State of Hawaii
Department of Public Safety
Health Care Division

Request for Proposals

RFP No.: PSD 06-HCD-38
DENTAL SERVICES FOR INMATES
AT THE
HALAWA CORRECTIONAL FACILITY

April 17, 2006

Note: If this RFP was downloaded from the State Procurement Office RFP Website each applicant must provide contact information to the RFP contact person for this RFP to be notified of any changes. For your convenience, you may download the RFP Interest form, complete and e-mail or mail to the RFP contact person. The State shall not be responsible for any missing addenda, attachments or other information regarding the RFP if a proposal is submitted from an incomplete RFP.

April 17, 2006

REQUEST FOR PROPOSALS

MOBILE DENTISTRY SERVICES FOR THE ISLAND OF HAWAII
RFP No. PSD 06-HCD-38

The Department of Department of Public Safety, Health Care Division, is requesting proposals from qualified applicants to provide general dental services to inmates detained in the State's correctional institutions. The contract term will be for a two-year period commencing on the date indicated on the Notice to Proceed. A single contract will be awarded under this request for proposals.

Proposals must be postmarked by US mail before midnight on May 17, 2006 or hand delivered by 4:30 p.m., Hawaii Standard Time (HST) at the drop off site that is designated on the following page.

Proposals postmarked after midnight on May 17, 2006 or hand delivered after 4:30 p.m. HST on May 17, 2006 will not be considered and will be returned to the applicant. There are no exceptions to this requirement.

The Health Care Division will conduct an orientation on April 24, 2006 at 10:00 am to 12:00 pm, HST, at 919 Ala Moana Boulevard, Room 413, Honolulu, Hawaii. All prospective applicants are encouraged to attend the orientation.

The deadline for submission of written questions is 4:30 p.m. HST on April 26, 2006. All written questions will receive a written response from the State by April 28, 2006.

Inquiries regarding this RFP should be directed to the RFP Contact Person, Mr. Marc Yamamoto at 919 Ala Moana Blvd., Room 413, or may be made by telephone to (808) 587-1215 or email at marc.s.yamamoto@hawaii.gov.

PROPOSAL MAIL-IN AND DELIVERY INFORMATION SHEET

NUMBER OF COPIES TO BE SUBMITTED:

ALL MAIL-INS MUST BE POSTMARKED BY UNITED STATES POSTAL SERVICE (USPS) NO LATER THAN

May 17, 2006

and received within ten (10) calendar days.

Department of Public Safety
Planning, Programming and Budget Office
919 Ala Moana Blvd., Room 413
Honolulu, Hawaii 96814

Mr. Marc Yamamoto
For further info. or inquiries
Phone: 587-1215
Fax: 587-1244

ALL HAND DELIVERIES WILL BE ACCEPTED AT THE FOLLOWING SITE UNTIL 4:30 P.M., May 17, 2006.

BE ADVISED: All mail-ins postmarked USPS after 12:00 midnight, May 17, 2006, will not be accepted for review and will be returned.

Hand deliveries will not be accepted after 4:30 p.m., May 17, 2006.

Deliveries by private mail services such as Fedex shall be considered hand deliveries and will not be accepted if received after 4:30 p.m., May 17, 2006.

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Section 1

Administrative Overview

Section 1
Administrative Overview

Applicants are encouraged to read each section of the RFP thoroughly. While sections such as the administrative overview may appear similar among RFPs, state purchasing agencies may add additional information as applicable. It is the responsibility of the applicant to understand the requirements of *each* RFP.

I. Procurement Timetable

Note that the procurement timetable represents the State's best estimated schedule. Contract start dates may be subject to the issuance of a notice to proceed.

Activity	Scheduled Date
Issuance of Request for Information (RFI)	April 3, 2006
Due date for RFI responses	April 10, 2006
Public notice announcing RFP	April 17, 2006
Distribution of RFP	April 17, 2006
RFP orientation session	April 24, 2006
Closing date for submission of written questions for written responses	April 26, 2006
State purchasing agency's response to applicants' written questions	April 28, 2006
Proposal submittal deadline	**May 17, 2006**
Proposal evaluation period	May 17–24, 2006
Provider selection and award	May 31, 2006
Notice of statement of findings and decisions (approx. date)	May 31, 2006
Contract start date	Date indicated on the Notice to Proceed

II. Request for Information Results

A request for information (RFI) was issued on April 3, 2006 inviting prospective applicants the opportunity to discuss questions regarding the scope of services, requirements of the subsequent request for proposals, as well as the type and range of services of the prospective applicant. Responses to the RFI were due on April 10, 2006, 4:30 p.m. (H.S.T.).

The following responses were received:
Not applicable—there were no response to our RFI.

III. Website Reference

The State Procurement Office (SPO) website is www.spo.hawaii.gov

	For	Click
1	Procurement of Health and Human Services	"Health and Human Services, Chapter 103F, HRS…"
2	RFP website	"Health and Human Services, Ch. 103F…" and "RFPs"
3	Hawaii Administrative Rules (HAR) for Procurement of Health and Human Services	"Statutes and Rules" and "Procurement of Health and Human Services"
4	Forms	"Health and Human Services, Ch. 103F…" and "For Private Providers" and "Forms"
5	Cost Principles	"Health and Human Services, Ch. 103F…" and "For Private Providers" and "Cost Principles"
6	Standard Contract -General Conditions	"Health and Human Services, Ch. 103F…" "For Private Providers" and "Contract Template – General Conditions"
7	Protest Forms/Procedures	"Health and Human Services, Ch. 103F…" and "For Private Providers" and "Protests"

Non-SPO websites

(Please note: website addresses may change from time to time. If a link is not active, try the State of Hawaii website at www.hawaii.gov)

	For	Go to
8	Tax Clearance Forms (Department of Taxation Website)	**http://www.hawaii.gov/tax/** click "Forms"
9	Wages and Labor Law Compliance, Section 103-055, HRS, (Hawaii State Legislature website)	**http://www.capitol.hawaii.gov/** click "Bill Status and Documents" and "Browse the HRS Sections."
10	Department of Commerce and Consumer Affairs, Business Registration	**http://www.hawaii.gov/dcca** click "Business Registration"
11	Campaign Spending Commission	**www.hawaii.gov/campaign**

IV. Authority

This RFP is issued under the provisions of the Hawaii Revised Statutes (HRS), Chapter 103F and its administrative rules. All prospective applicants are charged with presumptive knowledge of all requirements of the cited authorities. Submission of a valid executed proposal by any prospective applicant shall constitute admission of such knowledge on the part of such prospective applicant.

V. RFP Organization

This RFP is organized into five sections:

Section 1, Administrative Overview--Provides applicants with an overview of the procurement process.

Section 2, Service Specifications--Provides applicants with a general description of the tasks to be performed, delineates applicant responsibilities, and defines deliverables (as applicable).

Section 3, Proposal Application Instructions--Describes the required format and content for the proposal application.

Section 4, Proposal Evaluation--Describes how proposals will be evaluated by the state purchasing agency.

Section 5, Attachments --Provides applicants with information and forms necessary to complete the application.

VI. Contracting Office

The Contracting Office is responsible for overseeing the contract(s) resulting from this RFP, including system operations, fiscal agent operations, and monitoring and assessing provider performance. The Contracting Office is:

Wesley Mun
Department of Public Safety
919 Ala Moana Boulevard, Room 407
Honolulu, Hawaii 96814

Phone (808)	**587-2536**	Fax: (808)	**587-3378**

VII. Orientation

An orientation for applicants in reference to the request for proposals will be held as follows:

Date:	**April 24, 2006**	**Time:**	**10:00 a.m. to 12:00 p.m., H.S.T.**
Location:	**919 Ala Moana Boulevard, Room 413 Honolulu, Hawaii 96813**		

Applicants are encouraged to submit written questions prior to the orientation. Impromptu questions will be permitted at the orientation and spontaneous answers provided at the state purchasing agency's discretion. However, answers provided at the orientation are only intended as general direction and may not represent the state purchasing agency's position. Formal official responses will be provided in writing. To ensure a written response, any oral questions should be submitted in writing following the close of the orientation, but no later than the submittal deadline for written questions indicated in the next paragraph (VII. Submission of Questions).

VIII. Submission of Questions

Applicants may submit questions to the RFP Contact Person identified in Section 2 of this RFP. All written questions will receive a written response from the state purchasing agency.
Deadline for submission of written questions:
Date: **April 26, 2006** **Time:** **4:30 p.m.** HST
State agency responses to applicant written questions will be provided by**:**
Date: **April 28, 2006**

IX. Submission of Proposals

A. Forms/Formats - Forms, with the exception of program specific requirements, may be found on the State Procurement Office website (See page 1-2, Websites Referred to in this RFP. Refer to the Proposal Application Checklist for the location of program specific forms.

1. **Proposal Application Identification (Form SPO-H-200)** - Provides identification of the proposal.

2. **Proposal Application Checklist –** Provides applicants with information on where to obtain the required forms; information on program specific requirements; which forms are required and the order in which all components should be assembled and submitted to the state purchasing agency.

3. **Table of Contents -** A sample table of contents for proposals is located in Section 5, Attachments. This is a sample and meant as a guide. The table of contents may vary depending on the RFP.

4. **Proposal Application (Form SPO-H-200A) -** Applicant shall submit comprehensive narratives that addresses all of the issues contained in the Proposal Application Instructions, including a cost proposal/budget if required. (Refer to Section 3 of this RFP.**)**

5. **Tax Clearance –** A certified copy of a current valid tax clearance certificate issued by the State of Hawaii, Department of Taxation (DOTAX) and the Internal Revenue Service (IRS) will be required either at the time of proposal submittal or upon notice of award at the discretion of the purchasing agency.

   Refer to Section 4, subparagraph III.A.1, Administrative Requirements, and the Proposal Application Checklist (located in Section 5) to determine whether the tax clearance is required at time of proposal submittal for this RFP. Tax clearance application may be obtained from the Department of Taxation website. (See paragraph II, Website Reference.)

B. **Program Specific Requirements -** Additional program specific requirements are included in Sections 2 and/or 3, Service Specifications and the Proposal Application Instructions, as applicable. If Federal and/or State certifications are required, they are listed on the Proposal Application Checklist located in Section 5.

C. **Multiple or Alternate Proposals -** Multiple or alternate proposals shall not be accepted unless specifically provided for in Section 2 of this RFP. In the event alternate proposals are not accepted and an applicant submits alternate proposals, but clearly indicates a primary proposal, it shall be considered for award as though it were the only proposal submitted by the applicant.

D. **Wages and Labor Law Compliance -** Before a provider enters into a service contract in excess of $25,000, the provider shall certify that it complies with section 103-55, HRS, Wages, hours, and working conditions of employees of contractors performing services. Section 103-55, HRS may be obtained form the Hawaii State Legislature website. (See paragraph II, Website Reference.)

E. **Compliance with all Applicable State Business and Employment Laws.** All providers shall comply with all laws

governing entities doing business in the State. Prior to contracting, owners of all forms of business doing business in the state except sole proprietorships, charitable organizations unincorporated associations and foreign insurance companies be register and in good standing with the Department of Commerce and Consumer Affairs (DCCA), Business Registration Division. Foreign insurance companies must register with DCCA, Insurance Division. More information is on the DCCA website. (See paragraph II, Website Reference.)

F. **Campaign Contributions by State and County Contractors**. Contractors are hereby notified of the applicability of Section 11-205.5, HRS, which states that campaign contributions are prohibited from specified State or county government contractors during the term of the contract if the contractors are paid with funds appropriated by a legislative body. For more information, Act 203/2005 FAQs are available at the Campaign Spending Commission webpage. (See paragraph II, Website Reference.)

G. **Confidential Information –** If an applicant believes any portion of a proposal contains information that should be withheld as confidential, the applicant shall request in writing nondisclosure of designated proprietary data to be confidential and provide justification to support confidentiality. Such data shall accompany the proposal, be clearly marked, and shall be readily separable from the proposal to facilitate eventual public inspection of the non-confidential sections of the proposal.

Note that price is not considered confidential and will not be withheld.

H. **Proposal Submittal -** Proposals must be postmarked by USPS and received within ten days of the date designated on the Proposal mail-In and Deliver information sheet or hand delivered by the date and time designated on the Proposal Mail-In and Delivery Information Sheet attached to this RFP. Proposals shall be rejected when:

- postmarked after the designated date; or
- postmarked by the designated date but not received within 10 days; or
- If hand delivered, received after the designated date and time.

The number of copies required is located on the Proposal Mail-In and Delivery Information Sheet. Deliveries by private mail services such as FEDEX shall be considered hand

deliveries and shall be rejected if received after the submittal deadline. Dated USPS shipping labels are not considered postmarks.

Faxed proposals and/or submission of proposals on diskette/CD or transmission by e-mail, website or other electronic means **IS NOT permitted.**

X. Discussions with Applicants

A. Prior to Submittal Deadline. Discussions may be conducted with potential applicants to promote understanding of the purchasing agency's requirements.

B. After Proposal Submittal Deadline - Discussions may be conducted with applicants whose proposals are determined to be reasonably susceptible of being selected for award, but proposals may be accepted without discussions, in accordance section 3-143-403, HAR.

XI. Opening of Proposals

Upon receipt of proposal by a state purchasing agency at a designated location, proposals, modifications to proposals, and withdrawals of proposals shall be date-stamped, and when possible, time-stamped. All documents so received shall be held in a secure place by the state purchasing agency and not examined for evaluation purposes until the submittal deadline.

Procurement files shall be open to public inspection after a contract has been awarded and executed by all parties.

XII. Additional Materials and Documentation

Upon request from the state purchasing agency, each applicant shall submit any additional materials and documentation reasonably required by the state purchasing agency in its evaluation of the proposals.

XIII. RFP Amendments

The State reserves the right to amend this RFP at any time prior to the closing date for the final revised proposals.

XIV. Final Revised Proposals

The applicant's final revised proposal, *as applicable* to this RFP, must be postmarked by the date and time specified by the state purchasing agency and received within ten days or hand delivered by the date and time specified by the state purchasing agency. Final revised proposals shall be rejected when:

- Postmarked after the designated date; or
- Postmarked by the designated date but not receive within ten days or
- If hand carried, received after the designated date and time.

If a final revised proposal is not submitted, the previous submittal shall be construed as their best and final offer/proposal. *The applicant shall submit* ***only*** *the section(s) of the proposal that are amended, along with the Proposal Application Identification Form (SPO-H-200)*. After final revised proposals are received, final evaluations will be conducted for an award.

XV. Cancellation of Request for Proposal

The request for proposal may be canceled and any or all proposals may be rejected in whole or in part, when it is determined to be in the best interests of the State.

XVI. Costs for Proposal Preparation

Any costs incurred by applicants in preparing or submitting a proposal are the applicants' sole responsibility.

XVII. Provider Participation in Planning

Provider participation in a state purchasing agency's efforts to plan for or to purchase health and human services prior to the state purchasing agency's release of a request for proposals, including the sharing of information on community needs, best practices, and providers' resources, shall not disqualify providers from submitting proposals if conducted in accordance with sections 3-142-202 and 3-142-203 of the Hawaii Administrative Rules for Chapter 103F, HRS.

XVIII. Rejection of Proposals

The State reserves the right to consider as acceptable only those proposals submitted in accordance with all requirements set forth in this RFP and which demonstrate an understanding of the problems involved and comply with the service specifications. Any proposal

offering any other set of terms and conditions contradictory to those included in this RFP may be rejected without further notice.

A proposal may be automatically rejected for any one or more of the following reasons: (Relevant sections of the Hawaii Administrative Rules for Chapter 103F, HRS, are parenthesized)

(1) Rejection for failure to cooperate or deal in good faith. (Section 3-141-201, HAR)
(2) Rejection for inadequate accounting system. (Section 3-141-202, HAR)
(3) Late proposals (Section 3-143-603, HAR)
(4) Inadequate response to request for proposals (Section 3-143-609, HAR)
(5) Proposal not responsive (Section 3-143-610 (1), HAR)
(6) Applicant not responsible (Section 3-143-610 (2), HAR)

XIX. Notice of Award

A statement of findings and decision shall be provided to all applicants by mail upon completion of the evaluation of competitive purchase of service proposals.

Any agreement arising out of this solicitation is subject to the approval of the Department of the Attorney General as to form, and to all further approvals, including the approval of the Governor, required by statute, regulation, rule, order or other directive.

No work is to be undertaken by the awardee prior to the contract commencement date. The State of Hawaii is not liable for any costs incurred prior to the official starting date.

XX. Protests

Any applicant may file a protest against the awarding of the contract. The Notice of Protest form, SPO-H-801, is available on the SPO website. (See paragraph II, Website Reference.) Only the following matters may be protested:

(1) A state purchasing agency's failure to follow procedures established by Chapter 103F of the Hawaii Revised Statutes;

(2) A state purchasing agency's failure to follow any rule established by Chapter 103F of the Hawaii Revised Statutes; and

(3) A state purchasing agency's failure to follow any procedure, requirement, or evaluation criterion in a request for proposals issued by the state purchasing agency.

The Notice of Protest shall be postmarked by USPS or hand delivered to 1) the head of the state purchasing agency conducting the protested procurement and 2) the procurement officer who is conducting the procurement (as indicated below) within five working days of the postmark of the Notice of Findings and Decision sent to the protestor. Delivery services other than USPS shall be considered hand deliveries and considered submitted on the date of actual receipt by the state purchasing agency.

Head of State Purchasing Agency	**Procurement Officer**
Name: Frank J. Lopez	Name: May Kawawaki Price
Title: Interim Director	Title: Administrative Services Officer
Mailing Address: 919 Ala Moana Boulevard, Room 400 Honolulu, Hawaii 96814	Mailing Address: 919 Ala Moana Boulevard, Room 413 Honolulu, Hawaii 96814
Business Address: same as above	Business Address: same as above

XXI. Availability of Funds

The award of a contract and any allowed renewal or extension thereof, is subject to allotments made by the Director of Finance, State of Hawaii, pursuant to Chapter 37, HRS, and subject to the availability of State and/or Federal funds.

XXII. Monitoring and Evaluation

The criteria by which the performance of the contract will be monitored and evaluated are:

(1) Performance/Outcome Measures

(2) Output Measures

(3) Quality of Care/Quality of Services

(4) Financial Management

(5) Administrative Requirements

XXIII. General and Special Conditions of Contract

The general conditions that will be imposed contractually are on the SPO website. (See paragraph II, Website Reference). Special conditions may also be imposed contractually by the state purchasing agency, as deemed necessary.

XXIV. Liability Insurance

The Contractor shall maintain insurance acceptable to the State in full force and effect throughout the term of this contract. The policy or policies of insurance maintained by the Contractor shall provide the following limit(s) and coverage:

Coverage	Limits
Commercial General Liability (occurrence form)	$1,000,000 combined single limit per occurrence for bodily injury and property damage
Automobile, if applicable	
Bodily injury	$1,000,000/person $1,000,000/occurrence
Property damage	$1,000,000/accident
Professional Liability, if applicable	$1,000,000/claim $2,000,000 annual aggregate

Each insurance policy required by this contract shall contain the following clauses:

1. *"The insurance shall not be canceled, limited in scope of coverage or non-renewed until after 30 days written notice has been given to the State of Hawaii, Department of Public Safety, PPB Office, 919 Ala Moana Boulevard, Room 413, Honolulu, Hawaii 96814."*

2. *"The State of Hawaii, Department of Public Safety, is added as an additional insured as respects to operations performed for the State of Hawaii."*

3. *"It is agreed that any insurance maintained by the State of Hawaii will apply in excess of, and not contribute with, insurance provided by this policy."*

Each insurance policy shall be written by insurance companies licensed to do business in the State or meet Section 431:8-301, HRS, if utilizing an insurance company not licensed by the State of Hawaii.

The Contractor agrees to deposit with the State of Hawaii, on or before the effective date of this contract, certificate(s) of insurance necessary to satisfy the State that the insurance provisions of this contract have been complied with and to keep such insurance in effect and the certificate(s) therefore on deposit with the State during the entire term of this contract. Upon request by the State, Contractor shall furnish a copy of the policy or policies.

Failure of the Contractor to provide and keep in force such insurance shall be regarded as material default under this contract, entitling the State to exercise any or all of the remedies provided in this contract for a default of the Contractor.

The procuring of such required policy or policies of insurance shall not be construed to limit Contractor's liability hereunder nor to fulfill the indemnification provisions and requirements of this contract. Notwithstanding said policy or policies of insurance, Contractor shall be obliged for the full and total amount of any damage, injury, or loss caused by negligence or neglect connected with this contract.

If the Contractor is authorized by the Department Coordinator to subcontract, subcontractor(s) is not excused from the indemnification and/or insurance provisions of this contract. In order to indemnify the State, the Contractor agrees to require its subcontractor(s) to obtain insurance in accordance with the insurance provisions of this contract.

XXV. Cost Principles

In order to promote uniform purchasing practices among state purchasing agencies procuring health and human services under Chapter 103F, HRS, state purchasing agencies will utilize standard cost principles outlined in Form SPO-H-201 which is available on the SPO website (see paragraph II, Website Reference). Nothing in this section shall be construed to create an exemption from any cost principle arising under federal law.

XXVI. Campaign Contributions by State and County Contractors

Contractors are hereby notified of the applicability of Section 11-205.5, HRS, which states that campaign contributions are prohibited from specified State or county government contractors during the term of the contract if the contractors are paid with funds appropriated by a legislative body.

Section 2

Service Specifications

Section 2
Service Specifications

I. Introduction

A. Background

The Department of Public Safety, Health Care Division is responsible for the provision of health care to the individuals who are incarcerated throughout the State of Hawaii. This includes medical, dental and mental health services. The Halawa Correctional Facility (HCF) is presently without dental services. The HCF facility houses men of varied custody levels, in the Halawa Special Needs Facility (HSNF), 133 inmates and in the Halawa Medium Security Facility (HMSF), 1,011 inmates for a total of 1,144 inmates.

Both the HSNF and the HMSF have dedicated space for dental services.

B. Purpose or Need

The Department of Public Safety, Health Care Division requires the provision of dental services for the HCF. The routine dental services required will meet the Department's Oral Care policy and procedure, as well as the National Commission on Correctional Health Care Dental standards.

C. Description of the goals of the service

The service provider shall provide on site dental clinics at the HMSF and the HSNF. The services involve general dentistry and a variety of acute and chronic oral health problems, including but not limited to restorative and prophylactic services. Inmate patients are screened and referred by the facility dental staff and/or nurses.

The Health Care Division will provide the clinical space. The service provider will provide all of the necessary equipment and dental supplies. The service provider shall record all evaluations, dental care, and treatments provided in the patients' individual facility dental records. The service provider shall be subject to all of the policies and procedures of the Health Care Division.

D. Description of the target population to be served

The Department of Public Safety, Health Care Division, seeks general dental services for inmates detained in the State's correctional institutions at the HCF.

E. Geographic coverage of service

The required dental services shall be provided at the HCF on the island of Oahu.

F. Probable funding amounts, source, and period of availability

The funds allocated for this contract is $410,000 for each year of the contract, subject to the availability of funds after June 30, 2006.

II. General Requirements

A. Specific qualifications or requirements, including but not limited to licensure or accreditation

The applicant shall comply with the Chapter 103F, HRS Cost Principles for Purchases of Health and Human Services identified in SPO-H-201 (Effective 10/1/98), which can be found on the SPO website (See Section 5, POS Proposal Checklist, for the website address).

1. Applicants shall have:

    a. A DDS or DMD degree;
    b. A current Hawaii dental license;
    c. Practice experience in an institutional setting, preferred but not required;
    d. Experience in correctional dentistry, preferred but not required (significant correctional dentistry experience during training will be considered); and
    e. A minimum of two recent references.

2. Service provider shall be responsible for providing all necessary equipment and dental supplies necessary for providing dental services to inmates at the HCF.

3. Service provider shall not be an employee of the State of Hawaii, Department of Public Safety.

B. Secondary purchaser participation
(Refer to §3-143-608, HAR)

After-the-fact secondary purchases will be allowed.

C. Multiple or alternate proposals
(Refer to §3-143-605, HAR)

☐ Allowed ☒ Unallowed

D. Single or multiple contracts to be awarded
(Refer to §3-143-206, HAR)

☒ Single ☐ Multiple ☐ Single & Multiple

Criteria for multiple awards:

E. Single or multi-term contracts to be awarded
(Refer to §3-149-302, HAR)

☐ Single term (≤ 2 yrs) ☒ Multi-term (> 2 yrs.)

Contract terms:

The service provider shall enter into contract for the **two-year** period commencing upon the date indicated on the Notice to Proceed. Unless terminated, the contract may be extended for not more than three additional twelve-month periods or portions thereof without the necessity of rebidding, if mutually agreed upon in writing.

F. RFP contact person

The individual listed below is the sole point of contact from the date of release of this RFP until the selection of the successful provider or providers. Written questions should be submitted to the RFP contact person and received on or before the day and time specified in Section 1, paragraph I (Procurement Timetable) of this RFP.

Mr. Marc Yamamoto, PPB-Purchasing Specialist
Department of Public Safety
919 Ala Moana Blvd., Rm. 413
Honolulu, Hawaii 96814
Phone: (808) 587-1215 Fax: (808) 587-1244

III. Scope of Work

The scope of work encompasses the following tasks and responsibilities:

A. Service Activities (Minimum and/or mandatory tasks and responsibilities)

1. Service provider shall provide dental services at a minimum of sixteen (16) days (or mutually determined number of days based on patient needs) a month to inmates at the following facility on the island of Oahu.

   Halawa Correctional Facility (HCF)
   99-902 Moanalua Road
   Aiea, Hawaii 96702

   Point of Contact: Mary Tumminello
   Phone: 484-7292

2. Service provider shall:

   a. Provide general dental services and education related to oral health and hygiene according to *the Department of Public Safety, Health Care Division, Policy and Procedures for Oral Care* attached hereto as Attachment C.

   b. Examine and diagnose dental and oral diseases.

   c. Render indicated treatment for oral and dental diseases, including but not limited to oral diagnoses, dental prostheses, restorative dentistry, oral surgery, treatment of pain and infection in the oral cavity, taking of x-rays, and prescription medications according to the Department of Public Safety policies and procedures.

   d. Maintain records of all care and treatment rendered according to the Department of Public Safety format.

   e. Contractor shall be responsible for payment on all referrals.

   f. Review quarterly dental staff meeting minutes to keep abreast of all current practices of dentistry in the correctional system and express concerns to the Health Care Division Administrator.

g. Contractor shall provide the dental services associated with dental prostheses and will invoice the State for reimbursement for any Laboratory fees related to the fabrication of the prostheses. Patients will be required to complete the Prosthesis Purchase Agreement form per *the Department of Public Safety, Health Care Division, Policy and Procedures for Prostheses* attached hereto as Attachment D.

h. Develop and implement infection control practices in compliance with OSHA and HIOSHA guidelines. Includes standard precautions, adequately cleaning and sterilization of non-disposable dental instruments and performing monthly autoclave spore counts.

i. Administer and maintain the Inmate Medical Co-Payment Plan as it pertains to dental services per *the Department of Public Safety, Health Care Division, Policy and Procedures for Inmate Medical Co-Payment Plan* attached hereto as Attachment E.

j. Conduct regular sharps counts and monthly tool inventory counts per *the Department of Public Safety, Health Care Division, Policy and Procedures for Tool/Equipment Control* attached hereto as Attachment F. Provide documentation of above counts to the Clinic Services Administrator.

k. Be familiar with and adhere to all Departmental policies and procedures.

3. The service provider shall receive general supervision from the Department's Health Care Division Administrator.

4. Lockdowns

a. Scheduled Lockdowns: Service provider will be notified in advance of scheduled lockdowns. Service provider shall arrange with the facility's health care section to have patients called out ahead of the scheduled lock down, so that dental services will be provided on a continuous basis.

b. Unscheduled Lockdowns: The service provider shall utilize this time by doing internal audits on dental procedures and documentations.

5. Travel Time. Service provider shall not be paid for travel time.

6. Additional Hours. Dentist shall work only the approved or agreed upon hours for the HCF. Written permission from the Health Care Division Administrator shall be obtained before working additional hours.

B. Management Requirements (Minimum and/or mandatory requirements)

1) Personnel

The Provider and/or Sub-Provider shall notify each of its employees as well as employees of any subcontractors who provide services to any person committed to the custody of the Director of Public Safety for imprisonment pursuant to Chapter 706, Hawaii Revised Statutes (HRS), including a probationer serving a term of imprisonment pursuant to Section 706-624(2)(a), HRS and a misdemeanant or petty misdemeanant sentenced pursuant to Section 706-663, HRS, about the Hawaii Revised Statutes Section 707-731 relating to sexual assault in the second degree and Section 707-732, relating to sexual assault in the third degree. In addition, the Provider and any subcontractor shall maintain in each of the aforementioned employees and employees of any subcontractors' file, written documentation that the employee has received notice of the statutes.

The Provider and/or Sub-Provider shall employ staff that is suitable to deal with these offenders. The Provider and/or Sub-Provider shall not use persons currently serving a criminal sentence, including any on furlough from a correctional facility, on probation, on parole, or under the terms of a DAG/DANC plea. Any employee with a criminal history shall be subject to review and approval by the Department. The Department of Public Safety will review and agree to the employment of the service provider's staff and sub-providers, in writing. Upon request, the Provider and/or Sub-Provider shall submit any information necessary to determine whether approval will, at the discretion of the Department, be granted. Any changes to staff and/or Sub-Providers shall be subject to the prior written approval of the Department.

2) Administrative

a. Service provider shall operate their program in accordance with the rules, regulations, and policies of the Department of Public Safety.

b. Service provider is required to meet the qualifying requirements specified in Chapter 103F, Hawaii Revised Statutes.

c. Service provider shall maintain and show proof of a liability insurance policy of at least one million dollars. The Department of Public Safety shall be named as an additional insured and shall be notified at least thirty (30) days prior to cancellation.

d. Service provider shall provide the Corrections Health Care Administrator a copy of the current dental license, DEA certificate, and CPR certification for any dental providers servicing the contract. The Service provider will provide these credentials for additional dental providers that may be added to service this contract and as existing licenses and certificates are renewed. The Health Care Division requires that all current credentials be maintained in its files.

3) Quality assurance and evaluation specifications

This section is not applicable to this RFP.

4) Output and performance/outcome measurements

This section is not applicable to this RFP.

5) Reporting requirements for program and fiscal data

a. Service provider shall ensure that an informed consent Form DOC 0427 be completed and signed by the inmate prior to any dental procedures such as tooth extractions, root canal therapy, or other surgical procedures are performed per *the Department of Public Safety, Health Care Division, Policy and Procedures for Informed Consent* attached hereto as Attachment G.

b. Service provider shall ensure that the facility nurse records on Form DOC 0417, “Refusal to Consent to Medical or Surgical Treatment”, any inmate’s refusal for treatment.

b. Service provider shall submit quarterly reports of dental services rendered using Form DOC 0431b (Attachment C). Service provider shall submit three months of Dental Statistics Monthly reports on a quarterly basis along with a written summary.

6) Pricing structure or pricing methodology to be used

Applicant shall submit a cost proposal utilizing the pricing structure designated by the state purchasing agency. The cost proposal shall be attached to the POS Proposal Application.

7) Units of service and unit rate

Pricing Structure Based on Unit of Service – Negotiated

Pricing shall be based on a fee schedule/unit of service pricing structure or a capitated, per patient per month rate, for services described in *the Department of Public Safety's Policies and Procedures relating to Oral Care*, Attachment C. The rates submitted shall be subject to negotiation.

Service provider shall submit monthly itemized invoices, original and three copies, which detail the following:

1. Inmate name;
2. Facility of inmate;
3. Procedures completed;
4. Date of the procedure; and
5. Charge amount

The service provider shall not be compensated for downtime. However, once the Dental Clinic is scheduled, the nurse supervisor and/or the Facility Dental Staff shall make every effort to ensure that enough inmate patients are available on the list.

If a facility wide lockdown is scheduled, the Dental Clinic may be rescheduled and the service provider shall be notified in a timely manner.

IV. Facilities

This section is not applicable to this RFP.

Section 3

Proposal Application Instructions

Section 3
Proposal Application Instructions

General instructions for completing applications:

- *Proposal Applications shall be submitted to the state purchasing agency using the prescribed format outlined in this section.*
- *The numerical outline for the application, the titles/subtitles, and the applicant organization and RFP identification information on the top right hand corner of each page should be retained. The instructions for each section however may be omitted.*
- *Page numbering of the Proposal Application should be consecutive, beginning with page one and continuing through for each section. See sample table of contents in Section 5.*
- *Proposals may be submitted in a three ring binder (Optional).*
- *Tabbing of sections (Recommended).*
- *Applicants must also include a Table of Contents with the Proposal Application. A sample format is reflected in Section 5, Attachment B of this RFP.*
- *A written response is required for **each** item unless indicated otherwise. Failure to answer any of the items will impact upon an applicant's score.*
- *Applicants are **strongly** encouraged to review evaluation criteria in Section 4, Proposal Evaluation when completing the proposal.*
- *This form (SPO-H-200A) is available on the SPO website (see Section 1, paragraph II, Website Reference). However, the form will not include items specific to each RFP. If using the website form, the applicant must include all items listed in this section.*

The Proposal Application comprises the following sections:

- *Proposal Application Identification Form*
- *Table of Contents*
- *Program Overview*
- *Experience and Capability*
- *Project Organization and Staffing*
- *Service Delivery*
- *Financial*
- *Other*

I. Background and Summary

This section is not applicable to this RFP.

II. Experience and Capability

A. Necessary Skills and Experience

The applicant shall demonstrate that it has the necessary skills, abilities, knowledge of, and experience relating to the delivery of the proposed services. The applicant shall also provide a listing of verifiable experience with projects or contracts for the most recent five years that are pertinent to the proposed services.

B. Quality Assurance and Evaluation

This section is not applicable to this RFP.

C. Coordination of Services

This section is not applicable to this RFP.

D. Facilities

This section is not applicable to this RFP.

III. Personnel: Project Organization and Staffing

A. Proposed Staffing

This section is not applicable to this RFP.

B. Staff Qualifications

This section is not applicable to this RFP.

IV. Service Delivery

The Service Delivery Section shall include a detailed discussion of the applicant's approach to applicable service activities and management requirements from Section 2, Item III. - Scope of Work, including (if indicated) a work plan of all service activities and tasks to be completed, related work assignments/responsibilities and timelines/schedules.

Please discuss and attach sample reports indicating the dental work provided to each inmate. This report shall be provided to the Department on a timely basis.

V. Financial

A. Pricing Structure

Applicant shall submit a cost proposal utilizing the pricing structure designated by the state purchasing agency. The cost proposal shall be attached to the POS Proposal Application.

Pricing Structure Based on Negotiated Unit of Service Rate

In order to determine a price (unit rate) for a unit of service, the applicant and state purchasing agency negotiate the total costs (including agency administration) for operating a program at a specific capacity and divide by the total number of units of service that the program can produce at that capacity.

Applicant shall submit a fee schedule by procedure or an estimated fee to provide the services listed under Attachment C. All rates shall include all costs associated with carry out the terms of the contract, and all applicable taxes. The State reserves the right to negotiate with the applicant on any or all fees proposed.

All budget forms, instructions and samples are located on the SPO website (see the POS Proposal Checklist in Section 5 for website address). The following budget form(s) shall be submitted with the POS Proposal Application:

Budget forms are not required with this RFP.

VI. Other

A. Litigation

The applicant shall disclose any pending litigation to which they are a party, including the disclosure of any outstanding judgment. If applicable, please explain.

Section 4

Proposal Evaluation

Section 4
Proposal Evaluation

I. Introduction

The evaluation of proposals received in response to the RFP will be conducted comprehensively, fairly and impartially. Structural, quantitative scoring techniques will be utilized to maximize the objectivity of the evaluation.

II. Evaluation Process

The procurement officer or an evaluation committee of designated reviewers selected by the head of the state purchasing agency or procurement officer shall review and evaluate proposals. When an evaluation committee is utilized, the committee will be comprised of individuals with experience in, knowledge of, and program responsibility for program service and financing.

The evaluation will be conducted in three phases as follows:

- Phase 1 - Evaluation of Proposal Requirements
- Phase 2 - Evaluation of Proposal Application
- Phase 3 - Recommendation for Award

Evaluation Categories and Thresholds

Evaluation Categories		Possible Points
Administrative Requirements		**Pass or Rejected**
Proposal Application		**100 Points**
Program Overview	Not Applicable	
Experience and Capability	20 points	
Project Organization and Staffing	Not Applicable	
Service Delivery	40 points	
Financial	40 Points	
TOTAL POSSIBLE POINTS		**100 Points**

III. Evaluation Criteria

Phase 1 - Evaluation of Proposal Requirements

1. **Administrative Requirements**

2. **Proposal Application Requirements**

- Proposal Application Identification Form (Form SPO-H-200)
- Table of Contents
- Program Overview
- Experience and Capability
- Project Organization and Staffing
- Service Delivery
- Financial (All required forms and documents)
- Program Specific Requirements (as applicable)

Phase 2 - Evaluation of Proposal Application (100 Points)

1. ***Program Overview:*** No points are assigned to Program Overview. The intent is to give the applicant an opportunity orient evaluators as to the service(s) being offered.

   Not applicable to this RFP.

2. ***Experience and Capability (20 Points)***

   The State will evaluate the applicant's experience and capability relevant to the proposal contract, which shall include:

   - Demonstrated skills, abilities, and knowledge relating to the delivery of the proposed services.
   - Sufficiency of quality assurance and evaluation plans for the proposed services, including methodology.

3. ***Project Organization and Staffing (Not Applicable to this RFP)***

   The State will evaluate the applicant's overall staffing approach to the service that shall include:

A. Staffing _____

_____

Not applicable to this RFP. _____

_____

B. Project Organization _____

_____

Not applicable to this RFP. _____

_____

4. Service Delivery (40 Points)

Evaluation criteria for this section will assess the applicant's approach to the service activities and management requirements outlined in the Proposal Application.

5. Financial (40 Points)

Pricing structure based on negotiated unit of service rate

- Competitiveness and reasonableness of unit of service rate, as applicable
- Applicants proposal budget is reasonable, given program resources and operational capacity.

Phase 3 - Recommendation for Award

Each notice of award shall contain a statement of findings and decision for the award or non-award of the contract to each applicant.

Section 5

Attachments

A	Competitive POS Application Checklist
B	POS Proposal Application - Sample Table of Contents
C	Department of Public Safety, Health Care Division, Policy and Procedures for Oral Care.
D.	Department of Public Safety, Health Care Division, Policy and Procedures for Prostheses.
E.	Department of Public Safety, Health Care Division, Policy and Procedures for Inmate Medical Co-Payment Plan.
F.	Department of Public Safety, Health Care Division, Policy and Procedures for Tools/Equipment Control.
G.	Department of Public Safety, Health Care Division, Policy and Procedures for Informed Consent.

Proposal Application Checklist

Applicant: _____ RFP No.: _____

The applicant's proposal must contain the following components in the order shown below. This checklist must be signed, dated and returned to the purchasing agency as part of the Proposal Application. SPOH forms ore on the SPO website. See Section 1, paragraph II Website Reference.*

Item	Reference in RFP	Format/Instructions Provided	Required by Purchasing Agency	Completed by Applicant
General:				
Proposal Application Identification Form (SPO-H-200)	Section 1, RFP	SPO Website*	**X**	
Proposal Application Checklist	Section 1, RFP	Attachment A	**X**	
Table of Contents	Section 5, RFP	Section 5, RFP	**X**	
Proposal Application (SPO-H-200A)	Section 3, RFP	SPO Website*	**X**	
Tax Clearance Certificate (Form A-6)	Section 1, RFP	Dept. of Taxation Website (Link on SPO website)*		
Cost Proposal (Budget)				
SPO-H-205	Section 3, RFP	SPO Website*		
SPO-H-205A	Section 3, RFP	SPO Website* Special Instructions are in Section 5		
SPO-H-205B	Section 3, RFP,	SPO Website* Special Instructions are in Section 5		
SPO-H-206A	Section 3, RFP	SPO Website*		
SPO-H-206B	Section 3, RFP	SPO Website*		
SPO-H-206C	Section 3, RFP	SPO Website*		
SPO-H-206D	Section 3, RFP	SPO Website*		
SPO-H-206E	Section 3, RFP	SPO Website*		
SPO-H-206F	Section 3, RFP	SPO Website*		
SPO-H-206G	Section 3, RFP	SPO Website*		
SPO-H-206H	Section 3, RFP	SPO Website*		
SPO-H-206I	Section 3, RFP	SPO Website*		
SPO-H-206J	Section 3, RFP	SPO Website*		
Certifications:				
Federal Certifications		Section 5, RFP		
Debarment & Suspension		Section 5, RFP		
Drug Free Workplace		Section 5, RFP		
Lobbying		Section 5, RFP		
Program Fraud Civil Remedies Act		Section 5, RFP		
Environmental Tobacco Smoke		Section 5, RFP		
Program Specific Requirements:				

_____ Authorized Signature

_____ Date

Organization: _____
RFP No:_____

Sample

Proposal Application
Table of Contents

I. Program Overview 1

II. Experience and Capability 1
- **A.** Necessary Skills 2
- **B.** Experience 4
- **C.** Quality Assurance and Evaluation 5
- **D.** Coordination of Services 6
- **E.** Facilities 6

III. Project Organization and Staffing 7
- **A.** Staffing 7
  1. Proposed Staffing 7
  2. Staff Qualifications 9
- **B.** Project Organization 10
  1. Supervision and Training 10
  2. Organization Chart (Program & Organization-wide)
     (See Attachments for Organization Charts)

IV. Service Delivery 12

V. Financial 20
See Attachments for Cost Proposal

VI. Litigation 20

VII. Attachments
- **A.** Cost Proposal
  SPO-H-205 Proposal Budget
  SPO-H-206A Budget Justification - Personnel: Salaries & Wages
  SPO-H-206B Budget Justification - Personnel: Payroll Taxes and Assessments, and Fringe Benefits
  SPO-H-206C Budget Justification - Travel: Interisland
  SPO-H-206E Budget Justification - Contractual Services – Administrative
- **B.** Other Financial Related Materials
  Financial Audit for fiscal year ended June 30, 1996
- **C.** Organization Chart
  Program
  Organization-wide
- **D.** Performance and Output Measurement Tables
  Table A
  Table B
  Table C
- **E.** Program Specific Requirements

1.0 **PURPOSE**

To provide oral care to inmates under the direction and supervision of a dentist licensed in the State.

2.0 **REFERENCES AND DEFINITIONS**

.1 References

a. HRS, Section 26-14.6, Department of Public Safety; and Section 353C-2, Director of Public Safety, Powers and Duties.

b. National Commission on Correctional Health Care Standards for Prisons and Jails, (2003), Oral Care.

c. American Dental Association.

d. American Correctional Association Standards for Adult Local Detention Facilities, (1991), dental Screening and Examination.

e. Department of Public Safety Policy and Procedures Manual,
COR.10A.16, Inmates Requesting Private Medical Care Provider.
COR.10.1G.11, Prostheses
COR.10.1H.05, The Transfer of Medical Records.

.2 Definitions

a. Universal Dental Recording System: A mean of identifying teeth by number.

b. Prosthetics: Artificial devices to replace missing body parts; in this case, dentures, bridges, etc.

3.0 **POLICY**

.1 Dental examinations and treatments for inmates shall be performed by, and under the direction and supervision of, a dentist licensed to practice in the Sate of Hawaii.

.2 Dental care of inmates shall be timely and includes immediate access for urgent or painful conditions. The inmate's serious urgent and emergent dental needs shall be met.

4.0 **PROCEDURES**

.1 Dental screening of newly admitted inmates shall occur within fourteen (14) days of admission into the Department of Public Safety (PSD) jail facilities and seven (7) days after admission to prison facilities. Inmates who transfer from one PSD facility to another who received a dental screen while at the sending facility do not require a new screening at the receiving facility if the documentation in the dental record is received within the 14 to 7 days respectively.

.2 The dental screening shall include visual observation of the teeth and gums, noting any gross abnormalities which require immediate referral to a dentist. Health staff with documented training by a dentist can perform dental screens. The screening shall be recorded in the dental record.

.3 Instructions in oral hygiene and preventive oral education are given within one (1) month of admission by a dentist, dental hygienist, or health staff with documented training by a dentist.

.4 A dentist shall perform a dental examination on all inmates within thirty (30) days of admission to a PSD prison facility and within one (1) year of admission to a PSD jail facility. Inmates who transfer from one PSD facility to another who received a dental screen while at the sending facility do not require a new examination at the receiving facility if the documentation in the dental record transfers with the inmate.

Inmates who are re-admitted and who received a dental examination and treatments within the past year do not require a new examination unless so determined by the supervising dentist.

.5 Dental examinations shall include taking the patient's dental history, and extraoral head and neck examination, charting of teeth and examination of hard and soft tissue of the oral cavity with a mouth mirror, explorer and adequate illumination. The examination results shall be recorded on Form DOC 0424 Dental Examination (Attachment A) utilizing a number system, such as the Universal Dental Recording System (e.g., 1-32, A -T).

.6 Oral treatment shall be prioritized for emergencies, acute injuries to the teeth, acute injuries to the oro-facial complex, infection control, pain management, proper mastication and maintaining the patients' health status.

.7 Bitewing x-rays and additional radiographs may be taken at the time of the patient's first treatment appointment and thereafter as indicated.

.8 Each inmate shall have access to the preventive benefits of fluorides in a form determined by the dentist to be appropriate for the needs of the individual.

.9 Extractions shall be performed in a manner consistent with community standards of care and adhering to the American dental association's clinical guidelines. Extractions are limited to the following:

1. Non-restorable teeth;
2. Periodontally compromised teeth; and
3. Severe, acute or chronic infection.

Informed patient consent for extractions is required on DOC 0427, Consent to Operation, Post Operative Care, medical Treatment, Anesthesia or Other Procedure (Attachment B).

.10 Inmates can seek private dental care at their own expense under COR.10A.16, Inmates Requesting Private Medical Care Provider. For security reasons, dental staff should encourage the private provider to come to the facility to provide the services. Approval for private provider care must be approved by the Correctional Health Care Administrator or designee.

.11 Medical reviews of any inmates to be transferred to another correctional facility shall include consideration of any pending dental work. Should an inmate's pending transfer involve a facility at which an institutional dentist is not readily available and the inmate has major uncompleted dental work pending, the inmate shall not be transferred until dental services have been completed.

.12 All dental records shall be confidential. These records shall be maintained for all patients and shall include as indicated the:

a. Dental Treatment Record, DOC 0409 (Attachment C).

b. Dental Health Questionnaire, DOC 0411 (Attachment D).

c. Refusal to consent to Medical/Surgical Treatment/Medication, DOC 0417 (Attachment E).

d. Dental Examinations.

e. Consent to Operation, Post Operative..., DOC 0427, (Attachment B).

f. Perio Chart.

g. Dental Problem Sheet, DOC 0475 (Attachment F).

h. Medical Needs Memo, DOC 0449 (Attachment G).

i. Consultation Record, doc 0406 (Attachment H).

j. X-rays.

.13 When an inmate transfers to another PSD facility, the dental record shall be packed with the medical record and transferred according to P & P COR.10E.03, The Transfer of Medical Records.

.14 Dental records shall be notated in S-O-A-P or problem oriented format. All notes shall include the client's complaint, the examination, the diagnostic impression, and the treatment and treatment plans.

.15 Form DOC 0406 Consultation Record shall accompany the inmate to an outside dental referral. DOC 0406 will also be used when a dental consultant comes to the facility. The Consultation Record and the consultant's report shall be filed in the Consultation Index of the medical record. A copy of the consultation Record and consultant's report shall be filed in the dental record.

.16 All dental staff shall practice universal infection controls and infection controls. Infection control practices are defined by the American Dental Association and the Centers for Disease control and Prevention as including sterilizing

instruments, disinfecting equipment, and properly disposing of hazardous waste.

No inmate shall be denied dental treatment because of an infectious condition.

.17 Reviews of dental services will be included in the PSD health services quality assurance program as described in P & P COR.10A.05, Quality Improvement Program.

5.0 SCOPE

This policy and procedure applies to all correctional facilities and their assigned personnel.

APPROVAL RECOMMENDED:

Kay A Bauman MD
Medical Director
5/21/03
Date

Correctional Health Care Administrator
4/3/03
Date

Deputy Director for Corrections
5.10.03
Date

APPROVED:

Director
5/12/03
Date

Attachment A

CATEGORY CLASSIFICATION: _____

FACILITY _____

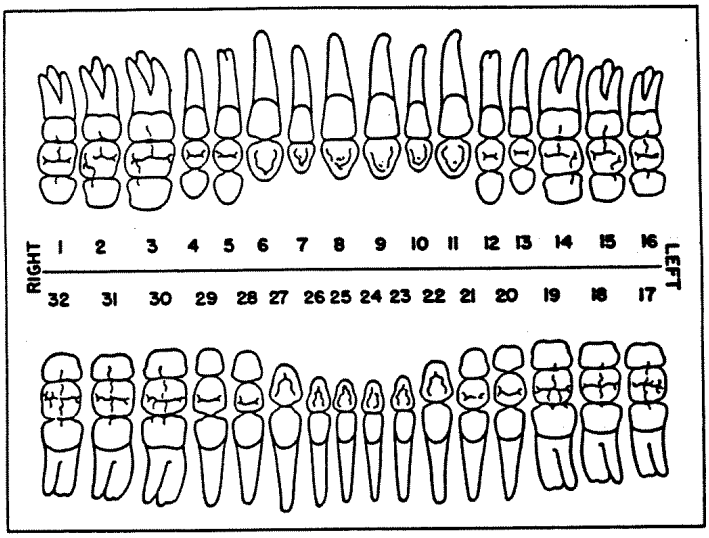
STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

DENTAL EXAMINATION

NAME _____ D.O.B. _____ SSN _____

Date Admitted _____ Exam Date _____

Medical Alert _____



Classifications:

Plaque _____

Stain _____

Calculus deposits _____

Slight____ Mod____ Severe____

Gingiva _____

Recession _____

Periodontal Condition _____

Prosthetics: FUD FLD PUD PLD

B. EXTRAORAL INSPECTION	Normal	Abnormal
Face		
Head		
Neck		
Lymph Nodes		
TMJ		
C. ORAL INSPECTION		
Lips		
Vestibule		
Mucosa		
Pharynx		
Tonsils		
Gingiva		
Palate		
Tongue		
Floor of the Mouth		

COMMENTS: _____

Attachment B

CONSENT TO OPERATION, POST OPERATIVE CARE, MEDICAL TREATMENT, ANESTHESIA, OR OTHER PROCEDURE

Patient: _____
SSN: _____ DOB: _____
Facility: _____ Date: _____

You have the right and obligation to make decisions concerning your health care. The physician must provide you with the information and advice concerning the proposed procedure so that you can make an informed decision_____.

(1) Explain the nature of the condition(s) in professional and ordinary language.
PROFESSIONAL: _____

ORDINARY LANGUAGE: _____

AT _____

(2) Describe procedures(s) to be performed in professional and ordinary language, if appropriate.
PROFESSIONAL: _____

ORDINARY LANGUAGE: _____

AT _____

(3) I recognize that, during the course of the operation, post operative care, medical treatment, anesthesia, or other procedure, unforeseen conditions may necessitate my above-named physician and his or her assistants, to perform such surgical or other procedures as are necessary to preserve my life and bodily functions.

(4) I have been informed that there are many significant risks, such as severe loss of blood, infection, cardiac arrest and other consequences that can lead to death or permanent or partial disability, which can result from any procedure.

(5) No promise or guarantee has been made to me as to result or care.

Any section below which does not apply to the proposed treatment may be crossed out. All sections crossed out must be initialed by both the physician and the patient.

(6) I consent to the administration of (general, spinal, regional, local) anesthesia by my attending physician, by an anesthesiologist, a nurse anesthetist, or other qualified party under the direction of a physician as may be deemed necessary. I understand that all anesthetics involve risks that may result in complications and possible serious damage to such vital organs as the brain, heart, lungs, liver and kidney.

These complications may result in paralysis, cardiac arrest and related consequences or death from both known and unknown causes.

(7) I consent to the use of transfusion of blood and blood products as deemed necessary. I have been informed of the risks which are transmission of disease, allergic reactions, and other unusual reactions.

(8) Any tissue or part surgically removed may be disposed of by the hospital or physician in accordance with accustomed practice.

(9) Any additional comments may be inserted here:
_____

(10) I have had the opportunity to ask questions about this form.

FULL DISCLOSURE

[ ] I AGREE TO AUTHORIZE THE PROCEDURE DESCRIBED ABOVE AND I AGREE THAT MY PHYSICIAN HAS INFORMED ME OF THE:

a) DIAGNOSIS OR PROBABLE DIAGNOSIS.
b) NATURE OF THE TREATMENT OR PROCEDURE RECOMMENDED.
c) RISKS OR COMPLICATIONS INVOLVED IN SUCH TREATMENT OR PROCEDURES.
d) ALTERNATIVE FORMS OF TREATMENT, INCLUDING NON-TREATMENT, AVAILABLE.
e) ANTICIPATED RESULTS OF THE TREATMENT.

_____ _____
Patient/Other Legally Responsible Person Sign, If Applicable Date

_____ _____
Physician Date

DOC 0427 (11/97) CONFIDENTIAL

STATE OF HAWAII

DEPARTMENT OF PUBLIC SAFETY

DENTAL TREATMENT RECORD

NAME:

DATE	TOOTH #	TREATMENT RECEIVED

DOC 409 (06/92)

CONFIDENTIAL

Page 1

Attachment D

DENTAL HEALTH QUESTIONNAIRE

NAME: _____ SSN: _____
(LAST) (FIRST) (MI)

FACILITY: _____ DOB: _____ SID: _____

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considere confidential.

1. Has there been any change in your general health within the past year — YES NO
2. My last dental/physical examination was on _____
3. Are you under the care of a physician — YES NO
   If so, what is the condition being treated _____
4. Have you had any serious illness or operation — YES NO
   If so, what was the illness or operation _____
5. Have you been hospitalized or had a serious illness within the past 5 years — YES NO
   If so, what was the problem _____
6. Do you have or have you had any of the following diseases or problems:
   a. Rheumatic fever or rheumatic heart disease — YES NO
   b. Heart problems (heart trouble, heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke) — YES NO
   c. High blood pressure — YES NO
   d. Allergy — YES NO
   e. Sinus trouble — YES NO
   f. Asthma or hay fever — YES NO
   g. Fainting spells or seizures — YES NO
   h. Diabetes — YES NO
   i. Hepatitis, jaundice or liver disease — YES NO
   j. Arthritis — YES NO
   k. Inflammatory rheumatism (painful swollen joints) — YES NO
   l. Stomach ulcers — YES NO
   m. Kidney trouble — YES NO
   n. Tuberculosis — YES NO
   o. Low blood pressure — YES NO
   p. Venereal disease — YES NO
   q. AIDS, HIV+, HIV- — YES NO
   r. Other — YES NO
7. Have you had abnormal bleeding associated with previous extraction's, surgery, or trauma — YES NO
   a. Do you bruise easily — YES NO
   b. Have you ever required a blood transfusion — YES NO
   If so, explain the circumstances _____
8. Do you have any blood disorder such as anemia — YES NO
9. Have you had surgery or X-ray treatment for a tumor, growth or other condition of your head or neck — YES NO
10. Are you taking any drug or medicine — YES NO
    If so, what _____
11. Are you allergic or have you reacted adversely to any medicines — YES NO
12. Have you had any serious trouble associated with any previous dental treatment — YES NO
    If so, explain _____
13. Do you have any disease, condition, or problem not listed above that you think I should know about — YES NO
    If so, explain _____

_____
Signature of patient & date

DOC 0411 (6/97)

CONFIDENTIAL

Attachment

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

REFUSAL TO CONSENT TO MEDICAL/SURGICAL/DENTAL TREATMENT/MEDICATION

NAME:_____ SSN:_____ SID:_____

DOB:_____ FACILITY:_____ DATE:_____ TIME:_____

I, the undersigned patient, refuse the following treatment and/or medication: _____

_____

_____
(Describe Treatment and/or Medication)

The risk of refusing treatment or medication has been explained to me and I accept the risk involved. I release the State, the Department, the facility, the Health Care Division, and its medical personnel from any responsibility whatever for any unfavorable reaction, outcome, or any untoward results due to this refusal on my part to accept treatment or medication.

_____ _____ _____
(Print Name of Patient) (Signature of Patient)* (Date)

I, the undersigned, have explained to the above named patient the risk involved in refusing treatment or medication recommended for the patient's continued good health.

_____ _____ _____
(Print Name) (Signature & Title) (Date)

A referral has been made to the attending physician: YES NO

I have reviewed this case and if necessary have further counseled this patient on the risk of refusing treatment or medication.

_____ _____ _____
(Print Name of Provider) (Signature & Title) (Date)

** If the patient refuses treatment and/or medication and refuses to sign this consent, please have refusal witnessed by another correctional employee.*

I have witnessed the above named patient refuse the recommended treatment or medication and I have also witnessed the patient's refusal to sign this consent form.

_____ _____ _____
(Print Name & Title) (Signature & Title) (Date)

DOC 0417 (3/95) CONFIDENTIAL

Attachment F

STATE OF HAWAII

DEPARTMENT OF PUBLIC SAFETY

DENTAL PROBLEM SHEET

Name:_____ Facility:_____

	Problem	Date Observed	Date Completed	NOTES
1.				
2.				
3.				
4.				
5.				
6.				
8.				
9.				
10.				
11.				
12				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				

DOC 0475 (6/92)

CONFIDENTIAL

Attachment G

MEDICAL NEEDS MEMO

Facility: _____ Date: _____

TO: _____ FROM: _____
(Signature/Title of Provider)

Inmate _____ Housed in _____
(Print Inmate's Name)

_____

_____

DURATION: _____Days; _____ Weeks; _____ Months; _____ Indefinitely

Duration not to exceed three months for medication reviews for chronic illnesses.
•Health Status Classification Report required if there is a *significant* change in health status.

Original: UTM/ACO/Work Supervisor
Canary: Medical Record
Pink: Inmate

DOC 0449 (12/2002) CONFIDENTIAL

Attachment H

CONSULTATION RECORD

_____ Facility

_____ S.I.D.

Name Last First Initial DOB SSN

REQUEST TO: DATE OF APPOINTMENT: TIME:

REASON FOR CONSULTATION:

Date_____ Requesting Physician_____M.D.

CONSULTANT'S REPORT (HISTORY, FINDINGS, DIAGNOSIS, RECOMMENDATIONS)

_____M.D.
Consultant's Signature

*Complete Form Doc 0497 if a significant change in health status has occurred.

Original: HCU
Yellow: Consultant's Copy

DOC 0406 (11/97)

CONFIDENTIAL

1.0 PURPOSE

To establish guidelines for the purchase of medically indicated prostheses and mechanical devices.

2.0 REFERENCES AND DEFINITIONS

.1 References

a. Hawaii Revised Statutes, Section 26-14.6, Department of Public Safety; and Section 353-2, Director of Public Safety, Powers and Duties.

b. National Commission on Correction Health Care, Standards for Health Services in Prisons and Jails (2003).

c. American Correctional Association, Standards for Adult Correctional Institutions, (1990), 3-4358.

.2 Definitions

a. Prostheses: Artificial devices to replace missing body parts or compensate for defective physical functions.

b. Orthotic Devices: Corrective shoes and shoe appliances for treatment of foot and lower limb defects.

c. Mechanical Prostheses: Motorized or mobile prostheses such as wheelchairs.

d. Correctional Health Care Administrator (CHCA): Administrator for the Health Care Division (HCD), Department of Public Safety (PSD).

e. Health Authority: The physician, health administrator, or agency responsible for the provision of health care services at an institution or system of institutions; the Clinical Section Administrator (CSA) is the health authority.

3.0 POLICY

.1 Doctors and dentist may prescribe medically necessary prostheses when indicated to aid function or when the health of the patient is otherwise adversely affected.

.2 The patient is responsible for the cost and care of the prosthetic or mechanical device. The patient's mandatory minimum sentence, his or her ability to pay for the prosthesis and more cost effective alternatives shall be considerations when approving a prosthetic purchase.

.3 Authorizations is required by the CHCA for recommended prosthetics and mechanical devices in excess of two hundred dollars ($200.00).

.4 All outstanding medical cost obligations shall be deducted from the inmate's account prior to the release of any account balance to the inmate.

4.0 PROCEDURES

.1 No prosthetic or mechanical device shall be removed from an inmate during intake into any facility without first notifying the Health Care Section (HCS). If HCS staff indicates that the device is not medically necessary, it will be removed and recorded and managed as the inmate's property.

.2 An inmate shall be permitted to wear any prosthesis brought in from the community upon authorization by HCS staff. HCS staff shall take security issues into consideration when granting authorization.

.3 Provisions shall be made for an inmate to purchase or maintain medical or dental prostheses, including corrective lenses, dentures, artificial limbs, wheelchairs and orthopedic appliances when ordered by the treating physician or dentist.

.4 Any inmate with a physical disability can request a prosthetic through the regular sick call procedure. If the treating physician or dentist determines that the prosthesis is necessary, the inmate's request shall be referred to the facility health authority for recommendation. The facility health authority must secure authorization from the CHCA prior to payment for prosthetic purchases in excess of two hundred ($200.00).

a. Except for security considerations, no authorization is required for prosthetic purchases, regardless of the expense, if the inmate pays the prescribed prosthesis in full at the time of purchase.

b. No special authorization by the CHCA is required for purchases by inmates who use the health care payment plan to purchase prosthetics that cost less than two hundred ($200.00) dollars. The facility health authority or designee is responsible for approving such purchases. The patient's mandatory minimum sentence, his or her ability to pay and cost effective alternatives shall be considerations during the approval process. Prosthetic purchases are subject to audit.

c. If the inmate has insufficient funds in his/her account to cover the full cost of the prosthesis and the cost of the prosthetic is over $200.00, authorization must be obtained by the CHCA. If authorized by the CHCA, the request shall be referred to the appropriate community provider or laboratory for construction of the device.

.5 When a payment plan is established for authorized purchases by inmates with insufficient funds, the funds shall be withdrawn from the inmate's account whenever there is more than ten dollars ($10.00) in the account. Use a joint voucher to transfer funds from the inmate's account to the facility's HCS operating fund if the transfer is made during the fiscal year that the prosthesis is purchased. After completion of the fiscal year, the funds shall be made out to the Director of Finance and transferred to the general fund. The inmate shall sign form DOC 0477, Prostheses Purchase Agreement (Attachment A) to authorize withdrawal of funds to pay for the prostheses.

.6 In the case of furloughed inmates, a collection of at least one-half the cost of the prosthesis will be made at the time of the initial examination and measurement. The balance shall be an agreed upon amount paid at regular intervals. Any purchase in excess of $200.00 requires the authorization of the CHCA. Payment shall be made to the HCS by cashier's check or money order. The furloughed inmate shall sign Form DOC 0477-B Furloughee Prosthesis Purchase Agreement (Attachment B).

.7 An inmate may refuse the purchase of a recommended prosthetic. A refusal of a prosthetic by an inmate shall be documented on form DOC 0417, Refusal to Consent to Medical/Dental Treatment/Medications (Attachment C).

5.0 SCOPE

This policy and procedure applies to all correctional facilities and their assigned personnel.

APPROVAL RECOMMENDED:

Kay A Bauma MD 5/2/03
Medical Director Date

4/30/03
Correctional Health Care Administrator Date

5.4.03
Deputy Director for Corrections Date

APPROVED:

James L. Nobeck
Director

5/06/03
Date

PROSTHESIS PURCHASE AGREEMENT

_____ _____ _____ _____
(Print Inmate's Name) (SSN) (SID) (DOB)

_____ 1. I have been informed about the prosthesis that I wish to purchase. I understand that I am
(initial) responsible for the cost of the prosthesis and that I am buying the prosthesis from a private business and not from the Department of Public Safety.

_____ 2. I understand that if I agree to purchase the prosthesis, and I have sufficient funds in my
(initial) account to pay for the full cost of the prosthesis, the entire amount will be deducted from my account.

_____ 3. The Health Care Section (HCS) has a reimbursement payment plan available if I do not have money
(initial) in my account to pay for the entire cost of the prosthesis. If I agree to the payment plan, the HCS will purchase the prosthesis from the private business so I can have it right away. I will be obligated to the terms of the payment plan for the entire cost of the prosthesis.

_____ 4. I understand I have the right to refuse the recommended prosthesis and the payment plan.
(initial)

_____ 5. If I agree to the payment plan, I understand that whenever there are funds in my account in
(initial) excess of ten dollars ($10.00), the excess will be withdrawn until the prosthesis is paid in full.

_____ 6. I understand that if I agree to the payment plan and I am released from jail or prison before I have
(initial) finished paying for the prosthesis, any funds remaining in my inmate account will be applied to my debt. I understand that if I ever return to jail or prison, I will be obligated to pay any outstanding balance owed the Health Care Section for the purchase of the prosthesis as soon as funds are deposited into my account, for any reason, from any source.

_____ 7. I understand that the prosthesis is non-refundable once it is made to specifications. A
(initial) prosthesis may be substituted for an item of equal value if the vendor's regulations allow for exchanges.

☐ I refuse the payment plan and I do not wish to purchase the prosthesis at this time. _____
(initial)

☐ I consent to the purchase of the following prosthesis _____ and authorize the amount of $ _____ to be deducted in full or by the reimbursement payment plan if I have insufficient funds in my account at this time. _____
(initial)

_____ _____
(Inmate Signature) (Date)

_____ _____
(Staff Signature/Title) (Date)

Prosthesis ordered on _____ from _____.

Prosthesis received on _____ Issued to inmate on _____ _____(I/M initial)

Original sent to fiscal on _____

Original: Fiscal
Canary: Medical Record
Pink: Inmate

DOC 0477 (07/02) CONFIDENTIAL

FURLOUGHEE PROSTHESIS PURCHASE AGREEMENT

If my funds are insufficient to cover the cost of the prosthesis, I understand that a cashier's check or money order amounting to half the cost of the prosthesis shall be paid to the Department to purchase the following prosthetic:

_____
(Type of Prosthetic)

A minimum of $_____ shall be paid at regular intervals every _____ until the cost of the prosthesis is paid in full.

_____ _____
Furloughee's Signature Date

Original: Fiscal Office
Canary: Medical Record
Pink: Inmate

DOC 0477-B (02/02) CONFIDENTIAL

	DEPARTMENT OF PUBLIC SAFETY CORRECTIONS ADMINISTRATION POLICY AND PROCEDURES	EFFECTIVE DATE: FEB 6 1999	POLICY NO.: COR.10D.18
		SUPERSEDES (Policy No. & Date): NEW	
	SUBJECT: INMATE MEDICAL CO-PAYMENT PLAN		Page 1 of 5

No. 99-483

1.0 **PURPOSE**

To provide guidelines and an organized process for inmate co-payments of certain medical services.

2.0 **REFERENCES AND DEFINITIONS**

.1 References

a. Hawaii Revised Statue, Chapter 353, 1998.

b. Journal of Correctional Health Care, Volume 3, Issue 2, Fall 1996.

c. Martin v. DeBruyn, 880 F. Supp. 610 (N.D. Ind. 1995).

.2 Definitions

a. Co-payment: A nominal amount paid by offenders for certain health care services.

b. Indigent: An inmate with less than ten dollars ($10.00) of income in his or her spendable and/or restricted accounts.

c. Dental treatment: The treatment of dental problem based on a prioritized triage system.

d. Health Care Provider: An individual certified or licensed to deliver health care services.

e. Health Care Services: Medical, dental, mental health and health information services.

f. NCCHC: The National Commission on Correctional Health Care standards are the recommended minimum requirements for prison health services.

g. Episode of care: From the beginning of treatment for injury or illness until there is no longer any required follow-up care as determined by the health care provider.

h. Infirmary: A designated area within a facility that is expressly set up and operated for the purpose of caring for patients who do not need hospitalization, but whose care can not be managed safely in an outpatient or in a general population setting.

I. Retrospective Billing System: This is not an accounting method. The terminology describes a system that charges the patient for medical services after the service is rendered to ensure access to health care.

3.0 **POLICY**

Inmates shall not be denied access to health care or treatment because of their inability to pay the co-payment fee. There shall be a retrospective billing system for services rendered.

4.0 **PROCEDURES**

.1 Inmates shall be informed on admission about their responsibility to the medical co-payment plan, the self-purchase/self-administration over-the-counter medication program, prosthetic purchases and other information regarding health care services. The information shall be in the form of a pamphlet. A poster describing access to health care shall be displayed in intake sections.

.2 On the fourteen (14) day physical, the inmate shall sign an agreement that informs him or her of the medical co-payment for inmate initiated services, and the inmate's responsibility regarding other medical services, on Form DOC 0459, Medical Co-Payments, Over-The-Counter Medications, Prosthetics Purchase Agreement (Attachment A).

.3 There shall be a co-payment charge of three dollars ($3.00) per visit for identified medical, mental health and dental services. There will be no charge for a return to clinic if ordered by the physician for an episode of care. Subsequent visits related to the initial request shall include a co-payment if not initiated or scheduled by a health care provider.

.4 For clinical services, before the end of each watch for large facilities or no later than the end of each day for small facilities, assigned medical staff shall total the co-payment cost of services and medications provided to each inmate on Form DOC 0414, Co-Payment Cost For Medical Services (Attachment B). The forms shall be submitted to the facility fiscal office every Monday. On holidays that fall on a Monday, the forms should be submitted to the facility fiscal office on the Friday preceding the Monday holiday.

.5 For infirmary services related to inmate elected medical procedures, the inmate shall pay the full cost of the infirmary stay per day. The cost shall be estimated using per day cost of semi-private rooms in a community hospital (e.g. Hilo Hospital, Maui Memorial, Liahi Hospital) The inmate will pay the full cost of any medications or medical supplies that by necessity are prescribed by the health care provider. The inmate must have sufficient funds to cover the estimated cost of the infirmary stay prior to the elected procedure. The charges shall be totaled and submitted to the facility fiscal office on the day of discharge. For calculating the infirmary length of stay, the date of admission shall not be counted. The date of discharge shall be counted. An admission and release on the same day is counted as one day.

.6 The inmate shall be billed after the service is provided. The co-payment charge shall be deducted from the inmate's account at the time the charges are filed and if there is a balance of over ten dollars ($10.00) in the account. If there is more than ten dollars in the account but less than the total co-payment amount owed by the inmate, the difference shall be deducted from the account.

.7 If an inmate is indigent at the time the charge is posted, the facility fiscal officer shall so indicate on DOC Form 0414 and return the form to the Health Care Section. The inmates debt will be resubmitted with the next batch of names on the following Monday.

.8 If an inmate discovers a billing error relating to the medical co-payment, he or she may request a review of the bill by the nurse manager. Items still in dispute will be submitted to the Health Information Branch Administrator for review. Any item still in dispute will be submitted to an independent appeals board.

.9 The facility Clinical Services Section shall submit to the Director through the chain-of-command, with a copy to the Warden, an annual comparison study of the amount (in percentages) by which medical request by inmates has been reduced for non-essential medical services compared to the previous calendar year.

.10 The facility fiscal office shall submit to the Director through the chain-of-command, with a copy to the facility nurse manager, the annual amount of funds recovered by the facility through the inmate co-payment plan for the calendar year.

.11 The following services are exempt from the medical co-payment fee:

a. Medical, mental health, and dental admission screenings, examinations, and diagnostic tests required by law, a Consent Decree or the NCCHC standards.

b. Mental health services for inmates in special housing or holding units, therapeutic housing, or transitional housing units.

c. Mental health referrals by medical staff or correctional employees.

d. A first visit with mental health staff by request from a general population inmate for any episode of care requiring assessment of the inmate's mental health.

e. Inmate requested diagnostic testing for suspected sexually transmitted diseases, HIV/AIDS, tuberculosis, or hepatitis.

f. Clinic visits to assess or clear an inmate for transfer, assignment to programs, work assignments, treatment facilities, or therapeutic communities.

g. Physician ordered infirmary admissions.

h. Industrial injuries.

h. Visits scheduled at the request of a health care provider. These visits may include, but are not limited to:

1. Diagnosis, treatment and care of communicable diseases;

2. Diagnosis, treatment and care of chronic illnesses, including regularly scheduled clinics or workshops for chronic disease management;

3. Dietetic consultations for chronic disease management;

4. Pre- and post-natal care and examination.

.11 Inmates shall be charged a co-payment for the following services:

a. Inmate requested medical, mental health (except as stated above) and dental treatment;

b. Inmate requests for a dietetic consultation not related to a medical condition or a chronic disease.

.12 Except for mentally ill inmates in special housing units, inmates shall pay the co-payment fee when treated for self inflicted wounds or self induced injury. This includes, but is not limited to:

a. Self inflicted wounds or injury

b. Fights with other inmates or staff, or deliberately punching, kicking, hitting, banging, etc., movable or immovable objects;

c. Recreational injuries.

d. Accidental or injuries.

SCOPE

This policy and procedure applies to all Correctional facilities and their assigned personnel.

APPROVAL RECOMMENDED:

Kenneth Kuehnewey MD
Health Care Division Administrator

2/1/99
Date

Deputy Director for Corrections

Date

APPROVED:

Director

2/6/99
Date

DEPARTMENT OF PUBLIC SAFETY

INMATE MEDICAL CO-PAYMENT, PROSTHETICS, AND OVER-THE-COURTER MEDICATION PURCHASES AGREEMENT

Facility _____ Date:_____

1. Did you receive a pamphlet at intake that discribes the Department's medical services for inmates? YES ☐ NO ☐.

2. If you answered no to question number one, have you been issued a pamphlet by the nurse during this interview? YES ☐ NO ☐ N/A ☐

3. Have you been informed by the nurse about inmate medical co-payments? YES ☐ NO ☐

4. Have you been informed by the nurse about inmate prosthetic purchases? YES ☐ NO ☐

5. Have you been informed by the nurse about over-the-counter medication purchases from the commissary (inmate store)? YES ☐ NO ☐

By signing this form, you are agreeing that you have been informed of the inmate medical co-payment plan and your responsibility to pay a three dollar ($3.00) co-payment fee when you seek non-emergency medical treatment. Treatment for communicable diseases, chronic diseases, emergency treatment, and medical screenings are exempt from the inmate medical co-payment. By signing this form you are also agreeing that you have been informed about purchasing prothetics and over-the-counter medications.

_____	_____
Print Name of Inmate	Name and Title of Health Care Staff
_____	_____
Inmate's Signature	Staff Signature
_____	_____
Date	Date

Original: Medical Record (Consent Index)
Canary: Inmate's Copy

DOC 0459 (7/98) CONFIDENTIAL

COST SHEET FOR MEDICAL CO-PAYMENT SERVICES

FACILITY: _____ DATE: _____

ME	SID	SSN	SERVICE CODE	SERVICE DATE	COST	PAID

DES: 01 MEDICAL; 02 DENTAL; 03 MENTAL HEALTH; 04 INFIRMARY; 05 SUPPLIES/MEDICATIONS

Original: Fiscal
Copy: Medical Unit

DOC 0414 (12/98)

CONFIDENTIAL

ACT 250

THE SENATE
NINETEENTH LEGISLATURE, 1998
STATE OF HAWAII

S.B. NO. 2249 S.D. 1 H.D. 2 C.D. 1

A BILL FOR AN ACT

RELATING TO CORRECTIONS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. Chapter 353, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§353- Nonemergency medical, dental, mental health services or treatment; intentional injury; payment by inmates.** (a) The department of public safety may develop policies and procedures governing the assessment of fees upon detainees and committed persons who receive certain medical, dental, or mental health services or treatment. In adopting these policies and procedures, the department shall safeguard the health and welfare of detainees and committed persons.

(b) The policies and procedures shall enable the department to assess fees upon detainees and committed persons who:

(1) Request certain nonemergency medical, dental, or mental health services or treatment; or

(2) Intentionally inflict injury to themselves.

(c) The policies and procedures shall include an appeals process to allow a detainee or committed person to appeal the assessment.

SB2249 CD1 JDC

(d) The department of public safety may adopt policies and procedures to establish a fee schedule for medical, dental, and mental health services or treatment under the following conditions:

(1) Fees shall be assessed from the detained or committed person's individual trust account pursuant to section 353-20; and

(2) Fees shall not be assessed if the individual trust account balance is less than $10; provided that the department may implement a procedure to recover fees in the future."

SECTION 2. One year after the start of the implementation of the assessment of fees for medical, dental, and mental health services or treatment, the department of public safety shall submit a report to the legislature that summarizes the total of moneys deducted from inmate accounts. The report shall include an estimate of savings to the department through the related reduction in nonemergency medical, dental, or mental health services or treatment, and intentional injuries.

SECTION 3. New statutory material is underscored.

SECTION 4. This Act shall take effect upon its approval.

APPROVED BY THE GOVERNOR ON

JUL 2 0 1998

"The Policies and Procedures for Tool/Equipment Control, Policy No COR.08-27, have been marked 'Confidential' and will be provided to the Provider awarded this contract.

The Provider (Contractor) shall comply with Policy No COR.08.27 titled: 'Tool/Equipment Control'. The Provider shall be responsible to maintain a complete inventory of all tools utilized in the performance of their services. Inventory of tools shall be done on a daily basis at the beginning of each work day and at the close of each work day. A monthly tool audit shall be conducted by the Provider and forwarded to the Tool Control Officer. All inventory records shall be subject to inspection by the Chief of Security and or Tool Control Officer."

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

TOOL/EQUIPMENT INVENTORY

SIGNED ANTITY	CURRENT QUANTITY	DESCRIPTION	REMARKS

/LOCATION: _____ DATE: _____

DC 8239 [Master doc #0093m]

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

TOOL/EQUIPMENT RECEIVING REPORT

TO: Chief of Security

FROM: Tool Control Officer

On _____, a _____
(date) (Name and Number of Tools)

for _____, was received at the Institution.
(Section/Unit)

This classification for this tool is _____.

This tool was etched and/or color coded to conform to Policy Statement.

Signature: _____
(Tool Control Officer)

cc: Tool Control Officer
Work Area Supervisor for whom the tool was purchased.

DOC 82357 (11/90) [Master doc #0096m]

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

TOOL/EQUIPMENT TURN-IN RECEIPT

TO: Tool Control Officer Date: _____

The tool(s) described below have been turned in to the Tool Control Officer.

Signature: _____
(Employee turning in tool(s)

DESCRIPTION OF TOOL(S)	NUMBER OF TOOL(S)

Turned in by: _____
(Work Area Supervisor) (Date)

Received by: _____
(Tool Control Officer) (Date)

Original to Tool Control Officer
Copy to Work Area Supervisor File
Copy to Chief of Security

DOC 8258 (11/90) [Master doc #0095m]

STATE OF HAWAII

DEPARTMENT OF PUBLIC SAFETY

MEMORANDUM

To: TOOL CONTROL OFFICER **Date:** _____

From: _____ **Reply Due:** _____

Subject: RESTRICTED TOOL WEEKLY INVENTORY

This is to certify that all restricted tools assigned to the _____ Shop have been physically inventoried and accounted for on this date.

_____ Supervisor _____ Date

Additional Remarks: _____

PSD 1005 (7/90)

STATE OF HAWAII

DEPARTMENT OF PUBLIC SAFETY

MEMORANDUM

To: TOOL CONTROL OFFICER **Date:** _____

From: _____ **Reply Due:** _____

Subject: MONTHLY TOOL/EQUIPMENT INVENTORY

This is to certify that all tools/equipment itemized on the attached Tool/Equipment Inventory Forms have been physically inventoried and accounted for on this date.

_____ Supervisor _____ Date

Additional Remarks: _____

PSD 1005 (7/90)

CORRECTIONS DIVISION

Material Pass

F-93A1.2

Attachment F

Date:_____

The following material passed Out thru Gate No._____ at _____ AM PM

Car No._____ Driver:_____

From:_____ Shop:_____ Unit

To:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Approved by: Passed by:

_____ _____

Unit Supervisor ACO

DOC 8242 (2/88)

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

LOST TOOL/EQUIPMENT REPORT

TO: Chief of Security Date: _____

FROM: Name: _____
Title: _____
Section/Unit: _____

The tool(s) listed below have been lost/stolen from this work site on this date: _____.

DESCRIPTION OF TOOL(S)	NUMBER MISSING

Circumstances surrounding this loss are as described below:

_____
_____
_____
_____
_____

cc: Tool Control Officer
Watch Supervisor
Work Area Supervisor

DOC 8259 (11/90) [Master doc #0097m]

STATE OF HAWAII

DEPARTMENT OF PUBLIC SAFETY

INCIDENT REPORT

Facility: _____

Prepared on: _____

TO: _____ (Administrator/section supervisor) THRU: _____ (Watch Supervisor)

DATE	TIME	NARRATIVE (Specify inmate name & ID and location if related to misconduct)

By: _____ Reporting Officer/Employee _____ Title

OC 8214 (6/93) ORIG — FACILITY ADMINISTRATOR CANARY — CONTROL CENTER PINK - ATTACH TO MISCONDUCT REPORT

NOT CONFIDENTIAL

	DEPARTMENT OF PUBLIC SAFETY CORRECTIONS ADMINISTRATION POLICY AND PROCEDURES	EFFECTIVE DATE: NOV 16 1998	POLICY NO.: COR.10F.01
		SUPERSEDES (Policy No. & Date): COR.10F.01 07/16/96	
	SUBJECT: INFORMED CONSENT		Page 1 of 4

No. 98-47674

1.0 PURPOSE

To provide guidelines for rendering medical examinations, treatments, and other medical procedures which require informed consent

2.0 REFERENCES AND DEFINITIONS

Section 26-14.6, Department of Public Safety; and Section 353C-2, Director of Public Safety, Powers and Duties.

.1 References

a. National Commission on Correctional Health Care, Standards for Health Services in Prisons, (1997), P-70, Jails, (1996), J-67.

b. National Commission on Correctional Health Care, Standards for Health Services, (1997), Right to Refuse Treatment, P-71, Jails, (1996), J-68.

c. National Commission on Correctional Health Care, Standards for Health Services in Prisons, (1997), Medical Research, P-72, Jails, (1996), J-69.

d. American Correctional Association, Standards for Adult Correctional Institutions, (1990), Informed Consent, 3-4372.

e. American Correctional Association, Standards for Adult Correctional Institutions, (1990), Inmate Participation in Research, 3-4373.

f. Hawaii Revised Statutes, 352-8, 671-3.

.2 Definitions

a. Informed Consent: Voluntary consent or agreement by a patient to a treatment, examination, or procedure after they have received the significant facts regarding the condition being treated and the nature, consequences, risks, benefits, and alternatives concerning the proposed examination, procedure, or treatment, including the right of refusal.

b. Attending Physician: A doctor of medicine or osteopathy who is rendering the treatment, examination, or procedure to the patient.

3.0 **POLICY**

.1 Information exchanged between a health care provider and a patient while rendering health care is privileged and confidential.

.2 Health care professionals shall promote trust between health care providers and patients. In this respect, health care professionals shall not participate in any activity or perform a procedure or treatment on a patient that aids or will result in disciplinary action.

.3 Informed consent by a patient shall be required for those examinations, treatments, and procedures that are intrusive or governed by informed consent standards in the community.

.4 The health care provider attending the patient shall be responsible for informing the patient of the condition and recommended procedure or treatment, and any risk that may be involved in the treatment, including available alternatives.

.5 A competent patient has the right to refuse medical care.

.6 In every case in which consent is waived by the health care provider, reasons for the decision to undertake the procedure without consent shall be documented in the medical record. The informed consent requirement may be waived for the following reasons:

a. An emergency that requires immediate medical intervention for the preservation of life or the safety of the inmate;

b. If in the professional opinion of the physician the physical or mental health of others is endangered.

c. When a psychiatrist or court of law judges an inmate to be incapable of understanding the information given according to the standard, legally defined criteria of competence.

.7 Inmates shall not participate in experimental projects involving medical, pharmaceutical, or cosmetic research, including adverse conditioning, psycho-surgery, electrical stimulation of the brain, or the application of

cosmetic substances to the body that are being tested for possible ill effects prior to sale to the general public.

This does not preclude the use of experimental medical procedures or treatments as part of a research protocol passed by an institutional human research review committee and subject to informed consent; nor does it preclude the collection of statistical or epidemiological data on inmates.

4.0 **PROCEDURE**

.1 When a patient consents to a treatment or procedure provided by the Health Care section, the attending physician shall ensure that Form DOC 0427, Consent to Operation, Post Operative Care, Medical Treatment, Anesthesia, or Other Procedure (Attachment A), if applicable, is reviewed with and signed by the patient. The attending physician shall enter a narrative progress note indicating the information provided and the results of the discussion with the patient. The clinic nurse shall ensure the form is completed and medical records staff shall file the form under the Consent Index in the medical record.

.2 When a patient refuses a scheduled medical appointment, medical treatment, surgical procedure, or medications, the patient shall be informed by the health care provider of the consequences and shall be required to sign form DOC 0417, Refusal To Consent To Medical Or Surgical Treatment (Attachment B). The patient's signing of the form shall be witnessed by staff. The attending physician shall review the refusal, and if appropriate, record a narrative statement in the progress notes regarding the refusal. The physician shall sign the form indicating the refusal was reviewed.

.3 When an inmate refuses medical care and refuses to sign Form DOC 0417, the refusal shall be witnessed by health care staff and facility staff (two people) who shall sign their names and write, 'inmate refused to sign' on the form and the date of refusal. The health care provider shall enter a narrative progress note regarding the refusal and the discussion with the inmate regarding the consequences of refusing treatment.

Inmates diagnosed with contagious or communicable diseases and who refuse treatment shall be medically quarantined by the health care authority, if necessary, to control spread of the disease.

5.0 **SCOPE**

This policy and procedure applies to all correctional facilities and their assigned personnel.

APPROVAL RECOMMENDED:

Health Care Division Administrator

10/23/98
Date

Deputy Director for Corrections

11/14/98
Date

APPROVED:

Director

11/16/98
Date

CONSENT TO OPERATION, POST OPERATIVE CARE, MEDICAL TREATMENT, ANESTHESIA, OR OTHER PROCEDURE

Patient: _____
SSN: _____ DOB: _____
Facility: _____ Date: _____

You have the right and obligation to make decisions concerning your health care. The physician must provide you with the information and advice concerning the proposed procedure so that you can make an informed decision_____.

(1) Explain the nature of the condition(s) in professional and ordinary language.
PROFESSIONAL: _____

ORDINARY LANGUAGE: _____

AT _____

(2) Describe procedures(s) to be performed in professional and ordinary language, if appropriate.
PROFESSIONAL: _____

ORDINARY LANGUAGE:_____

AT_____

(3) I recognize that, during the course of the operation, post operative care, medical treatment, anesthesia, or other procedure, unforeseen conditions may necessitate my above-named physician and his or her assistants, to perform such surgical or other procedures as are necessary to preserve my life and bodily functions.

(4) I have been informed that there are many significant risks, such as severe loss of blood, infection, cardiac arrest and other consequences that can lead to death or permanent or partial disability, which can result from any procedure.

(5) No promise or guarantee has been made to me as to result or care.

Any section below which does not apply to the proposed treatment may be crossed out. All sections crossed out must be initialed by both the physician and the patient.

(6) I consent to the administration of (general, spinal, regional, local) anesthesia by my attending physician, by an anesthesiologist, a nurse anesthetist, or other qualified party under the direction of a physician as may be deemed necessary. I understand that all anesthetics involve risks that may result in complications and possible serious damage to such vital organs as the brain, heart, lungs, liver and kidney.

These complications may result in paralysis, cardiac arrest and related consequences or death from both known and unknown causes.

(7) I consent to the use of transfusion of blood and blood products as deemed necessary. I have been informed of the risks which are transmission of disease, allergic reactions, and other unusual reactions.

(8) Any tissue or part surgically removed may be disposed of by the hospital or physician in accordance with accustomed practice.

(9) Any additional comments may be inserted here:

(10) I have had the opportunity to ask questions about this form.

FULL DISCLOSURE

[ ] I AGREE TO AUTHORIZE THE PROCEDURE DESCRIBED ABOVE AND I AGREE THAT MY PHYSICIAN HAS INFORMED ME OF THE:

a) DIAGNOSIS OR PROBABLE DIAGNOSIS.
b) NATURE OF THE TREATMENT OR PROCEDURE RECOMMENDED.
c) RISKS OR COMPLICATIONS INVOLVED IN SUCH TREATMENT OR PROCEDURES.
d) ALTERNATIVE FORMS OF TREATMENT, INCLUDING NON-TREATMENT, AVAILABLE.
e) ANTICIPATED RESULTS OF THE TREATMENT.

_____ _____
Patient/Other Legally Responsible Person Sign, If Applicable Date

_____ _____
Physician Date

DOC 0427 (11/97) CONFIDENTIAL