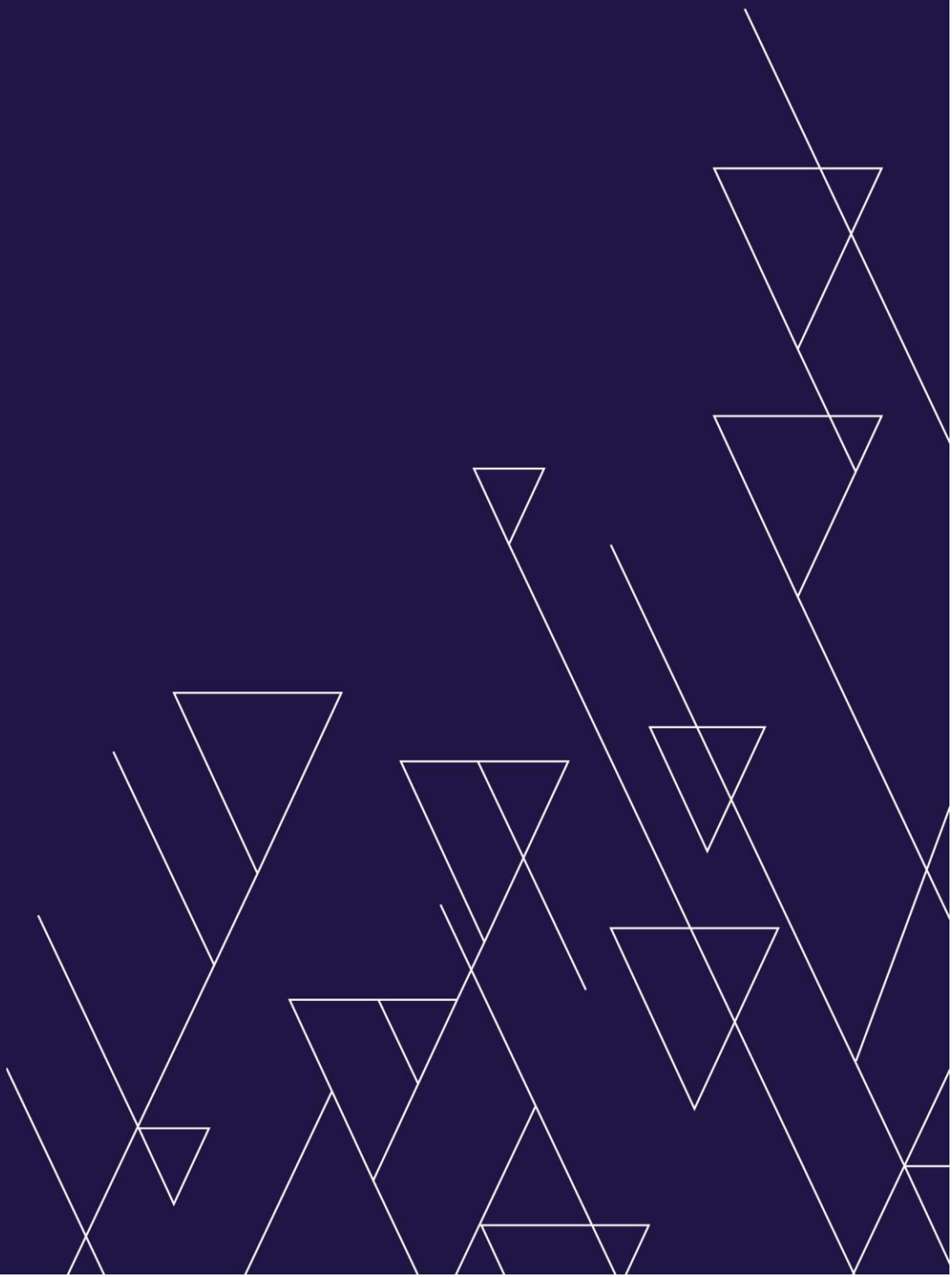
Annexure C

# Primary Healthcare Services in Victorian Men's Public Prisons

Specifications – v1.0 Final December 2022

Justice Health



VICTORIA State Government | Justice and Community Safety

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# Specifications

# 1. Primary Healthcare Services

## 1.1 The Context

Justice Health (the State) is the business unit in the Department of Justice and Community Safety (the department) responsible for overseeing the delivery of health services by contracted providers at Victorian public prison Service Locations.

The State requires a contemporary outcome-focused primary health Service that delivers quality, integrated, cost effective, and sustainable Services across Service Locations that support clinical governance, continuity of care, and innovation.

## 1.2 Service Aims

The State has a duty of care under the *Corrections Act 1986* to provide people in prison with access to services to maintain health and wellbeing of a standard and quality equivalent to that available in the community.

Three aims underpin the delivery of Primary Healthcare Services in the Victorian prison system: the right to healthcare; improving the health of people in prison; reducing reoffending; and reducing the overrepresentation of Aboriginal people.

a. The right to healthcare (physical, mental health and wellbeing) is met by ensuring:
    i. That people in prison have access to healthcare
    ii. Healthcare is person-centred, safe, and culturally appropriate
    iii. Service delivery promotes and preserves professional and clinical independence.

b. Improving the health of people in prison requires:
    i. Continuity of healthcare throughout their time in prison and on release to the community
    ii. That healthcare services are equitably accessible, timely and minimise service refusals
    iii. That healthcare services consider the person holistically
    iv. Strong partnerships between health service providers and between prison and community-based health services
    v. A health-promoting prison environment that encourages health agency to ensure that people have a better understanding of their health needs, lifestyle factors that impact on their health and ways to protect, maintain and make choices about their health, including an understanding of how to access health services

c. Improving rehabilitation outcomes for all and reducing the overrepresentation of Aboriginal people by:
    i. Addressing the health and wellbeing limitations that impact on a person's ability to participate in programs, education, training, and social engagement, through:
        - A proactive, trauma-informed health approach to identify and address the health and mental health-related factors that may impact on someone's ability to engage with training, education, work, social opportunities, family, and so on
        - Providing primary healthcare that meet the physical, social, emotional, spiritual and cultural wellbeing needs of Aboriginal people in prison in a culturally safe way
        - Partnerships with the wider corrections services, including corrections case management and release management.
    ii. Ensuring that Services are culturally safe through:

- A trauma informed approach that recognises the impacts of racism and trauma on health and mental health
- Employment and support of Aboriginal staff and continually building the cultural capability of all health staff
- Coordinated care through collaboration with Aboriginal Wellbeing Officers and Aboriginal Community Controlled Health Organisations.

## 1.3 Service Scope

The Contractor will deliver the Primary Healthcare Services in compliance and conformance with the terms and conditions of the Agreement, these Specifications, and all Schedules and Attachments. For avoidance of doubt, if the priority of documents in the Agreement differ to the order of documents in the Specifications, the priority of documents stated in the Agreement will prevail.

The Primary Healthcare Services will address the State's Five Focus Areas:

### 1.3.1 Focus Area 1: Health Assessment and Planning

Primary Health Assessment and Planning refers to the assessment and planning Services delivered to people as they enter and move through the custodial setting. Every person's health needs are assessed at the times of highest risk, namely upon reception, transfer, and when identified as being at risk. When needed, further assessments are undertaken, referrals made, integrated care plans developed, and release plans provided for those requiring ongoing care.

The Contractor will:

a. Deliver primary health assessments, develop care plans, and provide release summaries and conduct health release planning for people within ongoing health needs
b. Design and deliver health assessments and planning considering:
    i. the peak contact points with people in prison for health assessments and health care planning
    ii. the volume of Services, timeliness, information gathering and sharing
    iii. skills for rapidly evaluating and processing information received from police custody, community health services and people arriving in prison, and
    iv. the agility and sensitivity required when identifying and addressing the health needs of people entering and being released from prison.

### 1.3.2 Focus Area 2: Population Health

Population Health refers to the identification and treatment of communicable diseases, early detection, and health promotion and prevention within a custodial health setting.

The Contractor will:

a. Deliver evidence-based population health services with the aim of improving the health of people in prison, and the health outcomes of Priority Groups through tailored and integrated responses. The Contractor will take an integrated whole of system approach to create a health promoting environment for people and staff within the prison community.
b. Identify and treat communicable diseases, carry out early detection, develop and implement an annual Health Promotion Plan, and plan for and manage health delivery within Service Locations.
c. Plan for, prevent, and manage infection control and communicable outbreaks (e.g., upper respiratory infections, influenza, gastroenteritis, COVID-19, BBVs, STIs) at all Service Locations.
d. Provide a coordinated approach across the custodial setting, align with public health goals and aims to achieve improved health outcomes for people in prison prior to their release to the community.

e. Improve the health literacy, understanding of health risk factors, and build health agency so that people in prison can take control over their health and develop pro-social behaviours and habits.

### 1.3.3 Focus Area 3: Alcohol and Other Drugs Health

Alcohol and Other Drugs (AOD) Health refers to the provision of integrated care to address the end-to end health needs of people with AOD concerns, including medical care, withdrawal support, Medication Assisted Treatment of Opioid Dependence (MATOD), harm reduction information, AOD health programs, AOD peer support, Identified Drug User (IDU) reviews, and targeted release planning.

The Contractor will

a. Identify and manage the needs of people in prison with AOD concerns holistically and with an understanding that addressing AOD issues is not a linear process.
b. Deliver consistent health, harm reduction and motivational messaging at all available opportunities for people with AOD concerns in contact with the primary healthcare services, and actively refer people in prison to other service providers when needed, including referral to the forensic mental health service provider for shared care for dual diagnosis clients, and to additional AOD services available at the Service Location.

### 1.3.4 Focus Area 4: Primary Care

Primary Care refers to the delivery of health Services stemming from needs identified at any time during a person's term in prison.

The Contractor will deliver:

a. Primary care
b. Primary mental healthcare
c. Personal care assistance
d. Dental services
e. Advanced care planning
f. Medication management
g. Diagnostic services (radiology and pathology)
h. Allied health services
i. Medical aids and equipment
j. Bed-based medical care at Hopkins Correctional Centre
k. Referral management and coordination for access to specialist services in the community
l. Outreach Services for JLTC and Rivergum.

### 1.3.5 Focus Area 5: Tailored Response for Priority Groups

Priority Groups means the people in prison specified as being a priority for the State and specified as requiring tailored health responses.

The Contractor will deliver primary health Services tailored for the State's Priority Groups, being:

a. Aboriginal and Torres Strait Islander people in prison
b. Older people in prison
c. People living with a disability in prison
d. Young people in prison (18–25)
e. Culturally and Linguistically Diverse (CALD) people in prison
f. Lesbian, gay, bisexual, transgender, intersex, and queer (LGBTIQ+) people in prison.

## 1.4 Multidisciplinary Care

The Contractor will:

a. Deliver Primary Healthcare Services with appropriately qualified, and resourced multidisciplinary health teams within and across Service Locations to achieve improved health outcomes for people in prison. Suggested roles that the Contractor may consider when developing their multidisciplinary workforce is contained in Table 1.

b. Have a structured system for credentialing and delineating the scope of practice and clinical supervision to support safe, and quality service provision, consistent with the relevant policies, and in compliance with the Quality Framework (Attachment B). Clinical disciplines will have current registration through the Australian Health Practitioners Regulation Agency (AHPRA), or other board registration when applicable. Roles with certifications will have a minimum of certificate III or IV, depending on the role.

c. Address the State's Five Focus Areas in the design of the Primary Healthcare Services and will consider the most appropriate roles with shared or dedicated resourcing within and across the State's Five Focus Areas, the Service Locations and the regions, to maximise integration, continuity of care, and efficiencies.

*Table 1. Suggested multidisciplinary primary healthcare workforce mix*

| Primary Health Service Workforce | |
|---|---|
| - Aboriginal Health Practitioners<br>- Aboriginal Health Workers<br>- AOD Clinicians<br>- Audiologists<br>- Clinical Coordinators<br>- Communicable Disease Manager<br>- Dentists, dental assistants, hygienists, prosthetists<br>- Diagnostics: radiographers, radiologists, phlebotomists, and pathologists<br>- Dietitians<br>- Dual-diagnosis Clinicians<br>- Health Pathways Coordinators<br>- Health Promotion Officers<br>- Health Services Managers<br>- Hepatitis Specialist<br>- In-reach Aboriginal Health Promotion<br>- In-reach Health Promotion (other Priority Groups)<br>- MATOD Nurses<br>- Medical Practitioners | - Mental Health Nurses<br>- Nurse Immunisers<br>- Nurse Practitioners<br>- Occupational Therapists<br>- Optometrists<br>- Personal Care Assistants<br>- Pharmacists<br>- Pharmacy Technicians<br>- Physiotherapists<br>- Podiatrists<br>- Point of Care testing Nurses<br>- Provisional Psychologists (refer to MAP individual AOD support)<br>- Psychologists (refer to MAP individual AOD support)<br>- Registered Nurses<br>- Senior Health Promotion Officer<br>- Senior Occupational Therapist or Senior disability coordinator<br>- Social Workers<br>- Speech Pathologists |

## 1.5 Service Value and Innovation

The Service delivered by the Contractor will improve the health, wellbeing and rehabilitation outcomes of people in prison through its operational design, procedures and performance, by embedding governance and work practices that support innovation and continuous improvement. In addition, technology is used to improve Service access in conformance with the Service value dimensions. Value will also be achieved through integration with program and service responses in the wider prison system.

1. ***High quality care*** comprising technical and clinical quality as well as patient reported measures and outcomes:
   a. The physical and mental health and wellbeing of a person in prison is assessed, treated, and promoted

b. Care is safe, effective, inclusive, culturally and gender appropriate, patient-centred, and timely

2. ***Continuity of care*** that results in individual health benefits being maximised through the embedded practice of integrated and continuous care both within and across services and Service Locations:
   a. Provision of care and services across clinical, allied health, and program roles
   b. Communicate and cooperate well with other health services (in public and private prisons, and in the community) to realise integrated, well-orchestrated care across the continuum of care, including at the intersect between prison and release to the community
   c. Provide meaningful connection with other health service providers to support rehabilitation and reintegration
   d. Health needs are met through referral to facilitate reintegration for people being released from prison, particularly for older people with aged care needs, Aboriginal people, people with mental health disorders, people with disabilities, including people with cognitive impairment, LGBTI+ people, and people with substance use and dependence concerns
   e. Improve operational practice, efficiency of processes, service responsiveness, communication, and community connections.
3. ***Cost effective innovation*** demonstrates that health-promoting innovations are worth the additional costs and will contribute to longer term cost stability:
   a. Cost-saving services and improvements result in equal or better health
   b. Changes to services are systematically planned and delivered, and are supported with evidence of need and effectiveness
   c. Improved capacity for people in prison to participate in programs and services, including the use of in-cell technology or materials
   d. Service delivery reduces the occurrence, frequency and duration of hospital transfers, and reduces the need for movement between prisons and to external health services, through the use of telehealth, which is available at all public prisons
4. ***Sustainable services*** are provided efficiently and flexibly:
   a. Services are provided in the right place at the right time
   b. Scarce resources are efficiently used (that is, not misused, not overused)
   c. Health problems, health harms, and health deteriorations are minimised or prevented in cost effective and evidence-based ways.

## 1.6 Service Exclusions

The Contractor is not responsible for the following services or activities:

a. Primary healthcare services in private prisons (currently Fulham Correctional Centre, Port Philip Prison, and Ravenhall Correctional Centre)
b. Primary mental health services at the Melbourne Assessment Prison (which are delivered by the forensic mental health service provider at this location)
c. Mental health reception assessments and At-Risk Assessments at the Melbourne Assessment Prison and mental health reception assessments at the Metropolitan Remand Centre, (which are delivered by the forensic mental health service provider at these locations)
d. Forensic mental health services
e. Preparation of assessment orders for people in prison requiring transfer to a hospital for continuing mental healthcare upon their release to the community (which is the responsibility of the forensic mental health service provider)
f. Rapid Antigen Test kits or other rapid COVID point of care tests (which are provided by the State)
g. Fittings or fixtures for people in prison who require accommodation modifications (which is the responsibility of Corrections Victoria).

# 2. Obligation to Provide the Services

The Contractor will provide the Primary Healthcare Services in the terms of the Agreement, including the Schedules and Attachments to Schedules, and will provide the Services detailed in the Specifications, which are comprised of:

a. this Part A.2 - The Specifications

b. the Attachments to the Specifications:

   i. Attachment A - Legislation and Regulations and Policies and Guidelines

   ii. Attachment B – Healthcare Services Quality Framework for Victorian Prisons 2023

   iii. Attachment C - Primary Healthcare Performance Framework 2023

   iv. Attachment D - Notifiable Health Incidents and Reporting Guidelines 2021

   v. Attachment E - Service Locations and Baseline Prisoner Numbers

   vi. Attachment F - Clinical Hours and Service Availability by Service Location

   vii. Attachment G - AOD Services and Programs by Service Location

   viii. Attachment H - Contract Management and Reporting

The Contractor will provide and maintain all management and support necessary to enable the efficient and effective day-to-day delivery of the Services, which means all services, functions, duties, and resources, including corporate management, contract and services management, clinical governance and supervision, clinical support and location administration, training and education, and third-party arrangements, agreed as necessary to deliver the Service at the Service Locations, undertaken at the times and to the volumes required, with the level of staffing and qualifications agreed, and undertaken in compliance with the Specifications and the defined quality domains and performance levels.

## 2.1 Activities Incidental to the Service

The Contractor will provide all incidental services, functions, duties, or resource, and third-party arrangements necessary to enable the proper performance and provision of the Service in compliance with the Agreement and with the Specifications.

If other services, functions, or duties are identified by either party after the date of the Agreement and those services are incidental to the Service and are necessary for the proper performance and provision of the Service and would, in the reasonable opinion of the State, ordinarily be performed and expected as part of the Services, then the Contractor will perform those services at no additional cost to the State.

## 2.2 Obligation to be Accredited

In delivering the Primary Health Services the Contractor must:

a. In compliance with the conditions of the Agreement, be accredited to the *NSQHS Standards: Australian Commission on Safety and Quality in Healthcare* and must maintain accreditation during the term of Agreement and during options to extend the Agreement, if any.

b. Submit evidence to Justice Health of successfully maintaining their accreditations throughout the life of the Agreement, including a copy of finalised accreditation reports obtained from the relevant professional body.

c. Notify Justice Health within 5 Business Days of receipt of the accreditation report of any high priority recommendations or advanced completion surveys arising from an accreditation survey.

d. Notify Justice Health within 40 Business Days of receipt of the accreditation report with evidence that high priority recommendations or advanced completion surveys identified for action by have been actioned within a timeframe mandated by the professional body (or by the mandated date if later than 40 Business Days).

e. Use accreditation findings as one of the mechanisms to drive continuous Service improvement.

# 3. Additional Requirements

## 3.1 Staff On-boarding and Off-boarding

The Contractor will:

a. During transition-in of the Services, comply with all transition-in on-boarding processes and compliances required by the State in relation to Service Locations and document their on-boarding instruction package to enable the efficient transition-in of the Contractor's staff and subcontractors.

b. Following completion of transition-in of the Services, comply with the business as usual on-boarding processes and compliances required by the State in relation to Service Locations and document their business as usual on-boarding instruction package.

c. Include in their on-boarding package the mandated organisational and service specific induction, training and on-boarding requirements and processes, to support their staff commencing with the Services.

d. Make use of the State's on-boarding package and checklist to integrate with their organisational on-boarding requirements and processes.

## 3.2 Equipment, Maintenance, and Consumables

The Contractor will provide and maintain all equipment, and provide consumables necessary for delivery of the Services, in accordance with the conditions of the Agreement.

## 3.3 Structured Day

The Contractor will work with custodial staff at each Service Location to plan and coordinate the delivery of the Services, including outreach and in-reach health Services, to integrate with the custodial structured day,

## 3.4 Safe Environment

The Contractor will:

a. Deliver the Services in alignment with the security and operational requirements that apply in the Victorian prison environments, including Services delivered in restricted environments.

b. Support prison General Managers and custodial staff to achieve and maintain a safe prison system.

## 3.5 Information Systems and Records Management

### 3.5.1 Health Services Electronic Systems

The Contractor must create and maintain electronic records, including but not limited to:

a. In the State's Electronic Medical Records (EMR)

b. In the State's Client Management System (CMS) for notifiable incidents

c. In the Contractor's instance of a risk management system (e.g., RiskMan).

The Contractor will have access to a Justice Health data visualisation tool for understanding delivery and performance metrics and trends.

### 3.5.2 Commissioner's Systems

The Contractor must create and maintain electronic records in the Commissioner's information management systems, to the extent required, which will include:

a. Updating risks and recommended actions in the Commissioner's Electronic Justice System (currently E*Justice)

b. Record all AOD services and programs and participations in the Commissioner's interventions system (currently CVIMS)

c. Any other systems recording as directed at Service Locations.

### 3.5.3 Records Management

The Contractor will:

a. Create and maintain all health and program records, clinical notes, referrals, and release planning to be timely, comprehensive, accurate, and compliant with the systems, processes, and user guidelines, and with their own systems and operational guidelines, as may apply, to ensure appropriate, timely, and continuous delivery of care for the safety and well-being of people in prison

b. Accurately and consistently use the ICD-10-AM data code set in the EMR for recording diagnoses, disabilities, and external causes of injuries

c. Record translation needs, follow-up actions when people do not attend an appointment or refused, requests by Aboriginal people for cultural support (designated roles) at appointments

d. Provide timely sharing of health information as required

e. Follow local processes and liaise with custodial staff and Justice Health for updates to the Commissioner's systems when health staff become aware of updates or errors

### 3.5.4 Hardcopy Records

The Contractor will:

a. Create and maintain hardcopy health records to support the provision of health services for Rivergum residents

b. Scan and save to the EMR any documents that are not available from within the EMR (e.g., some assessment tools, specific consent forms)

c. Have in place processes and create hardcopy templates for use by staff if the State's network or EMR is unavailable

d. Request from Justice Health and securely manage, store, and return historic hardcopy medical files (pre-2015) that are held offsite.

## 3.6 Duty of Care and Appropriate Information Sharing

The duty of care to ensure the safety and welfare of people in prisons extends to everyone who provides services to people in prison.

In relation to sharing information, the Contractor will:

a. Appropriately share information permissible in compliance with legislation

b. Share information balanced by restrictions on the use and disclosure of confidential information within the *Corrections Act 1986* and the *Health Records Act 2001*.

c. Document and use correct information for people in prison, validating the client's name (and using preferred names, particularly for LGBTIQ+ people, and aliases) and multiple personal identifying checks (including name spelling, current name used, date of birth, ethnicity), whether for EMR recording, for onsite or offsite appointments, or for appropriate information sharing.

d. Not share confidential or health information without a person's consent if the information sharing is not related to the purpose the information has been collected, being for the provision of primary healthcare, or a

closely related secondary purpose of the information collection that the person might reasonably expect (e.g., disclosing to custodial staff the type of specialist referral, so that they can best support the client attending an external appointment).

e. Disclose health information as required (and lawful) when there is a serious and immediate threat to an individual's life, health, safety or welfare or a serious threat to public health, public safety, or public welfare.

f. Comply with the Multi-Agency Risk Assessment and Management Framework (MARAM).

g. Address family violence risk assessment and management, to align policies, procedures, practice guidance and tools to the MARAM Framework, which is contained in Section 190 of the Act.

## 3.7 Notifiable Incidents

The Contractor will:

a. Record and report notifiable incidents, including hazards, and people in prison complaints, in the State's nominated client management system, in compliance with the defined events and responsiveness in *Attachment D – Health Operations Notifiable Incidents*,

b. Record incidents in its own instance of a risk management system, to monitor, manage, and action improvements stemming from incidents and analysis of trends.

Service Linked Fee reductions will apply for non-compliance with the notifiable incidents performance measure defined in *Attachment C.*

## 3.8 Informed Consent

The Contractor will seek to obtain two consents at the reception medical assessment:

a. Written consent from the client for provision of primary healthcare while in prison, including authorised and legally permitted information sharing

b. Consent for obtaining access to medical information from the client's community health service provider (e.g., a hospital or GP), which will be printed, signed, and promptly sent to the external entity/entities.

The Contractor will also:

a. In addition to obtaining informed consent for the provision of primary healthcare obtain informed consent when specific health interventions or treatments or associated circumstances would ordinarily be appropriate practice including but not limited to attendance of a support person or family member, or in reach service to attend an appointment, AOD health program participation, receiving Naloxone on release to the community, consent that relates to health promotion activities, or participation in the MATOD program

b. Use a range of consent forms already developed and required to be used, which includes consent forms available in the EMR (e.g., COVID-19 vaccination consent)

c. Develop additional consent forms when needed, to be endorsed by Justice Health

d. Review consent forms from time to time or when requested by Justice Health.

## 3.9 Service Eligibility

There are no sentencing status or length of term restrictions for access to Services. People in prison, whether on remand or sentenced, are eligible to access all Services needed by them.

The Contractor will:

a. Manage wait lists for Services to prioritise based on urgency and to meet Service performance measures (*Attachment C* and as otherwise detailed in the Specifications).

b. Capture information for release planning including recommended treatments and active referrals (e.g., dental, optometry, audiology, a course of vaccinations) when health needs have been confirmed and either not commenced or are incomplete at the time of the person's release to the community.

## 3.10 Clinical Hours and Service Availability

The Service clinical hours and out of hours arrangements by Service availability are provided in *Attachment F – Clinical Hours and Service Availability by Service Location*.

The Contractor will:

a. Provide readily accessed and easy to understand written Service information, endorsed by Justice Health and by prison General Managers, so that people in prison and custodial staff at each Service Location are aware of the clinical coverage hours, how to access Services, expected responsiveness, and other access processes or matters that people in prison need to know.

b. Provide materials about Services in multiple languages.

c. Ensure that people in prison are aware that they may access a private registered medical practitioner, physiotherapist, or chiropractor at their own expense for the preservation of health.

a. Facilitate and schedule the delivery of private service arrangements when such requests have been approved by the Justice Health Principal Medical Officer.

## 3.11 Emergency Care and Transfer to Hospital

In the event of health emergencies, the Contractor must:

a. Promptly respond to emergency episodes and provide emergency care for people in prison, custodial staff, and prison visitors, up until the point of ambulance arrival and handover.

b. Ensure that all clinical staff can respond to and manage emergency care events, and that processes are documented and well understood by staff for timely response to health emergencies and escalation to emergency ambulance services at each Service Location.

c. Call an ambulance when clinically indicated.

d. Have in place processes for ambulance transfers that may not be emergency episodes but nonetheless require ambulance attendance and client transfer.

e. Refer eye emergencies directly to ophthalmology services, the Royal Victorian Eye and Ear Hospital, or to an appropriate emergency department.

f. Refer ear or auditory emergencies directly to the Royal Victorian Eye and Ear Hospital, or to an appropriate emergency department.

g. Promptly advise custodial staff that an emergency call has been placed and advise of emergency health incident if they are not already aware.

h. Provide clinical advice to custodial staff on whether a movement to hospital in a prison vehicle is appropriate.

When a person in prison requires emergency assessment and health management, they will be transferred to the nearest public hospital Emergency Department or Urgent Care Centre. Ambulance Victoria will determine the most appropriate public hospital, which may be a metropolitan tertiary hospital.

## 3.12 Service Feedback and Complaints

The Contractor will have in place systems to obtain, record, respond to, and escalate:

a. Complaints and feedback from people in prison who receive the Services, and from service stakeholders, in compliance with the Justice Health *Complaints Handling Framework* (which draws upon the Complaints: Good Practice Guide for Public Sector Agencies' and the Health Complaints Act 2016).

The Contractor will also:

a. Receive complaints and actively seek feedback from prisoners about individual staff members, the organisation and the Services provided, and will have links to relevant complaints and advocacy services.

b. Regularly review the feedback systems for their effectiveness in facilitating feedback and managing complaints.

c. Inform people in prison of how to make a complaint or provide feedback, including how to escalate a grievance in the case of an unsatisfactory investigation or complaint.

d. Manage and respond to complaints compassionately, comprehensively, and competently in a timely manner, with information provided to all parties about the action resulting from the complaint.

e. Undertake the specific additional feedback activities and reporting detailed in *Attachment H – Contract Management and Reporting.*

## 3.13 Primary Health Services Reporting and Compliance Submissions

The Contractor will report on the associated Key Performance Measures (KPMs) and Additional Data Requirements (ADRs), for the Services, to be submitted monthly, with aggregated delivery and performance analysis and narrative reports to be submitted bi-annually, following the close of quarter two and following the close of the full reporting year, and will provide all other reporting and compliance submissions as fully detailed in *Attachment H*.

Refer to *Attachment C – Primary Healthcare Performance Framework 2023*

Refer to *Attachment H – Contract Management and Reporting*

Refer to the Agreement, Schedule 4 - Service Linked Fee Reduction Model.

# 4. Focus Area 1: Health Assessments and Planning

## 4.1 Health Assessment Tools

The Contractor will:

a. Use evidence-based assessment tools that are culturally appropriate

b. Make use of assessment tools that have been endorsed and are available in the EMR

c. Gain endorsement from Justice Health for new health assessment tools.

## 4.2 Referral to Health Services

Reception medical assessments and subsequent assessments form the basis of ongoing care for people in prison, including referrals for services and treatment and for release planning.

For delivery of assessments and planning, the Contractor will, when indicated:

a. Identify and refer people to other health services

b. Make referrals to specialist services

c. Make referrals to the forensic mental health service provider

d. Make referrals to services for people in Priority Groups

e. Work collaboratively with custodial staff at each Service Location to ensure that transfers occur in a timely way that supports continuity of care and promotes the individual's health needs when transfers are required for external appointments to access specialist care.

## 4.3 Accommodation Placement and Management of Care

The Contractor will:

a. Promptly consult with custodial staff when safety and wellbeing matters are identified at reception or at any time during a person's time in prison, to assist with appropriate accommodation placement decisions, including people with health risks and those in Priority Groups.

b. Work with custodial staff to ensure appropriate ongoing management and care of people identified with health risks or for meeting the health needs of Priority Groups, including those with disabilities, cognitive impairments, and aging impairments, such as dementia.

## 4.4 Health Assessments

### 4.4.1 Reception Medical Assessment

The initial assessment on entry into the prison system establishes the current health profile of the person, and health treatment and planning, and release planning, are commenced.

For delivery of reception medical assessments, the Contractor will:

a. Provide reception medical assessments at the following Service Locations (days and reception numbers may change from time to time and are estimated below for 2023):

   i. MAP - Melbourne Assessment Prison (Monday to Saturday; est. 25 to 35 receptions per day)

   ii. MRC - Melbourne Remand Centre (Sunday to Friday: est.10 receptions per day)

b. Conduct a comprehensive face-to-face reception medical assessment within 24 hours of a person's arrival at a reception prison, provided by a Medical Practitioner (MP) and a Registered Nurse (at a minimum RN Grade 2), working as a team.

c. **Optional service:** If this Optional service is requested to form part of the Scope of Services by the State at any time during the Term, the Contractor will provide Point of Care testing nurses working alongside the MP and RN as part of the reception process.

d. Deliver the reception medical assessment in a manner to reduce the stressful process for people arriving in prison and to facilitate the continued movement through the CV reception process.

e. Draw upon collateral to inform the assessment, including, but not limited to:

   i. Review health information received from Police Custody, and if this information is not available, request it.

   ii. Seek, obtain, and review health information from community health service providers, which may require assisting the person to identify their community health service provider by showing them a map or photo of the practice on the computer.

   iii. Seek self-reporting of health needs and prior diagnoses from the client, which will be validated by the via collateral or further assessment.

   iv. Review existing Justice Health EMRs (from 2015 onwards)

   v. Request hardcopy medical records (pre-2015) from Justice Health, who will arrange retrieval from offsite storage.

f. Provide support for Aboriginal people at their reception medical assessment:

   i. Actively initiate the offer of support for the person if the Contractor believes this will be beneficial at the point of reception and arrange support at the earliest opportunity. When support is arranged, the Contractor will manage the reception medical assessment process for the Aboriginal client so that the service is still received within 24 hours of arrival.

ii. Arrange for the attendance of a member of the Contractor's Aboriginal (designated roles) health team. If a member of the Contractor's Aboriginal health team is not available, arrange for the attendance of a Corrections Victoria Aboriginal Wellbeing Officer (AWO) or Aboriginal Liaison Officer (ALO), if available.

iii. Ensure that colloquial language is avoided when asking people arriving in prison, or throughout their time prison, if they identify as Aboriginal or Torres Strait Islander, or both. The question must be posed formally and in full, and health staff will need to explain the purpose of the question and outline the additional health services available for Aboriginal people, being one of the reasons for requesting or confirming the information.

g. Provide support for transgender, gender diverse or intersex people at their reception medical assessment:

i) Ensure that colloquial language is avoided when asking people arriving in prison, or throughout their time in prison, if they identify as transgender, gender diverse or intersex. The question must be posed formally and in full on every reception, and health staff will need to explain the purpose of the question and outline the additional health services available for transgender, gender diverse or intersex people, being one of the reasons for requesting or confirming the information.

ii) Provide continuation of gender affirming treatments, including hormones or actively assess and prescribe for people who request gender affirming treatments. (An informed consent model will be implemented for all gender affirming treatments.)

h. Access translation services for people from CALD backgrounds who require it, including for people who speak English but who may prefer, and would find it more beneficial and comprehensible to discuss health matters in their first or nominated language when engaging with the Services.

i. Promptly refer people identified as requiring a suicide and self-harm at-risk assessment to the forensic mental health service provider for an at-risk assessment.

To address the immediate and ongoing health needs of people arriving in prison, the Contractor will, but is not limited to:

a. Assess injuries or immediate illness.

b. Have processes in place to ensure reception medical assessments do not continue if the health staff identify physical or mental health conditions that require immediate and urgent attention that preclude the assessment process being completed, or if the team believes there is a safety risk to the person or to others.

c. Promptly consult with custodial staff to provide clear clinical advice in relation to immediate interventions or accommodation recommendations. In these instances, the reception medical assessment will be completed the following day or at the earliest opportunity depending on the person's condition and as directed by custodial staff.

d. Refer people to the medical centre for any treatment that should be attended to at the time of reception (illness, injuries), whether following completion of an assessment or if the assessment needs to be abandoned.

e. Advise custodial staff when a person needs to be moved to the medical centre to receive treatment.

f. Offer every person Blood Borne Virus (BBV) testing, including Point of Care testing for hepatitis, and offer communicable disease testing.

g. Consider self-reporting of risk behaviours (injecting drug use, unprotected sex) to inform the health risks for the person and the offer of a range of possible screening tests, in addition to BBV.

h. Use the Australian Immunisation Register or other available information sources to obtain immunisation/vaccination status, and offering immunisations when gaps are identified (e.g., hepatitis or COVID-19).

i. Review existing and prescribing medications.

j. Record a person's allergies.

k. Record AOD concerns, and identification of withdrawal and risk of withdrawal.

l. Commence AOD medical withdrawal support and development of a substance withdrawal plan.

m. Commence on MATOD if community collateral confirmed, actively assess people who request induction for MATOD, and actively identify and discuss MATOD with people who may benefit, but who were not currently on MATOD in the community.

n. Record mental health conditions (which will be fully assessed by the forensic mental health service provider at receptions).

o. Record chronic medical conditions and initiation of Integrated Care Plans (ICP; per the defined criteria).

p. Refer for further primary health assessments including functional assessment, or Aboriginal Health Check.

q. Record pre-existing disabilities (including Acquired Brain Injury (ABI) or cognitive impairment).

r. Ask every person and record whether they identify as LGBTIQ+.

s. For people who identify as transgender, gender diverse or intersex:

    i. The reception medical assessment must consider endocrinology, mental health including suicide risk, family violence, sexual health, preventative care, and all people offered STI testing.

    ii. Ensure that a person's preferred name and pronoun are recorded and used by the Contractor / health staff when people arrive in prison and throughout their time in custody.

    iii. Seek and record current treatments.

t. Refer to custodial services, if appropriate, for example, for provision of assistance provided by Prison Service Workers

u. Refer to one or more allied health services

v. Refer for diagnostics, radiology or pathology, including at reception POC testing.

w. Schedule follow up appointments.

x. Make visual observations and record matters that further inform health needs, such as dental health, coherence, agitation, physical impairment, and personal hygiene and presentation.

y. Complete the assessment documentation and actions, including referrals and booking follow up appointments, after the person has left the assessment, so that the CV reception process for new arrivals is not delayed.

Service Linked Fee reductions will apply for non-compliance with the 24-hour reception medical assessment performance measure (valid exemptions apply).

### 4.4.2 AOD and Withdrawal Assessment

For delivery of AOD health assessments and withdrawal medical support, the Contractor will:

a. Record substance use history in the EMR, including the name/s of drugs of concern, past use, quantity, frequency, when started, last used, route of use, age of first regular use, age first injected, adverse effects, whether used in prison, and withdrawal scale/s.

b. Develop a withdrawal assessment and treatment processes that complies with recognised contemporary practice AOD withdrawal guidelines (refer to Turning Point guidelines, 2018), which will include processes to guide follow-up and monitoring of people who might not have disclosed AOD concerns, or who might not be experiencing withdrawal symptoms at the time of reception.

c. Use appropriate withdrawal tools, which may be more than one, when assessing a person at reception, and will continue to use the appropriate tools when medical / health reviews are conducted during treatment or monitoring and post-treatment or monitoring.

d. Consider the most appropriate treatment or monitoring location available at the Service Location, or transfer to hospital if medical care escalation is indicated.

e. Use the Drug and Alcohol Clinical Advisory Service (DACAS) for specialist advice, at reception, and following reception, as needed.

f. Provide post-withdrawal planning, including pharmacological support, and record cultural and social factors than may need to be addressed, and mental health concerns, which may be causal or co-existing (dual diagnosis), with the latter to be closely monitored during and following withdrawal.

g. Refer to the forensic mental health service provider, if needed.

### 4.4.3 At-risk of Self Harm and Suicide Assessment

For delivery of at-risk assessments, the Contractor will:

a. Have processes in place at Service Locations for anyone in the prison system to easily notify the primary mental health team of at-risk behaviours of a person in prison.

b. Manage the prevention of self-harm and suicide at the Service Locations as a priority and implement an integrated approach consistent with mental health legislation policies, and guidelines, which will entail the combined efforts of the Contractor, custodial staff, and the forensic mental health service provider.

c. Conduct an at-risk assessment within 2 hours of the Contractor being notified of person in prison identified with at-risk behaviours:

    i. Undertake a comprehensive assessment (using a validated tool) to determine if the person is at risk of suicide or self-harm

    ii. Provided face-to-face by a Mental Health Professional

    iii. If confirmed as being at-risk, the Mental Health Professional will allocate a risk rating, in line with Victorian Prison Codes, which will guide the mental health response and the health management by the Contractor and custodial staff.

d. Consider the clinical response for people identified as at-risk, the wellbeing and safety of the individual, and where possible, minimise isolation and maximise their interaction with others, while maintaining the safety of the individual and others. Custodial staff, once advised and in consultation with health staff, will arrange for placement or movement of the person at-risk if clinically indicated.

e. Develop risk management plans for all people in prison assessed as being at risk.

f. Seek a CV Aboriginal Wellbeing Officer (or equivalent) to be involved in the development of risk management plans for Aboriginal people and ensure Aboriginal people are offered the attendance of an AHP or AHW, if available.

g. Arrange a follow up wellbeing check by an AHP or AHW at the earliest possible opportunity, regardless of the person's assessment outcome or whether they requested the support.

h. Note any delay of at-risk assessments for Aboriginal people stemming from the option of having an AHP or AHW in attendance for cultural and wellbeing support. The assessment activity and safety of the person must take priority.

i. Wherever possible, request a CV Disability Officer to be involved in the development of risk management plans for people in prison with an intellectual disability.

j. Have systems in place to promptly communicate the at-risk assessment outcomes to CV prison management through the established systems, including recording updates in the Commissioners information system

k. Attend and record Risk Review Team meetings (also known as High Risk Assessment Team) and case conferences, commence development of at-risk management plans, provide referrals to the forensic mental health service provider, and document clinical notes in the EMR.

l. Ensure referrals from the Mental Health Professional to the forensic mental health service provider are timely and thorough.

m. Provide mandatory training for their clinicians, as part of their onboarding and ongoing employment processes, which must include suicide and self-harm and suicide training as stipulated or endorsed by CV, and regular refresher training.

Service Linked Fee reductions will apply for non-compliance with the 2-hour at-risk assessment performance measure (valid exemptions apply).

### 4.4.4 On Call and on Call Recall

Outside the normal clinical coverage hours (refer to *Attachment F – Clinical Hours and Service Availability by Location*) the Contractor must have on call Services at all Service Locations, and recall services for Service Locations without after-hours on-site staff, to be rostered with suitably qualified staff for undertaking at-risk assessments and for arranging medical treatment as needed, for phone orders for urgent medication, and escalation to custodial staff when necessary, including for accommodation recommendations if appropriate.

Refer also to Section 7.1.5 – Afterhours Urgent Care.

### 4.4.5 Fit to Travel Health Check

For delivery of fit to travel health checks, the Contractor will:

a. Complete a fitness to travel health check prior to people in prison being transferred to another prison location or to court.

b. Draw upon information from previous assessments and include a desktop review of the person's immediate health and wellbeing, health risks, communicable conditions, planned referrals or treatments, and mental health state, including any suicide or self-harm risks.

c. Provide custodial staff with all necessary information to ensure that the person is transferred safely.

d. Provide a medical certificate for a person in prison assessed as being unfit to transfer to court because they have an immediate health condition that precludes travel to court and appearance in court.

e. Consult promptly with custodial staff if a person is pending the provision of health services that can only be provided by, or accessed from their current location, but is otherwise fit to travel, to ensure that custodial staff are aware that there are care needs to be considered, or an immediate health condition, that precludes travel. Information sharing with custodial staff in these instances may be through the provision of a medical certificate given to the client.

### 4.4.6 Medications to Travel

The Contractor will ensure that prescribed medications are administered to travel with the person to and from facilities and people who are transferred to court must have access to their medications

a. Administer prescribed medications to travel with the person to and from Service Locations

b. For in-person court travel, provide sufficient medications to last for three days.

### 4.4.7 Inter-Prison Transfer Health Check

Transfers and clinical contacts with clients are an opportunity to elicit further disclosure of health history, including risk factors, and to offer communicable disease screening or to address newly identified health needs or emerging health concerns. Repeat health checks following transfers are a valuable contribution to creating a more thorough health profile and for ensuring that the client's health and wellbeing needs are being met.

For inter-prison health checks, the Contractor will:

a. Provide inter-prison transfer health checks within 24 hours of a person arriving at the receiving Service Location.

b. Provide inter-prison transfer health checks within 5 Business Days of the person arriving at Rivergum.

c. Undertake a desktop review of the EMR and a face-to-face review, which will draw upon information from previous assessments and include a review of the person's immediate health and mental health needs and current health status, including any appointments or referrals that need to be rescheduled.

d. Redirect and reschedule external referrals for diagnostics, or specialist services (including tele-health); to be undertaken by the receiving prison.

e. Notify the external health service that the person in prison has changed Service Location.

Service Linked Fee Reductions will apply for non-compliance with the 24-hour inter-prison transfer health check performance measure (valid exemptions apply).

### 4.4.8 Return from Court Welfare Check

For return from court welfare checks, the Contractor will:

a. Complete a face-to-face return from court welfare check within 24 hours of a person arriving at the receiving prison upon return from court, usually provided by a Mental Health Nurse (MHN) or may be provided by a RN if a MHN is not available.

b. Provide court return welfare checks following in-person court attendances or court attendances via video.

c. Ensure the welfare check addresses mental health concerns, including referrals or scheduling follow up appointments to monitor welfare or mental health concerns identified.

d. Refer the person for an at-risk assessment if indicated.

The highest volumes of court return welfare checks will typically be at Karreenga, Marngoneet, MAP, and MRC.

### 4.4.9 Return from Hospital Health Check

For return from hospital health checks, the Contractor will:

a. Complete a face-to-face health check within 24 hours of a person returning from hospital, usually provided by a RN, but may also be provided by a NP or a MP.

b. Undertake a health check, review the hospital discharge collateral, schedule follow up appointments or make referrals (e.g., to allied health) stemming from recovery or new care needs.

### 4.4.10 Functional Assessment

**Optional service:** If this Optional service is requested to form part of the Scope of Services by the State at any time during the Term, the Contractor will implement a functional assessment Service.

For functional assessments, the Contractor is required to:

a. Triage functional impairments (which may be temporary, chronic, degenerative, or irreversible) at the time of the reception medical assessment, or at any other time of intensifying a need.

b. Make referrals for functional assessments, including when a person self-refers or self-discloses an impairment.

c. Provide functional assessments, conducted by an Occupational Therapist (OT) within 5 Business Days of the referral being made, including when a referral is made at any time following the reception medical assessment, which may be at any Service Location.

d. Develop tools, endorsed by Justice Health, for assessing a person in prison's physical or cognitive capabilities, limitations, and risks during the functional assessment. The outcomes of the functional assessment may result in, for example, any one or more of the following:

   i. Referral to allied health services

   ii. Development and implementation of a Personal Care Assistance (PCA) plan

   iii. Referral for a neuropsychological assessment

   iv. Referral for medical equipment or aids

   v. Referral to one or more health teams for further assessment, diagnosis, or care

   vi. Referral to a bed-based medical service

   vii. Referral to Corrections Victoria programs and services, such as the Prison Disability Support Initiative.

e. Develop an assessment report and recommendations within 10 Business Days of the assessment being completed.

f. Communicate assessment outcomes and recommendations promptly to the client, and ensure actions are commenced when needed.

g. Appropriately share information with custodial staff in relation to a person's accommodation placement needs identified as part of the functional assessment.

h. Make referrals to health services, schedule other appointments, as well as recording that PCA support has been scheduled and commenced, if applicable.

i. Undertake periodic reviews of people in prison with confirmed functional impairments, to ensure that healthcare and support plans remain appropriate, including for people with temporary impairments.

If this Optional service is requested to form part of the Scope of Services by the State at any time during the Term, Service Linked Fee reductions will apply for non-compliance with the 5 Business Days functional assessment performance measure (valid exemptions apply).

### 4.4.11 Health Check (Aboriginal People)

For delivery of Health Checks for Aboriginal people, the Contractor will:

a. Develop a Health Check process and tool suitable and culturally appropriate for Aboriginal people that must be reviewed and accepted as being appropriate by Aboriginal health service providers and endorsed by Justice Health.

b. Develop a Health Check that addresses differing age cohorts and includes a comprehensive screening and assessment (as indicated for the age of the client) of physical health and social and emotional wellbeing.

c. Provide all Aboriginal people arriving at a reception prison with a Health Check within 10 Business Days of the client's arrival, or within 10 Business Days of identification of Aboriginal status (whichever is sooner), delivered by an Aboriginal Health Practitioner (AHP) (designated position) or an Aboriginal Health Worker (AHW) (designated position),

d. If the Health Check cannot be conducted by an AHP or an AHW, request attendance at the Health Check by a CV AWO or ALO, if available, to provide support for the client, unless the client declines consent for the attendance of a third party.

e. Note that the KPM of 10 Business Days applies regardless of the clinical role delivering the Health Check.

f. Prior to the Health Check, the AHW or MP will consult with the CV AWO who met with the client for a wellbeing check following reception, to collaboratively address health or wellbeing concerns that may have been discussed or become apparent during the wellbeing check and discuss how that information sharing might help to inform the Health Check. Pre-planning for the Health Check will aim to reduce duplication, be trauma informed, culturally sensitive, and enhance the Aboriginal client experience of engaging with the health services.

g. Review collateral and existing health records, seek and obtain further collateral (with client consent) if gaps in the client's records are identified during the Health Check.

h. Following the Health Check, update prescribing needs, schedule appointments with a MP or NP, or RN, or dental, or allied health services as needed, and refer to specific services if appropriate, such as AOD programs, immunisation, or further assessments.

Service Linked Fee reductions will apply for non-compliance with the 10 Business Day Aboriginal people health check performance measure (valid exemptions apply).

## 4.5 Integrated Care Plans

### 4.5.1 Integrated Care Plans (Aboriginal people)

For delivery of Integrated Care Plans (ICP) for Aboriginal people in prison, the Contractor will:

a. Develop an ICP for Aboriginal people to be completed within 29 Calendar Days of reception, or within 29 Calendar Days of identification of Aboriginal status (whichever is sooner), led by the AHP or AHW, in consultation with the broader health team.

b. Use information recorded as part of the reception medical assessment, screenings, the Health Check, and any other assessments provided to inform an Aboriginal person's ICP.

c. Consider risk factors, ongoing healthcare and treatment needs stemming from screening or assessment outcomes, dental or allied health services, AOD health interventions, health literacy and personal agency, and the person's own health, cultural, social, and wellbeing goals and needs.

d. Encourage the Aboriginal person to engage with the care plan process and provide input on what they need.

e. Identify and engage with a family member or nominated support person (if requested and consented) to support the Aboriginal person's health pathway.

f. Provide access to cultural support and traditional healing as part of the ICP.

g. Build and maintain strong partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs) to deliver in-reach services at the Service Locations.

h. Address the needs of Aboriginal people from other states or territories who must be offered additional cultural and social supports during their time in the Victorian prison system, including from local ACCHOs or local Elders.

i. Provide an active telephone handover of care to the receiving healthcare team within 5 Business Days following an Aboriginal person in prison being transferred from a public prison to a Victorian private prison.

j. Undertake ICP reviews as clinically indicated and recorded in the ICP, and no less than annually.

Service Linked Fee reductions will apply for non-compliance with the 29 Calendar Days ICP performance measure (valid exemptions apply).

### 4.5.2 Integrated Care Plans (People with Chronic Medical Conditions)

For delivery of ICPs for people with chronic medical conditions, the Contractor will:

a. Develop an ICP for people with a current chronic medical condition, to be completed within 29 Calendar Days of identification of the need. Identification of the need for an ICP might occur be at the reception medical assessment or at any other time during a person's term in prison.

b. Develop ICPs for people who have a current diagnosed chronic medical condition that has been (or is likely to be) present for six months or longer and requires active management, treatment, or monitoring.

c. Chronic medical conditions for the purpose of ICPs include but are not limited to:

- Asthma
- Cancer
- Cardiovascular disease
- Diabetes
- Renal disease
- Autoimmune disorders
- Musculoskeletal conditions causing pain or impacting upon quality of life
- Neurological conditions
- Gastrointestinal disorders
- Chronic Obstructive Pulmonary disease

d. Use information recorded as part of the reception medical assessment, and other assessment referrals, if any, to inform the ICP for people with current chronic medical conditions.

e. Undertake ICP reviews annually, or bi-annually, or as clinically indicated and recorded in the ICP.

Service Linked Fee reductions will apply for non-compliance with the 29 Calendar Days ICP performance measure (valid exemptions apply).

### 4.5.3 Integrated Care Plans (Transgender, Gender Diverse, and Intersex People)

For delivery of ICPs for (Transgender, Gender Diverse, and Intersex People), the Contractor will:

a. Develop an ICP for people identifying as transgender, gender diverse or intersex, to be completed within 29 Calendar Days of reception, or within 29 Calendar Days of identification of the need (whichever is sooner).

b. Undertake the reception medical assessment in accordance with 4.4.1 above.

c. Use information recorded as part of the reception medical assessment, screenings, and any other assessments provided to inform the ICP for transgender, gender diverse and intersex people.

d. Assess the general health and mental health needs on a case-by-case basis, including assessment of the health relating specifically to their needs as an individual who is transgender, gender diverse or intersex.

e. Build and maintain strong partnerships and referral pathways under a secondary consult model with community health service providers or in-reach service providers who specialise in health services for transgender, gender diverse and intersex people to deliver in-reach services at the Service Locations.

f. Ensure that a person's preferred name and pronoun is used at all times.

g. Address the client's personal health preferences, goals, and wellbeing aspirations, drawing upon community-based advisors or specialists as needed.

h. Undertake ICP reviews annually, or bi-annually, or as clinically indicated and recorded in the ICP.

Service Linked Fee reductions will apply for non-compliance with the 29 Calendar Days ICP performance measure (valid exemptions apply).

## 4.6 Release Planning and Continuity of Care

### 4.6.1 Release Planning as a Continuous Activity

For delivery of release planning, the Contractor will:

a. Commence release planning from the point of reception to ensure that Services are delivered with a timely, efficient, and sufficient release plan in mind to support continuity of care.

b. Address release planning as an ongoing activity and manage release health summaries as living documents that are updated regularly throughout a person's time in prison.

### 4.6.2 Release Planning Activities

For delivery of release planning and to ensure continuity of care when people are released to the community, the Contractor will:

a. Identify future opportunities for service delivery for inclusion in release plans.

b. Supply medications to people being released to the community, as needed.

c. Provide handover to community health services for people needing or receiving hepatitis treatment.

d. Ensure continuity of health services for people with ongoing AOD concerns.

e. Provide short health release summaries for all people being released to the community.

f. Provide detailed health release summaries for people with ongoing health needs (refer to section 4.6.3).

g. Identify clients who have accepted the offer of a BBV or other communicable diseases screening, or who have not commenced treatment, or who have commenced but not completed a treatment, or a course of immunisations, as well as those requiring an early detection test, for input to release planning and for referral to a community health service for the screening, assessment, or treatment.

h. Provide people being released with up to a five-day supply of their current medications, except for pharmacotherapy, for which a seven-day prescription will be directly provided by the Contractor to a community pharmacy for the client.

i. Coordinate the health release planning activity:

    i. Drawing upon the multidisciplinary Service team, including the primary health Aboriginal health workforce.

    ii. Work with CV case managers, CV reintegration teams, the forensic mental healthcare service, and other prison-based transition support services.

    iii. Liaise with community providers, including ACCHOs, as needed to ensure continuity of care upon release for people identified as having ongoing health needs

    iv. For older clients or clients with disabilities, when required, undertake health information sharing (with consent) with CV or other providers for preparation of applications for National Disability Insurance Scheme (NDIS, under 65 years) or Aged Care Assessment Services (ACAS, over 65 years), or the Home and Community Care Program for Younger People.

v. Provide handover to community health service providers for transgender, gender diverse or intersex people.

j. Quality assure the content of release summaries and ensure that pertinent health information from the person's time in prison is included and accurate to the extent that would reasonably be required by a community health service seeking to continue care for the person being released.

Following release to the community, including direct release from a court, former clients may provide consent to any community health provider at any time (or any other of their representatives, e.g., family, carer, or legal), to enable health information sharing. Requests with consent for information about people who have been released to the community are received and managed by Justice Health, who will liaise with the Contractor when needed for health summaries if they are not available in the person's EMR or if additional information is needed or requires clarification.

### 4.6.3 Release Planning Appointment

For release planning for people with ongoing health needs and for Aboriginal people, the Contractor will:

a. Provide a face-to-face release planning appointment for all people being released from prison with a known or expected release date with ongoing health needs or are from a Priority Group. This includes, but is not limited to:
   i. People who have an active Integrated Care Plan at the time of release
   ii. People who have an active Mental Health Recovery Plan
   iii. People who have other health issues requiring ongoing care, including a current communicable disease
   iv. People who have been prescribed pharmacotherapy treatment or ongoing AOD intervention needs
   v. People who are recovering from surgery or treatment.
   vi. All Aboriginal men.
   vii. All transgender, gender diverse and intersex people.

b. Make best endeavours to schedule release planning appointments for clients on remand, whenever practicable or reasonably foreseeable.

c. Undertake preparation for release planning appointments by reviewing client history and seeking input from other health and prison service providers as appropriate.

d. Undertake release planning appointments with attendance by a primary health clinician and other health staff as appropriate, and with agreement of the client, such as a primary health social worker, AHP or AHW, CV case manager, the forensic mental healthcare service, or CV reintegration team member.

e. Conduct release planning appointments in a manner to minimise repetition and to minimise multiple medical release planning reviews by different groups or clinicians.

f. Make extra efforts to engage clients who have ongoing health needs and who have been in prison for a longer period and have, therefore, lost their connections to community health services.

g. Allow for additional time for the release planning process and appointments for people who have been in prison for longer and consult with and appropriately share information with the CV reintegration team.

h. Develop a detailed health release summary and provide to the client (or their representatives, with consent) when the client has not attended a release planning appointment.

Service Linked Fee reductions will apply for non-compliance with the in-scope release planning appointments performance measure (valid exemptions apply).

### 4.6.4 Handover to Community

As part of comprehensive release planning and to support continuity of care, the Contractor will:

a. Undertake handovers as part of release planning based on the client's needs including:
    i. Direct contact with community health service providers.
    ii. Referrals and scheduling initial appointments.
    iii. Ensuring timely information sharing (through Justice Health from the community service provider, with client consent).
    iv. Discussion of handovers with the client, so that they understand the release planning process, the purpose of their planning involvement, ensuring they understand the reason for referrals or recommendations, making sure that services are geographically accessible for the client, and are best fit for their personal circumstances.
    v. Undertake warm handovers when indicated, which means including the client in a discussion with the community health service and will usually be by telephone (or video) with the community provider.
    vi. Arrange in-reach by community health service providers, which may be especially beneficial for Priority Groups in a variety of circumstances and will be considered for Aboriginal clients with ongoing health and cultural support needs and LGBTIQ+ people in prison; in-reach for handovers will be subject to the agreement of the client, the Service Location, and will often be contingent on the time available for planning in-reach activities as part of handover to the community.

### 4.6.5 Continuity of Care for Hepatitis Treatment

For continuity or commencement of hepatitis treatment as part of release planning, the Contractor will:

a. Develop strong partnerships with the Department of Health and with general and specialist community providers to ensure continuity of care for people with hepatitis.
b. Make referrals to community medical support as may apply, for hepatitis screening, assessment, treatment, treatment completion, or post-treatment follow-up (12 week, HCV PCR negative, cured, or not cured), for people who require it.
c. Also make referrals for clients who have completed treatment and are cured, but are known to engage in ongoing risk behaviour, who will be referred to a community health service provider for retesting for HCV viraemia (every six months).
d. Record hepatitis treatment status and specific community referral details and ensure that the client's release plan includes comprehensive information for continuity of care when the client is released.

### 4.6.6 Continuity of AOD Support

For continuity of AOD support as part of release planning, the Contractor will:

a. Have extensive knowledge of and build and maintain relationships with community AOD treatment organisations so that referrals and handover for ongoing AOD treatment forms part of client release planning when appropriate.
b. Liaise with case managers, CV reintegration teams, the forensic mental healthcare service or other transition support services, and community providers to ensure continuity of care upon release for people with ongoing AOD needs.
c. Make referrals to an appropriate General Practitioner in the community for clients requiring MATOD prescribing and medical support upon release and make an appointment with the community General Practitioner within 7 days of the client's release.

d. Arrange for the client's MATOD 7-day prescription to be sent directly to a community pharmacist and advise the client of the pharmacy so that the MATOD regime received during their time in prison can be maintained when they are released.

e. Provide verbal and printed information (to be available in a range of languages) to clients about their eligibility for a four-week subsidy of their MATOD community pharmacy fees upon release under the State's pharmacy post-release program, the claim and administration for which will be managed by the community pharmacist.

When AOD clients are released unexpectedly and do not have a referral for the MATOD subsidy program they can contact the Contractor at their last Service Location to organise a referral. The Contractor will ensure that clients know what to do in this circumstance, particularly remandees and people attending court.

### 4.6.7 Short Health Release Summary

For provision of the short health release summaries, the Contractor will:

a. Provide a hardcopy of the short health release summary to people being released to the community.

b. The short health summary will address health matters such as:

i. Previous and current list of prescribed medications and dosages, and referral for continuing prescribing

ii. Importantly, noting if or when the next dose of a particular medication is required.

iii. Test results or treatments received while in prison.

iv. Immunisation statuses.

v. Allergies, adverse events to treatments, or risk factors.

vi. Scheduled referrals that have been established as part of the client's health release planning.

### 4.6.8 Detailed Health Release Summary

For provision of the detailed health release summaries, the Contractor will:

a. Provide a hardcopy of the detailed health release summary to people in scope, being:

i. People who have an active Integrated Care Plan at the time of release

ii. People who have an active Mental Health Recovery Plan

iii. People who have other health issues requiring ongoing care, including a current communicable disease

iv. People who have been prescribed pharmacotherapy treatment or ongoing AOD intervention needs

v. People who are recovering from surgery or treatment.

vi. All Aboriginal men.

vii. All transgender, gender diverse and intersex people.

b. Develop strong relationships with local ACCHOs for in reach cultural, social and health support during the person's prison term, and outreach and referral for post-release support noting treatment and support are integral for improved health outcomes for Aboriginal people.

c. Provide outreach to post release programs and to ACCHOs, or the involvement of family and carers to support the necessary arrangements that will assist the client to maintain their health on release to the community and to facilitate their transition into the community.

d. Plan for release for Aboriginal people to be undertaken by the AHP and AHWs, to improve the release process and continuity of care for Aboriginal clients.

e. Collaborate with and share information with CV Aboriginal Continuity of Care services.

f. The detailed health summary will address health matters such as:

   i. Previous and current list of prescribed medications and dosages, and referral for continuing prescribing

   ii. Importantly, noting if or when the next dose of a particular medication is required.

   iii. The client's medical history, clinical risks or issues, communicable diseases.

   iv. Immunisation statuses, allergies, or adverse reactions or events stemming from health treatment.

   v. All diagnoses and interventions including operations, procedures, investigations, and complications of treatments during the client's time in prison.

   vi. Health service appointments that have been scheduled in the community with general or specialist providers (which will consider release location, housing arrangements, and community connections).

   vii. Details of handovers, including for MATOD prescribing (a GP handover), hepatitis treatment, and Aboriginal community health service providers, when applicable.

   viii. Recommendations for ongoing care or treatments.

# 5. Focus Area 2: Population Health

## 5.1 Communicable Diseases

### 5.1.1 Public Health Goals

The State aims to prevent re-infection of communicable diseases in prison and aims to eliminate Hepatitis B and C as a public health concern in Victoria by 2030.

### 5.1.2 Communicable Diseases: Offer, Screen, Assess, Treat

For delivery of communicable disease service, the Contractor will:

a. Make communicable screening offers at assessment points (reception, transfer, court return), and at primary care appointments for people who have previously declined the offer of screening.

b. Conduct communicable diseases screening and assessments for clients

c. Offer Blood Borne Virus (BBV) screening, which includes hepatitis B and C, as part of the reception medical assessment for all new prison receptions

d. Offer other hepatitis screening

e. Offer Sexually Transmissible Infections (STIs) screening

f. Actively identify and support people who may have had exposures stemming from unsafe behaviours or have otherwise been identified as being at-risk (when in the community or while in prison)

g. Actively identify risks or symptoms for other communicable diseases (e.g., tuberculosis, influenza, COVID-19, gastroenteritis, measles, Human Immunodeficiency Virus (HIV))

h. Conduct a diagnostic appointment for communicable disease screening within 3 Business Days of the screening need being identified

i. Communicate communicable disease screening results to the client promptly following the test results being received and reviewed by a clinician.

### 5.1.3 Point of Care Testing

**Optional service:** If this Optional service is requested to form part of the Scope of Services by the State at any time during the Term**,** the Contractor will implement a Point of Care Service at reception Service Locations.

The Contractor will implement and maintain Point of Care (POC) testing to improve screening uptake, wait times and follow up pathology appointments for non-attendance for hepatitis testing.

For delivery of POC testing, the Contractor will:

a. Provide POC testing at reception Service Locations

b. Deliver POC testing with POC testing nurses on all reception days and for the hours of reception at each reception Service Location

c. Procure POC testing devices, consumables, and ongoing support and maintenance for the devices

d. If requested by the State, expand the range of POC tests to be available at reception Service Locations.

### 5.1.4 Rapid Antigen Testing

When required by the State the Contractor will undertake Rapid Antigen Testing (RAT) for COVID-19 at nominated Service Locations (excludes testing for custodial staff or visitors; excludes purchase of the RAT kit consumables).

### 5.1.5 Hepatitis Assessment and Treatment

For delivery of hepatitis assessment and treatment, the Contractor will:

a. Provide treatment for people in prison living with chronic hepatitis C virus (HCV) infection and chronic hepatitis B virus (HBV) infection

b. Provide support to those identified as being at risk of having contracted hepatitis

c. Consult with a specialist, e.g. a gastroenterologist, hepatologist or infectious diseases physician experienced in the treatment of chronic hepatitis C infection for clients with cirrhosis, major comorbidities or significant drug-to-drug interactions

d. Ensure adequate authorised medical practitioners are available to prescribe s100 drugs for hepatitis treatment

e. Provide people referred for assessment with a liver health assessment and liver health care plan regardless of whether they proceed to antiviral therapy.

f. Provide people at risk of having contracted Hepatitis B or C with referral and access to:

    i. Hepatitis screening

    ii. Clinical assessment including Fibroscan (mobile devices)

    iii. Development of a liver health care plan for each person assessed

    iv. Hepatitis treatment eligibility assessment, pre-treatment investigation, treatment initiation treatment, post-treatment follow-up, post-release linkage to care including specialist referral where indicated, and for people who have been unable to commence or complete treatment while in prison.

g. Offer those with a negative test result a vaccine course.

### 5.1.6 Active Follow Through and Culturally Safe Support

For delivery of communicable disease services, the Contractor will:

a. Develop and use appropriate and plain language messaging and materials to encourage screening uptake and actively follow-up people who have been identified as being at a higher risk of contracting a

communicable disease, or who accepted an offer of screening, or assessment, or an appointment to discuss treatment, but failed to attend a follow-up appointment (including when POC testing was not provided to them at the time of reception).

b. Where appropriate, follow-up with the client's case worker or custodial staff consolation, seek culturally specific support, for example from the Contractor's Aboriginal health workforce, or Aboriginal wellbeing officers.

## 5.2 Early Detection

### 5.2.1 Early Detection of Disease

The Contractor must offer and provide timely early detection of diseases tests or referrals for tests when a need is identified by a clinician or is identified by and requested by the client.

**Optional service:** If this Optional service is requested to form part of the Scope of Services by the State at any time during the Term, the Contractor will implement a robust process to embed routine screening across all Service Locations equivalent to community practice to support early detection and treatment of common diseases.

For delivery of routine early detection of disease, the Contractor will:

a. Offer routine screening as clinically recommended and equivalent to community practice to support early detection and treatment of common diseases.

b. Prioritise and tailor screening programs for early detection by offering comprehensive health checks to at-risk and/or Priority Groups.

c. Conduct diagnostic appointments for routine early detection within 20 Business Days of the screening need being identified. If screening is being undertaken stemming from identification of symptoms that require investigation, then this will be completed within 5 Business Days of need identification.

d. Communicate early detection screening test results to the client within 5 Business Days of the test results being received and reviewed by a clinician, or sooner if a positive diagnosis.

Scheduling of early detection of disease for people in prison will include, but is not limited to:

a. Cervical screening

b. Mammograms

c. Bowel cancer screening

d. Liver and kidney function tests

e. Prostate Specific Antigen (PSA) test

f. Skin cancer screening

g. Diabetes screening

h. Respiratory test

i. Heart disease screening tests.

## 5.3 Prevention

The Contractor will develop and implement measures to prevent transmission of communicable disease in the custodial setting and into the community upon release.

### 5.3.1 Health Protections

For delivery of health protections, the Contractor will:

a. Develop, maintain and implement a Health Protection Plan (HPP)

b. Deliver vaccination programs as part of the HPP

c. Develop and maintain outbreak responses as part of the HPP

d. Ensure that people at each Service Location know where to access and how to correctly use condoms, dental dams, and bleach sachets (consumables that are purchased by the Contractor, with the exception of bleach sachets, which are the responsibility of Corrections Victoria), and will liaise with custodial staff if consumables are low in stock or are unavailable or inaccessible.

e. Provide PrEP (pre-exposure prophylaxis) and PEP (post-exposure prophylaxis) when clinically indicated to lower the risk of infection (for example, men having sex with men, those having sex with HIV+ people and / or those injecting drugs).

### 5.3.2 Health Protection Plan

The Contractor's health protection operational procedures will be referenced as the Health Protection Plan, which must be endorsed by Justice Health, in writing, during transition-in, and reviewed and submitted with notated updates on an annual basis, by no later than 31 August each year, for endorsement.

In providing a health protection plan, the Contractor will:

a. Plan for, prevent, and manage infection control and communicable outbreaks (e.g., upper respiratory infections, influenza, gastroenteritis, COVID-19, BBVs, STIs) at all Service Locations.

b. Provide operational procedures that are detailed and exhaustive to address health protection at Service Locations, including leadership, governance, communication plans, allocation of accountabilities, roles and responsibilities.

c. The operational procedures will be informed by health specialists in the community and comply with:

   i. State and federal government guidelines

   ii. Location outbreak management plans

   iii. Location business continuity plans.

In the HPP, the Contractor will outline:

a. Regular training to be undertaken by clinical and custodial staff

b. Education and guidance on infection control measures, including quarantine and isolation, physical distancing, cleaning and disinfection requirements, and appropriate Personal Protective Equipment (PPE)

c. Annual compliance audit planning against relevant procedures (including hand hygiene audits)

d. Roles and responsibilities system and at each location to ensure adherence to health protection plans and procedures, and in the event of a suspected outbreak or actual outbreak

e. Planning undertaken to ensure health staff are prepared, trained to undertake their roles and responsibilities in the event of a suspected or confirmed outbreak

f. A detailed business as usual communications plan

g. A detailed infection and outbreak communication plan

h. Escalation and de-escalation processes and roles and responsibilities, for the Contractor and stakeholders

i. How the Contractor will actively monitor and manage compliance with the plan and procedures and approach to regularly communicating with custodial and Justice Health about health protection activities.

j. If required for complying with prevailing legal and health directives, provide a pandemic safe plan for the Service Locations, and taking into account any prevailing Commissioner's Requirements.

### 5.3.3 Vaccination Program

The Contractor will develop processes to deliver a range of vaccination services within the delivery of other primary healthcare process and any special promotional events. For delivery of vaccinations programs, the Contractor will:

a. Use the Australian Immunisation Register or will otherwise ascertain the best available information about the vaccination status of people received into the prison system - including age or needs based immunisations that would normally occur over a lifetime – drawing upon available collateral and self-reporting.

b. Record any information on current immunisation status in the EMR if confirmed

c. Offer catch-up vaccines to people if needed, in compliance with the Australian Immunisation Handbook, for example, childhood infectious diseases, hepatitis A and B, influenza, and COVID-19, including booster.

d. Run regular Immunisation clinics at all Service Locations for during the year (e.g., influenza).

e. Update vaccination statuses and details in the Australian Immunisation Register (AIR).

### 5.3.4 Outbreak Health Response

Under the Health Protection Plan, the Contractor will design and implement surveillance systems, robust infection control, and outbreak management.

The Contractor will document information sharing with Corrections Victoria, Justice Health, their own staff, custodial staff and other providers, and the level and urgency of sharing will comply with incident notification and Corrections Victoria notification and reporting timeframes.

The Contractor's Health Protection Plan will be enacted when location specific or wider outbreaks occur.

In the event of a suspected or actual outbreak and where restrictions have been put in place (for example, quarantine arrangements or restricted prison entry), the Contractor must:

a. Comply with Commissioner directives for provision of Services (or ceasing provision of Services) or comply with prison specific business continuity plans when directed to by the prison General Manager and comply with directions from custodial staff.

b. Not deliver in-person Services other than those required under the State's business continuity plans or as permitted by the Commissioner following public health directives, including emergency provisions.

c. Rapidly implement non-contact delivery of primary health services when required by the circumstances, with use of telehealth to deliver Services to people in prison and for those in quarantine or isolation.

d. Provide primary mental health support for people in prison in protective quarantine or isolation and make referrals to Forensic Intervention Services (FIS) as clinically needed.

## 5.4 Health Promotion

**Optional service:** If this Optional service is requested to form part of the Scope of Services by the State at any time during the Term**,** the Contractor will design and implement a Health Promotion Service, including an Annual Health Promotion Plan.

Health Promotion is the process of enabling people to increase control over, and to improve, their own health. This applies to people in prison receiving health information, education and services that support informed choices, improve health agency and empower people in prisons to engage with their health whilst in prison and upon release.

For delivery of health promotion, the Contractor will:

a. Develop and implement an annual Health Promotion Plan (HPP) that encompasses health promotion across the primary healthcare services and specialised activities and events.

b. Take a whole of location approach, including working with CV, to foster a 'health promoting prisons' environment.

c. Provide health promotion that is broad and inclusive and offers variety combined with a mix of topics and activities that warrant high rotation. This should encompass multi-modal delivery with a mix of integrated activities and special events.

d. Evaluate learnings and successes from previous health promotional activities and demonstrate continuous improvement in each HPP.

e. Develop and provide materials to be used for health promotion activities and events, including materials and communications to promote the availability of the activities and events at each Service Location.

f. Procure and disseminate promotional materials on a range of topics for health messaging, such as communicable diseases and healthy food choices, and regular promotional campaigns for people in prison and custodial staff (e.g., influenza vaccines, harm reduction, posters, brochures, FAQs, etc).

g. Provide promotional material targeted at all health literacy levels in a custodial setting.

h. Provide materials suited for Aboriginal clients, in consultation with internal and community Aboriginal health service providers.

i. Provide materials in a range of languages for CALD clients, when a need has been identified at Service Locations.

j. Provide health promotion materials to Justice Health electronically for endorsement

### 5.4.1 Annual Health Promotion Plan

For provision of the HPP, the Contractor will:

a. Develop an annual Health Promotion Plan (HPP) to deliver a variety of health promotion programs at regular intervals throughout the year.

b. Plan for evidence-based health promotion programs designed to be practical and engaging for the target audiences and participants.

c. Consider local and system-wide educational and preventative needs that align with community health promotion campaigns when appropriate.

d. Encompass a range of program types, small to larger scale, and a range of delivery modes, and consider mediums and topics to engage harder to reach groups.

e. Ensure the plan is based on health and demographics needs analysis and designed in close consultation with Justice Health and custodial managers at each Service Location identified for programs and events during the year ahead.

f. Demonstrate that they have sought input from people in prison, custodial staff, other health and service providers, and have consulted with the Department of Health and community health promotion providers, especially in relation to opportunities for in-reach for specialist or culturally specific health promotion topics.

g. Collaborate with the Grampians Public Health Unit for Service Locations in the Grampians region, to strengthen the regional and community linkages with the prison population health services and health promotion activities and will implement plans to develop relationships with community health in every region.

h. Plan for delivery of limited health promotion programs at MAP, Rivergum, and JLTC to the extent practicable and appropriate for those locations, for example, vaccination programs, written materials promoting screening campaigns, posters, health brochures, and opportunistic health literacy conversations at clinical appointments.

i. Ensure that the structured day is considered when designing the annual plan and will coordinate with each Service Location for access to spaces or permissions and logistical planning for larger events.

j. Provide a draft HPP for review by Justice Health and Service Location General Managers during transition-in for year one, and no later than four weeks prior to the commencement of subsequent reporting years.

k. Share the final endorsed HPP with Service Location General Managers and Operations Managers, other health providers, and interested stakeholders (e.g., education and training providers, FIS).

The HPP will include:

a. Proposed promotional Service Locations and activities and events for the year

b. Program Logic

c. Promotional topic and health aims (e.g., mental health and wellbeing, nutrition and food preparation, oral hygiene)

d. Modes of delivery (e.g., group, in person, written, individual targeted, and may include planned opportunistic messaging on selected health topics each year, as part of routine clinical delivery)

e. Health promotion delivery staffing / roles

f. In-reach health promotion guests – specify invited community specialist health promotion or culturally specific practitioners

g. Duration and dates for activities or events (which may span over a year, or be brief, or be promotional, such as influenza vaccinations promoted between April to August)

h. Target audiences, participants, including demographic cohorts if applicable, and promotions that will encompass custodial staff and the broader prison community

i. How the programs will be evaluated (quantitatively or qualitatively)

j. Interrelated or follow up activities (e.g., rostered additional weekly clinic for four weeks following promotional event for skin checks)

k. Identify Impacts and Outcomes

l. Enablers, such as materials, equipment, spaces, and stakeholder consultation (e.g., prison General Manager approval, prison kitchens and purchasing).

# 6. Focus Area 3: AOD Health

For delivery of AOD health services, the Contractor will:

a. Provide AOD medical support

b. Develop and deliver ongoing contemporary harm reduction messaging and promote AOD programs to people in prison with AOD concerns

c. Deliver prison related and release related harm reduction group-based information sessions and address specific AOD release planning to ensure continuity of care for people with ongoing AOD support needs.

d. Deliver group based AOD health programs and provide AOD individual support for people at MAP with AOD concerns (group-based programs are not provided at MAP)

e. Develop and implement a new suite of evidence based AOD health program materials, and each year develop an Annual Program Schedule

f. Conduct AOD health program participation screenings and manage waitlists

g. Promote, recruit, train, and supervise AOD Peer Educators

h. Provide Identified Drug User (IDU) reviews at maximum and medium security Service Locations (as part of the Corrections Victoria IDU process)

i. Provide AOD treatment summaries and reports.

## 6.1 AOD Medical Support

### 6.1.1 Identification of AOD Needs

At the reception medical assessment, the Contractor will identify people who require AOD medical care or support and act promptly to address immediate medical withdrawal or initiate pharmacological treatment. The Contractor will also identify people for referral to AOD harm reduction information sessions and AOD health programs

### 6.1.2 Withdrawal Medical Support

For delivery of AOD medical support, the Contractor will:

a. Actively identify people currently or likely to experience AOD withdrawal, making use of an appropriate validated assessment tool

b. Provide withdrawal support, including structured monitoring and follow up as part of a planned process that involves medium to long term care of a chronic relapsing condition

c. Implement a robust process for monitoring of withdrawal symptoms throughout the withdrawal period and in accordance with a validated AOD withdrawal assessment tool

d. Provide appropriate interventions such as a prescribed regime of medications and support to alleviate or minimise the symptoms of withdrawal and reduce the risk of medical complications

e. When available at the Service Location, provide withdrawal management at a bed-based medical service, if clinically determined, or at cells or beds near the health centre upon arrangement with CV.

f. Provide post-withdrawal planning support including relapse prevention strategies, pharmacotherapies, health programs, communicable disease screening referrals, and dual diagnosis health needs.

### 6.1.3 Pharmacotherapy Support

The Victorian Prison Medication Assisted Treatment of Opioid Dependence (MATOD) program is a widely accepted approach to managing opioid dependence (a recognised chronic disease) and is an integral part of the response for treating drug use. The MATOD program aims to reduce the demand for and misuse of opioids while in prison and upon release, and reduce the harms caused by their use.

For delivery of pharmacotherapy support, the Contractor will:

a. Deliver pharmacotherapy to manage and treat opioid dependence.

b. As part of the reception medical assessment, identify people with an existing community prescription for opioid dependence and ensure their continued treatment in custody.

c. Work with people in prison who have been identified as likely to benefit from MATOD or who have requested the treatment while in custody, and offer MATOD as indicated for people who:

   i. Are opioid dependent at the time of imprisonment and not receiving treatment

   ii. Continue to use opioids (licit or illicit) in prison in a manner that constitutes a significant risk of harm

   iii. Are at significant risk of using opioids in prison or post-release.

d. Offer short or long acting injectables as an alternate treatment for opioid dependence, as outlined in the Corrections Victoria MATOD guidelines (referenced as the OSTP guidelines), *and Justice Health Long-Acting Injectable Buprenorphine Practice Guideline*.

### 6.1.4 Urine Drug Screen Verification

For delivery of urine drug screen verification, the Contractor will:

a. Review instances of positive drug findings as part of the Corrections Victoria's targeted and random drug testing regime for people in prison.

b. Verify whether metabolites found in urine samples of people in prison are attributed to prescribed medications.

c. Provide 95% of requests for urine drug screen verification within 5 Business Days of the request being received.

Service Linked Fee reductions will apply for non-compliance with the 5 Business Days urine verification performance measure (valid exemptions apply).

## 6.2 AOD Health Service and Program Volumes

The requirements for AOD health services and programs will be read in conjunction with *Attachment G - Annual AOD Health Services and Programs*, which provides the annual estimated volume of services and programs and distribution across the Service Locations.

## 6.3 AOD Services

### 6.3.1 AOD Messaging

The Contractor will:

a. Design and implement AOD harm reduction and relapse prevention messaging as an integrated component of the delivery of the Services.

b. Provide all Service staff with regular education and training in AOD harm reduction strategies and relapse prevention, and how to approach conversations and messaging tailored for different cohorts.

c. Actively maintain knowledge of trends, current and emerging drug use behaviours, and the contemporary lexicon used by people who have addictions or who misuse drugs, so that informal and formal interactions, including with program facilitators, have meaning and resonance for AOD clients.

### 6.3.2 AOD PRHR Harm Reduction

For delivery of Prison Related Harm Reduction (PRHR), the Contractor will:

a. Provide PRHR group-based information sessions at reception Service Locations for people newly entering the prison system.

b. Deliver PRHR to people newly entering the prison system within 5 Business Days of their reception date (with the arrival day counting as day zero).

c. Provide fact-based information about the legal consequences and health harms associated with substance use in a custodial setting, pharmacotherapy drug maintenance options in prison, and promote the availability of AOD health services and programs.

d. Include elements of RRHR, abbreviated content, for the purposes of people who may have no opportunity to attend a RRHR session prior to release.

e. Deliver harm reduction as co-presented sessions by an AOD clinician with one or more AOD Peer Educators or sole presented by the AOD staff.

f. Follow-up people who did not attend PRHR and:

i. Ensure that they are enrolled in the next available session if they are suitable for a group setting, or

ii. Provide an alternative individual delivery mode, or

iii. Confirm a valid exception category (including, for example, signed declines, released from prison).

Service Linked Fee reductions will apply for non-compliance with the PRHR performance measure (valid exemptions apply).

### 6.3.3 AOD RRHR Harm Reduction

For delivery of Release Related Harm Reduction (RRHR), the Contractor will:

a. Provide RRHR group-based information sessions at Service Locations within six weeks for people with a planned release date, and opportunistically for people who are a loss at court or released at short notice.

b. Through best endeavours provide the RRHR information session to any person with AOD concerns, even if they have not engaged with AOD health services previously. The Contractor will be highly responsive to providing the session to people being released with little prior notice, or with uncertain release timing.

c. Accept and action RRHR referrals from Corrections Victoria for people preparing for release.

d. Provide information about the potential harms associated with AOD use following release from prison, including harm reduction and relapse prevention strategies; RRHR sessions will reinforce learnings, drawing upon content from AOD health programs.

e. Provide information about Naloxone, including training in its use, and the availability of Naloxone on release to the community.

f. Provide information about the MATOD community pharmacy subsidy for those who require it and information about release planning options available.

g. Consider individual delivery of RRHR provided:

i. Formally, with self-learning booklets or on devices, when permitted, appropriate, and necessary (for example, people in protection or management unit)

ii. Informally and opportunistically at any clinical contact, especially for priority and harder to reach cohorts who might not engage formally with the Contractor in relation to their AOD concerns, or who might be more responsive to more personalised and brief messaging

iii. Both formally and informally at MAP, which includes as part of the reception PRHR session, because group delivery of RRHR is not practicable.

### 6.3.4 Naloxone Training and Dispensing

For delivery of Naloxone training and dispensing, the Contractor will:

a. Provide any person who requests Naloxone training and Naloxone for their release.

b. Dispense Naloxone at the time of release regardless of whether the person has received AOD services or programs during their time in prison.

c. Obtain written consent from the client prior to prescribing and dispensing Naloxone either at the time of being provided with Naloxone on release to the community or stemming from the person's earlier attendance at a RRHR information session.

d. Provide clear written information (brochure or flyer) for how and where to obtain further doses of Naloxone in the community.

### 6.3.5 AOD Health Program Screening

For delivery of AOD health program screening, the Contractor will:

a. Gain written endorsement from Justice Health of AOD screening tool and screening process including for:
    i. Desktop screening only, or
    ii. Face to face interview only, or
    iii. Desktop screen and face to face interview.
b. Draw upon AOD concerns identified at reception, at a harm reduction session, at subsequent health appointments, or through the MATOD program, and IDU Reviews.
c. Identify and recommend programs to best meet the client's AOD needs during their expected time in prison and upon release.
d. Draw upon AOD concerns identified at reception, at a harm reduction session, at subsequent health appointments, or through the MATOD program, and IDU Reviews
e. Identify and recommend programs to best meet the client's AOD needs during their expected time in prison and planning for their needs prior to release
f. Advise clients of their screening outcomes, recommended programs, and participation timetabling, which will take into account the client's other program, educational and training commitments, or court attendances
g. For clients not suited for group participation, alternative AOD support options will be explored with the client.

### 6.3.6 Referrals, Prioritisation, Communication, and Additional Services

For the delivery of AOD programs, the Contractor will:

a. Accept and manage self-referrals for participation in AOD health programs
b. Accept and action referrals from stakeholders, including FIS, custodial staff, or CCS on behalf of the Adult Parole Board, other health service providers, and referrals from third parties, such as family or a legal representative
c. Develop a self-referral form, which will be visibly and readily available at all Service Locations and will be reviewed and endorsed by Justice Health
d. Actively provide equitable access to programs for people in prison, making AOD health programs available to all people with AOD concerns who are suited for group participation, including equitable access to multiple programs when people in prison have requested or require more than one program
e. Actively manage program wait lists, flow-through, and prioritisation of program participants
f. Prioritise participation in programs to maximise the opportunity for clients suitable for group interventions to commence and complete one or more programs and release activities prior to release
g. Keep clients appraised, as far as practicable, of their progress on the program priority lists and actively follow up clients who have self-referred multiple times without having been offered a place in a program
h. Consult with the client and a case manager if they are not suited for and cannot be offered a group health program, to ensure they can still be supported with alternative services
i. Ensure that people with AOD concerns have information about and know how to access other prison-based services, including, for example, Alcoholics Anonymous and Narcotics Anonymous, faith-based services, and culturally specific services or in-reach activities that may help to address their ongoing need

j. Encourage clients to proactively seek out other programs and services to complement their engagement with the Contractor's AOD health services.

### 6.3.7 Identified Drug User Reviews

The Identified Drug User (IDU) Program managed by Corrections aims to educate users about the risks of drug use and to motivate them to stop using drugs. IDU is the status applied by Corrections Victoria to a person to identify them as having been found guilty of a prison-based drug offence.

The Contractor will contribute to the Corrections Victoria IDU program by:

a. Accepting all referrals from Corrections Victoria at maximum and medium security Service Locations, including people transferred back from a minimum-security Service Location due to a prison-based drug offence.

b. Using the IDU Review template provided with the referral by Corrections Victoria to undertake the structured process.

c. Conducting IDU reviews within 5 Business Days of receipt of a referral from Corrections Victoria, with the date of the referral counting as day zero. The measurement stops for the duration of an appeal process, if initiated by the client, and restarts / resets to day zero, if the Contractor is subsequently advised by the Prison Intelligence Unit that the client's appeal has been unsuccessful. For clients transferred back from a minimum-security Service Location because of a positive test, the measurement will commence on the date that the client arrives at the medium or maximum-security location.

d. If the person is eligible for the Corrections Victoria Drug-Free Incentive Program (DFIP), gain consent from the person for their participation.

e. Discussing harm reduction strategies and issues surrounding the AOD use and encourage people to participate in AOD health program.

f. Adding the person to AOD health program priority lists or review their current wait list status.

Service Linked Fee reductions will apply for non-compliance with the 5-day IDU review performance measure (valid exemptions apply).

### 6.3.8 AOD Individual Support at MAP

Individual AOD counselling support will be provided to people at MAP. The individual therapeutic support will be provided as and when needed for any client at MAP with current AOD concerns. Group AOD health programs will not be offered at MAP.

### 6.3.9 AOD Peer Educators

Recognising the value of lived experience, AOD Peer Educators assist with the prison related harm reduction information sessions as part of the reception process, provide up-to-date infection control, promote BBV screening and hepatitis c treatment options in prison and harm reduction and health information including naloxone training, and provide peer motivation and support to people in prison with AOD concerns, including for people who might otherwise choose not to disclose or engage with health services or structured programs.

To deliver the AOD Peer Educator service, the Contractor will:

a. Undertake ongoing recruitment promotions and actively identify people in prison who may be suitable and interested

b. Manage the application process, including liaising with custodial staff during the vetting process

c. Conduct the AOD Peer Program as and when needed to ensure that peer vacancies are filled (which may be delivered in groups or to individuals, depending on the level of recruitment activity)

d. Recommend and appoint peers (an employment agreement)

e. Provide fortnightly supervision for all peers, which may be run as a group or run for individual peers, depending on the needs of peer educators

f. Conduct formal quarterly reviews with peers, which are conducted with individually, to review their performance in the role and to support their ongoing development as an AOD peer educator

g. Conclude the peer employment agreement when they are released to the community, or when they are transferred to another Service Location (at which they may reapply to become an AOD peer, the employment does not carry over to the new location).

### 6.3.10 AOD Treatment Summaries and Reports

Requests for information about participation in AOD health interventions will typically come from Community Correctional Services officers on behalf of the Adult Parole Board.

The Contractor will:

a. Accept and respond to requests for an AOD Treatment Summary or AOD Treatment Reports

b. Provide reports within the timeframe indicated by the requestor.

## 6.4 AOD Health Programs

### 6.4.1 AOD Annual Program Schedule

For provision of an AOD annual Program Schedule, the Contractor will:

a. Develop an AOD Program Schedule, against which programs will be delivered during each reporting year.

b. Provide the Program Schedule in an agreed format for Justice Health endorsement during transition-in for year one, and no later than four weeks prior to the commencement of subsequent reporting years

c. Base the Program Schedule on the expectations outlined in *Attachment G*, and as further agreed upon endorsement of the new suite of AOD health programs to be offered at Service Location

d. When developing their Program Schedule, ensure that people with AOD program needs have equitable and regular opportunity to access a variety of programs

e. Schedule a range of programs to be available at each Service Location for up to 48 weeks of the year.

f. Note that flexibility will be accepted within the Program Schedule to deliver the same or like for like hours of programs at alternative Service Locations than those named in the schedule, to enable the Contractor to be highly responsive to changeable levels of demand and needs across the system.

Service Linked Fee reductions will apply for non-compliance with the Program Schedule performance measure (valid exemptions apply).

### 6.4.2 Program Delivery

For the delivery of AOD health programs, the Contractor will:

a. Deliver sole facilitated AOD health programs and services face-to-face at all Service Locations, unless otherwise directed

b. Allocate program facilitators who are qualified and trained in the use of the program materials, have a sound understanding of the underpinning theoretical basis of each program, and the intended aims and outcomes for participants

c. Provide program facilitators with ongoing support and professional development to ensure facilitation effectiveness

d. Provide AOD health programs tailored for Aboriginal men to be facilitated or supported by a designated role, which may include in-reach from the community, either a sole facilitator, or in partnership with the Contractor's AOD facilitators

e. Develop strategies to address skills development and attracting and retaining appropriately qualified Aboriginal people for AOD program facilitation

f. Deliver AOD health programs with a maximum group size of 10 participants to ensure that people with AOD concerns have an opportunity to undertake their requested or recommended health programs

g. As far as practicable, fill places that have been left vacant at short notice, such as when a client has a scheduling conflict, or actively declines to participate

h. Motivate and support people with AOD concerns to both commence and complete their recommended health programs. and work with the client and their CV case manager to address barriers or additional supports needed when recommended interventions are declined or incomplete.

i. Generate and print program commencements, completions, non-completions, and record withdrawals for the participants, and printed, and provide copies to custodial staff for their local intervention records.

### 6.4.3 Delivery Modes and Tailored Delivery

In addition to face-to-face group delivery, the Contractor will use technology or booklets for guided self-learning as alternatives for harm reduction sessions, or for other recommended AOD health program approaches for harder to reach cohorts, if applicable. This may include for people in protection or management or who may be unsuited to a group but are able to be receptive to harm reduction information.

Corrections Victoria will provide access to a pool of shared devices for delivery of self-learning, when appropriate and permitted at the Service Locations.

### 6.4.4 AOD Promotion and Materials

For the promotion of AOD health services, the Contractor will:

a. Actively promote the availability of AOD medical support, services, and health programs

b. Ensure that self-referral forms are readily visible and accessible at each Service Location

c. Promote AOD health programs via direct contact with clients, service description brochures and posters, endorsed by Justice Health, and other promotional efforts when opportunities arise, such as during population health events

d. Ensure that custodial staff, case managers, and other providers know of and understand the services and programs available from AOD health at each Service Location

e. Provide AOD fact sheets or brochures that are up to date and reflect current evidence, addressing a wide range of known and emerging substances of concern, with stocks to be maintained and easily accessible to people at all Service Locations

f. Make available to people in prison a fact sheet about Naloxone, from Justice Health, which forms part of targeted release planning, including Release Related Harm Reduction (RRHR) and provided at individual Naloxone training sessions prior to release to the community

g. Provide materials in multiple languages at Service Locations, with the range and number of languages depending on the population profile.

### 6.4.5 Program and Interview Rooms

Program and interview rooms at Service Locations are shared resources and do not belong to or fall under the management of the Contractor.

The Contractor will:

a. Work with custodial staff at each Service Location and other service providers to coordinate their booking needs within the constraints of high demand and competing scheduling requirements

b. Comply with local administrative processes for booking program and interview rooms

c. Deliver programs and individual screening appointments on units where suitable program or interview rooms are available

d. Comply with custodial guidance when considering when and where to deliver AOD programs and AOD program screening appointments at each Service Location.

## 6.5 New AOD Health Programs

For the initial provision of the AOD harm reduction and AOD program Services, the Contractor will:

a. Use existing prison related and release related harm reduction information session materials.

b. Deliver AOD health programs from the State's existing suite of programs, and from the Contractor's existing suite of programs, including a dual diagnosis program

c. Develop one or more AOD health programs for Aboriginal men, which is culturally appropriate.

### 6.5.1 Development of new harm reduction and AOD program materials

**Optional service:** If this Optional service is requested to form part of the Scope of Services by the State at any time during the Term, the Contractor will develop a new suite of AOD harm reduction information and group based AOD programs materials. The Contractor will:

d. Develop new AOD materials in multiple mediums for providing harm reduction information (both PRHR and RRHR) in group formats and for individual self-learning (print or electronic) for people unable to participate in group settings

e. Develop a new suite of closed format short to medium length AOD health programs for men and with clearly defined aims

f. Develop programs that are contemporary, evidence based, engaging, and have psychotherapeutic theoretical underpinnings drawn from, for example, acceptance and commitment therapy, cognitive behaviour and mindfulness-based therapy, and contingency management strategies, to strengthen thought processes and related behaviours

g. Develop programs that aim to help develop life skills and resilience, and that create and maintain behaviour change, including relapse prevention

h. Develop programs that take a trauma-informed, strengths-based approach and consider lived experience

i. Develop programs that are optimal for any drug of concern and for polydrug users

j. Produce facilitator manuals, participant manuals, and any supplementary materials, such as participant homework

k. Include in the facilitator manuals the basis of theoretical underpinnings and why the theory and choices have been made, and the contemporary evidence for the effectiveness of the approach for each program

l. Provide the endorsed printed program manuals, facilitator handbooks, and participant handouts, to the extent needed to conduct each program

m. Provide the endorsed printed and electronic self-learning harm reduction booklets.

The Contractor will also:

a. Develop tailored programs and materials, including alternative modes of delivery or specific strategies to meet the needs of those harder to reach and the Priority Groups.

b. Develop strategies for supporting CALD people with AOD concerns, which may include localised responses

c. Development tailored programs for Aboriginal people in close consultation with Aboriginal stakeholders, the department and Aboriginal community representatives.

Following development of material, and written endorsement by Justice Health, the Contractor will:

a. Rollout the harm reduction, relapse strategies, and alternative messaging guidelines and training for the broader Service team and the AOD health service and program facilitators

b. Pilot new programs at agreed Service Locations

c. Design client satisfaction surveys

d. Submit an evaluation report, to include client feedback summary in relation to each program type, facilitator feedback, prison-based stakeholder feedback, and proposed amendments to the initial materials, if any

e. Revise programs materials based on all feedback, including Justice Health feedback

f. Obtain written endorsement of final program materials from Justice Health

g. Provide facilitator training for the new materials across all Service Locations

h. Implement the suite of programs in accordance with the agreed annual Program Schedule.

Additionally, Justice Health will provide the Contractor with the AOD Peer Educator training program and facilitator manual, which will be reviewed and revised for content alignment with the new AOD materials as relevant to the training program for AOD Peer Educators.

### 6.5.2 Program Reviews

The Contractor will regularly review the suite of AOD health programs and harm reduction information to ensure that the relevance of the materials for the audiences are maintained, and that the currency of theoretical underpinnings and evidence-based practice are retained during the term.

At any time, Justice Health may request changes to harm reduction and AOD health program materials, which the Contractor will respond to with an action plan.

# 7. Focus Area 4: Primary Care

## 7.1 Health Centres, Clinics, In-reach and Out-reach

### 7.1.1 Access to Care

For the delivery of the Services, the Contractor will:

a. Manage Service Location health centres, consulting rooms, and office spaces to ensure that they and other health providers have the necessary access to the shared facilities when needed to meet their delivery obligations.

b. Work cooperatively with custodial staff, using location specific booking systems for access to use interview rooms and program rooms.

c. Manage and schedule clinics for the onsite dental suites and radiology rooms.

d. Managed and schedule mobile dental and mobile radiology services.

e. Schedule and manage in-reach health Services, which may be regular or as needed for primary care or specialist services delivered in partnership with community-based providers.

f. Make referrals to specialist health services in the community (specialist medical and surgical consultation and treatment, and elective procedures)

g. Advise and coordinate with custodial staff access to specialist health services in the community.

### 7.1.2 Primary Healthcare Outreach

For the delivery of the Services, the Contractor will:

a. Provide outreach clinics and services for clients in restricted environments, such as observation cells, protection units, or management units, working with custodial staff to ensure the safety of the client and the custodial environment is maintained.

b. Provide outreach administration of medications at Service Locations as needed.

c. Liaise with custodial staff to transfer a client to another Service Location to access a Service as appropriate (refer to *Attachment F*).

d. Provide outreach services at Judy Lazarus Transition Centre (JLTC) and at the Rivergum Residential Treatment Centre (Rivergum).

For delivery of outreach services for JLTC residents, the Contractor will:

a. Provide transfer assessments within 24 hours

b. Schedule weekly RN and MP clinics

c. Provide additional outreach services when requested

d. Arrange radiology, dental and allied health services to be scheduled at MRC when a need has been identified

e. Liaise with JLTC operational and MRC custodial staff for transfer arrangements for access to treatments at MRC

f. Provide integrated care plans when needed

g. Provide AOD harm reduction messaging when needed

h. Provide health promotion as appropriate and proportionate to the needs of the small transition location

i. Make referrals and appointments for access to specialist services when needed

j. Make referrals and appointments for access to primary health services in the community for clients who have documented approved to access a service in the community

k. Provide release planning when needed.

For delivery of outreach services for Rivergum residents, the Contractor will provide:

a. Provide transfer assessments within 5 Business Days
b. Schedule weekly RN and MP clinics
c. Provide additional outreach services when requested
d. Provide allied health services as needed
e. Arrange mobile radiology, if appropriate
f. Provide integrated care plans when needed
g. Provide AOD harm reduction messaging when needed
h. Provide health promotion as appropriate and proportionate to the needs of residents
i. Make referrals and appointments for access to specialist services when needed
j. Make referrals for dental services to the public dental system for general, specialist, or emergency dental care
k. Liaise with operational staff for movement arrangements for access to treatments in the community
l. Provide release planning when needed.

For any service that cannot practicably be provided on site at Rivergum, and for dental referrals, access will be provided in the community, and may only occur with the approval of the Commissioner, which should be obtained prior to making a referral or scheduling an appointment.

The Contractor is not responsible for on-call or emergency care at JLTC or Rivergum outside of planned clinic hours. Emergency care at those locations will be arranged by operational staff.

### 7.1.3 Primary Healthcare Clinics

The Contractor will provide:

a. Face-to-face primary healthcare clinics to treat, diagnose, refer, manage acute and chronic medical conditions, implement and review health plans, prescribe, dispense and administer medications, monitor illness, and refer clients for further diagnostics and investigations as medically indicated.
b. Scheduled and walk-in clinics to the extent required at each Service Location (refer to *Attachment F*).
c. MATOD, dental clinics, and diagnostic and allied health services scheduled to meet demand at each Service Location.

### 7.1.4 Track and Trigger Health Management

The Contractor must:

a. Implement track and trigger systems to monitor and manage health concerns and for timely identification of deterioration in a client's condition and be able to recognise and respond to acute deterioration, using, for example, Observation and Response Charts, Australian Commission of Safety and Quality in Health Care.
b. Document their track and trigger practices and processes.

### 7.1.5 Afterhours Urgent Care

In addition to on call after hours and on call / recall after hours Services detailed in *Attachment F,* the Contractor will:

a. Establish regional community-based partnerships or in-reach models for timely access to urgent but non-emergency in-person care by a Medical Practitioner.

b. Advise and work with custodial staff to arrange movement of clients when urgent health treatment needs arise afterhours.

## 7.2 Primary Health Responsiveness Performance

The following delivery responsiveness targets apply for the primary healthcare for self-referrals for scheduled and non-urgent appointments (refer to *Attachment C – Primary Healthcare Performance Framework 2023*):

a. Registered Nurse — 3 Business Days from the date of referral

b. Mental Health Nurse — 3 Business Days from the date of referral

c. Nurse Practitioner — 5 Business Days from the date of referral

d. Medical Practitioner — 10 Business Days from the date of referral

e. Dental – Aboriginal people — 12 Business Days (or sooner) from the date of referral

f. Dental – all other clients — 20 Business Days from the day of referral

g. Allied Health* — 15 Business Days from the date of referral

h. **Optional service:** If this Optional service is requested to form part of the Scope of Services by the State at any time during the Term, the Contractor will implement a Personal Care Assistance, refer to response times in Section 7.4 Personal Care

**Except where other measures apply, for example, referral to functional assessment by an Occupational Therapist.*

For non-scheduled and urgent or suspected urgent health needs, an available clinician will triage and manage immediate treatment. Following immediate treatment determine the further healthcare needs and promptly arrange access on the day or prioritise an appointment for the client, including for dental, diagnostics, allied health or external referrals. The contractor will closely monitor health conditions that may deteriorate or are pending a further clinical assessment before treatment can commence.

Service Linked Fee reductions will apply for non-compliance with each of the general primary health responsiveness Key Performance Measures (valid exemptions apply).

## 7.3 Primary Mental Healthcare

### 7.3.1 Primary Mental Healthcare Services

The Contractor will deliver primary mental healthcare services at all Services Locations, except MAP where the forensic mental health service provider delivers this service. The forensic mental health service provider delivers secondary mental healthcare services at all other prison locations and provides outpatient and bed-based mental health services at MAP andas well as the coordination of transfers to and from Thomas Embling Hospital.

For delivery of primary mental healthcare services, the Contractor will:

a. Provide mental health clinics and take an early intervention and mental health prevention approach,

b. Assess, prescribe, monitor, and manage the needs of clients with short term or chronic mental health conditions.

c. Encourage clients to take an active role in their mental health treatment and to gain a better understanding of mental illness, their treatment options, and be supported to build skills required to help them pursue their personal recovery.

d. Implement culturally appropriate mental health assessments and treatment processes.

e. Provide a trauma-informed primary medical and mental health response.

a. Work with the forensic mental health service provider to ensure that the most appropriate and timely mental healthcare and interventions are provided for clients while in prison, and for release planning for people with ongoing mental health conditions.

b. Consult with the forensic mental healthcare to implement joint care when indicated.

c. Make referrals to and manage wait lists for access to the forensic mental healthcare service consultant psychiatrists, forensic psychologists, forensic mental health nurse practitioners at regional locations where the forensic mental healthcare service provides outreach clinics.

d. Following conferral with the forensic mental healthcare service, liaise with custodial staff for transfer of clients experiencing acute mental illness or mental health deterioration to MAP at the earliest opportunity. Monitor and provide care for the client pending transfer and work with custodial staff to ensure the client's safe movement between locations.

e. Make referrals to Corrections Victoria psychology services as needed.

f. Implement processes to follow-up clients who have missed primary mental health appointments, including tailored processed for follow-up of Priority Groups and further follow-up when clients do not attend for a rescheduled appointment.

### 7.3.2 Mental Health Recovery Plans and Reviews

The Contractor will provide primary mental healthcare under an early-intervention and recovery-oriented practice.

a. When indicated, Mental Health Recovery Plans will be developed within 29 Calendar Days of a mental illness being identified and will be reviewed within 105 Calendar Days of the previous review date.

b. The Mental Health Recovery Plan will be developed with the client and in collaboration with the forensic mental health service provider where indicated, with treatment tailored to the client's needs including consideration of a range of therapies and interventions.

c. The client will be encouraged to actively engage with the treatment process and will be supported to develop skills to help them pursue their personal recovery. Recovery planning will aim to minimise the client's mental illness, prevent relapse and achieve long term positive outcomes.

d. Mental health recovery plans will be developed (or reviewed and updated):

    i. For people in prison with a mental health condition. including co-existing or dual-diagnosis, and are not currently under the care of the forensic mental health service provider

    ii. At referral back to the primary health Service from the forensic mental health service provider.

Service Linked Fee reductions will apply for non-compliance with the 29 Calendar Days mental health recovery plans performance measure (valid exemptions apply).

Service Linked Fee reductions will apply for non-compliance with the 105 Calendar Days mental health recovery plans review performance measure (valid exemptions apply).

## 7.4 Personal Care

### 7.4.1 Personal Care Services

**Optional service:** If this Optional service is requested to form part of the Scope of Services by the State at any time during the Term**,** the Contractor will implement a responsive and flexible personal care Service.

The Contractor will:

a. Provide personal care services for people of any age with a disability or health condition that compromises their functional capabilities, and a personal care need has been confirmed.

b. Support clients to maintain independence, self-worth, and dignity, and to safely remain in their current prison accommodation.

c. Provide a flexible personal care delivery model that responds to variable service demand and is able to appropriately support the varying levels of personal care needs of the client cohort, as described in their personal care assistance plans.

d. Provide for personal care services at the following Service Locations:

   i. Hopkins Correctional Centre

   ii. Langi Kal Kal

   iii. Other Service Locations as needed.

e. Accept and assess referrals for personal care at any time during a person's term in prison, which may be via:

   i. At reception medical assessments

   ii. As identified at any time by primary health clinicians

   iii. Self-referral as confirmed by a primary health clinician

   iv. Allied health services as confirmed by a primary health clinician

   v. Custodial staff and as confirmed by a primary health clinician

   vi. Other health providers as confirmed by a primary health clinician.

For the delivery of personal care services, the Contractor will:

a. Have in place processes to accept and manage referrals for a functional assessment to be undertaken by an Occupational Therapist.

b. Provide functional assessments that are culturally safe and appropriate for the client.

c. In preparing the personal care plan, the client's needs, goals, and preferences to optimise health and wellbeing will be reflected.

d. Provide a functional assessment outcomes report that indicates whether the need for personal care is temporary or ongoing and the level of dependence for personal care (minor to severe).

e. Provide personal care assistance when a need is confirmed, in accordance with the care needs and scheduling documented in the client's personal care plan.

f. Share information and make referrals and take all other actions to meet the client health and care needs as identified during the assessment and planning processes, including referrals for medical, dental, or allied health, requests for prescribing equipment or aids,

g. Make recommendations to custodial staff in relation to accommodation modifications or placement matters that will assist the client to maximise their independence and safety, or accommodation modifications required to enable the provision of personal care services.

h. Liaise with custodial staff for services that can be met by Prison Service Workers (PSWs; also known as prisoner carers) to support the overall quality of life and daily needs of people in prison and support associated with Activities of Daily Living (ADL). Prison Services Workers are managed by Corrections Victoria at Hopkins and Langi Kal Kal, and they support older persons with other ADLs such as assisting with mail, collecting food, cooking, ordering food, helping with eating, and cleaning the cell, bedroom, or cottage.

### 7.4.2 Personal Care Assistance

**Optional service:** If this Optional service is requested to form part of the Scope of Services by the State at any time during the Term**,** the Contractor will implement personal care assistance as part of the personal care Service.

For delivery of personal care assistance, the Contractor will:

a. Deliver personal care for clients with ongoing or temporary personal care needs in accordance with the personal care plan provided, which might include:
    i. Assistance with personal hygiene, including showering, oral hygiene and grooming
    ii. Assistance with perineal hygiene following toileting
    iii. Assistance with dressing
    iv. Manual handling: assistance with getting in and out of bed to access shower and toilet, getting in and out of toilet/shower, using hoists, etc.
b. Provide personal care services that are culturally safe and appropriate for the client and always maintain the dignity and preferences of the client to support their hygiene regime and dignity
c. Monitor the client's health and wellbeing for changes or concerns that require or may require referral for further assessment or referral for additional health services, including when directly requested by the client
d. Be supportive and respectful of and record feedback from the client in relation to their personal care needs and experience of the service
e. Be involved and consulted during care plan review processes and request initiation of a review when the personal carer recommends a review timeframe should be brought forward, including when the client's condition is improving or deteriorating.

The Contractor is not required to provide the following:

a. A residential older or disability care response
b. Other Activities of Daily Living not related to personal/private hygiene (role of Prison Service Workers)
c. Management of functional ability or accommodation modifications needed to ensure clients can access and move around Service Locations, which is the responsibility of Corrections Victoria.

### 7.4.3 Personal Care Responsiveness

**Optional service:** If this Optional service is requested to form part of the Scope of Services by the State at any time during the Term**,** the Contractor will implement a personal care Service in accordance with the following responsiveness aims.

The Contractor will manage personal care services to meet the following responsiveness:

a. Assign and commence personal care services within 24 hours (or less) of receiving a request for urgent personal care support, prior to a formal referral and prior to an assessment or care plan, such support to continue until an assessment report and a care plan become available.
b. Provide a first assessment appointment to be scheduled within 5 Business Days of receipt of a referral.
c. Follow up a minimum of 3 times clients who do not attend or who decline their appointment, with the first appointment included in the count.
d. Advise the client within 5 Business Days of the first assessment appointment of the assessment outcomes and recommendations, and their proposed personal care plan if a need has been confirmed.
e. Provide the final functional assessment report and recommendations within 14 Business Days of the first assessment appointment, and the proposed personal care plan if a need has been confirmed, which will be communicated to the Service Location Health Services Manager (HSM) and custodial staff.

f. Document in the assessment report and the care plan the activities to be scheduled and delivered according to the required intervals.

g. Assign and commence personal care services (or continue) services within 48 hours of assessment advice confirming that a need exists, and the assessment report and the care plan have been provided by the OT to the HSM.

h. Review of assessment reports and care plans every 6 months, or more frequently if identified in the assessment report and care plan at initiation of the personal care service (the assessment review intervals and the care plan review intervals will coincide).

i. Communicate updates to the assessment or changes to care plan to the HSM, custodial staff, and the client within 5 Business Days of the assessment review and update to the care plan.

## 7.5 Dental Services

The Contractor will provide dental Services to all people in prison requiring urgent dental care, and to people in prison who have been in prison for a period of 12 calendar months or longer, regardless of the sentencing status of the person prior or subsequent to the 12 month eligibility criterion being met.

**Optional service:** If this Optional service is requested to form part of the Scope of Services by the State at any time during the Term**,** the Contractor will work with the State to implement increased dental services to all people in prison, regardless of their time in custody and regardless of their sentencing status.

Until such time that the Optional service is requested by the State under this section 7.5, the Contractor will provide dental Services to all eligible people in prison to address the general, prosthetic, emergency and dental care and hygiene needs of people in prison.

For delivery of dental services, the Contractor will:

a. Manage and resource the Service Location dental suites and clinic times,

b. Provide mobile dentistry clinics or implement other arrangements for regional Service Locations with neither on site nor mobile dental services. Expansion of mobile dentistry to reduce the need for client movements is a preferred approach.

c. Provide priority access to dental services for Aboriginal people with dental needs, in compliance with the KPMs (refer to *Attachment C*).

d. Provide priority access to denture services for Aboriginal people with denture needs, which will be prioritised for the next available denture appointment.

e. Use a priority triage tool, such as the Dental Emergency Care Demand Management System (ECDMS), to support the management of dental services.

f. Develop and record a dental plan for the client following their initial appointment, if needed, and the dental service will schedule subsequent appointments for dental treatment or make dental referrals.

g. General dental care will include:

    i. Routine dental examinations or check-ups

    ii. Scaling and cleaning

    iii. Oral health advice

    iv. Extractions

    v. Fillings

h. Denture services will include:

    i. Providing new dentures or partial dentures

    ii. Denture repairs

    iii. Replacement of dentures that cannot be repaired

i. Clients presenting with any of the following will be deemed as requiring emergency dental care and will be provided with immediate access to care (or on the next Business Day or the next dental clinic day). Medical support, which may include infection or pain management, will be provided pending the client's access to dental treatment.
    i. Facial swelling
    ii. Bleeding (trauma affecting the mouth)
    iii. An accident involving damage to the mouth or teeth
    iv. Dental pain (in the teeth, mouth, gum, or jaw)
    v. Dentures (broken)
    vi. Other problem (e.g., ulcer, bleeding from recent extraction, mouth opening, dislodged/loose crown or bridge)

j. Provide prevention and health promotion information and will ensure that people in prison are supported to develop and maintain good oral hygiene practices and understanding of the link between oral and physical health.

k. Ensure that when clients are unable to commence treatment or unable to complete dental treatments while in prison, their release planning addresses community referral requirements and treatment recommendations in the release records and summary, which may include referral to the public dental wait list prior to the client's release to the community. People released from prison are considered a priority group for access to dental services under the Public Dental Scheme (DHSV).

### 7.5.1 Specialist Dental Care

When recommended by the Contractor's dentist, or when requested by a client, a request for access to specialist dental care in the community will be presented in a clinical dental report for the consideration of the Principal Medical Officer. If the request is endorsed, the referral will be made, and an appointment scheduled with a tertiary hospital.

## 7.6 Specialist Services

### 7.6.1 Planned Specialist Care Access

To facilitate access to specialist care, the Contractor will:

a. Assess the need for referral to specialist services and make appointments for health services based on the client's clinical needs and security risk assessment conducted by custodial staff.

b. Develop and maintain strong relationships with specialist health service providers including for provision of in-reach services.

c. Document and align their specialist care process with external provider processes, the established access hospital pathways, and the recording requirements and processes in the EMR.

d. Facilitate access to specialist services through any or a combination of the following:
    i. Transfer to a public hospital, through established hospital pathways
    ii. Use of telehealth
    iii. Use of in-reach services

e. Provide clients with clear information about the reasons for specialist care, the pathway for access, the healthcare process, including treatment, surgery, or further diagnostics that might be entailed, and advise them of appointments or rescheduling in a very timely manner.

### 7.6.2 Telehealth

Equipment for telehealth is available at all Service Locations.

For provision of access to specialist care, the Contractor will:

a. Optimise the use of telehealth as a mode of delivery to minimise prisoner movements and client declines of necessary health appointments and enabling timely access to care.

b. Attend telehealth appointments with the client, with outcomes of the appointment documented and followed up or treatment planning recorded in the EMR to ensure continuity of care.

### 7.6.3 Specialist In-reach Services

In-reach services enable the delivery of clinically appropriate specialist health service providers to people in prison while reducing the need for movement to external health services.

For provision of access to specialist care, the Contractor will:

a. Provide access to onsite facilities to enable in-reach services by specialists and will work with custodial staff to facilitate access for people in prison to attend their appointments.

b. Ensure that custodial staff know when in-reach services are scheduled and will follow the local processes for a visiting services provider to gain entry to the Service Location.

c. Be responsible for meeting at arrival and escorting in-reach service providers at Service Locations.

### 7.6.4 Health Pathways Coordination

For coordination of health pathways, the Contractor will:

a. Wherever possible, make referrals for specialist health services to hospitals with established hospital pathways. Hospital pathways for people in the Victorian prison system include:

   i. Access to metropolitan tertiary hospitals, prioritising use of secure hospital custodial wards

   ii. Access to local regional hospitals, which reduces the need for people in prison to be transferred to metropolitan Service Locations and hospitals to access specialist health services.

b. Provide health pathway coordination to manage the flow of clients between Service Locations and planned specialist appointments (including telehealth) and treatments in the community.

c. Consult, liaise, and advise on the management and prioritisation of clients for onsite bed-based medical services including step-up pending transfer to a community service and step-down following treatment in the community.

d. Work in partnership with hospitals (in-person and telehealth scheduling), custodial staff, and other prison locations that are a gateway to the established hospital pathways to manage the appointments and admissions and discharge coordination processes.

e. Ensure that custodial staff and transport services receive timely information about health pathway movements, including cancellations and rescheduling and will ensure that clients are provided with timely information when their appointment is rescheduled.

f. Actively monitor and follow-up clients, or ensure timely follow-up by a clinician, when a specialist service has been declined by the client.

g. Document declines, document follow-up actions, and use best endeavours to support and educate the client – including engaging other supports – to agree to the health interventions recommended for them.

h. Report on movements to and from specialist care, which will cover rescheduling, cancelled, and declined appointments.

The Contractor is not responsible for initiating and coordinating with custodial staff the safe movement of clients in the care of the forensic mental health service provider who require transfer and transport because of mental health concerns during their time in prison or upon release to the community.

### 7.6.5 Palliative Care

To address palliative care needs, the Contractor will:

a. Provide all appropriate care and support, which may include in-reach services and allied health services.

b. Refer to and engage with specialist palliative services to develop a palliative care treatment plan and escalation processes.

c. Initiate case conferences and coordination of prison-based health service responses that can most appropriately meet the client's needs and will involve the client's case manager, and other custodial staff or service providers.

d. Provide support for the client and for their family and friends, being sensitive to the cultural, religious, spiritual and personal needs of both the client and their family and friends, which will be addressed and actioned as part of the palliative care plan.

e. Work with custodial staff to ensure that the client is provided with care in the most appropriate accommodation, including community-based palliative care.

f. Follow the transfer to a hospital process when applicable, with supporting clinical recommendation, and anticipate this possibility in the palliative care plan and the tailored escalation process for each client.

## 7.7 End of Life Care

### 7.7.1 Advanced Care Planning

For addressing end of life care needs, the Contractor will:

a. Provide respectful and compassionate support to people in prison with terminal conditions.

b. Encourage clients to consider and document their end-of-life preferences, which will be addressed with sensitivity to cultural and religious, spiritual, and personal beliefs and needs of the client, and may include involvement of in-reach cultural supports, or the client's nominated medical decision-maker, or family and friends.

c. Make referrals to the Public Advocate or in-reach services as needed to address the client's planning process.

d. When appropriate, offer information and guidance to clients in relation to organ and/or tissue donation and clients will be assisted should they wish to document donor decisions.

e. Not make clients feel compelled to participate in advanced care planning.

f. Record alerts and save documents in the client's EMR, to include:

   i. Advanced Care Directives

   ii. Details of nominated substitute medical decision-makers

   iii. Organ/tissue donation wishes

   iv. Resuscitation orders

g. Have documented processes and accurate records relating to the client's wishes so that they or tother health providers are able to act on the client's end-of-life care and resuscitation orders.

h. Ensure that the above records are available to other health providers, if at some stage the client is in the care of other care providers.

### 7.7.2 Voluntary Assisted Dying

The Contractor will:

a. Understand the *Voluntary Assisted Dying Act 2017*, and the Department of Health guidelines for health service providers.

b. Have processes in place to notify the State of requests from people in prison for Voluntary Assisted Dying (VAD).

c. Continue to care for and support the client and assist the State as necessary as the protocols are followed.

When a VAD request is received, the State will manage the process and pathways, which entails accessing VAD services outside the prison.

## 7.8 Allied Health - Medication Management

### 7.8.1 Pharmaceuticals and Pharmacists

For delivery of pharmaceuticals, the Contractor will:

*a.* Provide and manage pharmaceuticals for people in prison in compliance with all applicable legislation, regulations, policies, guidelines, manufacturer's advice, and as specifically defined in *Attachment B – Healthcare Services Quality Framework for Victorian Prisons 2023.*

b. Establish a Pharmaceutical and Consumables Committee, in compliance with the conditions of the Agreement.

c. Have in place pharmacist arrangements in compliance with applicable laws.

d. Create and maintain at each Service Location an adequate supply of emergency medications, antidotes, and related information, and emergency poison telephone numbers prominently available to all health staff.

e. Provide and maintain all equipment necessary to securely and safely store, manage, dispense, administer, and dispose pharmaceuticals, and maintain accurate records of all medications held within the Service Locations.

The State will endorse the medication formulary, including an imprest, which will be reviewed annually and updated with the approval of Justice Health.

### 7.8.2 Medication Management

For delivery of medication management, the Contractor will:

a. Document processes and implement systems for the accurate, timely, and safe management of prescribing, transportation, storage, dispensing, administrating controlling, recording and disposing of medications to ensure clients have access to their prescribed medications.

b. Use the EMR to record medicine prescriptions.

c. Deliver, administer, and monitor medications prescribed by health practitioners to people in prison.

d. Have an incident management and investigation systems in place, and all adverse events related to medications must be reported, documented, investigated, and reviewed by a multidisciplinary team. Medication Adverse Events include, but are not confined to, prescription, administration, dispensing, documentation, disposal and storage errors.

e. Have a system in place to reduce the occurrence of medication incidents and to improve the safe management of medications will be in place.

f. Undertake regular end-to-end audits of the medication management systems and associated documentation, including regular stock audits, with discrepancies reported in the Contractor's risk management system.

### 7.8.3 Prescribing

For delivery of prescribing the Contractor will:

a. Prescribe the safest, most clinically effective, and most cost-effective medications.

b. Avoid wherever possible prescribing of medications known to have potential for dependency or misuse and only prescribed when clinically indicated.

c. Have documented processes for prescribing Highly Specialised Drugs.

d. Clearly and accurately document prescriptions, signed for in full, with name, date and signature and recorded in the client's EMR.

e. Maintain the EMR to include client allergy alerts or other known adverse drug reactions that will be accessible at the point of prescribing, dispensing, and administering medication.

f. Have documented continuum of short-term strategies for safely managing a client's immediate health needs, including medication when required and nurse-initiated medications, only as necessary.

g. Provide people in prison with easily understood information about their medications, including the name, purpose, dose, administration schedule and risks or expected side effects.

h. Not withdraw health support will or other treatment and support programs based on a client's non-compliance with medication.

### 7.8.4 SafeScript

The Contractor must check SafeScript prior to writing or dispensing a prescription for medicines monitored through the system.

Medicines that are monitored include:

a. All Schedule 8 medicines

b. Benzodiazepines, such as diazepam

c. 'Z-drugs' (zolpidem, zopiclone)

d. Quetiapine

e. Codeine containing products.

### 7.8.5 Administering Medications

Prescribing and ordering records are completed in the EMR, with client medication administering and client medication charts currently paper based.

For the delivery of administration of medications, the Contractor will:

a. Document and embed operational practices based on recognised national safety standards when using paper-based dispensing and medication charts and will regularly audit quality and compliance.

b. Enter all administration of prescribed medication in the client's EMR.

c. Provide clear information about self-administration of medications where applicable and implement processes to minimises the risk of diversion and for the safe self-administration of medications in the custodial setting.

d. Develop processes for medications requiring supervision by custodial staff, and for instances requiring that custodial staff issue medications.

e. Record in a client's EMR refusals to comply with their medication regime and communicate to the Medical Practitioner or the Nurse Practitioner for further advice, and if appropriate, advise the client's case manager, for example, and consider cultural or other supports to assist the client with their health and wellbeing management.

## 7.9 Allied Health - Diagnostic Services

### 7.9.1 Secure Diagnostic Messaging and Images Storage

The Contractor will have in place or develop and maintain:

a. A single secure messaging system for all diagnostic messaging to interface with the EMR, compliant with the department's ICT security requirements, to be reviewed and approved by the department's Cyber Security Management Team, and the process for firewall rule changes implemented. Alternatively, the Contractor will require and manage all diagnostic services used by them for provision of the Service to have compliant software that has been approved by the department and that has been implemented following the department's processes.

b. Have in place or develop and maintain a secure imaging storage system for receiving, accessing, and storing radiology images from all radiology providers used by the Contractor for the Services. Only the radiology report will be received into the EMR, the images will be accessed and viewed via the Contractor's secure imaging storage solution.

### 7.9.2 Radiology and Pathology Services

People in prison will be provided with timely access to radiology and pathology services as clinically necessary.

The Contractor will:

a. Manage and maintain the Service Location x-ray and ultrasound rooms and maximise the use of mobile radiology for Service Locations that do not have onsite radiology rooms, to minimise the need for client transfers to other Service Locations or to community services.

b. Refer clients to the most appropriate and closest public hospital for radiology services where these services cannot practicably be provided at a Service Location.

c. Arrange pathology services through laboratories approved by the relevant body, including having arrangements with pathology providers located within proximity to Service Locations.

### 7.9.3 Communicate Diagnostic Results

The Contractor will ensure that:

a. The referring practitioner reviews and actions all diagnostic results in a timely manner.

b. Clients are notified of medical test results within 5 Business Days, or sooner if clinically indicated, of the test results being received in the EMR.

c. Processes are in place for diagnostic responsiveness to still be met when clients are transferred prior to their results being communicated to them.

## 7.10 Allied Health Services

Allied health Services will be provided to people in prison to support diagnosis, treatment, rehabilitation, prevention, and minimise the impacts of disease and disability, and to maintain or improve health and wellbeing.

Allied health professionals will form part of the multidisciplinary Services team and will be involved in the assessment and treatment of people in prison, including people living with a disability, the care of older people, those with chronic medical conditions and for those requiring rehabilitation.

Allied health services include but are not limited to; audiology, dietetics, optometry, physiotherapy, podiatry, occupational therapy, speech pathology, and medical aids and equipment.

For delivery of allied health Services, the Contractor will:

a. Deliver allied health services in accordance with evidence-based practice.

b. Be knowledgeable of the contribution that access to timely allied health services (and dental) can make to improving a client's ability to be prosocial and to engage in prison or community-based opportunities that may help to reduce reoffending and may improve their life prospects, such as education and training, employment, rehabilitation program and social development.

c. Document and embed practices and assessments to actively identify the allied health needs of people in prison.

d. Accept self-referrals for allied health services and clinically assess the needs of the client and refer them to allied or other health services as most appropriate.

e. Triage and prioritise allied health services and manage wait lists to meet the demand at each Service Location and to meet the KPMs (*Attachment C*).

f. Develop a treatment plan for people receiving allied health services, in collaboration with the client and include recommended treatment plan review intervals.

g. Ensure that Service Locations with high demand have frequently scheduled access to allied health services.

h. Ensure that regular allied health service needs are reflected in the treatment plan and recurrent appointments scheduled, for example for high need cohorts, such as older or disabled clients.

i. Prioritise older clients for optometry or audiology services, including replacement of damaged glasses or hearing aids.

For delivery of allied health Services, the Contractor will:

a. Provide optometry services to people in prison who require monitoring of a pre-existing eye condition, experience eye symptoms or changes in vision, have a diagnosis of diabetes (Type 1 & 2), have other clinical indicators (such as prescribed Plaquenil or corticosteroid use), or who require review or replacement of existing prescription glasses, including for damaged or lost glasses.

b. Provide one pair of glasses, either bifocal, trifocal, or multifocal prescription, except in circumstances where separate reading glasses and distance glasses would better meet the clinical needs of the client.

c. Provide only plastic frames and acrylic scratch-resistant lenses, unless otherwise clinically indicated

d. Not provide tinting or prescription sunglasses unless clinically necessary

e. Not provide contact lenses unless clinically necessary. People who arrive in prison who already have contact lenses will continue to be provided with a contact lens case and disinfection solution to ensure their lenses remain safe for use.

f. Not provide sunglasses.

For delivery of dietetic services, the Contractor will:

a. Refer and assessed people in prison when a medical or therapeutic diet needs to be prescribed to promote the nutritional status of the client who has an acute or chronic medical condition.

b. Record prescribed medical diets in the client's EMR and review and update when needed.

c. Consult with and provide timely information sharing with custodial staff to ensure that the client's prescribed dietary needs can be met and commenced.

For delivery of audiology services, the Contractor will:

a. Provide audiology services to all people in prison who experience auditory symptoms or changes in hearing, or who require review or replacement of existing hearing aids, including for damaged or lost aids.

b. Provide standard hearing aids to clients, unless otherwise clinically indicated.

c. Provide information about their responsibilities for care of hearing aids to clients issued with hearing aids.

d. Provide maintenance (including battery replacement), repair or replacement of hearing aids when the audiologist determines the existing unit requires updating.

For delivery of podiatry services, the Contractor will:

a. Provide podiatry services to people in prison for diagnosis or medical, surgical, mechanical, physical, and adjunct treatment of the diseases, injuries, and defects of the foot.

b. Be knowledgeable of the high need for podiatry services within Priority Groups, and at particular Service Locations.

c. Be knowledgeable of and able to identify podiatry needs stemming from disease, such as diabetes, and will be watchful of conditions that a client might not be aware of or might only become aware when the condition has progressed.

For delivery of speech pathology services, the Contractor will:

a. Provide speech pathology services to people in prison when a need has been identified to help them communicate effectively, which might be pre-existing and long term, or stemming from illness or medical interventions, including dental (e.g., first time with dentures),

b. Provide speech pathology for people in prison having problems with swallowing or drinking safely and be knowledgeable and able to identify clients who are having difficulties with food or swallowing and refer them

to allied health services to assist with their condition.

c. Be aware that people in prison with speech, language, communication, fluency or voice concerns might not self-refer for a speech pathology service and be unaware that the service could help them and contribute to their wellbeing and social behaviours.

d. Take the initiative to discuss speech pathology with people in prison when they observe during their interactions that the service would be of value to the client.

For delivery of physiotherapy services, the Contractor will:

a. Provide physiotherapy services people in prison to treat conditions including but not limited to physical, respiratory, and neurological, using techniques such as massage, manipulation and exercise where clinically indicated.

For delivery of occupational therapy services, the Contractor will:

a. Provide occupational therapy assessments.

b. Provide occupational therapy services to people in prison to help develop, recover, improve, or maintain skills needed for their better health outcomes.

For provision of allied medical aids and equipment, the Contractor will:

a. Provide medical aids and equipment to people in prison when a need has been identified, which will often, but not always, be for Priority Groups, or may be an ongoing or temporary need, including after medical treatments or injuries.

b. Create and maintain a register of all aids and equipment prescribed for clients at each Service Location.

c. Provide clients with medical certificates so that custodial staff are aware that the person is authorised to have the medical aid or equipment.

d. Consult with custodial staff prior to issuing aids and equipment, and if the use of specific aids or equipment is contraindicated due to security concerns, the Contractor will consider the best alternatives to still meet the needs of the client.

e. Provide clients with information about the correct use of aids or equipment, and their responsibilities for the care of any aid or equipment or devices provided to them (including hearing aids, or glasses).

f. Undertake regular reviews to monitor the health and physical support needs of client's issue with medical aids and equipment.

## 7.11 Prison Bed-based Medical Service

Bed-based medical services are available in the Victorian public prison system at Hopkins Correctional Centre (eight beds).

The Contractor will manage the prison bed-based medical services in compliance with the scope of eligibility, and in consultation with custodial staff to ensure the appropriate and safe placement of people in prison.

The Contractor will resource the bed-based medical services as follows:

a. Medical Practitioner coverage

b. 24-hour Registered Nurse coverage

c. 24-hour emergency response

d. 24-hour on-call response

e. Specialist staff to support the scope of services delivered, including in-reach

f. Allied health services to support people receiving a bed-based service.

Bed-based medical services enable provision of services for the immediate care of clients with health issues of low to medium acuity, which will include:

a. Peri- and post-operative (including step-down) care, where clients have been discharged from a hospital for step-down care prior to being medically cleared to return to their prison accommodation
b. Management of active health problems including review of medications, treatment of existing conditions such as high blood pressure including intravenous or antibiotic medications
c. Management of infections, injuries, and intensive wound management including after assaults (for observation)
d. Management of infections and/or infectious diseases requiring specific precautions or isolation
e. Assessment of vulnerable clients, including after sexual assault
f. Alcohol and other drugs, including withdrawal management, medication review and referral to pharmacotherapy (opioid substitution therapy)
g. Management or review of clients with complex medication regimes
h. Management of clients with chronic medical conditions who are at risk of an adverse medical event.
i. For delivery of chemotherapy or dialysis (at locations where equipment is available)
j. Management of clients requiring a high degree of rehabilitation services
k. To support older clients needing an aged care response that can no longer be appropriately achieved in the client's usual accommodation.
l. Palliative care on a case-by-case basis.

# 8. Focus Area 5: Tailored Response for Priority Groups

The prison primary health experience will aim to remove the challenges experienced by Priority Groups in accessing and receiving care while in prison and on release to the community.

Except for the requirements under 8.1 and 8.2, which will be implemented from contract commencement, the State and the Contractor will work together to achieve incremental implementation during the Term to improve the quality and appropriateness of primary health Services for all priority groups.

The design and delivery of the Contractor's Service will:

a. Deliver Services tailored to address the unique and often complex needs of Priority Group clients tailored at the collective and individual levels and integrated across the Services.
b. Address the barriers that can and do arise for people in prison who fall into in one or more of the Priority Groups.
c. Purposefully reduce the wellbeing and health harms that can occur because of lack of workforce training, awareness, sensitivity, or knowledge, which might engender service avoidance, active declines, reluctance to disclose health concerns or history, healthcare commissioners, or create negative experiences for priority clients.
d. Improve health engagement with Priority Groups by providing Services that are safe, culturally appropriate, gender appropriate, patient-centred, timely, and non-discriminatory, so that the dignity, health, mental health, and personal agency of Priority Groups are protected and promoted.
e. View health as an element of rehabilitation requiring a more proactive health approach to identify and address the factors that may impact on a person's ability to engage in personal development and rehabilitation interventions, education, skills training, work and social opportunities.

The Contractor will provide trauma-informed care based on five principles:

a. Safety (physical, emotional, psychological)
b. Trustworthiness

c. Choice

d. Collaboration

e. Empowerment

The Contractor will adopt trauma-informed practices in the delivery of Services, which includes but is not limited to:

a. Avoiding excessive or repeated assessments and will streamline the reception medical assessment (for example, excluding assessment questions that are not necessary for the individual concerned)

b. Ensuring that women (including transgender women in men's prisons) can access female health practitioners without incurring additional wait times

c. Treating people as individuals by listening to them and their health concerns

d. Fostering trusting and respectful relationships between health staff and clients

e. Working collaboratively with the client, emphasising choice and prioritising the preferences of the client insofar as they are not detrimental to their health risks or health outcomes

f. Ensuring that the client feels safe to engage with health and mental health Services

g. Providing as much privacy as possible, such as the option of having a female health practitioner for women (including transgender women in men's prisons) where medical procedures require disrobing

h. Providing clients with the opportunity to give feedback about their experience and implementing annual action plans to address common issues experienced by clients with the Service.

## 8.1 Health Staff Training and Development

As part of the Workforce Training and Development Plan (including for client facing subcontractors) for transition-in, business as usual on-boarding, and annual professional development, the Contractor must identify and include regular (including refresh) training and development opportunities to address:

a. Unconscious biases and stigmatisation that can lead to direct or indirect discrimination against people due to their age, ethnicity, sexuality, disability, sex, or gender identity.

b. Aboriginal and Torres Strait Islander cultural awareness and understanding.

c. Acquiring a working understanding of the Victorian Charter of Human Rights and Responsibilities and the Racial and Religious Tolerance Act 2001, and anti-discrimination legislation.

d. Understanding of holistic, trauma-informed care, identifying the symptoms and a person's history of trauma, and delivery of care that does not trigger or exacerbate trauma symptoms.

e. Effective engagement with younger clients and an understanding of the needs of younger people in prison.

f. Familiarity with and able to apply evidence-based differences in medical risk factors or conditions that are associated with ethnicity.

g. Learning about diverse linguistic and cultural influences, traditions, and upbringing, including cultural barriers that may make it difficult to broach or identify some health matters with clients.

h. Recognising when inappropriate behaviours or grooming may be occurring in the provision of care, which might especially occur in the delivery of care to Priority Groups and understanding behaviours that are not acceptable when providing care to people in prison.

i. Provision of care to LGBTIQ+, noting the need for particular training and development on the healthcare needs of transgender, gender diverse, and intersex people.

Additionally, the Contractor will seek out and schedule ongoing Service Location collaborations and training from custodial staff for their health teams to gain understanding of and actively contribute to the therapeutic and rehabilitative focus in various Service Locations.

## 8.2 Aboriginal and Torres Strait Islander People in Prison

For delivery of Services to Aboriginal people in prison, the Contractor will:

a. Recruit, develop, and maintain a primary health Aboriginal workforce.

b. Build partnerships with Aboriginal community health service providers and Aboriginal cultural and social supports for in-reach services for Aboriginal people in prison and out-reach for continuity of care upon release to the community.

c. Create direct and indirect health, wellbeing, cultural wrap-around, and social supports for Aboriginal clients as fully integrated aspects of the Services.

d. Recognise that addressing prejudice and discrimination and providing a culturally safe and appropriate care environment for Aboriginal clients is not a didactic model. The responsibility and the work to prioritise the physical, social, spiritual and emotional wellbeing of Aboriginal clients, and to do so in a manner that is meaningful, respectful, tailored and consistent with their cultural needs, will be embedded across the whole Service.

To improve the health management and outcomes of Aboriginal people in prison, and contribute to reducing over-representation, the Contractor will at a minimum:

a. Undertake the Service Specifications detailed for Aboriginal clients.

b. Provide Services meet the physical, social, emotional, spiritual, and cultural wellbeing needs for Aboriginal people in a culturally safe way.

c. Foster a trauma-informed, and inclusive environment that is responsive to the needs of Aboriginal people.

d. Partner and collaborate with other health services and partner and collaborate with the wider custodial service providers.

e. Create collaboration pathways with Corrections Victoria (including the AWOs and ALOs) and Justice Health through information sharing to support participation in cultural and other programs.

f. Recognise the impact of experiences of trauma and racism, continually build the cultural capability of all health staff, coordinating care with Aboriginal Wellbeing Officers and establishing meaningful partnership with Aboriginal Community Controlled Health Organisations (ACCHOs) to enhance health service delivery and to support transition and continuity of care for Aboriginal people leaving custody.

g. Create linkages to traditional healing and custodial programs designed for spiritual health and cultural care to support social and emotional wellbeing

h. Make interpreter services available for Aboriginal people for whom English is not their preferred language.

i. Provide health information in plain English and or traditional languages.

## 8.3 Older People in Prison

Older people are a growing cohort in Victoria's prison population and present with an increasing range of complex health needs including chronic medical conditions, cognitive and functional impairments.

An older person is defined, 50 years and over for non-Aboriginal people, and 45 years and over for Aboriginal people.

To improve the health management and outcomes of older people in prison, the Contractor will at a minimum:

a. Undertake the Service Specifications detailed for older clients.

b. Make prompt referrals to appropriate services including allied health, dental, personal care, specialist geriatric, neurology, or other provider initiatives for older clients that meet their needs and promote their health, wellbeing, independence, and dignity.

c. Implement systems to monitor the health of older people in prison to make early identification of symptoms, changes in health, deterioration in existing conditions, the onset of impairments, mobility limitations, new visual or sensory impairments, cognitive decline or behavioural changes, and provide timely diagnosis or referrals and early interventions or treatments to address confirmed or emerging health needs.

d. Ensure that older people in prison are provided with the right level and types of allied health services to optimise their health, safety, wellbeing, and independence.

## 8.4 People Living with a Disability in Prison

People living with disability experience varying degrees of physical and cognitive impairment, which can lead to limited mobility and impaired ability to carry out Activities of Daily Living (ADLs). Disability can be related to genetic disorders, illnesses, accidents, ageing, injuries, or a combination of these factors.

To improve the health management and outcomes of people in prison with a disability, the Contractor will at a minimum:

a. Undertake the Service Specifications detailed for clients with a disability.

b. Manage the health of people with a disability, including managing all health conditions that are related to the person's disability.

c. Provide clients with a disability with equal and timely access to Services.

d. Work closely with custodial staff to identify people living with a disability in a timely manner.

e. Develop and implement a mechanism to systematically identify people entering prison who have any type of disability and co-ordinates this approach with Corrections Victoria to ensure consistency.

f. Provide a safe and accessible Service for people in a prison with a disability.

g. Comprehensively and in an integrated manner, manage all medical issues related to a person's impairment, including referrals to allied health, forensic mental health and specialist services.

h. Proactively refer clients living with a disability to the most appropriate Corrections Victoria service or other services that meet the needs of the client.

i. Consistently and accurately record a diagnosis and associated details of a client's disability.

j. Ensure that clients with disabilities are assessed and provided with appropriately fitted medical aids or equipment, including assistive technology when required.

k. Assist the release planning process with completing, reviewing and signing off on medical information for NDIS applications for disabled clients, including completing NDIS health assessments where required and accurately recording medical details in the client's EMR to satisfy the requirements for NDIS.

## 8.5 Young People in Prison (18–25)

Many young people in prison have multiple experiences of disadvantage, neglect and trauma. Many also have learning and developmental disabilities, mental health illnesses, AOD concerns, or have experienced adverse childhood experiences.

To improve the health management and outcomes of young people in prison the Contractor will at a minimum

a. Undertake the Service Specifications detailed for young clients.

b. Place an emphasis on disease prevention and tailor its Services to young people in prison, such as health promotion, exercise, physiology, impulsivity control, the mental health response, and AOD health programs, taking into account the needs of the younger age cohort, neurodiversity, and effective modes of engagement.

c. Partner with local organisations, e.g., the YMCA, YSAS, or Headspace to deliver in-reach health or wellbeing services for young clients.

## 8.6 Culturally and Linguistically Diverse (CALD) People in Prison

The Victorian prison system has a culturally and linguistically diverse population, with up to a fifth of people in prison born in non-English speaking countries.

To improve the health management and outcomes of CALD people in prison, the Contractor will at a minimum:

a. Undertake the Service Specifications detailed for CALD clients.

b. Provide people from CALD backgrounds with interpreter services in the client's preferred language when they request an interpreter, and connect them with interpreter services at health appointments, including for clients who ostensibly have good English language skills, but may be more comfortable in communicating and receiving medical information in their preferred language.

c. Embed inclusive and non-discriminatory processes and behaviours across the Service so that delivery is respectful of everyone's linguistic and cultural backgrounds, beliefs, values, customs, and lifestyles.

d. Have printed health information, promotional, and program materials available in multiple languages (the range of languages available at each Service Location may vary, depending on demographics).

e. Provide in-reach health services from local health organisations tailored for the CALD community.

f. Develop strategies to increase the ethnic, cultural, and linguistic diversity of the Service workforce.

## 8.7 LGBTIQ+ People in Prison

While people who are lesbian, gay, bisexual, transgender, intersex, or queer have health needs that are not related to their sexuality, gender identity or gender expression, people in prison who are trans or gender diverse are likely to have unique health needs that require specialised, multidisciplinary care to ensure the preservation of health. Transgender and gender-diverse people often experience high levels of trauma and stress related to their status, therefore it is important for primary health staff to adopt a trauma-informed approach when communicating and providing care. Additionally, there are health risks for men who have sex with men.

To improve the health management and outcomes for LGBTIQ+ people in prison the Contractor will at a minimum:

a. Undertake the Service Specifications detailed for LGBTIQ+ clients.

b. Provide inclusive and non-discriminatory Services in all aspects of care that is respectful, responsive to specific needs, and considers the impact of stigma and discrimination that may have been experienced by people in these communities; recognising that this may result in more time for assessments and appointments.

c. Implement rigorous practices to include the use of the person's preferred pronouns and name by health staff when referring to or talking to the person, and only asking questions relating to the person's sex, gender identity, or gender expression for the sole purpose of determining accommodation needs, classification, and healthcare and support needs.

d. Recognise that some people in prison may not identify with or use the terms "trans", "transgender" or "gender diverse". Likewise, they may not self-disclose at their entry to prison and may take steps to affirm their gender for the first time while in prison.

e. Recognise that transgender and gender-diverse people often experience high levels of trauma and stress related to their status, therefore it is important for health staff to adopt a trauma-informed approach when communicating and providing care.

f. Recognise that transgender and gender diverse people may need interventions to address their trauma and may need additional choices and autonomy to engage in particular kinds of medical care, such as a self-administered cervical swab for human papillomavirus testing among transgender men.

g. Ensure that primary healthcare services are provided for transgender men or transgender women in men's prisons who may require primary health services relating to the gender they had been assigned at birth.

h. Establish meaningful partnership with community health services that specialise in LGBTIQ+ health to enhance health service delivery and to support transition and continuity of care for people leaving custody.

i. Providing as much privacy as possible, such as the option of having a health practitioner of a particular sex where medical procedures require disrobing.

j. As part of release planning, provide referrals to support LGBTIQ+ people's health post-release.

The Contractor will also provide access to the following health Services:

a. Referrals to gender counselling and peer support programs for transgender people and liaison with case managers and Corrections Victoria reintegration teams.

b. Referrals to specialist services such as endocrinology, gynaecology, mental health, speech pathology, assisted reproduction.

c. Referrals to specialist services for transgender and gender diverse people who have or have decided to transition, including community health services with expertise in working with transgender and gender diverse people.

d. Where referrals are required for external or specialist providers, the Contractor considers whether the service is inclusive and responsive to the needs of clients who are trans or gender diverse (for example, have received formal accreditation by a third party such as the Rainbow Tick), and will ensure that referrals to specialist and specialist advise is sought from the most appropriate community health provider to meet the needs of the person in prison, which may be referral to more than one specialist health provider.

e. Continuing or new medication management by a Medical Practitioner of gender affirming treatments, including Hormone Replacement Therapy (HRT), and providing clinical staff with knowledge of gender affirming treatments to respond to questions posed by transgender clients in prison. (An informed consent model will be implemented for all gender affirming treatments.)

f. Access to pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) when indicated.

## 8.8 Choice of Care

All Services are available to all people in prison who are required to receive or are suitable and eligible for receiving the Service. People in prison can choose to accept or decline Services. People in Priority Groups can choose to decline a Service tailored for them, preferring to receive non-tailored care or mainstream interventions.

When an offer is made for a tailored Service and actively declined, e.g., offer of a Health Check for Aboriginal people or attendance of an AHP or AHW at an appointment, this will be noted in the client's health record or interventions case, e.g., offer of an AOD health program designed for Aboriginal men.

## 8.9 Active Follow-up

For delivery of Services to Priority Groups, the Contractor will:

a. Actively follow-up with clients in Priority Groups, and the broader health client population, when health appointments have been missed – e.g., no-show, declined – and undertake further follow-up when clients do not attend for a rescheduled appointment.

b. Have in place guidelines and practices to ensure that clients in the defined Priority Groups are followed-up at least once (unless stated as more frequently for a particular service) when engagement with health Services has not been provided and a Service has been recommended, including when a client fails to attend two sequential scheduled appointments.

c. Encourage and support clients to discuss their concerns.

d. Address barriers to engagement, including with the support of case managers or other providers when appropriate.

e. Refer clients to health promotion or cultural support opportunities, for example, which may require arranging in-reach services to meet the needs of Priority Groups.

# Attachment A – Legislation, Regulations, Policies and Guidelines

The Contractor will comply with, or be familiar with, the following legislation, regulations, policies and guidelines, as they relate to the Service, and comply with changes or replacements to such during the term. The Contractor will identify and comply with any additional references relevant to the quality and safe delivery of the Service in prisons on an ongoing basis, including:

- International agreements
- Legislation
- Standards and guidelines
- Program and service specifications as articulated in relevant contracts
- Corrections Victoria Commissioner's Requirements
- Corrections Victoria Deputy Commissioner's Instructions and Operating Procedures
- State government policies and guidelines.

| National Legislative Instruments |
|---|
| Aged Care Act 1997 |
| Aged Care Quality and Safety Commission Act 2018 |
| Australian Human Rights Commission Act 1986 |
| Disability Discrimination Act 1992 |
| Privacy Act 1988 |
| Therapeutic Goods Act 1989 |

| Victorian State Legislative Instruments |
|---|
| Abortion Law Reform Act 2008 |
| Assisted Reproductive Treatment Act 2008 |
| Bail Act 1977 |
| Bail Amendment (Stage One) Act 2017 |
| Bail Amendment (Stage Two) Act 2018 |
| Carers Recognition Act 2012 |
| Charter of Human Rights and Responsibilities Act 2006 |
| Child Wellbeing and Safety Act 2005 |
| Children Legislation Amendment (Information Sharing) Bill 2017 |
| Children, Youth and Families Act 2005 |
| Coroners Act 2008 |
| Corrections Act 1986 |
| Crime Act 1958 |
| Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 |
| Dangerous Goods Act 1985 |
| Disability Act 2006 |

Disability Service Safeguards Act 2018

Drugs, Poisons and Controlled Substances Act 1981

Environment Protection Act 2017

Family Violence Protection Act 2008

Freedom of Information Act 1982

Guardianship and Administration Act 2019

Health Complaints Act 2016

Health Practitioner Regulation National Law Act 2009

Health Records Act 2001

Health Services Act 1988

Human Services (Complex Needs) Act 2009

Human Tissue Act 1982

Improving Cancer Outcomes Act 2014

Medical Treatment Planning and Decisions Act 2016

Mental Health Act 2014

Occupational Health and Safety Act 2004

Pharmacy Regulation Act 2010

Post Sentence Detention and Supervision Scheme

Privacy and Data Protection Act 2014

Public Health and Wellbeing Act 2008

Public Records Act 1973

Radiation Act 2005

Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015

Sentencing Act 1991

Serious Offenders Act 2018

Serious Sex Offender Registration Act 2004

Therapeutic Goods (Victoria) Act 2010

Victorian Institute of Forensic Medicine Act 1985

Voluntary Assisted Dying Act 2017

Worker Screening Act 2020

**International Standards and Guidelines**

Biohazard Waste Industry Australia & NZ, *WI Industry Code of Practice for the Management of Clinical and Related Wastes (8th Edition)*

International Organization for Standardization, *Australian Standard/New Zealand Standard on Risk Management* (AS/NZS ISO 31000:2018)

International Organization for Standardization, *Australian/New Zealand Standard on Management of Clinical*

*and Related Wastes* (AS/NZS 3816:2018).

International Organization for Standardization, *Australian/New Zealand Standard on Office-based healthcare facilities – reprocessing of reusable medical and surgical instruments and equipment, and maintenance of the associated environment* (AS/NZS 4815:2006)

Optional Protocol on the Convention Against Torture (OPCAT)

Royal Australian College of General Practitioners, *Infection prevention and Control Standards. For general practices and other office-based and community-based practices (5th Edition)*

Royal Australian College of General Practitioners, *Infection Prevention and Control Standards (5th Edition)*

United Nations Declaration on the Rights of Indigenous Peoples, 2008

United Nations, *Handbook on Prisoners with Special Needs, 2009*

United Nations OCHR Basic Principles for the Treatment of Prisoners (1990)

WHO Moscow Declaration on Prison Health as Part of Public Health (2003)

United Nations Standard Minimum Rules for the Treatment of Prisoners (2015)

## National Regulations

Australian Human Rights Commission Regulations 2019

Disability Discrimination Regulations 2019

Privacy Regulation 2013

Therapeutic Goods (Charges) Regulations 2018

Therapeutic Goods (Medical Devices) Regulations 2002

Therapeutic Goods Regulations 1990

## Victorian State Regulations

Child Wellbeing and Safety (Information Sharing) Regulations 2018

Corrections Regulations 2019

Disability Service Safeguards Regulations 2020

Drugs, Poisons and Controlled Substances Regulations 2017

Family Violence Protection (Information Sharing and Risk Management) Regulations 2018

Freedom of Information (Access Charges) Regulations 2014

Health Complaints Regulations 2019

Health Records Regulations 2012

Health Services (Quality and Safety) Regulations 2020

Improving Cancer Outcomes (Diagnosis Reporting) Regulations 2015

Medical Treatment Planning and Decisions Regulations 2018

Mental Health Regulations 2014

Occupational Health and Safety (COVID-19 Incident Notification) Regulations 2021

Occupational Health and Safety Regulations 2017

Public Health and Wellbeing Regulations 2019

## National Policies, Standards, and Guidelines

Australian Commission on Safety and Quality in Health Care, *Medication Safety Standards*

Australian Commission on Safety and Quality in Health Care, *National Model Clinical Governance Framework, 2017*

Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards: User Guide for Aboriginal and Torres Strait Islander Health*

Australian Commission on Safety and Quality in Health Care, *National Standards for Mental Health Services*

Australian Commission on Safety and Quality in Health Care, *The Measurement for Improvement Toolkit, 2006*

Australian Commission on Safety and Quality in Health Care, *The Ossie Toolkit for the implementation of the Australian Guidelines for the Prevention of Infection in Health Care, 2010*

Australian Commission on Safety and Quality in Health Care, *Australian Open Disclosure Framework, 2013*

Australian Commission on Safety and Quality in Health Care, *National Hand Hygiene Initiative*

Commonwealth of Australia, *National Guidelines for Medication-Assisted Treatment of Opioid Dependence, 2014*

Commonwealth of Australia, *National Hepatitis C Testing Policy 2020*

Department of Health, *National Clinical Guidelines and Procedures for the Use of Naltrexone in the Management of Opioid Dependence*, 2003

Department of Health, *National Framework for Communicable Disease Control, 2014*

Department of Health, *National Guidelines for Medication-Assisted Treatment of Opioid Dependence, 2014*

National Standards for Disability Services

Attorney-General's Department, *The Australian Government guidelines on the recognition of sex and gender, 2015*

National Disability Insurance Agency, *Operational Guideline – Planning and Assessment – Supports in the Plan – Interface with Justice, 2014*

National Health and Medical Research Council and the Australian Commission on Safety and Quality in Healthcare, *Australian Guidelines for the Prevention and Control of Infection in Healthcare, 2019*

*Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020*

## Victorian State Policies, Standards, and Guidelines

Code of Conduct for Victorian Public Sector Employees

DataVic Access Policy

Victorian Government Supplier Code of Conduct

## Department of Justice and Community Safety Standards, Policies and Guidelines

COVID-19 Vaccination Policy - October 2021

Justice Security Manual Section 5 Information Security

Justice Security Manual Section 6 ICT

## Corrections Victoria Standards, Policies and Guidelines

Guiding Principles for Corrections in Australia, 2018

Reintegration Pathway

*Victorian Prison Drug Strategy,* 2002

Yawal Mugadjina Program Guidelines, 2018

## Corrections Victoria Commissioner's Requirements

1.2.7 Identified Drug User Program - Category IDU A

1.3.1 Incident reporting

1.3.3 Reporting and Review of Prisoner Deaths

1.3.4 Information Management and Security

1.3.5 Notification of Privacy Complaints and/or Alleged Privacy incidents

1.4.8 Conduct and Ethics

1.4.9 Management of prisoners during the COVID-19 Pandemic

2.3.1 Management of at-Risk Prisoners

2.4.1 Management of Prisoners who are Trans, Gender Diverse or Intersex

2.4.2 Anti-Discrimination with respect to prisoners

2.5.1 E*Justice Risks and Recommended Actions

3.4.1 Living with mum program

5.1.1 Issue of medications by Correctional Officers

5.1.2 Medical Emergency - Where a prisoner seeks not to be resuscitated

5.1.3 Prisoners with an end-of-life illness

5.1.4 Infectious Disease Outbreak

1.2.9 Contraband and Controlled Items

1.4.4 Access to and security of Corrections Victoria data for research and evaluation purposes

2.3.4 Prisoner video conferencing / telecourt procedures

2.3.7 Smoke-Free work environment

2.4.3 Disclosure of prisoner/offender information

2.7.1 Aboriginal and Torres Strait Islander Prisoners

3.1.1 Transitional support and preparation for release

3.1.2 Judy Lazarus Transition Centre

3.2.1 Management of Visits to Prisoners

3.3.2 Exercise Awareness

| Corrections Victoria Deputy Commissioner's Instructions |
| --- |
| 1.02 At Risk Procedures |
| 1.04 Contraband and Controlled Items |
| 1.05B Searching Staff in Victorian Prisons Policy Fact Sheet |
| 1.06 Keys, Locks and Electronic Access Cards |
| 1.07 Dangerous Goods, Tools, Equipment and Materials |
| 1.08 Contractors in Prisons |
| 1.11 Reception, Care and Control of Prisoners |
| 1.17 Separation Regimes |
| 1.19 Incident Reporting and Monitoring |
| 1.20 Deaths in Prisons |
| 1.21 Taking Forensic Samples from Prisoners |
| 1.25 Fire Safety, Prevention, Preparedness, Response and Recovery |
| 2.01 Discharge of Prisoners |
| 2.02 Prisoner Placements and Review |
| 2.04 Voluntary Starvation |
| 2.07 Aboriginal and Torres Strait Islander prisoners |
| 2.08 Prisoners with a Disability |
| 2.09 Prisoners from Culturally and Linguistically Diverse Backgrounds |
| 2.11 Prisoner Records Management |
| 2.15 Infection Control in Prison |
| 2.16 Smoke-Free Work Environment |
| 3.03 Prison Industries |
| 3.07 Religion |
| 3.10 Programs Designed to Reduce Offending Behaviour |
| 3.14 Preparation for release |
| 3.17 Peer Listener Support for Prisoners |
| 4.03 Food |
| 4.04 Hygiene |
| 4.13 Opioid Substitution Therapy Program |
| 4.17 Communication Protocol between Health and Forensic Intervention Services |

## Justice Health Policies, Standards, and Guidelines

Aboriginal Social and Emotional Wellbeing Plan

Advance Care Planning 2021

Communicable Diseases Framework, 2017

Complaints Handling Framework, 2019

Corrections Ageing Prisoner and Offender Policy Framework 2015-2020

Healthcare for people in prison who are trans or gender diverse 2021

Healthcare for prisoners with intersex variations 2021

JCare Access Policy, 2017

JCare System Audit Framework (V1) 2016

JCare User Manuals (V2 2020)

Notifiable Health Incidents and Reporting Guidelines 2021

Organ and/or Tissue Donation Policy 2021

Petition for Mercy Policy 2021

Practice guidance – Long-Acting Injectable Buprenorphine, 2021

Prisoners refusing food and/or fluids (V2.1), 2017

Refusal of Treatment Policy (V2.1), 2014

Resuscitation Orders 2021

Scanning Guidelines – as provided within JCare – Scanning Documents, 2021

Victorian Prison Opioid Substitution Therapy Guidelines, 2015

## Department of Health Policies, Standards, and Guidelines

Clinical Risk Management

Guidance for supplying methadone & buprenorphine (+/- naloxone) dose(s) to a third party in the context of the COVID-19 pandemic

Hepatitis C Prevention, Treatment and Care: Guidelines for Australian Custodial Settings, 2008

Infection control guidelines

Maintenance pharmacotherapy for opioid dependence, 2018

Open Disclosure Framework

Policy for maintenance pharmacotherapy for opioid dependence, 2016

Specialist clinics in Victorian public hospitals: Access policy, 2013

Victoria's end of life and palliative care framework, 2016

Victorian Health Incident Policy and Policy Guide, 2011

Victorian Hepatitis B Strategy 2016 – 2020, 2016

Victorian Immunisation Schedule and vaccine eligibility criteria, 2019

## Other Guidelines

Australasian Sexual Health Alliance, *Australian STI Management Guidelines for use in Primary Care, 2019*

Dental Board of Australia, *Code of Conduct*

Dental Board of Australia, *Guidelines for Infection Control, 2010*

Royal Australian College of General Practitioners, *Guidelines for preventive activities in general practice, 9th edition, 2018*

Royal Australian College of General Practitioners, *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people, 2018*

Turning Point Alcohol and Drug Centre Inc., *Alcohol and Other Drug Withdrawal Practice Guidelines 3rd Edition, 2018*

# Attachment B – Healthcare Services Quality Framework for Victorian Prisons 2023

The Part A - Attachment B- Healthcare Services Quality Framework for Victorian Prisons 2023 is provided in the embedded MS Word document, below, and referenced as Trim: CD/22/921010 Schedule 2 - Service Specification - Attachment B – Healthcare Services Quality Framework for Victorian Prisons 2023.

Healthcare Services Quality Framework fo

# Attachment C - Primary Healthcare Performance Framework 2023

The Part A - Attachment C - Primary Healthcare Performance Framework 202 is provided in the embedded MS Word document, below, and referenced as Trim: CD/22/921035 Schedule 2 - Service Specification - Attachment C - Primary Healthcare Performance Framework 2023.

Primary Healthcare Performance Framew

# Attachment D – Notifiable Health Incidents and Reporting Guidelines 2021

The Justice Health Incidents and Reporting Guidelines 2021 are provided in the embedded PDF, below, and referenced as Trim: CD/22/921051 Schedule 2 - Attachment D – Notifiable Health Incidents and Reporting Guidelines 2021.


Notifiable Health Incidents and Reporti

# Attachment E - Service Locations and Baseline Prisoner Numbers

The Contractor will provide the Services at the Service Locations and for the Baseline Prisoner Numbers shown in the Table below.

The Bed Capacity (being the number of prison beds that could be operational at the location) forecast for July 2023 is current in December 2021 and will be updated prior to entering into an Agreement.

The Baseline Prisoner Numbers (being the operational number of people in prison and being the baseline annual number for Service volumes and Annual Service Fee) forecast for July 2023 are current in December 2021 and will be updated prior to entering into an Agreement.

Following commencement of the Services, the Baseline Prisoner Numbers will be reviewed annually, in accordance with the conditions of the Agreement.

*Table 2: Primary Healthcare Services Locations and Baseline Prisoner Numbers*

| Service Location | Bed Capacity Forecast Est. July 2023 | Baseline Prisoner Numbers Forecast Est. July 2023 |
|---|---|---|
| **Barwon Prison (Lara)**<br>Male, Maximum security<br>Remand and sentenced<br>1140 Bacchus Marsh Road<br>Lara VIC 3212<br>Region-Barwon South West | 671<br>Inclusive of one post sentence detention unit:<br>Piper Detention Unit (Barwon) – inside the prison boundary – Barwon inclusive | 390 |
| **Beechworth Correctional Centre (Beechworth)**<br>Male, Minimum security<br>Sentenced prisoners<br>494 Flat Rock Road<br>Beechworth VIC 3747<br>Region-Hume Region | 210 | 165 |
| **Dhurringile Prison (Dhurringile)**<br>Male, Minimum security<br>Remand and sentenced prisoners<br>Murchison-Tatura Road, via Murchison 3610<br>Region-Hume | 328 | 204 |
| **Hopkins Correctional Centre (Ararat)**<br>Male, Medium and minimum security<br>Remand and sentenced prisoners with protection requirements<br>Warrak Road<br>Ararat VIC 3377<br>Region-Grampians | 790<br>Includes 8 medical beds<br>Inclusive of two post sentence detention units:<br>Greenhill Detention Unit (Hopkins) – inside the prison boundary – Hopkins inclusive<br>Rivergum residential treatment centre (Hopkins) – outside the prison boundary – refer to Rivergum | 744 |
| **Judy Lazarus Transitional Centre (JLTC)**<br>Male, Minimum security | 25 | 18 |

| Service Location | Bed Capacity Forecast Est. July 2023 | Baseline Prisoner Numbers Forecast Est. July 2023 |
|---|---|---|
| Transitional centre. 50 Adderley Street<br>West Melbourne VIC 3003<br>Region – West Metropolitan | | |
| **Karreenga (Marngoneet Annex)**<br>Male, Medium security<br>Remand and sentenced protection prisoners<br>1170 Bacchus Marsh Rd<br>Lara VIC 3212<br>Region-Barwon South West | 300 | 265 |
| **Langi Kal Kal (Trawalla)**<br>Male, Minimum security<br>Sentenced prisoners with low-to-medium protection requirements<br>Western Hwy<br>Trawalla VIC 3373<br>Region-Grampians | 428 | 349 |
| **Loddon Prison (Castlemaine)**<br>Male, Medium security<br>Sentenced prisoners<br>Matheson St<br>Castlemaine VIC 3450<br>Region-Loddon Mallee | 468 | 375 |
| **Marngoneet Correctional Centre (Lara)**<br>Male, Medium security<br>Remand and sentenced<br>1170 Bacchus Marsh Rd<br>Lara VIC 3212<br>Region-Barwon South West | 559 | 515 |
| **Melbourne Assessment Prison (MAP)**<br>Male, Maximum security<br>Remand and sentenced prisoners, includes the Acute Assessment Unit, a 16-bed, forensic mental health facility<br>317-353 Spencer Street<br>West Melbourne VIC 3003<br>Region – West Metropolitan | 305 | 197 |
| **Metropolitan Remand Centre (MRC) –**<br>Male, Maximum security<br>Remand and prisoners awaiting sentencing<br>Middle Road<br>Ravenhall VIC 3023<br>Region - North West Metropolitan | 954 | 818 |
| **Middleton (Loddon Annex)**<br>Male, Restricted minimum security<br>Sentenced prisoners<br>Matheson St<br>Castlemaine VIC 3450<br>Region-Loddon Mallee | 275 | 226 |

| Service Location | Bed Capacity Forecast Est. July 2023 | Baseline Prisoner Numbers Forecast Est. July 2023 |
|---|---|---|
| **Rivergum Residential Treatment Centre**<br>Post sentence unit<br>Next to Hopkins Prison<br>Outside the prison boundary<br>Ararat VIC 3377<br>Region-Grampians | 20 | Est. 10 |
| **Estimated baseline prisoner numbers 1 July 2023** | | **4276** |

# Attachment F - Clinical Hours and Service Availability by Service Location

## Clinical Hours

The Contractor will provide Services to Service Locations on-site in person within the medical facilities (which includes medical centres, dental rooms, radiology rooms, and interview or consult and program rooms), or at satellite clinics conducted at Service Locations, or at the Service Location making use of mobile services.

Primary healthcare will be available with on-site clinicians during the Clinical Hours shown in the Table below.

Where Clinical Hours indicate seven days per week, this is inclusive of weekends and Victorian State public holidays.

Where hours are indicated, they refer to local time, Melbourne, Victoria.

## On Call Services

Outside the Clinical Hours described in the Table below, the Contractor will have on call services available for all Service Locations, to be rostered with suitably qualified health staff capable of providing the following primary health and mental healthcare services:

- On call and recall services in prisons for at-risk assessments
- Phone orders for urgent medication that must be dispensed out of hours and for medical bed-based services
- On call service to provide escalation of care support to onsite nursing staff.

## Access to Services

On site services will, as far as practicable, bring Services to the client, to maintain efficient and cost-effective delivery, and to reduce people movements when clinically appropriate (e.g., mobile radiology or other diagnostics, telehealth for specialist consultations, mobile dentistry).

The Contractor will facilitate access to services that are available at other Service Locations when specific services are not available at the client's current Service Location and make referrals and facilitate access to specialist services as required.

When agreed, the Contractor will introduce mobile services at Service Locations that do not have on-site facilities.

In regions, the Contractor will initiate local off-site third-party access arrangements for Service Locations that do not have, e.g., a Medical Practitioner as may sometimes be necessary, dentistry, radiology, and optometry.

## Dental and Allied Health Services Hours

Dental and allied healthcare services will be provided during Business Days, being days that are not a Saturday, Sunday or public holiday (being a public holiday appointed as such under the *Public Holidays Act 1993* (Vic)) in Melbourne, and being between 9:00am to 5:00pm in Melbourne, Victoria, local time.

## AOD Harm Reduction and Programs Hours

AOD health harm reduction group information sessions and group programs and individual services, such as IDU reviews and AOD program screenings, will be provided during Business Days, being days that are not a Saturday, Sunday or public holiday (being a public holiday appointed as such under the *Public Holidays Act 1993* (Vic)) in Melbourne, and being between 9:00am to 5:00pm in Melbourne, Victoria, local time.

| Service Location | Clinical Hours | Service Availability |
|---|---|---|
| Barwon Prison<br>• Maximum | Monday – Friday, 5:00am – 8:30pm | Health Assessment and Planning<br>• Includes after hours on-call/recall for at-risk assessments |

| Service Location | Clinical Hours | Service Availability |
|---|---|---|
| • security<br>• Male | Saturday – Sunday, 7:00am – 7:00pm | • Excludes Reception Medical Assessments |
| | | Population Health |
| | | AOD Health<br>• Excludes PRHR |
| | | Primary Care<br>• Excludes Bed-based Services<br>• Dental – On site dental room<br>• Radiology – On site Mobile |
| Beechworth Correctional Centre<br>• Minimum security<br>• Male | Monday, Wednesday, Thursday, Friday, 7:00am – 7:00pm<br>Tuesday, 7:00am – 9:00pm | Health Assessment and Planning<br>• Includes after hours on-call/recall for at-risk assessments<br>• Excludes Reception Medical Assessments |
| | | Population Health<br>• |
| | | AOD Health<br>• Excludes PRHR<br>• Excludes MATOD<br>• Excludes IDU Reviews |
| | | Primary Care<br>• Excludes Bed-based Services<br>• Dental – Offsite<br>• Radiology – Offsite |
| Dhurringile Prison<br>• Minimum security<br>• Male | Monday – Sunday, 7:00am – 8:00pm | Health Assessment and Planning<br>• Includes after hours on-call/recall for at-risk assessments<br>• Excludes Reception Medical Assessments |
| | | Population Health<br>• |
| | | AOD Health<br>• Excludes PRHR<br>• Excludes IDU Reviews |
| | | Primary Care<br>• Excludes Bed-based Services<br>• Dental – Mobile<br>• Radiology - Offsite |
| Hopkins Correctional Centre<br>• Medium security<br>• Male | Monday – Sunday, 24 hours | Health Assessment and Planning<br>• Excludes Reception Medical Assessments |
| | | Population Health<br>• |
| | | AOD Health |

| Service Location | Clinical Hours | Service Availability |
|---|---|---|
| | | • Excludes Harm Reduction Information Sessions |
| | | Primary Care<br>• Includes medical bed-based Services<br>• Dental – Onsite<br>• Radiology – Onsite |
| Judy Lazarus Transition Centre<br>• Minimum security<br>• Male | In reach as needed and regular scheduled clinics<br>E.g., RN clinic Wednesday – 7:00am – 1:00pm<br>MP clinic once per week x 2 hours | Health Assessment and Planning<br>• Includes transfer assessment (within 24 hours, as outreach from MAP)<br>• Release Planning only (when requested)<br>• Integrated Care Plans (if needed) |
| | | Population Health<br>• |
| | | AOD Health<br>• Includes harm reduction messaging only |
| | | Primary Care<br>• Dental – Offsite (via MRC)<br>• Radiology – Offsite (via MRC)<br>• Allied Health – Offsite (via MR) |
| Karreenga (Marngoneet Annex)<br>• Medium security<br>• Male | Monday – Sunday, 7:00am – 7:00pm | Health Assessment and Planning<br>• Includes after hours on-call/recall for at-risk assessments<br>• Excludes Reception Medical Assessments |
| | | Population Health<br>• |
| | | AOD Health<br>• Excludes PRHR |
| | | Primary Care<br>• Excludes Bed-based Services<br>• Dental – Onsite<br>• Radiology – Mobile |
| Langi Kal Kal Prison<br>• Minimum security<br>• Male | Monday – Friday, 7:00am – 7:00pm<br>Saturday – Sunday, 7:00am – 1:00pm | Health Assessment and Planning<br>• Includes after hours on-call/recall for at-risk assessments<br>• Excludes Reception Medical Assessments |
| | | Population Health<br>• |
| | | AOD Health<br>• Excludes PRHR<br>• Excludes IDU Reviews |
| | | Primary Care<br>• Excludes Bed-based Services<br>• Dental – Onsite |

| Service Location | Clinical Hours | Service Availability |
|---|---|---|
| | | • Radiology – Offsite (via Hopkins) |
| Loddon Prison<br>• Medium security<br>• Male | Monday – Sunday, 7:30am – 7:30pm | Health Assessment and Planning<br>• Includes after hours on-call/recall for at-risk assessments<br>• Excludes Reception Medical Assessments |
| | | Population Health<br>• |
| | | AOD Health<br>• Excludes PRHR |
| | | Primary Care<br>• Excludes Bed-based Services<br>• Dental – Onsite<br>• Radiology – Mobile |
| Marngoneet Correctional Centre<br>• Medium security<br>• Male | Monday – Friday, 5:00am – 9:30pm<br>Saturday – Sunday, 6:30am – 7:30pm | Health Assessment and Planning<br>• Includes after hours on-call/recall for at-risk assessments<br>• Excludes Reception Medical Assessments |
| | | Population Health<br>• |
| | | AOD Health<br>• Excludes PRHR |
| | | Primary Care<br>• Excludes Bed-based Services<br>• Dental – Onsite<br>• Radiology – Mobile |
| Melbourne Assessment Prison<br>• Maximum security<br>• Male | Monday – Sunday, 24 hours | Health Assessment and Planning<br>• Includes Reception Medical Assessments<br>• Excludes at-risk assessments |
| | | Population Health |
| | | AOD Health<br>• Excludes AOD Health Programs |
| | | Primary Care<br>• Excludes Primary Mental Health Nursing<br>• Excludes Bed-based Services<br>• Dental – Offsite (via MRC)<br>• Radiology – Offsite (via MRC)<br>• Allied Health – Offsite (via MRC) |
| Metropolitan Remand Centre<br>• Maximum security<br>• Male | Monday – Sunday, 24 hours | Health Assessment and Planning<br>• Includes Reception Medical Assessments<br>• |
| | | Population Health |

| Service Location | Clinical Hours | Service Availability |
|---|---|---|
| | | AOD Health |
| | | Primary Care<br>• Excludes Bed-based Services<br>• Dental – Onsite (including for JLTC and MAP prisoners)<br>• Radiology – Onsite (X-ray only) (including for JLTC and MAP prisoners)<br>• Radiology – Mobile (non-X-ray) (including for JLTC and MAP prisoners)<br>• Allied Health (including for JLTC and MAP prisoners) |
| Middleton (Loddon Annex)<br>• Restricted-Minimum security<br>• Male | Monday – Sunday, 7:00am – 7:00pm | Health Assessment and Planning<br>• Includes after hours on-call/recall for at-risk assessments<br>• Excludes Reception Medical Assessments |
| | | Population Health<br>• |
| | | AOD Health<br>• Excludes PRHR<br>• Excludes IDU Reviews |
| | | Primary Care<br>• Excludes Bed-based Services<br>• Dental – Onsite<br>• Radiology – Mobile |
| Rivergum Residential Treatment Centre<br>• Post-Sentence Unit<br>• Male | In reach as needed and regular scheduled clinics<br>E.g., RN clinic 1 hours per week x 2, GP clinic 1 hours per week x 1 | Health Assessment and Planning<br>• Includes transfer assessment (within 5 Business Days)<br>• Includes release planning only (when requested)<br>• Integrated Care Plans (if needed) |
| | | Population Health<br>• Includes minimal Health Promotion |
| | | AOD Health<br>• Includes harm reduction messaging only |
| | | Primary Care<br>• Excludes Bed-based Services<br>•<br>• Excludes Dental<br>• Excludes Diagnostics - unless mobile, if appropriate |

# Attachment G - AOD Services and Programs by Service Location

## Annual AOD Health Service Estimates

The Contractor will provide the following AOD health Services across the public prison system as needed and report on the occasions of service, and compliance against the performance measures, if applicable.

The volume of AOD services are not targets and are available annually in response to the level of demand at specific Service Locations and across the system as a whole, which can be volatile within and across years.

AOD service volumes may be subject to review when Baseline Prisoner Numbers are reviewed annually.

*Table 3: Annual AOD service volume estimates*

| AOD Service | Service Locations | Delivery Mode | Target | System Volume |
|---|---|---|---|---|
| Prison Related Harm Reduction (PRHR) | Reception prisons only:<br>- MAP<br>- MRC<br>- | - In person group information Sessions<br>- By exception, individual delivery with device or self-learning booklet | 100% of newly arriving people, within 5 Business Days (day of arrival counts as day zero)<br>Valid exemptions apply<br>Service Linked Fee reductions apply for non-compliance | Est. 500 groups (30 – 40 minutes) per year across system |
| AOD Health Program Screening | All Service Locations, except MAP, and JLTC and Rivergum | - Desktop review<br>- In person interview<br>- Or both | 100% of people to confirm availability and suitability prior to scheduling a place in one or more AOD health programs | Est. if all unique clients, 3960 hours (15 - 30 minutes) per year across system<br>Repeated screenings are not required for each program enrolment |
| Identified Drug User (IDU) Review | All Service Locations, except minimum security Service Locations | - In person interview and completion of IDU review form<br>- Or remote delivery when available and appropriate | 100% of people referred by Corrections Victoria, within 5 Business Days (day of referral counts as day zero)<br>Valid exemptions apply | Est. 1850 review sessions (30 minutes) per year across system |
| Release Related Harm Reduction (RRHR), including Naloxone training | All Service Locations, excluding JLTC and Rivergum | - In person group information Sessions<br>- Opportunistic individual delivery by any clinician or allied health team member prior to release, including Naloxone training<br>- By exception, individual delivery with | All people referred by Corrections Victoria reintegration teams<br>All people self-referring<br>Offer to all people who have engaged with the AOD Health team during their time in prison, including program | Est. 465 groups (60 minutes) per year across system<br>Plus est. 100 individual sessions at MAP (30 minutes) |

| AOD Service | Service Locations | Delivery Mode | Target | System Volume |
|---|---|---|---|---|
| | | device or self-learning booklet | participants, and IDUs | |
| AOD Individual Support | Available at MAP only | - Provide in person individual general AOD counselling<br>- No group programs are delivered at MAP | As needed and prioritised by the AOD Health team | Est. 220 sessions (60 minute sessions or part thereof) per year |
| AOD Peer Educators | All Service Locations, excluding JLTC and Rivergum | Recruit, screen, train, supervise, and undertake reviews, to maintain a team of AOD Peer Educators | Maintain a minimum of two employed AOD Peer Educators at all included Service Locations, with a maximum of up to four, for high need locations | Est. 20 minimum and up to 28 Peers across system |
| AOD Treatment Reports | All Service Locations, excluding JLTC and Rivergum | Generate AOD treatment reports from within the Corrections interventions software, and add clinician notes, and save the report in the system | When requested by the APB, via FOI, internal other providers, upon request of the prisoner<br>Within the timeframe stipulated by the APB or court, when applicable | Est. 600 requests per year<br>Est. 500 reports per year<br>Multiple requests for the same reports do not require the report to be generated multiple times |

## Annual AOD Health Program Estimates

The Contractor will provide the following AOD health programs across the public prison system as needed.

Program types and numbers for the whole of system will be finalised during transition-in as part of the Program Schedule planning for year one, and annually agreed for subsequent years. The variety of the new suite of programs and the length of programs will affect the estimated number of programs to be delivered.

AOD program volumes may be subject to review when prisoner number triggers occur.

*Table 4: Annual AOD health program volume estimates*

| AOD Programs | Service Locations | Delivery Mode | Target | System Volume |
|---|---|---|---|---|
| Delivery of new program suite developed per Specification | All Service Locations, excluding MAP, JLTC and Rivergum | - In person group programs<br>- 10 participants per group | 100% Program Schedule achieved<br>Valid exemptions apply<br>Service Linked Fee reductions apply for non-compliance | Est. 330 - 400 group programs<br>Est. 4060 - 4500 program contact hours |

## AOD Health Services and Programs Estimate by Service Location

Estimated distribution of AOD health programs and services by location for the prisoner numbers baseline Service are shown in the Table below. Location estimates are for guidance only and will be affected by the suite of AOD health programs to be offered and by the fluctuations in demand for services and programs that occur at the location level.

Program types and numbers estimated by Service Location and targets for the whole of system will be finalised during transition-in as part of the Program Schedule planning for year one, and annually agreed for subsequent years.

*Table 5: Year one estimate distribution of AOD health programs and services by location*

| Location | AOD Health Programs and Services | Est. Annual No.# |
|---|---|---|
| **Barwon Prison** | Release Related Harm Reduction | Circa. fewer than 100 |
| | IDU Reviews | Circa. greater than 400 |
| | AOD Program Screening | As needed |
| | AOD Health Programs | *Est. level of demand*<br>Programs: 25<br>Program contact hours: 320 |
| | AOD Peer Educators | 2 |
| | AOD Peer Educator Program – 12-hour training program | As needed |
| **Beechworth Correctional Centre** | Release Related Harm Reduction | Circa. fewer than 30 |
| | AOD Program Screening | As needed |
| | AOD Health Programs – a variety of polydrug use cognitive behaviour group interventions, including for dual-diagnosis needs, and culturally appropriate for Aboriginal people | *Est. level of demand*<br>Programs: 30<br>Program contact hours:360 |
| | AOD Peer Educators | 2 |
| | AOD Peer Educator Program – 12-hour training program | As needed |
| **Dhurringile Prison** | Release Related Harm Reduction | Circa. fewer than 50 |
| | AOD Program Screening | As needed |
| | AOD Health Programs – a variety of polydrug use cognitive behaviour group interventions, including for dual-diagnosis needs, and culturally appropriate for Aboriginal people | *Est. level of demand*<br>Programs: 30<br>Program contact hours: 360 |
| | AOD Peer Educators | 2 |
| | AOD Peer Educator Program – 12-hour training program | As needed |
| **Hopkins Correctional Centre** | Release Related Harm Reduction | Circa. fewer than 50 |
| | IDU Reviews | Circa. fewer than 100 |
| | AOD Program Screening | As needed |

| Location | AOD Health Programs and Services | Est. Annual No.# |
|---|---|---|
| | AOD Health Programs – a variety of polydrug use cognitive behaviour group interventions, including for dual-diagnosis needs, and culturally appropriate for Aboriginal people | *Est. level of demand*<br>Programs: 45<br>Program contact hours: 540 |
| | AOD Peer Educators | 4 |
| | AOD Peer Educator Program – 12-hour training program | As needed |
| **Karreenga (Marngoneet Annex)** | Release Related Harm Reduction | Circa. fewer than 25 |
| | IDU Reviews | Circa. fewer than 100 |
| | AOD Program Screening | As needed |
| | AOD Health Programs – a variety of polydrug use cognitive behaviour group interventions, including for dual-diagnosis needs, and culturally appropriate for Aboriginal people | *Est. level of demand*<br>Programs: 26<br>Program contact hours: 320 |
| | AOD Peer Educators | 2 |
| | AOD Peer Educator Program – 12-hour training program | As needed |
| **Langi Kal Kal** | Release Related Harm Reduction | Circa. fewer than 30 |
| | AOD Program Screening | As needed |
| | AOD Health Programs – a variety of polydrug use cognitive behaviour group interventions, including for dual-diagnosis needs, and culturally appropriate for Aboriginal people | *Est. level of demand*<br>Programs: 26<br>Program contact hours: 320 |
| | AOD Peer Educators | 2 |
| | AOD Peer Educator Program – 12-hour training program | As needed |
| **Loddon Prison** | Release Related Harm Reduction | Circa. fewer than 40 |
| | IDU Reviews | Circa. fewer than 100 |
| | AOD Program Screening | As needed |
| | AOD Health Programs – a variety of polydrug use cognitive behaviour group interventions, including for dual-diagnosis needs, and culturally appropriate for Aboriginal people | *Est. level of demand*<br>Programs: 28<br>Program contact hours: 340 |
| | AOD Peer Educators | 2 |
| | AOD Peer Educator Program – 12-hour training program | 12 |
| **Marngoneet Correctional Centre** | Release Related Harm Reduction | Circa. fewer than 50 |
| | IDU Reviews | Circa. greater than 300 |
| | AOD Program Screening | As needed |
| | AOD Health Programs – a variety of polydrug use cognitive behaviour group interventions, including for dual-diagnosis needs, and culturally appropriate for Aboriginal people | *Est. level of demand*<br>Programs: 45<br>Program contact hours: 540 |

| Location | AOD Health Programs and Services | Est. Annual No.# |
|---|---|---|
| | AOD Peer Educators | 4 |
| | AOD Peer Educator Program – 12-hour training program | As needed |
| **Melbourne Assessment Prison** | Prison Related Harm Reduction | Circa. 300 |
| | Release Related Harm Reduction | Circa. fewer than 100 (not groups) |
| | IDU Reviews | Circa. fewer than 100 |
| | AOD Individual Support x 60-minute sessions | Circa., 200 plus |
| | AOD Peer Educators | 2 |
| | AOD Peer Educator Program – 12-hour training program | As needed |
| **Melbourne Remand Centre** | Prison Related Harm Reduction | Circa. fewer than 200 |
| | Release Related Harm Reduction | Circa. fewer than 60 |
| | IDU Reviews | Circa. greater than 700 |
| | AOD Program Screening | As needed |
| | AOD Health Programs – a variety of polydrug use cognitive behaviour group interventions, including for dual-diagnosis needs, and culturally appropriate for Aboriginal people | *Est. level of demand*<br>Programs: 50<br>Program contact hours: 600 |
| | AOD Peer Educators | 4 |
| | AOD Peer Educator Program – 12-hour training program | As needed |
| **Middleton (Loddon Annex)** | Release Related Harm Reduction | Circa. fewer than 30 |
| | IDU Reviews | Circa. fewer than 50 |
| | AOD Screening | As needed |
| | AOD Health Programs – a variety of polydrug use cognitive behaviour group interventions, including for dual-diagnosis needs, and culturally appropriate for Aboriginal people | *Est. level of demand*<br>Programs: 25<br>Program contact hours: 360 |
| | AOD Peer Educators | 2 |
| | AOD Peer Educator Program – 12-hour training program | As needed |

# Attachment H - Contract Management and Reporting

## Contract Management and Reporting

The State and the Contractor will manage, monitor, and report on the Contractor's Primary Healthcare Service achievements under the Agreement, the Specifications, the quality domains, the Key Performance Measures (KPMs), and the Additional Data Requirements (ADRs), against, but not limited, to the State's Five Focus Areas:

a. Health Assessment and Planning
b. Population Health
c. Alcohol and Other Drugs Health
d. Primary Care
e. Tailored Response for Priority Groups.

Contract management and reporting will provide an understanding of the extent to which the Services are meeting the State's aims:

a. The right to health care (physical, mental health and wellbeing)
b. Improving the health of people in prison
c. Improving rehabilitation outcomes and reducing overrepresentation

Contract management and reporting will provide an understanding of the extent to which the Services are contributing to and maintaining improved health, wellbeing, and outcomes for people in prison through:

a. High quality care
b. Continuity of care
c. Cost effective innovation
d. Sustainable services.

Contract management and reporting excludes the management and reporting of Service transition-in activities.

## Contract Management and Clinical Governance Meetings

The Contractor will meet with Justice Health representatives and stakeholders as summarised in the Table below. Meeting cycles may change during the term when requested by Justice Health. The Contractor will attend additional meetings when required. Standing agendas for meetings will be provided by Justice Health.

*Table 6: Contract management and clinical governance meetings*

| Meeting type | Purpose | Frequency |
|---|---|---|
| Contract management | Business as usual contract management will address all matters relating to the delivery of the Services, excluding clinical governance. Clinical governance meeting minutes will be tabled at contract management meetings, for action of any contractual, compliance, or performance matters arising. | Monthly |
| Operations management | Following transition-in, the Contractor will meet with Justice Health and Corrections Victoria representatives to discuss operational matters relating to the provision of the Services. Operational management meetings will continue for up to six months following contract commencement.<br>Operational issues will subsequently be addressed in contract management meetings or scheduled separately from time to time, if needed. | Fortnightly or monthly or as needed |
| Clinical governance | Clinical governance meetings will address clinical governance risks, issues, and incidents, and monitor clinical delivery, clinical audit findings, improvement activities, and matters arising from the Contractor's internal clinical governance | Every six weeks |

| Meeting type | Purpose | Frequency |
|---|---|---|
| | meetings (the minutes of which will be provided to Justice Health). The Contractor must discuss and report specifically on key risks, issues, service delivery and improvement activities for clinical delivery to the Priority Groups. | |
| Contract performance reviews | Following the close of Q2 and receipt of the Contractor's half year data and narrative report and following the close of Q4 and receipt of the Contractors full year data and narrative report, the parties will meet to review overall Service performance, trends and issues, agree improvement actions, and review action outcomes from previous reviews (if any), which will address the State's Five Focus Areas and Service aims. | Bi-Annual<br>Mid – February<br>Mid – August |
| Mid-year review of the AOD program schedule | The Contractor will meet with Justice Health to review progress against the delivery of the annual AOD Program Schedule, which may result in revisions to the schedule, if so, a revised schedule will be submitted by the Contractor for Justice Health approval and will become the new schedule for the remainder of the reporting year. | Annual<br>Late - January |
| Annual review of baseline prisoner numbers | If the annual baseline prisoner numbers review (at the end of Q3) results in a change to the baseline prisoner numbers for the following year, the Contractor will meet with Justice Health to agree and finalise the decreased or increased delivery modelling and Service Fee outcomes stemming from a Service Change request issued by the State, for commencement from 1 July of the relevant year. | Annual<br>Week one May |
| Annual AOD program schedule establishment | The Contractor will meet with Justice Health to review and finalise the proposed annual AOD Program Schedule for the following year. | Annual<br>Mid-June |
| Pharmaceuticals Governance | Pharmaceuticals<br>The State will endorse the medication formulary (including an imprest), which will be reviewed annually | Annual<br>Mid-June |
| Annual KPM review | The Contractor will meet with Justice Health annually to review the Key Performance Measures in the Performance Framework and the associated fee reduction model, to be confirmed as ongoing as is, or agreed for revisions as a Service Change. | Annual<br>Week two May |
| Annual contract resourcing review | Within the framework of the commercial principles, the Contractor will meet with Justice Health annually to review the level and distribution of resourcing applied under the agreement (and as reflected in the Service Payment Model) to ensure that services, quality, and value for money are being maintained or improved during the Term, and to agree resourcing adjustments if appropriate. | Annual<br>Week two May |

## Submission of Reports

All data, reports, and compliance requirements will be submitted to Justice Health electronically.

## Templates and Documentation

Justice Health and the Contractor will agree suitable formats for the submission of data and reports.

The Contractor will develop templates for submission of narrative reports.

When a mandated data collection format is provided by Justice Health, the Contractor will comply with its use, which may be for collection and submission of KPMs or for ADRs.

When required, the Contractor will use agreed templates for manually recording data that is not otherwise available from the EMR or from the interventions system.

All reporting templates, tools, and documentation are subject to Justice Health endorsement and will be updated or improved by the provider when requested by Justice Health.

Reporting templates, tools, and documentation may change over time and will be reviewed from time to time to ensure that relevant and necessary Service aspects are being reported and analysed. The parties will work collaboratively to ensure that reports are clear, relevant and efficient, to the extent practicable.

## Data Source of Truth

Data for the Services, both KPMs and ADRs will be generated from the EMR (currently JCare), and for AOD, from the Commissioner's interventions management system (currently CVIMS).

To ensure the accuracy and timeliness of Services data, the Contractor must use the workflows, actions, data sets, fields, documents, and templates provided in the EMR and the electronic systems, to the extent applicable for the service or activity being recorded and will adhere to the rules of use provided by Justice Health in user manuals.

The Contractor will also be responsible for the accuracy and timeliness of any data that is required to be recorded manually, if not available from an electronic system.

## Generating Data and Reporting Rules

In some instances, Justice Health will run reports from the EMR or the electronic interventions management system, to confirm compliance with KPMs, or for monitoring healthcare OOS and AOD programs and services. If so, the parties will agree the reports required to be submitted by the Contractor and will agree a process for Justice Health to likewise share data reports to the Contractor for their review, action, or confirmation.

Regardless of which party generates and shares data, the Contractor remains responsible for the accuracy of the KPMs and the ADRs.

For KPM reporting, where percentage responses are required (as defined in the Performance Framework), the Contractor must provide absolute figures for the numerator and the denominator, in addition to the percentage figure. Where only absolute figures are required, no other data is needed.

Unless expressly stated otherwise, KPMs and ADRs are required to be reported by Service Location and at the aggregate for all Service Locations. Following year one, narrative analysis reports will include quarterly, or half-yearly, or full year on year comparisons for KPMs and ADRs that have a measurement.

## Data Visualisation Tool

Access to the Justice Health data visualisation tool (currently Tableau) will allow both parties to view performance and service volumes in real time, for EMRs only, not for AOD interventions, for which real time reports can be generated at any time from within the Commissioner's system.

## Monthly Reports and Compliance Submissions

The Contractor will submit or validate the following data each month, following the close of the reporting month.

*Table 7: Monthly reports and compliance submissions*

| No.# | Deliverable | Due Date |
|---|---|---|
| 1. | KPMs<br>Primary Healthcare Performance Framework 2023<br>All KPMs under the PF will be reported monthly, by Service Location:<br>a. Health Assessment<br>b. At-Risk Assessment<br>c. Prison Related Harm Reduction<br>d. Alcohol and Other Drug Programs: Programs delivered | 10 Business Days following the close of the reporting month |

| No.# | Deliverable | Due Date |
|---|---|---|
| | e. IDU reviews<br>f. Detected substance drug test verification<br>g. Aboriginal Health Check<br>h. Integrated Care Plan (Aboriginal people)<br>i. Integrated Care Plan (transgender, gender diverse or intersex)<br>j. Integrated Care Plans (people with chronic medical conditions)<br>k. Mental Health Recovery Plans<br>l. Review of Mental Health Recovery Plans<br>m. Primary Healthcare response times: Non-urgent self-referrals<br>n. Notifiable Health Incidents | |
| 2. | Notifiable Incidents<br>Notifiable Health Incidents and Reporting Guidelines 2021<br>Notifiable incidents will be reported monthly, by Service Location and whole of system, and by incident type:<br>a. Clinical and non-clinical incidents and near misses recorded on the Contractor's notifiable health incidents register<br>b. Any other adverse events<br>c. Trends and themes by Service Location and at the aggregate<br>d. Year on year comparison of incident data (following year one) | 10 Business Days following the close of the reporting month |

## Quarterly Reports and Compliance Submissions

The Contractor will submit or validate the following data each quarter and provide the reports and compliance submissions following the close following the close of the reporting quarter (Q1 – July to September; Q2 – October to December; Q3 – January to March; Q4 – April to June).

*Table 8: Quarterly reports and compliance submissions*

| No.# | Deliverable | Due Date |
|---|---|---|
| 3. | KPMs<br>Primary Healthcare Performance Framework 2023<br>a. All KPMs under the PF will be reported cumulatively on a quarterly basis.<br>b. To be submitted with the intention to invoice. | 10 Business Days following the close of the reporting quarter |
| 4. | KPMs – Revised<br>Primary Healthcare Performance Framework 2023<br>a. If applicable, to adjust the KPM outcomes and the intention to invoice submission. | 5 Business Days following a Justice Health notification |
| 5. | ADRs<br>Log of Requests - Family Violence Information Sharing Scheme (FVISS)<br>a. Submit information sharing activity log – information sharing that was provided independently of Justice Health | 5 Business Days following the close of the reporting quarter |
| 6. | ADRs<br>Prisoner Complaints and Feedback<br>a. Number of written complaints received<br>b. Current status of complaint<br>c. Resolution or outcome<br>d. Responded to within 28 days of complaint | Business Day 10 following the close of the reporting quarter |

| No.# | Deliverable | Due Date |
|---|---|---|
| | e. Other prisoner feedback – compliments or complaints | |
| 7. | ADRs<br>Workforce<br>a. Vacancies at quarter end by location, role category, position title, and FTE<br>b. Backfill or locum arrangements<br>c. Current recruitment activities and strategies | Business Day 10 following the close of the reporting quarter |
| 8. | ADRs<br>a. Advanced Care Planning activities (if any) | |
| 9. | ADRs<br>Population Health – including but not limited to:<br>a. BBV tests undertaken<br>b. BBV test outcomes<br>c. Other communicable disease teats<br>d. Other communicable disease teats outcomes<br>e. Immunisations, by type<br>f. Rapid Antigen Tests, if any<br>g. Number and type of early detection tests offered<br>h. Number and type of early detection tests completed<br>i. Number and type of early detection tests with positive result (requiring further investigation, treatment or referral to specialist)<br>Hepatitis treatment by location, to include:<br>a. Number of new referrals<br>b. Number of assessments<br>c. Number of new treatments commenced<br>d. Total number of treatments in progress<br>e. Number of completed treatments<br>f. Number of treatments discontinued / not completed<br>g. Number of liver health care plans currently in place | Business Day 15 following the close of the reporting quarter |
| 10. | ADRs<br>AOD Health – including but not limited to:<br>a. Withdrawal support provided<br>b. MATOD Data Report, by location and prisoner CRN:<br>c. New MATOD recipients<br>d. All ongoing MATOD recipients<br>e. All discontinuing MATOD recipients, due to release to the community<br>f. Number of AOD programs and services delivered<br>g. Program and service completions and non-completions, and valid and non-valid non-completions and by sentencing status<br>h. Wait list numbers by program type and by sentencing status<br>i. Number of people screened as not suitable for a program<br>j. Number of peers currently employed<br>k. Number of peer training programs conducted<br>l. Number of peer supervision sessions provided<br>m. Number of peer quarterly reviews provided<br>n. The number of AOD treatment report requests received<br>o. The number of AOD treatment reports provided | Business Day 15 following the close of the reporting quarter |

| No.# | Deliverable | Due Date |
|---|---|---|
| 11. | ADRs<br>Services by Service Location – including but not limited to:<br>a. All Occasions of Service (OOS) by service role<br>b. Average number of days waiting for an appointment by service role<br>c. Other communicable disease teats outcomes<br>d. Total pathology tests<br>e. Referrals to bed-based medical services by reason, by reason, bed utilisation, average bed stay<br>f. Total ICPs currently in place by type of ICP<br>g. Total mental health recovery plans currently in place<br>h. Number of referrals made to forensic mental healthcare services<br>i. Number of short health release summaries<br>j. Number of detailed health release summaries<br>k. Number and type of in-reach services<br>l. Number and type of outreach services as part of release planning<br>m. Number of short health release summaries<br>n. Number of detailed health release summaries<br>o. Number of translation services accessed by unique CRN and languages accessed<br>p. Occasions of wellbeing and cultural support for Aboriginal people<br>q. Number of occasions Aboriginal people requested attendance of Aboriginal support role and number of occasions the support was provided (either Aboriginal health or CV worker)<br>r. Updated register of current equipment and aids provided to clients | Business Day 15 following the close of the reporting quarter |
| 12. | a. | |
| 13. | ADRs<br>Rivergum<br>a. OOS by service type and clinical role<br>b. Number of referrals to public dental services<br>c. Other referrals to community health providers approved by the Commissioner, (if any) by service type | Business Day 15 following the close of the reporting quarter |
| 14. | a. | |
| 15. | ADRs<br>a. Dental on site OOS<br>b. Dental mobile OOS<br>c. Dental external OSS<br>d. Dental denture OOS<br>e. Attendances and cancellations or non-attendance | Business Day 15 following the close of the reporting quarter |
| 16. | ADRs<br>a. Allied health OOS by allied health role<br>b. Radiology on site OOS<br>c. Radiology mobile OOS<br>d. Radiology external OOS<br>e. Attendances and cancellations or non-attendance | Business Day 15 following the close of the reporting quarter |
| 17. | ADRs<br>Specialist appointments– including but not limited to: | Business Day 15 following the close of the reporting quarter |

| No.# | Deliverable | Due Date |
|---|---|---|
| | a. External appointments scheduled and attended (either at another prison location or in community) – includes secondary, tertiary or other non-urgent specialist service, by specialist type, and reason<br>b. Hospital pathways (if applicable)<br>c. Specialist services provided via telehealth, by specialist type<br>d. Movements to and from specialist care, including rescheduling<br>e. External appointments cancelled or not attended, with reasons by category for non-attendances | |
| 18. | Financial Records:<br>Comprehensive unaudited statements | 31 January<br>31 August<br>Bi-annual, or more frequently if requested |

## Bi-Annual Reports and Compliance Submissions

The Contractor will submit or validate the following data bi-annually and provide the reports and compliance submissions following the close of the reporting quarter (Q2 – October to December and Q4 – April to June).

*Table 9: Bi-annual reports and compliance submissions*

| No.# | Deliverable | Due Date |
|---|---|---|
| 19. | Progress against the AOD Program Schedule | 31 January<br>31 July |
| 20. | | |
| 21. | | |
| 22. | ADRs<br>Hand Hygiene Audit (80%)<br>Results of self-audit of hand hygiene | 28 February<br>31 August |
| 23. | ADRs<br>Report on Health Records Audit (5% of records)<br>Results of self-audit of prisoner health records | 28 February<br>31 August |
| 24. | ADRs<br>Medication Management Audit<br>Results of self-audit of medication management charts | 28 February<br>31 August |
| 25. | ADRs<br>Report on Dental Services Records Audit<br>Results of self-audit of dental services | 28 February<br>31 August |
| 26. | Financial Records: Comprehensive unaudited statements | 28 February<br>31 August<br>And more frequently if requested |
| 27. | Contract Performance Narrative Report<br>a. Half yearly report<br>b. Full year report<br>The Contract Performance Report will provide and address: | 28 February<br>30 September |

| No.# | Deliverable | Due Date |
|---|---|---|
| | a. An executive summary of whole of Service and overall performance and against the State's aims<br>b. Summaries for delivery and overall performance against each of the State's Five Focus Areas<br>c. Cumulative KPM performance and analysis<br>d. Cumulative ADRs and analysis<br>e. Partnerships, collaborations and integration internally<br>f. Partnerships and collaborations with the community<br>g. Attracting and retaining workforce<br>h. Building cultural awareness, understanding, humility, and respect within the workforce<br>i. Key achievements, challenges, and improvements<br>j. Key risks and issues managed and resolved<br>k. Trends and year on year comparison, whole of system and by Service Location (following year one<br>l. Learnings for the next reporting period (half year or full year) | |
| 28. | Submission of internal committee meeting minutes<br>a. Risk and Quality Committee<br>b. Medical Advisory Committee<br>c. Appointment and Credentialing Committee<br>d. Medication Safety Committee | As advised by the Contractor<br>Within 10 business days following meeting |
| 29. | Submission of audit reports stemming from internal committee initiatives | As advised as advised by the Contractor<br>As soon as practicable following receipt of the report |

## Annual Reports and Compliance Submissions

The Contractor will submit or validate the following data annually and provide the reports and compliance submissions following the close of the reporting year.

*Table 10: Annual reports and compliance submissions*

| No.# | Deliverable | Due Date |
|---|---|---|
| 30. | | |
| 31. | AOD Program Schedule for the following year | 1 June |
| 32. | Workforce Training and Development Plan for the following year | 1 July |
| 33. | MARAM report - Planned actions to support the ongoing operation of the organisation's MARAM Framework alignment | 31 July |
| 34. | Pharmaceuticals - medication formulary (including an imprest), current and proposed changes, if any | 31 July |
| 35. | Workforce Compliance Report, showing each of the following for all roles:<br>a. Professional accreditation currency and registration number, if applicable<br>b. Currency of security clearance check (last date of check)<br>c. Mandatory professional education, training, or development<br>d. Cultural awareness and understanding training or development<br>e. Human rights training<br>f. AOD program facilitation and service delivery skills development | 31 August |
| 36. | Rates of influenza immunisation for prisoner facing staff (unidentified data): | 31 August |

| No.# | Deliverable | Due Date |
|---|---|---|
| | Staff have current influenza vaccination<br>80% of prisoner-facing staff are vaccinated | |
| 37. | Rates of COVID-19 immunisation all staff (unidentified data):<br>100% of on-site staff fully immunised<br>Fully immunised being the number of immunisations recommended and prevailing at the time | 31 August |
| 38. | Annual Summary Report | 31 August |
| 39. | Annual update to the Health Protection Plan | 31 August |
| 40. | Where applicable, annual submissions will clearly indicate updates from the previous reporting years (with tracking and a register of changes).<br>Organisational leadership and governance, including but not limited to:<br>a. Organisational Governance<br>b. Clinical Governance<br>c. Service Quality Assurance Plan<br>d. Service Risk Management Plan<br>e. Business Continuity Plan<br>f. Business Continuity testing evidence and outcomes | 31 August |
| 41. | Service Operating Manuals: Policies and Procedures<br>a. To be reviewed and revised annually, provide tracked changes<br>b. Service Operating Manuals change register to be provided | 31 August |
| 42. | Annual Update of Transition Out Plan and Handover Package | 30 September |
| 43. | | |
| 44. | Client and Stakeholder Feedback: Analysis and Narrative Report | 30 September |
| 45. | Financial Records:<br>Comprehensive audited statements<br>Parent company guarantor (fi applicable) statements | Within 120 calendar days after the close of the financial year |
| 46. | Financial Records:<br>Business plan of the provider for the ensuing financial year and budget for the ensuing two financial years | Within 120 calendar days after the close of the financial year |
| 47. | Evidence of currency of required insurances<br>a. Public and Products Liability<br>b. Professional Indemnity<br>c. Medical Indemnity<br>d. Cyber Insurance<br>e. Indemnity for security or privacy breaches<br>f. Workers' Compensation<br>g. Motor Vehicle<br>h. Property Insurance | Various - insurance anniversary dates |
| 48. | Notify relevant insurance claims | Immediately upon occurrence of event<br>At the time of a claim |
| 49. | Per accreditation cycle:<br>a. Obtain and maintain certificate of health service accreditation<br>b. Submit evidence of current accreditation | Submit accreditation review report – every two years |

| No.# | Deliverable | Due Date |
|---|---|---|
| | c. Submit evidence that high priority recommendations have been actioned<br>d. Undertake mid-accreditation reviews | Submit high priority recommendations within 5 Business Days |
| 50. | Action Plan – Survey Results:<br>Corrections Victoria Prisoner Experience Survey | As advised<br>Approximately every 12 months |
| 51. | Outcomes of Survey Action Plan:<br>Corrections Victoria Prisoner Experience Survey | As advised<br>Approximately every 12 months |