days of week	Union Hours/ Provider	Day	Evening	Night
					1x4x2 (Sat-Sun) 0700-1100hrs Remainder of shift on-call	(Sat-Sun) 1600-2100hrs Remainder of shift on-call	
NCC	60 / RN	0630-1830	Mon - Fri	36 / RN	1x7x2 (Sat/Sun)	1x3x5 (Mon-Fri) 1x3x2 (Sat/Sun) Remainder of shifts on-call	
NFPC	60 / RN 60/ Clerk	0700-1900 0700-1900	Mon – Fri Mon - Fri	30 / Clerk 17.5 / MHC 24 / MHS 72 / LPN 193 / RN	1x6x5 (All work for MD clinic) 1x3.5x5 1x4x5 (Mon-Fri) (leave when screening finished) 1x2x2 (Sat,Sun) (leave when screening finished) 1x8x2 (Sat, Sun) 1x10x5 (excluded do meds.) 1x12x2 (Sat, Sun)	1x8x7 1x12x7 1x5x7 (on call within nursing station for remaining hrs of shift)	
PGRCC	60 / RN	0630-1830	Mon - Fri	7 / Clerk 10 / MHS 28 /LPN or PT 27 / RN	1x3.5x2 (MD clinic days) 1x2x7 1x3x2 0800-1100hrs (Sat-Sun)	1x2x5 (leave when screening finished) 1x2x7 1x3x5 1900-2200	

Centre	Excluded Staff Hrs/ Provider	Shift Times	Days of week	Union Hours/ Provider	Day	Evening	Night
					Remainder of shift on-call	(Mon-Fri) 1x3x2 (Sat-Sun) Remainder of shift on-call	
SPSC	60 / RN 60 / RN 20 /Clerk	0630-1830 1030-2230 0700-1700	Mon – Fri Mon – Fri Tues/Wed	20 / LPN 73 / RN	1x4x5 0630-1030hrs (Mon-Fri) (Complete meds and related work) 1x7.5x2	1x4x5 (Mon-Fri) (Complete meds and related work) 1x4x5 1830-2230hrs (Mon-Fri) Remainder of shift on-call 1x3x2 1800-2100hrs (Sat-Sun) Remainder of shift on-call	
VIRCC	60 / RN 60 /PT	0630-1830 1030-2230	Mon – Fri Mon - Fri	22.5 / LPN 4 / LPN or PT 61 / RN	1x7.5x3 1x4x5 (Mon-Fri) 1x4x2 (Sat-Sun) Remainder of shift on-call	1x2x2 (Sat.Sun) 1x5x5 (Mon-Fri) Remainder of shift on-call 1x4x2 (Sat-Sun) Remainder of shift on-call	

Staffing levels after 48 hours

An application will be made to the Labour Relations Board as soon as possible to request a new order.

Staffing levels will be based on that order.

PROPONENT CAPABILITY (4.2)

CORPORATE EXPERIENCE (4.2.1)

19. Corporate Experience Appendices (Appendix D Form)

Complete Appendix D.

See TAB 1 for our completed *Appendix D – Corporate Experience Form*. We have completed one for the overall aspects of our company's experience.

Additionally for your information we have included several projects to demonstrate our experience. See TABS 2 to 6 for projects

20. Improving Health Care Service

Describe a situation where the Proponent organization was instrumental in improving health care service delivery. Include a complete description of the issue prior to the improvement, the Proponent's role in identifying the issue as well as planning, developing and implementing the improvement, and the methodology used to validate that an improvement had occurred.

Following are two examples where Calibre Health Services (CHS) was instrumental in improving health care service delivery.

Pages 63 through 69 redacted for the following reasons:
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S13

EXPERIENCE OF KEY PERSONNEL (4.2.2)

CONTRACTOR'S MANAGER & BACKUP MANAGER (4.2.2.1)

21. Positions and Incumbents/Resumes

The name and personal resume of the person intended for each position.

CONTRACTOR'S MANAGER

S22 – see resume in TAB 32

BACKUP MANAGER

S22 – see resume in TAB 33

COMMUNICABLE DISEASE LEAD

S22 – see resume in TAB 34

TECHNOLOGY LEAD – PAC

S22 see resume in TAB 35

TECHNOLOGY LEAD – GENERAL

S22 see resume in TAB 36

QUALITY IMPROVEMENT LEAD

S22 – see resume in TAB 36

MEDICATION AND SUPPLY SERVICES LEAD

S22 – see resume in TAB 37

MENTAL HEALTH AND ADDICTIONS LEAD

S22 – see resume in TAB 38

DISCHARGE PLANNING LEAD

S22 – see resume in TAB 39

MEDICAL LEAD

S22 – see resume in TAB 40

RADIOLOGY LEAD

S22 – see resume in TAB 41

BUSINESS & FINANCE LEAD

S22 – see resume in TAB 42

LABOUR RELATIONS LEAD

S22 – see resume in TAB 43

22. Proposed Incumbents' Experience

A high-level overview of the proposed individual's experience, detailing how the applicable numbered items [i.e. (a) through (xx)] are met. Include the name of the company relevant to the experience cited, the dates (month and year) that the proposed individual worked on the specific assignment or position, and a description of the named individual's duties and responsibilities.

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Pages 72 through 133 redacted for the following reasons:
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PRICE (4.3)

Proponents **must** submit costs to provide Health Care Services for all nine Correctional Centres. Proposals and costs to provide the Services to fewer than all nine Centres will not be accepted.

Calibre Health Services Inc. will provide health care services to all nine Correctional Centres. The cost information below applies to all of these centres.

The Province reserves the right to change levels of Service at any time for any reason. Proponents are advised that the Ministry may increase or decrease the number of Correctional Centres where Services are required during the term of the Contract, which would require a change to the levels of Service. In addition, different pricing and levels of service may be negotiated at any time that the Inmate count in one or more Correctional Centres fluctuates by more than 20% of what is identified in this RFP. This applies to both increases and decreases to the Inmate population.

A. While the Province may have the right to change levels of Service at any time for any reason, including increasing or decreasing either the number of Correctional Centres or the inmate count fluctuates more than 20%, S21

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B. The concern below was submitted to the Province for consideration during the RFP process and as seen in the reply, it was declined (ON-001946_Addendum_3, Questions 2 on page 3).

> **Proponent's Question:** "With regard to RFP #ON-001946 - Appendix B sec. 15.01."*The Province may terminate this agreement at any time, without cause, by giving at least 30 days written notice of termination to the Contractor.*" S21

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Province Reply: "The sample Contract included on BC Bid provides the standard default and termination clause as indicated above. This is a standard clause for all government contracts. While the provision will not be amended at this time, it is open for negotiation between the Province and the successful Proponent at the time of Contract negotiation."

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DIRECT SERVICE DELIVERY – ACTUAL COSTS (4.3.1)

Calibre Health recognizes that section (4.3.1) will form part of the Contract that results from this Request for Proposal. Furthermore that this data was provided as information only; and that Proponents are not required to provide a response specific to section 4.3.1 as per RFP #ON-001946, page 70. However, CHS has prepared this information based on our calculated wages and benefit rates. Please see Tab 46. It is understood that actual wages and benefits costs will be paid as per the BCNU agreement with Calibre Health Services Inc., posted with the RFP as Appendix N to demonstrate equivalencies in wages.

The RFP indicates on 68, in paragraph 9 that the Ministry will pay actual costs at sessional rate for non-direct patient care by the physician and psychiatrists for approved services not billable directly to MSP. Currently, CHS provides Physician Callback Services for emergencies that are not outlined in the RPF. These are billed at a minimum of 3 hours of sessional rate. It would be considered as a sub category under Sessional Rate, even though it is direct patient care, if the Branch wants this service to continue.

Addictions Counsellors:

- It is important to note that in the RFP document at sec 3.7.2.14 it states in the second paragraph, *"Provision of addiction counselling should be in accordance with the hours of service defined in Appendix C."*

- The posted RFP Appendix C – Hours of Service, on the cover page it states: *"Addictions Services will be provided on a per hour basis."* However, unlike all other positions set out in Appendix C there is no hours of service set out for the Addictions Counsellor, as suggested by the language of sec. 3.7.2.14.

- The only reference to hours of service for Addictions Counsellors is found in Section 4.1.1.3 - Note 1, which states: *"In addition, the Addictions Counsellors will provide no less than 35 hours / week in each Centre."*

- Therefore the Proponent has put forward a proposal with suggested hours of service for the Addictions Counsellors under section 4.1.1.3 – Response Guideline # 7.

HEALTH CARE MANAGERS' AND ASSISTANT HEALTH CARE MANAGERS' WAGES AND BENEFITS (4.3.2)

The Province will pay for actual costs of wages for the Health Care Managers and Assistant Health Care Managers, to the maximum of $48.06 per hour for the Health Care Managers, and $46.40 per hour for the Assistant Health Care Managers for hours approved by the Ministry.

CHS will accept the stated wages for the HCMs and AHCMs. Even though these "actual costs of wages" for the HCM/AHCMs outlined in the RFP are lower than their expectation for remuneration. These leaders also expect parity with increases that their staff receive. They would not be satisfied with a reduction in pay. Skilled Health Care Managers and Assistant Health Care Managers are crucial to having a well-run health care unit. In order to retain and attract these professionals the pay must stay competitive with the community. Therefore CHS will increase the current practice of awarding to deserving HCMs a performance based bonus to offset the wage level outlined. The bonus is built on objective measures of

quality control; and effective staff recruiting which will reduce overtime costs and ensure the hours of service are met. Other criteria are based on the efficient, safe operation of the health care unit within the framework of the Corrections Health Care Services Contract. This bonus strongly encourages performance based leadership from the managers. These bonuses are part of our Administrative Fee (see Tab 47).

Since 2003, our Health Care Managers have worked a 7.5 hour day providing them with a flex bank of 0.5 hours a day. They have the potential of taking one flex day per month and an extra week off once per year. Under current CHS contract, when the extra week is taken 4 of the 5 days have been backfilled. This adds a potential of 30 hours of backfilled time per year at 8 centres. The cost for this coverage has been added to our Administrative Fee (see Tab 47).

23. Benefit Percentage for Management (first 2 years)

Identify the benefit percentage that is proposed to be applied to the hourly wages of the Health Care Managers and Assistant Health Care Managers. Clearly specify this percentage for each of the first two years of the Contract Term.

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24. Breakdown of Benefits

Provide a breakdown of the benefits included in the percentages proposed.

See the percentage breakdown for these benefits under Tab 48

ADMINISTRATIVE FEE (4.3.3)

25. Administrative Costs for Years 1 and 2

Provide a firm, fixed, all-inclusive price for administrative costs for each of the first two years of the Contract term.

Further to paragraphs A and B under *Price (4.3)*, on page 130; and the information provided under *Direct Service Delivery – Actual Costs (4.3.1)*, on

page 131 the fixed, all-inclusive price for the administrative costs for each of the first two years of the Contract term is:

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26. Budget Breakdown for Years 1 and 2

Include a breakdown of what is included and the amount budgeted for each item identified for both years 1 and 2, that clearly identifies recruitment and retention costs, all costs associated with Functional Leads wages and benefits, admin staff wages and benefits, and all other costs included as a single category.

Tab 47 provides the breakdown of what is included and the amount budgeted in our proposal for the items in Year 1 and 2 for our Administration Fee.

Recruitment and retention are further outlined in Response Guideline #16, as well as addressed on page 132, when addressing wages for the HCM and AHCM.

Several expenses in Calibre Health's existing contract with BC Corrections have not been included in the posted RFP. As these need to continue, they have been incorporated into our Administration Fee (see Tab 47, items 24-28).

Start up Costs:

- As CHS has provided quality services for several years, our "start up costs" will be minimal. Start up costs will primarily relate to the creation of an Addiction Counselling program. The establishment of a standardized approach to addictions management throughout the province requires development of a job description, baseline inventory of existing programs and choice of assessment tools. As outlined earlier in our proposal (pages 20 and 44), our recommendation is to have an Addictions Transition Coordinator role for the first 3 months.

- Recruitment and hiring of the Addictions counsellors will require funding for travel and accommodation for CHS Management.

- Addiction counsellors will require orientation and training which will be delivered in a group setting. Remuneration for orientation hours, as well as travel and accommodation expenses for some counsellors and trainers will be required. This travel expense is identified in our Administration Fee, Start up Costs for Year 1, under Tab 49.

CONCLUSION

Calibre Health Services Inc. has a reputable and cooperative history with BC Corrections. To quote our policy statement:

Calibre Health is committed to promoting the health and wellness of persons in custody. We believe in creating an environment that fosters integrity and quality of care."

Calibre anticipates continuing our relationship with Corrections to provide "calibre health services" over the next five years and into the future.

"APPENDIX D"

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Appendix D – Corporate Experience Form

Proponent's Company Name:	Calibre Health Services Inc. (CHS)

Project 1 Name:	***Provision of Health and Mental Health Services to BC Corrections.***
Dates (month and year)	April 1, 2003 – Present
a) Describe the organized health system specific to this project, and how the Proponent delivered health services for this system within a set budget.	From 1985 to 2003 Joye Morris Health Services filled the contract to provide health services to BC Corrections at VIRCC. During this same period of time the health care delivered to BC Corrections was provided in a variety of manners. Some centres hired their own government nurses, some had individual contractors, and still others were covered by contractors handling multiple centres. Some of the nursing service was unionized with BCNU while others were not. There was little consistency in the delivery of health care. Based on the corporate experience garnered from that venture in November of 2002 a bid was made on the Province wide contract (#133406) and accepted. April 1st, 2003 Calibre Health Services, previously known as Joye Morris Health Services, contracted with BC Corrections to provide a comprehensive health and mental health service for the provincially incarcerated adults in BC. S21

Pages 145 through 158 redacted for the following reasons:
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S21
S21, S22
S22

BRITISH COLUMBIA NURSES' UNION

February 2, 2010

BC Corrections Branch
Ministry of Public Safety, Solicitor General
Victoria BC

To whom it may concern:

Re: Calibre Health Services Inc. and Corrections BC

As the Senior Director at the British Columbia Nurses' Union (BCNU), I am writing this letter to support the bid of Calibre Health Services to renew their contract with Corrections BC.

Calibre Health provides professional health services to the clients of Corrections BC in a number of facilities in BC. The labour relations between BCNU and Calibre Health are described as professional with honesty and respect as the cornerstone. At times the leadership at Calibre Health is described as tough in negotiations but there is also a degree of fairness in their decision making. Areas of dispute are often handled in a transparent fashion and creative problem solving is the norm. On occasion we do have legal challenges, but the parties have a mature relationship and move past these types of disagreements and continue to build on areas of common ground.

We do share this aspect of providing professional health services to patients and clients. It is in our mutual interest that Calibre renews their contract with Corrections BC. Stability for the employees, the employer, Corrections BC and the Government of BC will ensure quality services to all of those involved. Accordingly, we recently negotiated and ratified a new two year collective agreement to ensure stability. Thank you.

Please feel free to contact me at 604-433-2268.

Yours truly,

Gary Fane
Executive Director,
Strategic Development & Negotiations

c: Joye Morris, President, Calibre Health Services

GF/lp/

Pages 160 through 224 redacted for the following reasons:
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34.03 General Education Programs

(A) **Employer Requested Leave**

An employee shall be granted leave with the applicable rate of pay to take courses at the request of the Employer. The Employer shall bear the full cost of the course including tuition fees and course required books, necessary traveling and subsistence expenses. Courses identified by the joint OH&S Committee to promote a safe and healthy workplace and approved by the Employer, shall be treated like Employer requested leave.

Where the Employer requires an employee, as a condition of employment to perform first aid duties in addition to the normal requirements of the job, the cost of obtaining and renewing the OFA Certificate shall be borne by the Employer. Unless extenuating circumstances prevent them from being successful, where employees do not successfully complete the course and the employee fails to complete the second course and/or examination, the employee will be placed on an unpaid leave of absence until they successfully complete the course. The costs associated with taking the subsequent course(s) shall be borne by the employee.

(B) **Duration and Expenses**

Leave of absence and reasonable expenses with pay shall be granted for education programs subject to the approval of the Employer.

(A) **Employee Requested Leave**

The parties to this agreement share a desire to improve professional standards by giving the employees the opportunity on occasion to participate in workshops, short courses, similar out-service programs or continuing education courses to keep up to date with knowledge and skills in their respective fields, to acquire continuing professional specific credits required to complete or maintain current licensing registration standards.

The Employer shall grant one (1) day's education leave of absence with pay, subject to the above approval, for each normally scheduled work day, as posted, that an individual regular employee gives of her own time. Such educational leave of absence with pay is not to exceed five (5) days of Employer contribution in any one year. **The Employer shall indicate to the employee, in writing, the acceptance or refusal of such request at least forty-eight (48) hours prior to the commencement date of the requested leave. Approval for leave under this Article is subject to operational requirements and budget constraints.**

The Employer shall consider at its discretion paying up to fifty percent (50%) of the cost of tuition, course required books and necessary travelling and subsistence expenses for the above educational activities. Should the employee leave the service of the Employer within one year from the time of the leave, then the employee will refund to the Employer the full amount of the cost of expenses noted above.

(B) **Leave on Day Off**

Should alterations of the normally scheduled work day be made by the Employer so that an employee's educational day off falls on an off-duty day, the employee shall be paid for that day and be given an additional day off.

Pages 227 through 342 redacted for the following reasons:
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