Council for Court Excellence
Improving Justice for the Community

**Testimony of the Council for Court Excellence**
**Before the Committee on the Judiciary and Public Safety**
**of the Council of the District of Columbia**

**Budget Oversight Hearing for the**
**Department of Corrections**

**May 6, 2026**

Thank you, Chairperson Pinto, for the opportunity to testify at today's Budget Oversight Hearing on the Department of Corrections (DOC). My name is Katie McConville, and I am providing this testimony in my capacity as the Policy Counsel for the Council for Court Excellence (CCE). CCE is a nonpartisan, nonprofit organization with the mission to bring people together to conduct research, educate, and advocate to make D.C.'s unique legal systems more just, equitable, and accountable to the community. For over 40 years, CCE has worked to improve the administration of justice in the courts and related agencies in D.C. through research and policy analysis, convening diverse stakeholders, and creating educational resources for the public. Please note that in accordance with our policy, no judicial member of CCE participated in the formulation or approval of this testimony. This testimony does not reflect the specific views of, or endorsement by, any judicial member of CCE.

My testimony today concerns the proposed operating budget for the Department of Corrections, focusing on the health care and dietary needs of jail residents, as well as staffing issues at the jail.

## Health care

From the publicly available information in this year's proposed budget, it is not clear whether health care for jail residents will be adequately funded in FY27. Over the past year, the number of people in the jail has ballooned to over 2,200 people, with an average daily population of 2,211 residents in the jail for the week ending April 24, 2026.[i] Despite the increase in the jail's population, the FY27 budget proposes a modest increase of $176,000 for 'Inmate Health Services.'[ii] Unity Health Care (Unity) is contracted to provide comprehensive medical, behavioral health, pharmacy and dental services in the jail; I have included a copy of their contract with my testimony. Under that contract, the District must pay Unity approximately $6.7 million dollars more annually for "core services" when the population exceeds 2,200 residents.[iii] This is hard to square with the small increase in the DOC budget for health services.

We hope Council will ask the Department to explain how the population that Unity's contract is based upon is determined – for example, a week, a month, or longer of sustained population of over 2,200 – so that it can be clear whether jail residents are receiving adequate healthcare at this level of funding. Because the

contract is structured on a "Not to Exceed" basis, we hope Council will ask DOC what population level has been used to determine Unity's payments in FY26 to date.

According to DOC's most recent performance oversight hearing responses, at the end of 2025 Unity had 180 employees and 42 vacancies—a vacancy rate of 23%—which forced it to rely on "36 agency contractors, in addition to employee overtime and extended hours, to fill clinical vacancies."[iv] With a class action lawsuit pending against DOC for denying residents with basic access to medical care (see attached document), we urge Council to ask DOC to provide evidence that the currently proposed health care funding levels will be adequate to ensure jail residents are provided constitutionally-mandated levels of health care services.[v] As we requested in last year's budget oversight testimony, we also hope that DOC provides additional clarity around jail resident health contracts and how funds are allocated between physical, mental, and behavioral health services.

**Food**

We are also concerned that the proposed budget will not allow DOC to address concerns with the amount, quality, and types of food served to jail residents. The contract for food services at the jail, which is currently fulfilled by Aramark Correctional Services (Aramark), is up for solicitation this year. As noted in the report CCE released in 2025 on behalf of the D.C. Auditor, under Aramark, residents have reported that "DOC does not provide adequate portions, variety, or sufficient fresh fruits and vegetables in its resident meals."[vi] In their FY25 Annual Report on DC DOC, the Corrections Information Council reported that 63% of residents responding to their survey said "hot food was not served hot," and 37% "indicated they do not receive fruit."[vii] Most recently, ANC Commissioner Cunningham noted in his DOC oversight testimony before this committee on February 4, 2026, "The lack of oversight is most evident in the food condition in the DC jail, which is unacceptable. Aramark has repeatedly failed to serve adequate nutritious food to DOC residents. It is time for D.C. to invest in D.C.-based food providers who care about the health of our community."[viii]

In the 2025 ODCA audit of conditions in the jail, D.C. jail residents also reported relying on commissary as their meals were too small.[ix] This is an insufficient and inequitable solution as the D.C. jail commissary does not carry fresh produce, has high prices, and is strictly limited based on housing classification.[x] We also found that the cost per diem for food services during the audit period was $6.56—including labor to prepare and serve food—reflecting the financial constraints that likely contribute to the lack of variety and fresh options under the current vendor.[xi] Despite sustained attention on the quality of food in the D.C. jail in the last few years,[xii] the current operating budget for DOC does not detail an explicit budget for food services, and last year's budget earmarked a decrease of over $16,500,000 for both 'Inmate Health and Inmate Food Services' contracts.[xiii] We urge Council to ensure that the new solicitation for food services at that jail is budgeted so as to ensure DOC has the ability to provide healthy food, particularly given the increased jail population.[xiv]

We also echo Commissioner Cunningham's request that the District remove barriers to new and possibly local vendors to apply for this food solicitation; this includes removing any requirement that vendors have worked specifically in correctional facilities in the past. And it should not be allowable for Aramark to further profit by their providing unacceptable quality and quantity of food, through selling care package meals for $12-$15 through their iCare subsidiary.[xv] Council should instead ensure provisions of the SECURE DC Omnibus

Amendment Act of 2024 (SECURE DC) related to food services in the jail are funded in FY2027.[xvi] Section 32 of SECURE DC would have improved food services in the D.C. jail, and while it was adopted into law in June 2024, it has not yet taken effect because it remains unfunded.[xvii]

**Staffing**

The DOC spends the second most of any District agency on overtime, and overtime spending continues to grow- from $19 million in FY22 to over $30 million in FY25.[xviii] We question whether the $ 26,000,000 proposed for overtime pay in the FY2027 budget will be adequate for DOC to maintain staffing levels,[xix] given the jail population was 10% less in FY25—nearly 190 people—than it is today.[xx]

In addition, the requested $26,000,000 in overtime pay is unlikely to be sufficient to meet operational needs due to chronic staffing vacancies at DOC. While the Department of Corrections reports a decline in vacancy rates from 27% in FY2024 to roughly 12% in FY2025 and FY2026, this is due to "92 positions being swept [by DOC] due to long term inability to fill them."[xxi] Even with the 92 positions being removed from DOC's vacancy calculus, 101 positions remained unfilled at DOC in FY2026.[xxii] These vacancies directly impact the ability of DOC staff to meet operational needs, and increase the agency's reliance on overtime spending, as "staff shortages are the number one driver of overtime utilization" at DOC.[xxiii] It is also unclear whether staff and resident safety and well-being can be maintained at this reduced level of staffing. We urge the Council and DOC to request and approve an overtime budget in FY2027 that more accurately reflects current staffing shortages, rising population pressures, and the agency's demonstrated spending trends, rather than relying on a figure that is likely to result in shortfalls and continued strain on correctional staff. We also urge DOC and Council to continue to pursue funding to renovate and replace the jail, as current facilities and layout likely require more security staff than would be needed in an updated facility, and the jail's poor physical condition likely contributes to the difficulty in hiring.

Despite the difficult financial environment, it is incumbent upon the District to protect the health, safety and overall wellbeing of those we hold in our custody. We ask the Council to fund the DOC operating budget in a manner that protects the lives of both jail residents and facility staff and helps rather than hinders reentry. We also encourage the Council to continue to pursue policies that can safely reduce the jail population, which would help decrease correctional expenses in the long run. Thank you.

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[i] D.C. Department of Corrections, "DC Department of Corrections (DOC) Daily Population Report," April 24, 2026, DOC Official Population Counts by Facility, https://doc.dc.gov/node/307122.

[ii] *See* "FY 2027 Proposed Budget and Financial Plan, *Government of the District of Columbia, Office of Mayor Muriel Bowser*, April 14, 2026, p. 357, https://app.box.com/s/sh0kf066e74i83cqxsona9x3jcowh5eg.

[iii] *See* "AWARD/CONTRACT CW115280," *Office of Contracting and Procurement of the District of Columbia*, January 1, 2025, page 4.

[iv] "2026 Department of Corrections Performance Oversight Hearing Responses," Government of the District of Columbia Office of Councilmember Brooke Pinto, January 2026, pg. 188, https://dccouncil.gov/wp-content/uploads/2026/03/responses.pdf.

[v] *V.C. et. al. v. District of Columbia*, U.S. District Court for the District of District of Columbia, (2023) https://clearinghouse.net/case/44144/.

[vi] Kathleen Patterson, "Urgent Need for a New D.C. Jail," Office of the District of Columbia Auditor, May 28, 2025, https://dcauditor.org/report/dc-jail-report-update-report-5-28-25/.

[vii] District of Columbia Corrections Information Council. Annual Report on the District of Columbia Department of Corrections, Fiscal Year 2025. Washington, DC: District of Columbia Corrections Information Council, 2025. https://cic.dc.gov/sites/default/files/dc/sites/cic/page_content/attachments/DOC%20Annual%20Rep%20FY25_KM%2012.9.25.pdf.
[viii] Council of the District of Columbia, Committee on the Judiciary and Public Safety. Performance Oversight Hearing (audio recording). Washington, DC, 2026. https://archive-video.granicus.com/dc/dc_9a7ef837-6317-4c4d-9182-7e0c3ae9d1c6.mp3.
[ix] Kathleen Patterson, "Urgent Need for a New D.C. Jail," Office of the District of Columbia Auditor, May 28, 2025, https://dcauditor.org/report/dc-jail-report-update-report-5-28-25/.
[x] Kathleen Patterson, "Urgent Need for a New D.C. Jail," Office of the District of Columbia Auditor, May 28, 2025, https://dcauditor.org/report/dc-jail-report-update-report-5-28-25/.
[xi] Kathleen Patterson, "Urgent Need for a New D.C. Jail," Office of the District of Columbia Auditor, May 28, 2025, https://dcauditor.org/report/dc-jail-report-update-report-5-28-25/.
[xii] *See* "DC Department of Corrections Food Service Report," *Corrections Information Council*, August 2, 2024. https://cic.dc.gov/sites/default/files/dc/sites/cic/page_content/attachments/DOC%20FY24Q2%20Report_Food%20Services%20%208.2.24.pdf (recommending "1. The DOC should continue their pursuit to serve a variety of fruits in addition to apples[,]" and "2. The DOC should log the temperatures of food arriving to housing units before it is served to ensure food is still the appropriate temperature."); "We're Hungry in Here – D.C. Department of Corrections Food Survey Results," *DC Greens*, November 2023. https://dcgreens.org/wp-content/uploads/2024/07/DCG-Doc-Food-Survey_FINAL-Nov-7-23.pdf.
[xiii] "FY 2026 Proposed Budget and Financial Plan," *Government of the District of Columbia, Office of Mayor Muriel Bowser*, May 27, 2025, p. C-27. https://app.box.com/s/bn361fp8vj3u30kgxw98tr1r20ps7hxg.
[xiv] "FY 2026 Proposed Budget and Financial Plan," *Government of the District of Columbia, Office of Mayor Muriel Bowser*, May 27, 2025, p. C-27. https://app.box.com/s/bn361fp8vj3u30kgxw98tr1r20ps7hxg.
[xv] iCare, "iCare Terms and Conditions," Aramark, (2025), https://www.icaregifts.com/terms-conditions.html.
[xvi] Secure DC Omnibus Amendment Act of 2024. D.C. Law 25-175 § 32 (2024) https://code.dccouncil.gov/us/dc/council/laws/25-175.
[xvii] Healthy food at correctional facilities. [Not Funded], D.C. Code § 24–211.09 (2025), https://code.dccouncil.gov/us/dc/council/code/sections/24-211.09; Secure DC Omnibus Amendment Act of 2024. D.C. Law 25-175 (2024) https://code.dccouncil.gov/us/dc/council/laws/25-175; "Urgent Need for New D.C. Jail," *Council for Court Excellence on behalf of the Office of the D.C. Auditor (ODCA)*, May 28, 2025, p. 107. https://cdn.prod.website-files.com/659c0df344c9c8325dd821ca/6837197775af1c53f8f34cf0_JailUpdate_Web_v5.pdf.
[xviii] *See* "FY 2027 Proposed Budget and Financial Plan, VOLUME 1 – EXECUTIVE SUMMARY" *Government of the District of Columbia, Office of Mayor Muriel Bowser*, April 14, 2026, table FL03, https://app.box.com/s/bu4s5pglxq6bnyf41798dhi2xthvy0fl.
[xix] *See* "FY 2027 Proposed Budget and Financial Plan, VOLUME 2 - AGENCY BUDGET CHAPTERS - PART I" *Government of the District of Columbia, Office of Mayor Muriel Bowser*, April 14, 2026, p. 355, https://app.box.com/s/sh0kf066e74i83cqxsona9x3jcowh5eg.
[xx] "CCE Analysis Shows Rising Population at the D.C. Jail Since Federal Law Enforcement Surge," *Council for Court Excellence*, October 2, 2025, https://www.courtexcellence.org/news-items/dc-jail-pop-rising-surge.
[xxi] "2026 Department of Corrections Performance Oversight Hearing Responses," *Government of the District of Columbia Office of Councilmember Brooke Pinto*, January 2026, pg. 98, https://dccouncil.gov/wp-content/uploads/2026/03/responses.pdf.
[xxii] "2026 Department of Corrections Performance Oversight Hearing Responses," Government of the District of Columbia Office of Councilmember Brooke Pinto, January 2026, pg. 98, https://dccouncil.gov/wp-content/uploads/2026/03/responses.pdf.
[xxiii] "2026 Department of Corrections Performance Oversight Hearing Responses," Government of the District of Columbia Office of Councilmember Brooke Pinto, January 2026, pg. 99-100, https://dccouncil.gov/wp-content/uploads/2026/03/responses.pdf.

# AWARD/CONTRACT

1. Title: Resident Comprehensive Healthcare Services

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| 2. Contract Number | 3. Effective Date | 4. Requisition/Purchase Request/Project No. |
|---|---|---|
| CW115280 | January 1, 2025 | |

| 5. Issued By: Peter Kern — Code | 6. Administered by (If other than line 5) |
|---|---|
| Office of the Contracting and Procurement<br>441 4th Street, NW, Suite 330 South<br>Washington, DC 20001<br>peter.kern@dc.gov | Department of Corrections<br>3924 Minnesota Ave NE (2nd Floor)<br>Washington, DC20019 |

| 7. Name and Address of Contractor (No. street, city, county, state and Zip Code) | 8. Delivery |
|---|---|
| Unity Health Care, Inc<br>1100 New Jersey Ave SE, Suite 500<br>Washington, DC 20003 | ☐ FOB Origin ☒ Other |
| | 9. Discount for prompt payment: |
| | 10. Submit invoices to the Address shown in Section 7.2 (2 copies unless otherwise specified) |
| Duns No. — TIN | |

| 11. Ship to/Mark For — Code | 12. Payment will be made by — Code |
|---|---|
| | |

| 13. Remit Address: | 14. Accounting and Appropriation Data |
|---|---|
| Same as 7 | ENCUMBRANCE CODE: |

| 15A. Item | 15B. Supplies/Services | 15C. Qty. | 15D. Unit | | 15F. Amount |
|---|---|---|---|---|---|
| 0001-0010 | (Base year) | 12 Months | Monthly | | $49,955,512 NTE |
| 1001-1008 | (Option Year 1) | 12 Months | Monthly | | $50,519,892 NTE |
| 2001-2008 | (Option Year 2) | 12 Months | Monthly | | $51,831,152 NTE |
| 3001-3008 | (Option Year 3) | 12 Months | Monthly | | $53,181,747 NTE |
| 4001-4008 | (Option Year 4) | 12 Months | Monthly | | $54,576,866 NTE |
| | | | | | |
| | **Contract Amount** for Residents 1,701 – 2,200 ☞ | | | | **$49,955,512 NTE** |

16. Table of Contents



Contracting Officer will complete Item 17 or 18 as applicable

17. ☒ CONTRACTOR'S NEGOTIATED AGREEMENT
(Contractor is required to sign this document and return (2) copies to issuing office.) Contractor agrees to furnish and deliver all items, perform all the services set forth or otherwise identified above and on any continuation sheets, for the consideration stated herein. The rights and obligations of the parties to this Agreement shall be subject to and governed by the following documents: (a) this award/contract, (b) the solicitation, as amended, and (c) such provisions, representations, certifications, and specifications, as are attached or incorporated by reference herein. (Attachments are listed herein.)

18. ☐ AWARD (Contractor is not required to sign this document.) Your offer on Solicitation Number including the additions or changes made by which additions or changes are set forth in full above, is hereby accepted as to the items listed in B.3 and on any continuation sheets. This award consummates the contract which consists of the following documents: (a) this award/contract, and (b) your offer. No further contractual document is necessary.

| 19A. Name and Title of Signer (Type or print) | 20A. Name of Contracting Officer |
|---|---|
| Jessica H. Boyd<br>President & CEO | Kai Moore for Deborah J. White |

| 19B. | 19C. Date Signed | 20B. District of Columbia | 20C. Date Signed |
|---|---|---|---|
| (Signature of person authorized to sign) | 11/20/2024 | (Signature of Contracting Officer) | 12/16/2024 |

## SECTION B: CONTRACT TYPE, SUPPLIES OR SERVICES AND PRICE/COST

**B.1** The District of Columbia (the District) Office of Contracting and Procurement (OCP), on behalf of the Department of Corrections (DOC), is seeking a contractor to provide a Comprehensive Medical, Behavioral Health, Pharmacy, and Dental Services Program for District correctional residents that is in the best interest of the District.

**B.1A** DOC believes that the resident is an integral part of the community while incarcerated and when returned to society. DOC supports residents' re-entry into society by working to enhance the individual's health outcomes, support successful community integration, and reduce recidivism. A DOC comprehensive health care system with a robust discharge planning component supports the goals of successful and sustained resident re-entry with improved public safety and public health outcomes.

**B.1.1** Medical services at the Central Cell Block Clinic (CCBC, C.5.29) require triaging arrestees with medical/mental health issues, stabilizing those that can be addressed on site, or transported by DOC officers or Fire and Emergency Medical Services (FEMS, C.3.55) with DOC escorts to the hospital as routed by the Office of Unified Communications; or, in case of arrestees with mental health symptoms, transported directly to the Comprehensive Psychiatric Emergency Program (CPEP, C.3.30) operated by the Department of Behavioral Health (DBH, C.3.44).

**B.1.2** The contractor shall be a 340 B (C.3.1) covered entity specified HRSA ID RWIID72 and RWIIU20002 to procure, manage, control, and cost-effectively dispense pharmaceuticals to the DOC residents**. If not 340B eligible, the contractor shall provide medications at the same price as a 340B entity.** The contractor shall also dispose of medications as necessary and in accordance with all federal and District laws and regulations.

**B.2** The District contemplates a mixed model of requirements, cost reimbursement, and firm fixed price types of contract in accordance with 27 DCMR Chapter 24.

**B.2.1 REQUIREMENTS CONTRACT**
Dispensing of Pharmaceuticals
Triage Medical Services

**B.2.1.1.** The District will purchase its requirements (B.2.1) of the contractor's articles or services included herein. The estimated quantities stated herein reflect the best estimates available. The estimate shall not be construed as representing that the estimated quantity will be required or ordered or that conditions affecting requirements will be stable. The estimated quantities shall not be construed to limit the quantities the District may order from the contractor or to relieve the contractor of its obligation to fill all such orders.

a) Delivery or performance shall be made only as authorized in accordance with the Ordering Clause, G.7. The District may issue orders requiring delivery to

multiple destinations or performance at multiple locations. If the District urgently requires delivery before the earliest date that delivery may be specified under this contract, and if the contractor does not accept an order for the accelerated delivery, the District may acquire the urgently required goods or services from another source.

b) **There is no limit on the number of orders that may be issued. The District may issue orders requiring delivery to multiple destinations or performance at multiple locations**.

c) Any order issued during the effective period of this contract and not completed within that period shall be completed by the contractor within the time specified in the order. The contract shall govern the contractor's and District's rights and obligations with respect to that order to the same extent as if the order were completed during the contract's effective period, provided that the contractor shall not be required to make any deliveries under this contract after December 31, 2029.

**B.2.2 Cost Reimbursement**

In-Patient Hospitalization
Procurement of Pharmaceuticals

**B.2.3 Firm Fixed Price**

Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services
Transition Implementation in year one of the contract
Software Integration in base year of the contract

## B.3 PRICE SCHEDULE

### B.3.1 Base Year

#### B.3.1.1 Requirements

| Contract Line Item No. (CLIN) | Item Description | Average Monthly Population Ranges | | Monthly Price* | Total Annual Estimated Price |
|---|---|---|---|---|---|
| CLIN 0001 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 0-1,700 Residents | | $3,180,159 | $38,161,908 |
| CLIN 0002 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 1,701 – 2,200 Residents | | $3,356,992 | $40,283,904 |
| CLIN 0003 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 2,201 – 2,700 Residents | | $3,915,005 | $46,980,060 |
| CLIN 0004 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 2,701 – 3,200 Residents | | $4,471,812 | $53,661,744 |
| | | | | Estimated Quantity | |
| CLIN 0005 C.5.22 | Dispensing Pharmaceuticals to Residents | | $2.03 Per Prescription dispensed to an Resident** | 750,000 Prescriptions | $1,522,500 |
| CLIN 0006 C.5.29 | Provide Triage Medical Services at CCBC by Board Certified and Licensed Nurse Practitioner/PA or MD 24/7 service including holidays | | $148.30 Per labor hour worked*** | 8,760 Hours | 1,299,108 |
| Not-to-Exceed Total Requirements Pricing | | | | | NTE $43,105,512 |

* For purposes of consistency, Offeror shall use one twelfth (1/12) of the total estimated annual price to determine the estimated monthly price.

**Price Per Unit of Prescriptions Dispensed includes all costs and profits to the contractor for the control, management, dispensing, disposing of, and for procuring of Pharmaceuticals except the price the contractor pays for the pharmaceuticals.

Total Estimated Price: Multiply Price Per Unit times Estimated Quantity.

***The price per labor hour shall be a fully loaded hourly rate that includes all direct and indirect costs and profits. The contractor shall not exceed the ceiling price for services at the CCBC and shall determine that price by multiplying the approved hourly rate with the shown labor hours (365 days x 24 hours = 8,760 hours).

Note: When estimating annual prices for Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services there are 365 days in a year and 366 days in base year four, with February 29, 2028 as the additional day.

### B.3.1.2 Cost Reimbursements

| Contract Line Item No. (CLIN) | Item Description | Not to Exceed (NTE) Cost |
|---|---|---|
| 0007 C.5.20 | In-Patient Hospitalization Cost | $1,500,000 |
| 0008 C.5.22 | Cost of Pharmaceuticals | $4,950,000 |
| NTE Total Cost Reimbursements | | $6,450,000 |

### B.3.1.3 Fixed Price

| Contract Line Item No. (CLIN) | Item Description | Total Price |
|---|---|---|
| 0009 C.5.20 | Transition Implementation completed within 90 days of effective day of contract* | $0.00 |
| 0010 C.5.23.3 | Software Integration | $400,000 |
| Total Fixed Price | | $400,000 |

*Price shall cover all expenses associated with startup transition and mobilization into DOC.

### Base Year Summary

| | | |
|---|---|---|
| Contract Line Item Nos. (CLINs) 0002, 0005, 0006 | Total NTE Requirements B.3.1.1 Note: Do not Include CLINs 0001, 0003 and 0004. | $43,105,512 |
| 0007, 0008 | Total NTE Cost Reimbursements B.3.1.2 | $6,450,000 |
| 0009, 0010 | Total for Fixed Price Items B.3.1.3 | $400,000.00 |
| **Not-to-Exceed Total Price Base Year for 1,701 – 2,200 Residents** 01/01/25-12/31/25 | | NTE $49,955,512 |

### B.3.2 Option Year One
### B.3.2.1 Requirements

| Contract Line Item No. (CLIN) | Item Description | Average Monthly Population Ranges | | Monthly Price | Total Annual Estimated Price |
|---|---|---|---|---|---|
| CLIN 1001 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 0-1,700 Residents | | $3,248,233 | $38,978,796 |
| CLIN 1002 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 1,701 – 2,200 Residents | | $3,430,303 | $41.163.636 |
| CLIN 1003 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 2,201 – 2,700 Residents | | $4,005,008 | $48,060,096 |
| CLIN 1004 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 2,701 – 3,200 Residents | | $4,578,477 | $54.941,724 |
| | | | | Estimated Quantity | |
| CLIN 1005 C.5.22 | Dispensing Pharmaceuticals to Residents | | $2.09 Per Prescription dispensed to an Resident | 750,000 Prescriptions | $1,568,175 |
| CLIN 1006 C.5.29 | Provide Triage Medical Services at CCBC by Board Certified and Licensed Nurse Practitioner/PA or MD 24/7 service including holidays | | $152.75 Per labor hour worked | 8,760 Hours | $1,338,081 |
| Not-to-Exceed Total Requirements Pricing | | | | | NTE $44,069,892 |

### B.3.2.2 Cost Reimbursements

| Contract Line Item No. (CLIN) | Item Description | Not to Exceed (NTE) Cost |
|---|---|---|
| 1007 C.5.20 | In-Patient Hospitalization Cost | $1,500,000 |
| CLIN 1008 C.5.22 | Cost of Pharmaceuticals | $4,950,000 |
| NTE Total Cost Reimbursements | | $6,450,000 |

**Option Year One Summary**

| | | |
|---|---|---|
| Contract Line Item Nos. (CLINs) 1002, 1005, 1006 | Total NTE Requirements B.3.2.1 Note: Do not Include CLINs 1001, 1003 and 1004. | $44,069,892 |
| 1007, 1008 | Total NTE for Cost Reimbursements B.3.2.2 | $6,450,000 |
| **Not-to-Exceed Total Price Option Year One for 1,701 – 2,200 Residents** 01/01/26-12/31/26 | | NTE $50,519,892 |

### B.3.3 Option Year Two

### B.3.3.1 Requirements

| Contract Line Item No. (CLIN) | Item Description | Average Monthly Population Ranges | | Monthly Price | Total Annual Estimated Price |
|---|---|---|---|---|---|
| CLIN 2001 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 0-1,700 Residents | | $3,344,845 | $40,138,140 |
| CLIN 2002 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 1,701 – 2,200 Residents | | $3,532,309 | $42,387,708 |
| CLIN 2003 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 2,201 – 2,700 Residents | | $4,124,208 | $49,490,496 |
| CLIN 2004 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 2,701 – 3,200 Residents | | $4,714,838 | $56,578,056 |
| | | | | Estimated Quantity | |
| CLIN 2005 C.5.22 | Dispensing Pharmaceuticals to Residents | | $2.15 Per Prescription dispensed to an Resident** | 750,000 Prescriptions | $1,615,220 |
| CLIN 2006 C.5.29 | Provide Triage Medical Services at CCBC by Board Certified and Licensed Nurse Practitioner/PA or MD 24/7 service including holidays | | $157.33 Per labor hour worked*** | 8,760 Hours | $1,378,224 |
| Not-to-Exceed Total Requirements Pricing | | | | | NTE $45,381,152 |

### B.3.3.2 Cost Reimbursements

| Contract Line Item No. (CLIN) | Item Description | Not to Exceed (NTE) Cost |
|---|---|---|
| 2007 C.5.20 | In-Patient Hospitalization Cost | $1,500,000 |
| CLIN 2008 C.5.22 | Cost of Pharmaceuticals | $4,950,000 |
| NTE Total Cost Reimbursements | | $6,450,000 |

### Option Year Two Summary

| | | |
|---|---|---|
| Contract Line Item Nos. (CLINs) 2002, 2005, 2006 | Total NTE Requirements B.3.3.1 Note: Do not Include CLINs 2001, 2003 and 2004. | $45,381,152 |
| 2006, 2007 | Total NTE Cost Reimbursements B.3.3.2 | $6,450,000 |
| **Not-to-Exceed Total Price Option Year Two for 1,701– 2,200 Residents** 01/01/27-12/31/27 | | NTE $51,831,152 |

### B.3.4 Option Year Three
### B.3.4.1 Requirements

| Contract Line Item No. (CLIN) | Item Description | Average Monthly Population Ranges | | Monthly Price | Total Annual Estimated Price |
|---|---|---|---|---|---|
| CLIN 3001 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 0-1,700 Residents | | $3,444,356 | $41,332,272 |
| CLIN 3002 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 1,701 – 2,200 Residents | | $3,637,375 | $43,648,500 |
| CLIN 3003 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 2,201 – 2,700 Residents | | $4,246,983 | $50,963,796 |
| CLIN 3004 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 2,701 – 3,200 Residents | | $4,855,289 | $58,263,468 |
| | | | | Estimated Quantity | |
| CLIN 3005 C.5.22 | Dispensing Pharmaceuticals to Residents | | $ Per Prescription dispensed to an Resident | 750,000 Prescriptions | $1,663,677 |
| CLIN 3006 C.5.29 | Provide Triage Medical Services at CCBC by Board | | $ Per labor hour worked | 8,784 Hours* | $1,419,570 |

| | | | | | |
|---|---|---|---|---|---|
| | Certified and Licensed Nurse Practitioner/PA or MD 24/7 service including holidays | | | | |
| Not-to-Exceed Total Requirements Pricing | | | | | NTE $46,731,747 |

*Calendar year 2028 is a leap year (366 days @24 hours per day = 8,784 hours).

### B.3.4.2 Cost Reimbursements

| Contract Line Item No. (CLIN) | Item Description | Not to Exceed (NTE) Cost |
|---|---|---|
| 3007 C.5.20 | In-Patient Hospitalization Cost | $1,500,000 |
| CLIN 3008 C.5.22 | Cost of Pharmaceuticals | $4,950,000 |
| NTE Total Cost Reimbursements | | $6,450,000 |

### Option Year Three Summary

| | | |
|---|---|---|
| Contract Line Item Nos. (CLINs) 3002, 3005, 3006 | Total NTE Requirements B.3.4.1 Note: Do not Include CLINs 3001, 3003 and 3004. | $46,731,747 |
| 3007, 3008 | Total NTE Cost Reimbursements B.3.4.2 | $6,450,000.00 |
| **Not-to-Exceed Total Price Option Year Three for 1,701 – 2,200 Residents** 01/01/28-12/31/28 | | NTE $53,181,747 |

### B.3.5 Option Year Four

### B.3.5.1 Requirements

| Contract Line Item No. (CLIN) | Item Description | Average Monthly Population Ranges | | Monthly Price | Total Annual Estimated Price |
|---|---|---|---|---|---|
| CLIN 4001 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 0-1,700 Residents | | $3,546,851 | $42,562,212 |
| CLIN 4002 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 1,701 – 2,200 Residents | | $3,745,593 | $44,947,116 |
| CLIN 4003 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 2,201 – 2,700 Residents | | $4,373,442 | $52,481,304 |
| CLIN 4004 C.3.36 | Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services | 2,701 – 3,200 Residents | | $4,999,954 | $59,999,448 |

| | | | | Estimated Quantity | |
|---|---|---|---|---|---|
| CLIN 4005 C.5.22 | Dispensing Pharmaceuticals to Residents | | $2.28 Per Prescription dispensed to an Resident | 750,000 Prescriptions | $1,713,587 |
| CLIN 4006 C.5.29 | Provide Triage Medical Services at CCBC by Board Certified and Licensed Nurse Practitioner/PA or MD 24/7 service including holidays | | $166.91 Per labor hour worked | 8,760 Hours | $1,466,163 |
| Not-to-Exceed Total Requirements Pricing | | | | | NTE $48,126,867 |

**B.3.5.2 Cost Reimbursements**

| Contract Line Item No. (CLIN) | Item Description | Not to Exceed (NTE) Cost |
|---|---|---|
| 4007 C.5.20 | In-Patient Hospitalization Cost | $1,500,000 |
| CLIN 4008 C.5.22 | Cost of Pharmaceuticals | $4,950,000.00 |
| NTE Total Cost Reimbursements | | $6,450,000 |

**Option Year Four Summary**

| | | |
|---|---|---|
| Contract Line Item Nos. (CLINs) 4002, 4005, 4006 | Total NTE for Requirements B.3.5.1 Note: Do not Include CLINs 4001, 4003 and 4004. | $48,126,867 |
| 4007, 4008 | Total NTE Cost Reimbursements B.3.5.2 | $6,450,000.00 |
| **Not-to-Exceed Total Price Option Year Four for 1,701 – 2,200 Residents** 01/01/29-12/31/29 | | NTE $54,576,866 |

**Grand Total Price Summary for 1,701 – 2,200 Residents**

| | |
|---|---|
| Base Year B.3.1 | $49,955,512 NTE |
| Option Year One B.3.2 | $50,519,892 NTE |
| Option Year Two B.3.3 | $51,831,152 NTE |
| Option Year Three B.3.4 | $53,181,747 NTE |
| Option Year Four B.3.5 | $54,576,866 NTE |
| Grand Total Not-to-Exceed Price All Years | $260,065,169 NTE |

**B.4** An offeror responding to this solicitation which is required to subcontract shall be required to submit with its proposal, any subcontracting plan required by law. Proposals responding to this RFP may be rejected if the offeror fails to submit a subcontracting plan that is required by law. For contracts in excess of $250,000, at least 35% of the dollar volume of the contract shall be subcontracted in accordance with section H.9.

A Subcontracting Plan form is available as an attachment or at http://ocp.dc.gov, click on "Required Solicitation Documents."

**B.5** For contracts in excess of $250,000, at least 35% of the dollar volume of the contract shall be subcontracted in accordance with section H.9.

A subcontracting plan form is available as an attachment or at http://ocp.dc.gov, click on "Required Solicitation Documents."

**B.6 NONPROFIT FAIR COMPENSATION ACT OF 2020, D.C. Code § 2-222.01 *et seq*.**

**B.6.1** Nonprofit organizations, as defined in the Act, shall include in their rates the indirect costs incurred in provision of goods or performance of services under this contract pursuant to the nonprofit organization's unexpired Negotiated Indirect Cost Rate Agreement (NICRA). If a nonprofit organization does not have an unexpired NICRA, the nonprofit organization may elect to instead include in its rates its indirect costs:

(1) As calculated using a *de minimis* rate of 10% of all direct costs under this contract;

(2) By negotiating a new percentage indirect cost rate with the awarding agency;

(3) As calculated with the same percentage indirect cost rate as the nonprofit organization negotiated with any District agency within the past 2 years; however, a nonprofit organization may request to renegotiate indirect costs rates in accordance with B.6.2; or

(4) As calculated with a percentage rate and base amount, determined by a certified public accountant, as defined in the Act, using the nonprofit organization's audited financial statements from the immediately preceding fiscal year, pursuant to the OMB Uniform Guidance, and certified in writing by the certified public accountant.

**B.6.2** If this contract is funded by a federal agency, indirect costs shall be consistent with the requirements for pass-through entities in 2 C.F.R. § 200.331, or any successor regulations.

**B.6.3** The Contractor shall pay its subcontractors which are nonprofit organizations the same indirect cost rates as the nonprofit organization subcontractors would have received as a prime contractor.

## SECTION C: SPECIFICATIONS/WORK STATEMENT

Contents of Section C

**C.1 SCOPE:**

The Government of the District of Columbia Office of Contracting and Procurement on behalf of the Department of Corrections, is seeking a contractor to provide Comprehensive Medical, Behavioral Health, Pharmacy, and Dental Services to DOC residents. This work encompasses primary, urgent and specialty medical care; mental health services; dental services; arrangement for in-patient hospital care; and pharmacy services at DOC's Central Detention Facility and Correctional Treatment Facility; and triaging and stabilization for Central Cell Block Clinic arrestees. The contractor shall provide services that include the following:

**C.1.1 Comprehensive Medical Care**: including intake assessment, primary care, urgent medical care, specialty clinics and in-patient hospital cost.

**C.1.2 Comprehensive Behavioral Health Care**: The contractor shall organize, manage and provide services through a Trauma Informed Care Lens, including intake screening and assessment, and, if applicable, crisis management, suicide management, and acute and persistent in-house behavioral health services. The contractor shall provide a variety of therapeutic modalities as well as programming designed to initiate, maintain and support rehabilitation. The contractor shall provide services including (but not limited to) Cognitive Behavioral Therapy, Dialectic Behavioral Therapy, Acupuncture and Tapping (Emotional Freedom Techniques), TAMAR GROUPS (Trauma, Addictions, Mental Health and Recovery), Narcotics Anonymous, Alcoholics Anonymous, and Trauma-Informed Care Work Group curriculum from SAMHSA at a minimum.

**C.1.3 Dental Services**: including screening, teeth-cleaning, preventive care, emergency care, routine services, and instruction in oral hygiene and preventive oral education.

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**C.1.4 Discharge Planning**: including Intake Initial Discharge Treatment Plan, follow up appointments, discharge medications, and provision of information and locations regarding community health care providers.

**C.1.5 Pharmacy Services**: including pharmacy purchases, distribution and control. The contractor shall purchase pharmaceuticals according to 340B program policies and

procedures or system that meets or exceeds financial cost benefits of a 340B program.

**C.1.6 Medical and Behavioral Health Screening** of all CCB arrestees and triaging and stabilization of CCBC arrestees in need of medical services on 24 hours a day, seven days a week basis.

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## C.2 APPLICABLE DOCUMENTS

The following documents are applicable to this procurement and are hereby incorporated by this reference:

| Item No. | Document Type | Title |
|---|---|---|
| 1 | Industry Standards | **American Correctional Association (ACA, C.2)** http://www.aca.org |
| 2 | Industry Standards | **National Commission on Correctional Health Care (NCCHC, C.2)** http://www.ncchc.org/ |
| 3 | Industry Standards | **National Academy of Sciences Food and Nutrition Board Dietary Reference Intakes-Applications in Dietary Planning** http://www.nap.edu/books/0309085373/html/ |
| 4 | Pharmacy Regulations | Department of Health Pharmacy Regulations http://doh.dc.gov/node/157862 |
| 5 | District Licensing and Registration | Department of Health Professional Licensing http://doh.dc.gov/service/health-professionals |
| 6 | DOC Program Statement | Program Manual 6000.1 Medical Management, Attachment J.19 |
| 7 | DOC Program Statement | RESERVED |
| 8 | DOC Program Statement | RESERVED |
| 9 | DOC Program Statement | 6080.2 Suicide Prevention, Attachment J.21 |
| 10 | DOC Program Statement | 6050.4 Drug/Alcohol Testing (MEDAT, C.3.70A) Mandatory Employee Drug and Alcohol Testing Program, Attachment J.20 |
| 11 | DOC Program Statement | 2000.2 Record Retention, Attachment J.11 |
| 12 | DOC Program Statement | 1300.3 Health Information Privacy, HIPAA, Attachment J.10 |
| 13 | DOC Program Statement | Technical Reference Manual (Health Privacy Information Operations), Attachment J.10. |
| 14 | DOC Program Statement | 3800.3 “ADA: Communications for Deaf and Hearing Impaired,” Attachment J.14 |
| 15 | DOC Program Statement | 2920.8 Environmental Safety and Sanitation, Attachment J.13 |
| 16 | DOC Program Statement | RESERVED |
| 17 | DOC Program Statement | 5010.3 Contraband Control, Attachment J.16 |
| 18 | DOC Program Statement | 2420.0 Information Security, Attachment J.12 |
| 19 | Industry Standards | Centers for Disease Control (CDC, C.2) Guidelines for Control and Management for TB in Correctional Facilities https://www.cdc.gov/tb/topic/populations/correctional/default.htm |

| Item No. | Document Type | Title |
|---|---|---|
| 20: PREA | The 2003 Prison Rape Elimination Act | https://www.gpo.gov/fdsys/pkg/PLAW-108publ79/pdf/PLAW-108publ79.pdf |

## C.3 DEFINITIONS

These terms when used in this RFP have the following meanings:

**C.3**.1 340B Covered Drugs - Drugs covered under the 340B Drug Pricing Program approved by the Covered Entity for dispensing to its Patient;

**C.3.**2 340B Covered Entity - An entity as defined in Section 340B (a) (4) of the Public Health Service Act, 42 U.S.C. § 256b (a) (4);

C.3.3 340B Drug Pricing Program – The federal drug discount program established under Section 340B of the Public Health Service Act, 42 U.S.C. § 256b;

C.3.4 340B Program Member – A Covered Entity's Enrollee in whose name a prescription for a 340B Covered Drug is written by an Authorized Prescriber. For the purposes of ascertaining each Party's rights and obligations under the Agreement and this Addendum, all 340B Program Members will be deemed Program Members as defined in and used throughout the Agreement.

C.3.5 AA- Alcoholics Anonymous;

C.3.6 ACA - American Correctional Association;

C.3.7 ACLS - Advanced Cardiovascular Life Support;

C.3.8 ACPE – American Council of Pharmaceutical Education;

C.3.9 ADAP – Aids Drug Assistance Program;

C.3.10 ADP – Average Daily Population;

C.3.11 AM – Anger Management;

C.3.12 AMA - American Medical Association;

C.3.13 AMHU - Acute Mental Health Unit;

C.3.14 Administrative Encounters - Clinical staff engaging in activities which result in clinical services being provided to a patient with no clinician/patient interaction. Examples might be chart reviews, medication reorders or standard pre-ordered lab tests. These types of services should be classified as "administrative encounters" or "chart encounters," and are entered into a patient's medical record.

C.3.15 Arrestee - Person arrested by MPD on non-citationable criminal offenses who must appear before a magistrate at arraignment court to determine whether he/she requires preventative detention at DC DOC facilities;

C.3.16 RESERVED

C.3.17 Business Day - Any day on which offices of the Government of the District of Columbia are open for business;

C.3.18 CA – Contract Administrator;

C.3.19 CBT - Cognitive-Behavioral Therapy;

C.3.20 CCA - The Corrections Corporation of America;

C.3.21 CCB – Central Cell Block;

C.3.22 CCBC – Central Cell Block Clinic;

C.3.23 CCC- Chronic Care Clinic;

C.3.24 CDC- Centers for Disease Control and Prevention;

C.3.25 CDF - Central Detention Facility;

C.3.25A CDS – Controlled Dangerous Substance;

C.3.26 CE – Continuing Education;

C.3.27 CIPS – Correctional Institute Pharmacy System;

C.3.28 CLIN – Contract Line Item;

C.3.29 CME – Continuing Medical Education;

C.3.30 CPEP – Comprehensive Psychiatric Emergency Program;

C.3.31 CPR – Cardiopulmonary Resuscitation;

C.3.32 CTF - Correctional Treatment Facility;

C.3.33 CTRD – Counseling, Testing, Referral, and Discharge;

C.3.34 Central Cell Block (CCB) - The location where most arrestees who must be transported to arraignment are held pending arraignment. Address: 300 Indiana Ave. NW, Washington, DC 20001.

C.3.35 Central Cell Block Clinic (CCBC) - On-site ambulatory clinic at the CCB where non-emergency routine care for arrestees and first aid (if needed) for staff, are provided. Address: 300 Indiana Ave. NW, Washington, DC 20001.

C.3.36 Comprehensive Medical, Behavioral, Health, Pharmacy, and Dental Services at the Central Detention Facility (CDF) and the Correctional Treatment Facility (CTF, a system of medically necessary health care that includes but is not limited to preventative and therapeutic services providing for the physical and mental well-being of a population. Health care services required by residents are delivered both inside and outside DOC, including primary and specialty physician and other health professional services, hospital services (in-patient and outpatient), nursing, pharmaceutical dispensing, laboratory, diagnostics, and other ancillary services.

C.3.37 Contract Administrator (CA) - The person at DOC, designated by the contracting officer as the day to day administrator of contracts. The CA shall NOT have the authority to:

1. Award, agree to, or sign any contract, delivery order or task order. Only the CO shall make contractual agreements, commitments or modifications;
2. Grant deviations from or waive any of the terms and conditions of the contract;
3. Increase the dollar limit of the contract or authorize work beyond the dollar limit of the contract,
4. Authorize the expenditure of funds by the contractor;
5. Change the period of performance; or
6. Authorize the use of District property, except as specified under the contract.

C.3.38 DBT - Dialectical Behavior Therapy;

C.3.38A DHHS – Department of Health and Human Services;

C.3.39 DC – District of Columbia (Washington, DC.;

C.3.40 DCDC – Resident ID Number, the unique resident identifier that links records in the Offender Management System to those in the Electronic Medical Record and the Pharmacy Information System;

C.3.41 DEA – Drug Enforcement Administration;

C.3.42 DOC - Department of Corrections;

C.3.43 DOH - Department of Health;

C.3.44 DBH - Department of Behavior Health

C.3.45 DOJ – Department of Justice;

C.3.46 DUR – Drug Utilization Review;

C.3.46A EFT: Emotional Freedom Technique or "Tapping"

C.3.47 EMR - Electronic Medical Record;

C.3.48 ePHI - Electronic Protected Health Information;

C.3.49 eMAR - Electronic Medication Administration Record;

C.3.50 Emergency 911 Services - The District of Columbia's emergency number used when required to contact Fire and Emergency Medical Services (F&EMS) and the Metropolitan Police Department (MPD), which includes transportation and medical treatment while in transit.

C.3.51 Emergency Room Care – Care intended to provide rapid treatment for sudden illness or trauma victims.

C.3.52 Encounter - Face-to-face visit between a patient and a licensed medical practitioner (nurse, dental, mental health or medical), which results in clinical services being rendered to the patient and those services being documented in the patient's electronic medical record.

C.3.53 FBOP - Federal Bureau of Prisons;

C.3.54 FBU – Federal Billing Unit;

C.3.55 FEMS- Fire and Emergency Medical Services;

C.3.56 Federal Resident - Resident housed by DC DOC for federal agencies and whose off-site care must be pre-authorized by representatives of those agencies. Providers bill those representatives directly for off-site care provided to federal residents.

C.3.57 FTE – Full-Time Equivalent personnel, stated in terms of individuals working a regularly scheduled 40-hour week, usually 1,920 usable labor hours per year for one FTE, after 160 hours are deducted from 2,080 available hours. The 160 deducted hours represent annual leave, sick leave, jury duty, and other leave and are recognized separately within fringe benefit costs and fringe benefit rates.

C.3.58 HIV - Human Immunodeficiency Virus;

C.3.58A HIPAA – Health Insurance Portability and Accountability Act;

C.3.58B HRSA – Health Resources and Services Administration;

C.3.59 HWH - Halfway House;

C.3.60 IDTP - Initial Discharge Treatment Plan;

C.3.61 IGP –Resident Grievance Procedure;

C.3.62 IRC - Resident Reception Center, the DOC unit processes incoming residents prior to housing placement and outgoing residents.

C.3.63 Infirmary -Medical care unit including bed-space located at the Correctional Treatment Facility;

C.3.64 Resident - Person remanded post-arraignment to DC DOC custody;

C.3.65 Resident Medical - Medical care unit located in the Central Detention Facility;

C.3.66 Resident Reception Center (IRC) - DOC unit that processes incoming residents prior to housing placement and outgoing residents.

C.3.67 JACCS - Jail and Community Corrections System;

C.3.68 RESERVED;

C.3.69 LPN – Licensed Professional Nurse;

C.3.70 Lock-Down – Occurs when normal activities in affected housing units are halted because of a present threat – e.g., security threat. Lock-Down lasts until it is deemed safe to resume normal operations.

C.3.71 MAT- Medication Assisted Treatment;

C.3.72 MD – Medical Doctor;

C.3.72A MERT - Medical Emergency Response Team;

C.3.73 MH – Mental Health;

C.3.74 MHU - Mental Health Unit;

C.3.74A MPD – Metropolitan Police Department;

C.3.74B MRT – Moral Reconation Therapy;

C.3.75 Mental Health Unit (MHU) - A secure treatment unit at the Central Detention Facility which can house up to 73 seriously and persistently mentally ill residents who require higher levels of supervision;

C.3.76 Mid-Level Practitioner - A clinical medical professional who provides patient care under the supervision of a physician, Mid-levels includes Nurse Practitioner (NP) and Physician's Assistant (PA);

C.3.77 NA – Narcotics Anonymous;

C.3.78 NCCHC - National Commission on Correctional Health Care;

C.3.79 NIC – National Institute of Corrections;

C.3.80 NP – Nurse Practitioner;

C.3.81 RESERVED;

C.3.82 NTE – Not to Exceed;

C.3.82A OHSA – The Office of Health Services Administration;

C.3.83 OMS - Offender Management System;

C.3.84 OCP – Office of Contracting and Procurement;

C.3.85 OTP - Opioid Treatment Program is DOC's comprehensive medications for opioid use disorders program which includes both initiation and maintenance of medication assisted treatment and offers all forms of approved medications as indicated/appropriate;

C.3.86 PA – Physician Assistant

;

C.3.87 PHI - Protected Health Information;

C.3.88 PI – Performance Improvement;

C.3.89 PPD - Purified Protein Derivative/Mantoux skin test used to screen for tuberculosis;

C.3.90 PREA - The 2003 Prison Rape Elimination Act. In order for facilities to comply with this law, facilities must satisfy a triennial audit of practices based on over 105 mandatory standards. All DOC administered or operated facilities are PREA compliant;

C.3.91 RESERVED;

C.3.92 P&T – Pharmacy and Therapeutics;

C.3.93 RESERVED;

C.3.94 RFP - Request for Proposals;

C.3.95 RPR - Rapid Plasma Reagin, a screening test for syphilis;

C.3.96 RN – Registered Nurse;

C.3.97 RSAT - Residential Substance Abuse Treatment;

C.3.98 RESERVED;

C.3.99 Restrictive Housing Unit – A housing unit which is separated from the general population. There are three forms of restrictive housing: 1) administrative, 2) disciplinary, and 3) protective custody.

C.3.99A Standard Contract Provisions, July 2010;

C.3.100 SAMHSA – Substance Abuse and Mental Health Services Administration;

C.3.101 SDU - Step Down Unit located at the Central Detention Facility; a therapeutic community for those who have successfully transitioned from the Acute Mental Health Unit to prepare them for future transition to communal living environments;

C.3.102 SRA – Suicide Risk Assessment;

C.3.103 Section B – Contract Type, Supplies or Services and Price/Cost;

C.3.104 Section C – Specifications/Work Statement;

C.3.105 Sick Call - Non-emergency care rendered to residents provided within 24 hours of request;

C.3.106 Special Conveyance - DOC transportation for medical trips, such as clinic appointments or medically appropriate emergency room transports (per contractor clinical judgment);

C.3.106A SUD – Substance Use Disorder;

C.3.106A TBD – To Be Determined;

C.3.107 TIC – Trauma Informed Care;

C.3.108 TST – Mantoux Tuberculosis Skin Test;

C.3.109 TB – Tuberculosis;

C.3.110 TBA – To Be Announced;

C.3.110A Tamar Groups - Trauma, Addictions, Mental Health and Recovery;

C.3.111 Telemedicine - Technology based patient consultations for on-site medical Specialty Services listed in the RFP with the primary exception of Physical / Occupational Therapy, Dialysis and Podiatry;

C.3.112 Treatment Plan - Therapeutic strategy that may incorporate patient education, dietary adjustment, an exercise program, drug therapy, and the participation of nursing and allied health professionals;

C.3.113 Triage - The sorting and classifying of resident's health requests to determine priority of need and the proper place for healthcare to be rendered;

C.3.114 USMS - United States Marshals Service;

## C.4 BACKGROUND

**C.4.1** The District of Columbia Department of Corrections is primarily responsible for managing the detention of adult male, female and pre-trial detainees and sentenced misdemeanants. In addition, parole violators awaiting a final revocation hearing, short-term sentenced felons, and long-term sentenced felons awaiting transfer to the Federal Bureau of Prisons are confined by the department. DOC also operates the Central Cell Block (CCB), a post-arrest and pre-arraignment holding facility for adult men and women arrested on charges for which citations cannot be issued and immediate release cannot be effected under DC law. DOC is a District government agency funded primarily through local funds. In FY 2023 it has an annual operating budget of approximately $200 million and 1,319 authorized full-time equivalent (FTE) positions.

**C.4.2** DOC houses residents at the CDF and the CTF, with the official resident bed capacities of the two facilities at 2,164 and 1,400 respectively. The CTF opened in May 1992 as a specialized medium security institution. The CDF opened in 1976. Most residents housed in CDF are awaiting adjudication of cases or are sentenced for misdemeanor offenses. Both facilities are accredited by the NCCHC and the ACA, both are part of the Opioid Treatment Program, and are also PREA compliant. Each of these accreditation systems has both mandatory and essential standards designed to ensure that correctional agencies have systems in place that not only reflect a level of care consistent with community standards but also ensure adherence to minimal national standards.

**C.4.3** In FY 2022 the District housed an average of 1,388 residents per day, 1,017 were housed at the CDF, 370 at the CTF, and the remaining one at the Fairview Community HWH. DOC's residents are approximately 60% pretrial detainees or sentenced misdemeanants, 20% are held for the USMS, and 20% parole violators, sentenced felons, and writs and holds. Approximately 34% of DOC residents are maximum security, 59% medium security, and the remainder minimum security.

**C.4.4** DOC residents are 92% men and 8% women. Over 90% of residents are African American, about 5% are Hispanic, 3% are White and the remaining are of various races and ethnicities. About 75% of intakes had some history of mental illness or substance abuse; nearly half, 46% of intakes had active diagnoses of mental illness. Approximately 28 residents daily have HIV/AIDS. Among other chronic conditions, hypertension, asthma, diabetes, and kidney disease are prevalent in significant numbers. The median age of men was 33 years and women was 37 years. The median length of stay for men in custody is 90 days and for women 47 days; median lengths of stay to release were 17 days and 11 days respectively.

In FY 2022 there were 152 external hospital stays of more than 24 hours averaging about 12.6 days each for an FY 2022 total of 814 inpatient-days with the annual cost of in-patient care averaging about $240 thousand.

**C.4.5** CCB houses adult men and women arrestees for up to 72 hours while they are awaiting arraignment. The CCB housed approximately 10,500 arrestees in 2021 and

over 8,000 arrestees from January 2022 through the end of November 2022. Approximately 12% percent of these arrestees required care at the Central Cell Block Clinic. DOC is responsible for the provision of on-site medical and behavioral health screening as well as providing medical services at the CCBC.

**C.4.6** DOC is responsible for the supervision, custody, and care of all residents and arrestees in its facilities; the supervision, custody, and overseeing the care of residents at hospitals; and, the supervision and custody of arrestees in hospitals. DOC and its health services provider under this contract is NOT responsible for the medical care of arrestees in hospitals.

**C.4.7 Overview of Current Health Care Services**

**C.4.7.1** Three guiding principles underlie the District's resident health care system:

1) Strict Compliance with national accreditation standards for the quality of care provided;
2) Aggressive Cost Control; and
3) Continuity of Care, Community Oriented Correctional Health Services (COCHS) Model preferred.

The first two principles are somewhat self-explanatory. The third, continuity of care, means that providers would ideally have access to information and records about a person's complete health status prior to incarceration, and that any treatment required post incarceration would ideally be arranged with community-based providers prior to release, including the sharing of appropriate health treatment and assessment information during the period of incarceration. COCHS implies, among other things, that the care the individual would receive in the facility mirrors that which the individual would receive if presenting with the same conditions in the community. The District's resident health care system has the following five main components:

**C.4.7.1.1** Comprehensive Medical Care:

1) Intake Screening and Assessment;
2) Primary Care;
3) Urgent Medical Care;
4) Specialty Clinics;
5) In-patient Hospitalization.

**C.4.7.1.2** Comprehensive Behavioral Health Care: This shall be provided by the contractor through a Trauma Informed Lens/Structure and shall include intake screening and assessment, crisis management, suicide attempt management, suicide prevention efforts, acute and persistent in-house behavioral health services, care in the therapeutic community of the SDU, and men's mental health step down unit, as well as the men's and women's wellness unit (SUD focus). This also involves providing or ensuring the community provision of the following services: MH programming (TBD), which includes Anger Management, NA, AA, additional treatment with acupuncture, and skills-based learning with Trauma Informed Care treatment groups using SAMHSA's curriculum as the guide, EFT or tapping.

**C.4.7.1.3** Dental Services: including screening, teeth cleaning, preventive care, emergency care, and routine services.

**C.4.7.1.4** Discharge Planning: including IDTP at intake, follow up appointments, discharge medications and provision of information and locations regarding community health care providers.

**C.4.7.1.5** Pharmacy Services: Procurement, distribution and control of pharmaceuticals according to 340B guidelines or the procurement and provision of pharmaceuticals from another source at an equivalent price point and associated cost to the District, and, using the Medication Packaging Machine on site as well as the eMAR.

**C.4.7.2** Tables 1 through 6 below show relevant historical medical housing beds, and current and projected population.

### C.4.7.2.1 Department of Correction's Resident Medical (C.3.65) Housing Beds and Population Statistics

| Table 1: Current Infirmary (C.3.63) Beds | | | | |
|---|---|---|---|---|
| **Facility** | **Cell Type** | **Number of Cells** | **Beds in Each Cell** | **Total Beds** |
| CDF | Individual Cells | 4 | 1 | 4 |
| CTF | Common Room | 4 | 3 | 12 |
| CTF | Single Beds | 27 | 1 | 27 |
| **TOTAL INFIRMARY BEDS** | | | | **43** |

**Specialty Care Clinic Attendance On-Site CY 2022**

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 2243 | 270 | 320 | 316 | 274 | 319 | 256 | 315 | 313 | 395 | | |

**Specialty Care Clinic Attendance Off-Site CY 2022 (CDF)**

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 45 | 44 | | | | 8 | | | | | | |

**Specialty Care Clinic Attendance Off-Site CY 2022 (CTF)**

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 8 | 53 | | | | 5 | 22 | | | | | |

**Table 2: Current and Projected Average Daily Population by Facility**

| Facility | Average Daily Population by Calendar Year Projected 2023-2028 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Year | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 |
| CDF | 1260 | 1034 | 1059 | 1006 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 |
| CTF | 516 | 447 | 427 | 359 | 400 | 400 | 400 | 400 | 400 | 400 |
| HWH | 26 | 8 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| DOC ADP | 1798 | 1489 | 1486 | 1366 | 1400 | 1400 | 1400 | 1400 | 1400 | 1400 |
| ADP of Inmates Requiring Health Services | 1772 | 1481 | 1486 | 1365 | 1400 | 1400 | 1400 | 1400 | 1400 | 1400 |

Currently all residents are served by DOC and counted as DOC residents.

**Table 3: Current and Projected Average Daily Male Population by Facility**

| Facility | Average Daily Male Population by Calendar Year | | | | | | Projected 2023-2028 | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Year | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 |
| CDF | 1260 | 1034 | 1059 | 1006 | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 |
| CTF | 404 | 306 | 363 | 295 | 288 | 288 | 288 | 288 | 288 | 288 |
| HWH Residents[1] | 22 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ADP Requiring Health Services | 1686 | 1346 | 1422 | 1301 | 1288 | 1288 | 1288 | 1288 | 1288 | 1288 |

1. HWH residents are considered community residents and not covered by this solicitation.

| Table 4: Current and Projected Average Daily Female Population by Facility | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Facility** | **Average Daily Female Population by Calendar Year** | | | | | | **Projected 2023-2028** | | | |
| Year | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 |
| CDF | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| CTF | 112 | 141 | 64 | 64 | 112 | 112 | 112 | 112 | 112 | 112 |
| HWH Residents[1] | 4 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ADP Requiring Health Services | 112 | 141 | 64 | 64 | 112 | 112 | 112 | 112 | 112 | 112 |

1.HWH residents are considered community residents and not covered by this solicitation.

| Table 5: Current and Projected Intakes by Facility | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Facility** | **Intakes[1] by Calendar Year** | | | | | | **Projected 2023-2028** | | | |
| Year | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 |
| CDF | 10502 | 3729 | 3329 | 4404 | 4500 | 4500 | 4500 | 4500 | 4500 | 4500 |
| Male | 9452 | 3356 | 2996 | 3964 | 4050 | 4050 | 4050 | 4050 | 4050 | 4050 |
| Female | 1050 | 373 | 333 | 440 | 450 | 450 | 450 | 450 | 450 | 450 |
| Total | 10502 | 3729 | 3329 | 4404 | 4500 | 4500 | 4500 | 4500 | 4500 | 4500 |

All DOC intakes occur at CDF.

| Table 6: Current and Projected Releases by Facility | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Facility** | **Releases by Calendar Year** | | | | | | **Projected 2023-2028** | | | |
| Year | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 |
| CDF | 9693 | 3630 | 3256 | 4063 | 4000 | 4000 | 4000 | 4000 | 4000 | 4000 |
| 500DC SC | 757 | 179 | 98 | 280 | 500 | 500 | 500 | 500 | 500 | 500 |
| Total | 10450 | 3809 | 3354 | 4343 | 4500 | 4500 | 4500 | 4500 | 4500 | 4500 |

**C.4.7.2.2** The following contains descriptions of services provided to residents located at various facilities.

| Facility/Address | Service Summary Description | Population |
|---|---|---|
| Central Detention Facility<br>(D.C. Jail)<br>1901 D Street, S.E.<br>Washington, D.C. 20003<br><br>Correctional Treatment Facility<br>1901 E. Street S.E.<br>Washington, D.C. 20003 | On-site Comprehensive Medical, Behavioral Health, Pharmacy and Dental Services. | All populations assigned to the CDF and CTF. The Average Daily Population for FY 2017 was about 2,000. |
| Central Cell Block Clinic<br>300 Indiana Ave, NW<br>Washington, D.C. 20001 | Onsite Clinic for medical triaging, treating and stabilization with referral to local emergency rooms when necessary. | Approximately 2,000 require clinic or emergency room services annually. |

### C.4.8 DC Department of Corrections Facts and Figures

Link to Facts and Figures: https://doc.dc.gov/node/344892

## C.5 REQUIREMENTS

**C.5.1** The contractor shall implement the full terms of the contract in coordination and collaboration with DOC and DOC contractors and shall provide discharge planning, comprehensive medical, behavioral health, pharmacy, and dental services in accordance with legal requirements imposed by federal and District of Columbia laws, District licensing or professional boards, court orders, NCCHC, ACA and DOC Administrative Directives/Policy Statements, including compliance with aspects of the Health Insurance Portability and Accountability Act (HIPAA, C.3.58A) of 1996. The contractor shall provide pharmacy services, which shall be in accordance with and adherence to the Federal 340B guidelines if that procurement system is utilized.

**C.5.1.1** The contractor shall begin transition activities no later than ten days after contract award and shall submit a Final Transition Plan to the contract administrator for approval. Transition plan shall include:

**C.5.1.1.1** Detailed plans for securing necessary staff at CDF, CTF and CCB;

**C.5.1.1.2** Timeline for pharmacy services (if applicable);

**C.5.1.1.3** Implementation of new policies and procedures;

**C.5.1.1.4** Detailed specialty services structure (if applicable);

**C.5.1.1.5** An operations manual (F.3.42) to include procedures, protocols and methodologies for treatment; a description of treatment programs; nursing care procedures for infirmary care;

**C.5.1.1.6** A Final Staffing Plan (F3.43), including FTE's per labor category, staff deployment, job descriptions, key personnel resumes, functional assignments, proposed distribution of hours worked by regular staff and overtime hours; a training plan; and

**C.5.1.1.7** A Quality Management Program Manual (F.3.44) in draft copy within 60 days of contract award and approval by CA with final copy within 90 days of contract award.

**C.5.1.2** The contractor shall provide a draft transition plan to CA within ten days of contract award and complete transition plan within 30 days of contract award (F.3.45).

**C.5.1.3** During the period of startup transition and mobilization into DOC the contractor shall become familiar with all aspects of the medical units and services provided in the CDF and CTF.

**C.5.1.4** Contractor shall begin providing services upon completion of the transition period, no later than 90 days after the effective date of the contract.

**C.5.2** The contractor shall comply with all reporting deadlines and ensure accuracy of all data submitted as defined in section C.5.41 "Reporting".

**C.5.3** The contractor shall provide medical and behavioral health services to all residents in DOC custody. In the event services end by either the contract expiration or termination, the contractor shall continue services, if requested by DOC, until new services are operational within the terms of the continuity clause I.13.

**C.5.4** The contractor shall purchase all pharmaceuticals for CTF and CDF and CCBC.

**C.5.4.1** Pharmaceuticals for the CCBC will be paid for separately by DOC. DOC will assume the cost of all information technology infra-structure, including upgrading its Correctional Institute Pharmacy System and Centricity EMR. The contractor shall fully utilize the EMR and eMAR DOC has purchased.

**C.5.4.2** RESERVED.

**C.5.5** The contractor shall conduct, at a minimum, on-site specialty clinics as listed in C.5.18 and F.3.5. The contractor shall add as many specialty clinics onsite as possible. The contractor shall implement the use of telemedicine (C.3.111) to the fullest extent possible.

## C.5.6 CONTRACTOR EXPERIENCE AND ACCREDITATION

**C.5.6.1** **Comprehensive Medical and Behavioral Health Contractor** shall have recent and significant experience (not less than five years) with proven effectiveness in its integrated work administering correctional health care programs (medical and behavioral health), i.e., the contractor is currently providing similar services with this population or has provided similar integrated medical and behavioral health services to a client comparable to the District within the past ten years.

**C.5.6.2** **Pharmacy Subcontractor,** if utilized, shall have recent and significant experience with proven effectiveness in administering pharmacy management services in a correctional health care program. The contractor shall have no less than five years' experience as outlined in section C.5.36.5. The contractor shall have demonstrable experience successfully operating medication packaging machines, CIPS and eMAR systems and utilizing a clinical pharmacist to assist with medical use enhancements, and running an OTP compliant pharmacy program.

**C.5.6.3** The contractor shall provide resumes of key personnel, all of whom shall have had significant experience in administering or providing comprehensive health care services (C.3.36) in corrections, all of whom have had experience of at least three years in providing on-site comprehensive care comparable to the District, specifically in a jail setting or correctional program. **Key personnel shall include the Medical Director, Behavioral Health Director, Health Services Administrator, Director of Nursing, Pharmacy Director, and Infection Control Coordinator**. The key staff shall work on-site at least 80% of the time at the DC Jail and shall operate as the leadership throughout the contract duration (C.5.35).

**C.5.6.4** The contractor(s) shall provide Comprehensive Medical and Behavioral Health Care Services in accordance with the standards of the American Medical Association; applicable ACA Performance-Based Standards for Adult Local Detention Facilities; NCCHC Standards for Health Services in Jails; the Health Resources and Services Administration of the United States Department of Health and Human Services; Prison Rape Elimination Act; Estelle v Gamble 429 U.S. 97, 103 (1976); DOC Program Manual 6000.1; Medical Management, 6080 Suicide Prevention, District law; and Federal Bureau of Prisons Standards.

**C.5.6.5** The contractor shall cooperate with the District to maintain ACA and NCCHC accreditation, along with PREA compliance at the CDF, CTF and CCB. The District may terminate the contract pursuant to the default clause and other provisions in the Standard Contract Provisions if the contractor fails to maintain ACA or NCCHC health care accreditation. The loss of NCCHC or ACA accreditation at the CDF, CTF or CCB due to the contractor's failure to meet one or more essential or mandatory health care standards may result in termination of contract. Successful appeal of the loss of accreditation will vacate the imposition of the adjustment. The contractor shall be excused from the accreditation adjustment due to deficiencies attributable to the DOC or District, whether in connection with this contract or otherwise.

**C.5.6.6** The contractor shall have at least five years of high-level competency, familiarity, and experience, in using electronic medical record systems and electronic Medication Administration Record System. DOC shall provide training as needed on DOC's systems. The contractor acknowledges that all DOC information systems (including Time-Clock, JACCS, EMR, eMAR, and Pharmacy Information Systems) are governed by HIPAA and other regulations and are auditable at any time by various authorities including the DC Department of Health, US DOJ, DC Auditor, and Inspector General and shall maintain all records with the highest standards of information quality and accuracy.

**C.5.6.7** The contractor shall have the capacity and proven experience with this population to provide Comprehensive Health Care Services, as outlined in this Scope of Work, to residents either directly or through medical subcontractor.

## C.5.7 INTAKE

### C.5.7.1 INTAKE SCREENING

**C.5.7.1.1** The contractor shall conduct a full assessment, intake screening (as outlined in NCCHC J-E-02) of all residents immediately upon arrival at the IRC (C.3.62). PAs, NPs, or MDs shall perform intake assessments.

**C.5.7.1.2 RESERVED**

**C.5.7.1.3** The contractor shall conduct a review of demographic information, triage (C.3.113) data, and documentation of any psychiatric or medical or court alerts during the intake process. The contractor shall gather data from CRISP database and other databases as data sharing agreements between DC agencies permits. The contractor shall perform a medical, behavioral health, substance use/abuse, suicide risk assessment, and oral screening in accordance with DOC Program Manual 6000.1, Medical Management.

**C.5.7.1.4** The contractor shall complete an intake form in its entirety on each resident at intake and documented in the EMR.

**C.5.7.1.5** The contractor shall implant a Mantoux Tuberculosis skin test (TST, C.3.108) at intake and read at 48-72 hours unless the EMR reflects that the resident had a TB (C.3.109) skin test planted and read at a DOC facility within 90 days prior to the current intake or has history of a positive skin test in the past. The contractor shall document this in the EMR.

**C.5.7.1.6** The contractor's onsite provider shall examine and refer a positive Tuberculosis skin test for appropriate clinical follow-up within 24 hours of positive reading. The contractor shall document this in the EMR.

**C.5.7.1.7** RESERVED.

**C.5.7.1.8** The contractor shall perform a posterior-anterior chest x-ray for all male and female Residents who have not received a chest x-ray in the past 12 months and who are known to be HIV-positive or are determined in the provider's medical judgment to be high-risk for tuberculosis. The contractor shall perform x-ray using tele-radiology. The contractor shall perform all x-rays in accordance with the Centers for Disease Control (CDC) Guidelines for Control and Management for TB in Correctional Facilities. The contractor shall also perform these tests on new Weekenders who will not be in the facility long enough to have a TST read. The contractor shall document all test and result information in the EMR.

**C.5.7.1.9** The contractor shall provide urine pregnancy testing for all female intakes and shall refer all positive results to a physician, PA, or NP. The contractor shall document all test and result information in the EMR.

**C.5.7.1.10** HIV Counseling, Testing, Referral, and Discharge Planning : The contractor shall conduct an HIV test on each intake using serology (4th Generation testing) and provide all necessary follow-up care. Residents with documented HIV results in the DOC EMR within the previous 120 days of intake do not require another test unless requested. Hepatitis C testing in conjunction DOH funding or outside funding will also occur on residents with Hepatitis C risk factors.

**C.5.7.1.11** The District will provide the contractor with condoms at no expense to the contractor, upon request.

**C.5.7.1.12** The contractor shall provide residents with IDTP at intake that is completed before an resident is housed. The contractor shall provide residents who are referred to the physician or mid-level (C.3.76) practitioner for their IDTP upon completion of the assessment. The IDTP includes the diagnoses, medications follow-up, and a list of all local D.C. clinics that residents may visit in the event they are released within 24-hours of intake. It is the District's intent that residents be connected to their community provider of choice. The contractor shall provide information on a broad range of primary and (where appropriate) specialty care providers both within and outside its own network of clinics. The contractor shall fully document IDTP and Treatment Plan and any referrals provided in the EMR.

**C.5.7.1.13** The contractor shall complete a transfer health assessment for all residents transferring between facilities to include but not be limited to, medical record review, medication evaluation and medical intervention. The contractor shall document this in the EMR.

**C.5.7.1.14** The contractor shall provide all residents with information describing the process and procedure for accessing health care services, including the grievance process. The contractor shall provide information in English and Spanish or other translations as needed. The contractor shall also use the language assistance help line for language other than English including sign language. The contractor shall document provision of this information in the EMR.

**C.5.7.1.15 Contractor shall enroll all eligible residents into Medicaid at Intake.**

**C.5.7.1.16** The contractor shall conduct COVID tests and/any other infectious/ transmissible disease surveillance and screening (e.g., Monkey-pox, SARS, MERS, MRSA) and testing of residents during the intake process as specified by DC Health and CDC protocols.

**C.5.7.2 INTAKE HEALTH ASSESSMENT**

**C.5.7.2.1** The contractor shall perform an intake health assessment as outlined in NCCHC Policy J-E-04 for each resident as identified by the screening process immediately.

**C.5.7.2.2** The contractor shall review the EMR and other databases to review include CRISP, and other agency databases as intra agency data sharing agreements permit for care received in a prior DC DOC incarceration as well as the current intake screening form, demographic information, triage data and observe any psychiatric, suicide, or medical alerts.

**C.5.7.2.3** The contractor shall conduct an oral interview and assessment, a review of systems, a review of substance abuse history and administer a brief assessment tool to evaluate substance use (NIDA) that may result in a referral for treatment.

**C.5.7.2.4** The contractor shall complete a gynecological exam within 30 days of intake for female residents who evidence specific problems or a history suggesting need. The contractor shall perform Papanicolau smears and HPV testing based on the latest evidence-based criteria for age-based screening. The contractor shall follow up upon abnormal Papanicolau smear results in accordance with gynecological clinical guidelines and presenting symptoms.

**C.5.7.2.5** The contractor shall perform a screening urine test for Gonorrhea and Chlamydia on all residents. The contractor shall conduct serology for Syphilis on all intakes, regardless of last test.

**C.5.7.2.6** The contractor shall administer first dose medications as prescribed during intake or health assessment, prior to an resident's departure from intake area. The contractor shall document this in DOC's eMAR (Accuflo) and the EMR.

**C.5.7.2.7** The contractor shall refer each resident identified as a chronic care patient to the Chronic Care Clinic. The contractor shall complete initial CCC appointments within 30 days of referral.

**C.5.7.2.8** The contractor shall perform an annual Health Assessment on all residents who have been incarcerated for at least 12 months within seven days of the anniversary of their intake date.

**C.5.8 TRIAGING OF SICK CALL COMPLAINTS**

The contractor shall collect and triage all automated (when system implemented) and paper health complaints from residents twice a day regardless of housing unit. The contractor shall document DOC specified data daily from all manual sick call

requests on either paper form or automated system (when system implemented) provided by DOC. The contractor shall conduct all triage activities under the direction of a registered nurse. The contractor shall provide sick call within 24 hours for all residents on their housing units. The contractor shall provide emergency services by health staff as described in C.5.11, within 24 hours of receipt, 24 hours a day, seven days a week, with a face-to-face encounter for a healthcare request conducted by a qualified health care professional per new NCCCH guidance. The contractor shall work with DOC as indicated by OHSA, to work toward conducting sick call clinic on a daily sign-up basis, eventually eliminating the need for sick call slips and nurse triaging.

**C.5.9 PROVIDER SICK CALL**

**C.5.9.1** The contractor shall provide residents with primary and acute care services conducted by a mid-level practitioner. The contractor shall use the paper-based system in place at both facilities until daily sign up for sick call protocol established. The contractor shall see residents who request sick call/primary care services within 24 hours of receipt of referral. The contractor shall include its sick call protocols in its operations manual. The contractor shall scan sick call slips into the EMR daily.

**C.5.9.2** The contractor shall provide **DAILY** sick call services for all housing units.

**C.5.9.3** The contractor shall develop a treatment plan for all residents in need of ongoing medical care and shall incorporate any outstanding treatment concerns into the discharge plan upon an resident's release into the community for follow-up and continuity of care as described in section C.5.27, "Discharge Planning."

**C.5.9.4 RESERVED**

**C.5.9.5** The contractor shall triage all sick call requests and shall perform sick call rounds in accordance with ACA, NCCHC standards and DOC Program Manual 6000.1, Medical Management. The contractor shall work with DOC on transition to triage-less, process using sign-up sheet in place of individual forms.

**C.5.10 INFIRMARY CARE**

**C.5.10.1** The contractor shall be responsible for operating the infirmary located at CTF. The contractor shall provide infirmary care for residents requiring continual nursing care, chronic illness care, and all acute and chronic conditions which cannot be managed in the general population. At a minimum, the contractor shall operate the infirmary so as to include the following:

**C.5.10.2** The contractor shall provide a physician assistant, or nurse practitioner who is available for consultation 24 hours a day.

**C.5.10.3** The contractor shall provide daily on-site supervision of the infirmary by a Registered Nurse.

**C.5.10.4** The contractor shall provide on duty nursing staff within sight or sound of patients 24 hours a day.

**C.5.10.5** The contractor shall document a complete in-patient record that includes the electronic medical record for each resident admitted to the infirmary, including an admission work-up and discharge plan.

**C.5.10.6** The contractor shall maintain a manual of nursing care protocols and procedures for infirmary care.

**C.5.10.7** The contractor shall utilize the infirmary to the fullest capacity to reduce off-site hospitalizations when medically appropriate.

**C.5.10.8.** The contractor shall be aggressive with respect to obtaining outside hospital records after an resident has been hospitalized, requesting outside records and following up with phone call requests as needed to secure procurement of outside records within one week. The contractor shall obtain legal agreements with all contracted hospitals to include provision of dictated comprehensive hospital records within two months of being awarded contract.

**C.5.11 URGENT CARE**

**C.5.11.1** The contractor shall provide urgent care services in the CDF and CTF. The contractor shall be responsible for providing urgent/emergency medical assessment and stabilization services, including first aid, Narcan administration, and cardiopulmonary resuscitation for residents, DOC staff, contractor staff, and visitors 24 hours per day, seven days a week. The contractor shall also assess and provide care as indicated for residents in need of an urgent behavioral health evaluation if a behavioral health provider is not in the facility. Other than life threatening emergencies, the contractor shall provide all urgent care services, which shall include Narcan on site at either facility. As applicable, the contractor shall have emergency responses that are ACLS -based and the contractor shall have emergency responders who have been ACLS trained. The contractors shall use emergency devices that are interchangeable with FEMS devices. The contractor shall inventory and replenish all first aid kits in accordance with agency program statements. Kit contents shall be reviewed annually with OHSA and FEMS Medical Director to ensure state of the art emergency response. The contractor shall treat all urgent care cases with the assigned daily staff. The contractor shall not staff urgent care with a separate entity.

**C.5.11.2** The contractor shall contact the District of Columbia FEMS for transfers to emergency rooms for services beyond the scope of contractor capabilities. The contractor shall communicate and work with FEMS on site as warranted after either the contractor or DC DOC staff contact FEMS via 911. Whoever notices the need for FEMS contacts FEMS. No waiting for contractor.

**C.5.11.3** FEMS will provide emergency transport services. The contractor shall notify appropriate correctional staff that an escort is necessary immediately after FEMS is contacted so that FEMS personnel may be escorted into the facility with appropriate urgency.

**C.5.11.4** The contractor shall be financially responsible for all 911 ambulance costs for the resident population.

**C.5.11.5** The contractor shall be financially responsible for all inter-hospital ambulance transfers for the resident population.

**C.5.11.6** The District will be responsible for all 911 transportation costs for DOC staff and visitors.

**C.5.11.7** The contractor shall notify DOC of all DOC/special conveyance (C.3.106) emergency room transports. The contractor shall secure accompanying medical documentation in a sealed manner and in accordance with HIPAA requirements at all times. The contractor shall provide the medical documents that accompany residents out on special conveyance emergency room transport as well as 911 ambulance transports.

## C.5.12 CHRONIC CARE CLINIC

**C.5.12.1** Contractor shall provide residents with chronic care and specialty care services by a qualified licensed provider on-site. Contractor shall identify residents with chronic care conditions at any point that they present with conditions/needs or request care during incarceration, e.g., intake, sick call, urgent care, or any other provider encounter. Contractor shall provide all residents with evidence of a chronic illness an initial CCC visit, within 30 days of referral.

**C.5.12.2** Once an resident is on an established chronic care case load, if the condition is considered “stable” and the resident is still in custody, the contractor shall provide follow up care every 30, 60 or 90 days depending on condition stability, no less than every six months and no more frequently than indicated by the community standard.

**C.5.12.3** The contractor shall develop and document a comprehensive treatment plan for all residents diagnosed with a chronic condition. The contractor shall incorporate any outstanding treatment concerns into the discharge plan upon an resident’s release into the community for follow-up and continuity of care. Contractor shall track referral process in subsequent EMR notes and also include need for TIC MH needs as a part of the comprehensive care provided to what we know is a community that has experiences with significant trauma, which can manifest in somatization and other manifestations.

## C.5.13 INFECTION CONTROL AND MEDICAL SURVEILLANCE OF RESIDENT WORKERS

**C.5.13.1** The contractor shall adopt existing infection control program, including but not limited to compliance with federal and local public health laws and regulations, ACA and NCCHC standards, OSHA regulations, and CDC guidelines. Contractor shall implement program upon commencement of services. This program also includes a written exposure control plan.

**C.5.13.2** The contractor shall collect, securely store, and dispose of all bio-hazardous waste generated in all medical areas of the correctional facilities in a manner conforming to federal, state, and local requirements.

**C.5.13.3** The contractor shall provide ongoing training (by its Infection Control Specialist) on handling and disposal of bio-hazardous waste for staff and residents. Contractor shall provide bio-hazardous spill kits for cleaning and decontamination of blood spills. Contractor shall document use and make the documentation available to the Office of Health Services Administration as requested.

**C.5.13.4** The contractor shall maintain evidence of annual TB screening and initial hepatitis B vaccinations for all onsite staff. The contractor shall make these documents available to the Office of Health Services Administration on an annual basis or per request and in the format requested.

**C.5.13.5** The contractor shall provide all environmental-friendly, consumable medical cleaning supplies in accordance with H.11 and H.12. The District will provide resident labor supervised by the DOC for all cleaning in medical areas.

C.5.13.6 The contractor shall insure that an environmental inspection of health services areas is conducted monthly to verify that equipment is inspected and maintained, the unit is clean and sanitary, and measures are taken to ensure that the unit is occupationally and environmentally safe.

C.5.13.7 Contractor shall develop a medical surveillance program to identify and oversee resident occupational-associated risk from potential chemical, particulate, environmental, or infectious exposure through work activities at the jail. The contractor will also conduct medical assessments prior to work assignments and track resident workers in the EMR and quarterly as well as meet with custody quarterly to discuss the resident worked program.

## C.5.14 DENTAL SERVICES

**C.5.14.1** The contractor shall provide routine and emergency dental services to residents consistent with DOC Program Manual 6000.1, Medical Management, District of Columbia Department of Health Municipal Regulations, and NCCHC and ACA standards.

**C.5.14.2** The contractor shall ensure that the dentist and his/her qualified staff be available for, respond to, and render appropriate treatment of dental emergencies within 24 hours of notification.

**C.5.14.3** The contractor shall respond to routine dental referrals within five (5) business days. The contractor shall provide treatment that is based upon assessed needs. The contractor shall provide, at the minimum, the following services:

**C.5.14.3.1** The contractor shall provide Oral Screenings within 14 days of intake by a qualified medical professional.

**C.5.14.3.2** The contractor shall provide Dental Exam by Dentist within 12 months of intake, supported by diagnostic x-rays if necessary.

**C.5.14.3.3** The contractor shall provide Treatment of Dental Pain: The contractor shall only provide the following services as indicated to residents who have been in custody for over one year: fillings, extractions of non-restorative teeth, gross debridement of symptomatic areas, and repair of partials and dentures. Exceptions may be made for residents who have been in custody for less than a year when presenting with severe and acute pain as indicated.

**C.5.14.4** The contractor shall provide residents with patient education and nutritional/dietary counseling as needed (F.3.46).

**C.5.14.5** The contractor shall provide semi-annual radiology testing for dental staff to detect exposure to radiation.

## C.5.15 RADIOLOGY

**C.5.15.1** The contractor shall be responsible for all X-ray services including maintenance of equipment and supplies. The contractor shall be responsible for procuring, installing, and maintaining any new radiology equipment that is required.

**C.5.15.2** The contractor shall perform X-ray services on a routine basis and an emergency basis, as needed.

**C.5.15.3** DOC will provide two fixed units and a tele-radiology system. The contractor shall ensure that all X-rays are captured within 24 hours of order and read through tele-radiology within 24 hours of the images being taken.

**C.5.15.4** The contractor shall receive approval from CA prior to purchasing any x-ray equipment.

## C.5.16 LABORATORY

**C.5.16.1** The contractor shall develop a laboratory services program, including but not limited to phlebotomy, specimen prep, stat results, expected turn-around times,

panic values, and any quality improvement indicators. The contractor shall record lab results into DOC's electronic medical record.

**C.5.16.2** The contractor shall provide routine laboratory services. contractor's laboratory services shall be through an appropriately licensed facility.

**C.5.16.3** The contractor shall require the submission and retention of laboratory facilities' Quality Improvement Plan, monthly productivity statistics and quality performance results; and make them available to DOC (F.3.1, F.3.2, F.3.51, F.3.52).

**C.5.16.4** The contractor shall provide the CA documentation of results of the six-monthly internal audits in electronic format within 10 days of completion. The internal audit shall include current supplies and equipment of all areas of the laboratory.

**C.5.17 NUTRITION SERVICES**

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**C.5.17.1** The contractor shall assess nutritional requirements and management The contractor shall notify the appropriate food services manager of any medically necessary special diets.

**C.5.17.2** The contractor's dietician shall evaluate all diets for nutritional adequacy by a Registered or Licensed Dietitian at least annually or whenever the menu is changed substantially and report findings to the Office of Health Services Administration.

**C.5.17.3** DOC's licensed dietician and the contracted food services vendor shall provide internal controls, conduct audits, and monitor the effectiveness and appropriateness of therapeutic diets at DOC service sites and shall be forwarded to OSHA as requested.

**C.5.18 ON-SITE SPECIALTY CLINICS** (F.3.5)

**C.5.18.1** Specialty services are those clinical services for an resident patient that are beyond the scope of the onsite medical delivery team. The contractor shall provide at a minimum, the following on-site Specialty Services:

**C.5.18.2** 1) Cardiology, 2) Ophthalmology, 3) Dermatology, 4) Obstetrics and Gynecology, 5) Orthopedics, 6) Neurology, 7) Podiatry, 8) Infectious Disease, 9) General Surgery, 10) Physical Therapy/ Occupational Therapy, and 11) Dialysis. The contractor shall conduct clinics at both the CDF and CTF. Dialysis and Physical and Occupational Therapies are exclusive to the CTF, but the contractor shall serve residents in all DOC facilities.

**C.5.18.3** The contractor shall provide parameters for access to each specialty clinic identifying "urgent" and "routine" priorities:

**C.5.18.4** The contractor shall provide "urgent" specialty services within 15 days of the referral by the examining practitioner.

**C.5.18.5** The contractor shall schedule routine appointments based on next available appointment, but ideally not later than 60 days after referral. The contractor shall re-evaluate resident prior to a routine appointment to determine if there is still a need for the specialist in accordance with clinical indications and accepted medical practices, and, document the determination in the EMR.

**C.5.18.6** The contractor shall provide all specialty clinics on site within six months from contract award date.

**C.5.18.7** RESERVED

**C.5.18.8** RESERVED

**C.5.18.9** The contractor shall provide dialysis services at the CTF. The contractor shall conduct Dialysis clinic three days a week: Monday, Wednesday, and Friday. DOC will escort residents who have an MD's order for dialysis from CDF to CTF if they are housed at CDF.

**C.5.18.10** The contractor shall retain Dialysis Quality Improvement Plan, monthly productivity statistics and quality performance results and make them available to DOC upon request (F.3.47).

**C.5.18.11** The District reserves the right to amend the minimum onsite specialty services provided by the contractor to best meet the needs of the District. This may require the contractor to add additional specialty services, for which the contractor will be entitled to an equitable adjustment pursuant to the Standard Contract Provisions (SCP Changes Clause for Comprehensive Medical, Mental Health and Dental Services. The contractor shall then provide an updated completed Cost Breakdown Schedule and proposed revised Staffing Plan prior to any contract modification approval or associated price adjustment.

## C.5.19 BEHAVIORAL HEALTH SERVICES

**C.5.19.1** The contractor shall provide Trauma-Informed behavioral health services to residents including, but not limited to:

**C.5.19.1.1** Behavioral health screening, assessments, lab, and diagnostic testing;

**C.5.19.1.2** Control, dispensing, and administration of all psychotropic and behavioral health medication;

**C.5.19.1.3** Monitoring of medication to ensure resident compliance and evaluate effectiveness in alleviation of symptoms; and,

**C.5.19.1.4** Suicide prevention, intervention, and treatment for psychiatric emergencies. The contractor shall provide suicide prevention practices in alignment with DOCs Suicide Prevention Task Force recommendations including those of the work group.

**C.5.19.2** The contractor shall treat residents with the most severe forms of mental illness as well provide appropriate therapeutic and programmatic modalities to treat residents with more stable chronic behavioral health conditions.

**C.5.19.3** The contractor shall provide basic services for the general population as described in DOC Program Manual 6000.1, Medical Management and PS 6080 Suicide Prevention policies and consistent with the DOC goal for continuity of care, specifically for Suicide Prevention and Intervention.

**C.5.19.4** The contractor shall provide integrated therapeutic modalities organized under a Trauma-Informed Care structure which shall include at a minimum, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Cognitive Behavioral Social Skills Training for Schizophrenia, TAMAR TIC Groups, and tapping, acupuncture, psychoeducation, social skills training and cognitive remediation in addition to psychotropic medications for residents in need. The contractor shall ensure its staff are trained to competency in these modalities and receive refresher trainings annually, and provide documentation of such refresher trainings to DOC OHSA. The contractor shall provide enhanced programming that shall include, at a minimum NA, AA, Anger Management, and TAMAR TIC groups. See attachment J.45 with a selected list of expected mental health programming.

**C.5.19.5** As an initiative to manage behavioral health care inside DOC, the contractor shall:

**C.5.19.6** Exchange information with the Department of Behavioral Health/DOC Liaisons on-site and community providers to ensure continuity of care/discharge planning;

**C.5.19.7** Be familiar with the District's public behavioral health system operated by the Department of Behavioral Health,

**C.5.19.8** Identify a lead mental health staff to work with DBH and its provider network;

**C.5.19.9** Participate in scheduled meetings as needed with DBH providers and DBH designated staff to ensure appropriate discharge planning takes place, including the identification of needed community services;

**C.5.19.10** Coordinate transfer of needed records between DOC and behavioral health vendor or facility, including Saint Elizabeths Hospital; have key staff participate in regular meetings (as decided upon by vendor and DBH) to help assure smooth transfer of care between facilities.

**C.5.19.11** Treat residents with a consistent medication regimen by aligning DOC mental health formulary with the District's Medicaid formulary so that the same medications are provided. Also ensure that residents transferred from St. Elizabeths shall stay on their same medication.

**C.5.19.12** The contractor's staff shall participate in trainings offered by DBH and others; and, shall provide documentation to OHSA.

**C.5.19.13** The contractor shall provide behavioral health for residents on all behavioral health units, and coordinate visits by behavioral health providers such as those associated with Core Service Agencies.

**C.5.19.14** The contractor shall contact the designated behavioral health provider and DBH staff to prioritize coordination of care and discharge planning for residents in safe cells.

**C.5.19.15** All of the contractor's behavioral and medical health staff shall be trauma-informed care trained and receive updated TIC training annually. The contractor shall provide documentation of training to OHSA annually.

**C.5.19.16** The contractor's Behavioral Health Director shall be a forensically-experienced licensed psychologist preferred with an addictions specialty and be a TRAUMA Informed care TAMAR facilitator at least weekly. Should the Health Director not have Addictions Specialty, there shall be another designated staff member with an Addictions Specialty, ideally as evidenced by at least five years of MAT experience and qualified to write prescriptions for Suboxone and all forms of MAT used on site.

## C.5.20 BEHAVIORAL HEALTH INTAKE

**C.5.20.1** The contractor's screening and mental health assessment evaluations shall reflect DOC Suicide Prevention Protocols.

**C.5.20.2** The contractor shall provide sufficient staff to conduct an initial behavioral health screening, assessment and suicide risk assessment for all intakes regardless of their projected length of incarceration. The contractor shall conduct NIDA –based SUD screening before residents are housed as part of the initial Intake Process outlined in C.5.7.1. The contractor's SRA (C.3.102) shall reflect either a low, moderate or high-level of suicide risk. DOC will place residents on a housing unit and the contractor shall provide follow up care related to the degree of suicide risk at intake and at any point in time thereafter when a SRA is conducted.

**C.5.20.3** The contractor's Intake provider (MD/PA/NP) shall refer residents to the behavioral health clinician for a comprehensive behavioral health assessment prior to housing placement. The behavioral health clinician's assessment shall reveal the need for referral to a psychiatrist or inform the resident how to access behavioral health services during their incarceration. The contractor's

psychiatrist shall see residents referred to a psychiatrist by the behavioral health clinician within 24 hours of referral.

**C.5.20.4** The contractor shall document **all** EMR notes on patients with behavioral health issues comprehensively with respect to assessment of condition and treatment plan. Contractor shall document any protective factors as well as those that may increase risk of suicidality. The contractor shall also document potential impact on resident's behavioral health status during its pre-Restrictive Housing clearance exams. The contractor shall coordinate agreement between the provider and the behavioral health clinician upon where the resident should be housed after being in the IRC and shall note in the EMR. The contractor shall make determination based on pertinent custody/charge information.

**C.5.20.5** The contractor shall advise DOC Operations (major or shift commander) when an resident needs to be housed immediately on the Acute Behavioral Health Unit or the Intake Unit because of a diagnosed active behavioral health condition or because they are being treated or observed for drug or alcohol withdrawal. DOC will house the resident accordingly.

## C.5.21 IN-PATIENT, STEP DOWN, SAFE-CELLS, AND OUTPATIENT BEHAVIORAL HEALTH CARE

**C.5.21.1** The contractor shall provide all aspects of in-patient (in-patient, behavioral health units at CDF and CTF), step-down behavioral health unit at CDF, safe-cell care, and out-patient (open-population) on-site behavioral health care at CDF and CTF.

**C.5.21.2** The contractor shall be responsible for staffing behavioral health inpatient units and safe cells in the CDF and CTF. These special beds are provided for residents who require a higher level of care for serious and persistent behavioral illnesses, have a high risk for suicide or have clinical diagnoses.

**C.5.21.2.1** The contractor shall ensure that a mental health clinician shall regularly participate on the adjustment housing board and the transgender housing committee as required. In addition, the contractor shall have a mental health clinician on-site 16 hours 7 days/week, including holidays.

**C.5.21.3** The contractor's qualified behavioral health professional shall see patients referred to behavioral health services, except for those referred through intake screening and health assessment, within 24 hours of referral.

**C.5.21.4** The contractor shall develop a program plan for behavioral health services provision, which shall include staffing deployment and on-call coverage. The contractor shall provide this plan to the Office of Health Services Administration as requested for approval. The contractor shall, at a minimum, achieve NCCHC Mental Health Certification for the Behavioral Health Director within twelve months of contract award.

**C.5.21.5** The contractor shall operate a behavioral health step-down housing unit for men. The contractor shall operate the behavioral health step-down unit as a behavioral health and co-morbidity recovery-based treatment community and shall provide staffing for this unit. Staffing will be periodically reviewed by the CA to ensure staffing adequately meets DOC's needs. The contractor shall provide at a minimum the services of 0.5 FTE Psychiatrist, whose services may be shared with other DOC services, for example, the Acute Behavioral Health Unit based upon demand; and, shall provide at least 1.5 FTE Mental Health Clinicians to staff the Step-Down Unit. The contractor shall provide integrated therapeutic modalities including at a minimum Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Cognitive Behavioral Social Skills Training for Schizophrenia, psychoeducation, social skills training and cognitive remediation, in addition to psychotropic medications for residents in need. The contractor shall provide enhanced programming that shall include, at a minimum NA, AA, Anger Management, and TAMAR TIC (C.3.107) groups. The contractor shall support the provision of yoga and mindfulness, art therapy, and music therapy groups by outside organizations by coordinating with them as needed (primarily about space).
See attachment J.45 with a selected list of expected mental health c.5.26.1programming.

**C.5.21.6** The contractor shall operate a women's behavioral health treatment community unit and SUD Therapeutic Housing Unit at the Correctional Treatment Facility and provide both acute and step-down programming for residents housed there. DOC will provide staff for resident supervision and case management in the unit. The contractor shall partner with DOC staff in a treatment team approach to monitor the progress of residents within the unit. The contractor shall provide the services of 0.5 FTE Psychiatrist, whose services may be shared with other DOC services, for example, the Acute Behavioral Health Unit based upon demand; and, shall provide 1.5 FTE Behavioral Health Clinicians. The contractor shall provide integrated therapeutic modalities including at a minimum, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Cognitive Behavioral Social Skills Training for Schizophrenia, TAMAR Group, psychoeducation, social skills training and cognitive remediation in addition to psychotropic medications for residents in need. The contractor shall provide enhanced programming that shall include, at a minimum NA, AA, Anger Management, and TIC groups. The contractor will support the provision of yoga and mindfulness, art therapy, and music therapy groups by outside organizations by coordinating with them as needed (primarily about space). Should those organizations discontinue programming, the contractor shall ensure that within 2 months, these services will continue to take place with the same frequency as they were taking place before discontinued. This will be subject to the availability of funds and the execution of a contract modification.
See attachment J.45 with a selected list of expected mental health programming.

The combined requirement for C.5.21.5 and C.5.21.6 shall not exceed 0.5 FTE Psychiatrist and 1.5 FTE Behavioral Health Clinicians.

**C.5.21.6.1** The contractor shall operate a Men's SUD Focused Therapeutic Housing Unit to provide comprehensive programming, medical and MH services for residents housed there. DOC will provide staff resident supervision and case management. Staffing model to continue per SOR plan programmatic offerings shall be the same as the Women's Therapeutic Unit overall with Covington Based Curricula focused on men in recovery.

**C.5.21.7** The contractor shall provide care for residents placed in safe cells as per Suicide Prevention Policy and Procedures 6080.2. Care shall include OHSA audit requirements.

**C.5.21.8** The contractor shall provide the following behavioral health services:

**C.5.21.8.1** Open Population Management Clinics;

**C.5.21.8.2** Behavioral Health Sick Call;

**C.5.21.8.3** High Acute Observations;

**C.5.21.8.4** Application and Maintenance of Restraints;

**C.5.21.8.5** Development of Behavior Management and Individual Treatment Plans;

**C.5.21.8.6** Consultations Routine and Emergency;

**C.5.21.8.7** Individual Counseling and Psychotherapy (Including CBT and DBT and other comprehensive treatment groups and individual treatments as outlined and specified in section C.5.21.6 and in attachment J.45;

**C.5.21.8.8** Discharge Planning;

**C.5.21.8.9** Psychotropic Medication Management/Clinics;

**C.5.21.8.10** Suicide Assessment;

**C.5.21.8.11** Behavioral Health Programs on Therapeutic Community Housing Units (C.5.21.8.7);

**C.5.21.8.12** Assessment of potential impact to behavioral health prior to placement in Restrictive Housing; and,

**C.5.21.8.13** Documented behavioral health rounds on a weekly basis on the Restrictive Housing Units;

**C.5.21.8.14** The contractor shall document evidence in the EMR to demonstrate a multidisciplinary approach to promote integration between behavioral health and medical treatment, e.g. documenting agreement on housing unit

recommended between provider and MHC in IRC, which shall also reflect any pertinent custody information and legal charges against residents. The contractor shall participate as a part of DOC's multi-disciplinary teams focused on understanding and effectively addressing the non-compliant and/or destructive behavior of those who frequently utilize Restrictive Housing. The contractor shall provide this as requested, to the Office of Health Services Administration.

## C.5.22 PHARMACY SERVICES / MANAGEMENT OPERATIONS

**C.5.22.1** The contractor shall manage and operate DOC's Automated Pharmacy Management System which includes an automated dispenser of pharmaceuticals, the TCGRx ATP machine, and Inspect Rx system. The contractor shall generate and submit various detailed reports (J.22) to CA. CA will specify reports prior to award. The contractor shall obtain all the necessary training for staff responsible for operating automated dispensing machines. The contractor shall provide detailed staffing plan that supports delivery of operations which shall include, but not be limited to: a detailed staffing chart depicting employee coverage; plan for inventory control; and schedule for training. **The contractor shall purchase all pharmaceuticals based on the current formulary.** Any changes to the formulary must be approved by the CA.

**C.5.22.2** The contractor shall possess a minimum of five years of corrections-based experience in the management and distribution of pharmaceuticals in a maximum-security facility. The contractor shall manage inventory, packaging, distribution, accounting for and auditing of pharmaceuticals. The contractor, together with their subcontractor (if using subcontractor for pharmacy services), shall:

**C.5.22.3** Review current pharmacy operations and interview stake holders;

**C.5.22.4** Review District of Columbia DCMR 22 regulatory and contractual requirements related to pharmaceuticals; and, shall document the status of adherence with the aforementioned requirements within 90 days of award. The contractor shall prepare and implement a written plan to address any deficiencies identified. Contracting officer and contract administrator will approve the plan; and

**C.5.22.5** The contractor shall review impact of any recently passed federal health care legislation on pharmaceuticals and report findings to the CA.

**C.5.22.6** Upon DOC's notification of resident's release or transfer the contractor shall prepare and issue medications in the following manner:

**C.5.22.7** The contractor shall provide Residents transferring to the Federal Bureau of Prisons with a seven day supply of medications if such are medically required;

**C.5.22.8** For Residents transferring to the HWH the contractor shall provide a three day supply of medications; and prescriptions for each of their medications;

**C.5.22.9** For all HIV positive residents the contractor shall provide 30-day supply of medication upon release to community;

**C.5.22.10** For all other community releases the contractor shall provide a 30-day supply of medications and a prescription;

**C.5.22.11** For all Courthouse releases the contractor shall provide a 30-day supply of medications and a prescription;

**C.5.22.12** For all Residents released to the community after ten p.m. the contractor shall provide a 30-day supply of medications; and,

**C.5.22.13** The contractor shall deliver all prescription medications, i.e., those prescribed by the responsible practitioner and compounded and dispensed by the pharmacy, to the residents in conformance with District law. The contractor shall provide on-call coverage by a licensed pharmacist 24 hours/day, seven days/week including holidays for routine and emergency needs.

**C.5.22.14** The contractor shall ensure formulary management, pharmacy and therapeutic coordination. A clinical pharmacist shall assist contractor with pharmaceutical enhancements to help ensure pharmacy safety and cost effectiveness. The contractor shall work with DOC's Office of Health Services Administration to conduct a quarterly Pharmacy and Therapeutics Committee Meeting. The contractor shall develop policies and procedures to include medications on the formulary and other committee processes. The contractor shall keep committee abreast of current drug topics, guidelines, standards, and regulatory changes that will affect medication. The purpose of the P&T committee is to exercise tight control on pharmaceutical expenditures without sacrificing quality health care outcomes.

**C.5.22.15** DOC will chair the Pharmacy and Therapeutics Committee which meets quarterly with contractor's key clinical and administrative staff as well as pharmacist-unless otherwise re-scheduled by DOC. Written minutes of all Pharmacy and Therapeutics Committee meetings will be prepared and maintained by DOC.

**C.5.22.16** The contractor shall enforce disease state management protocols. The contractor shall work in conjunction with the P&T Committee to serve as educator on medication topics to help design the most cost-effective treatment strategies for the most common disease states. The contractor, in collaboration with the P&T committee, shall develop treatment algorithms and protocols that will result in consistent positive outcomes and reduce variability in patient care.

**C.5.22.17** The contractor shall implement therapeutic interchange protocols for automatic substitution of specific medications for more cost-effective alternatives. The P&T Committee will set forth specific instructions for pre-defined circumstances that govern permissible therapeutic exchanges. For example, P&T Committee may direct that when Lexapro 10 mg (an expensive drug) is ordered, an automatic substitution will occur at the pharmacy level with Celexa 20mg (an inexpensive equivalent).

However, if Lexapro 40 mg is ordered, which is outside the accepted dosage range, the contractor shall perform a Drug Utilization Review (DUR, C.3.46) or non-formulary procedure instead of a therapeutic interchange to determine whether a substitution is warranted. Therapeutic interchanges, as well as DURs, streamline the prescribing process and help avoid repetitive and unnecessary non-formulary requests. They also maintain continuity of care by minimizing the time the patient is without medication due to non-formulary status.

**C.5.22.18** The contractor shall, in conjunction with DOC, and the P&T committee, perform frequent drug utilization reviews in order to electronically recommend to providers more cost-effective medications. When non-formulary medications, or cost prohibitive formulary medications are ordered, the contractor shall provide clinical recommendations with supporting rationale and cost avoidances.

**C.5.22.19** The contractor shall maintain documentation and provide DOC all relevant information necessary for ordering controlled drugs and maintaining prescription logs, inventory, medication administration records, patient profiles and prescriptions. The contractor's prescription practices shall be subject to District and Federal Government audits.

**C.5.22.20** The contractor shall maintain and provide necessary accounting and reporting so that DOC will receive reimbursements to which it is entitled, including but not limited to the DOH AIDS Drug Assistance Program. The contractor shall utilize a formulary approved by DOC and dispensing of pharmaceuticals shall be in accordance with District of Columbia and Federal laws, and pharmacy regulatory boards.

**C.5.22.21** The contractor shall ensure medications are available to all areas that require administration or distribution. The contractor shall maintain documentation of all stocked medications issued outside of the pharmacy. The contractor shall work with nursing where all medications are dispensed to ensure a level of par levels and shall log declining stock levels the management system is set up for non-patient medications

**C.5.22.22** The contractor shall maintain a collaborative relationship with DOC and any of its contractors. The contractor shall perform other parts of the RFP either alone, or in consultation with the health services contractor, to include but not limited attendance at required meetings.

**C.5.22.23** The contractor shall provide, if applicable, on-site pharmacy services at the CDF, including but not limited to pharmaceutical operations with licensed pharmaceutical staff (if required); inventory control; periodic inventory reconciliations and audits; and dispensing, distribution and disposal of all pharmaceuticals. The contractor shall ensure pharmaceuticals are delivered to resident population in a manner that is consistent with distribution best practice within a jail setting.

**C.5.22.24** The contractor shall fulfill all auditing/reporting obligations of both a 340B and OTP agreement if engaged in one and be fully responsible for any financial penalties resulting from erroneous auditing.

**C.5.22.25** The contractor shall submit a revised pharmacy staffing plan to the CA for approval within 30 days of any future system enhancement. (F.3.6).

**C.5.22.26** In the event contract is terminated, the contractor shall ensure that all DOC pharmaceutical information/ data is provided to DOC within 30 days of termination of contract. In addition, DOC shall retain ownership of all software, hardware and data in the event of contract termination or expiration.

**C.5.22.27** The contractor shall pay for costs related to any computers, lap tops or tablets that they break related to the eMAR system.

**C.5.23 Medical Information Systems**

**C.5.23.1** The contractor shall be responsible for building interfaces among DOC various applications. The contractor shall design, develop, test and deliver all interfaces as specified in (C.5.23.3) at their own expense. DOC will provide the contractor necessary access to the specified systems to perform the task. DOC reserves the right to retain 20% of total contract integration cost. These funds shall be released to the contractor upon completion and being fully tested by DOC.

The contractor shall provide DOC network and application access with individual logon credential. All business or non-business-related activities performed on DOC network shall be subject to being monitored and recorded. The contractor s shall be strictly responsible for any access rule violation or any type of operation disruption or damage.

**C.5.23.2** Once the Clinical systems integration with OMS is upgraded the contractor shall have it fully tested, functional and operational within six months of contract award or upgrade, whichever is later.

**C.5.23.3** The contractor shall submit an integration plan for the DOC EMR, CIPS, TCGRx (if needed), OMS and eMAR application once OMS is updated. DOC's vendor for the OMS upgrade will collaborate with the contractor upon vendor's contract award to discuss detailed specifications for each interface.

(A) Offender Management System (OMS, C.3.83) ←Bidirectional Interface → EMR

Interface shall include but not be limited to the following vital information:

#DCDC (C.3.40) number, Name, Age, Gender, Race

**C.5.23.4** DOC EMR is GE Centricity 9.8, client server application with 100 user licenses. The current database version is Oracle 11.2. And current interfaces are: a) Centricity ->EMR link -> LabCorp (Bi-directional) b) hypersend for LabCorp c) DTS (Data Transfer) for OMS, Centricity.

**C.5.23.5** DOC OMS current version is 6.1.1, current database version is Oracle 11.2.0.4. DOC will soon be migrating to a new Microsoft Dynamics based information system called Offender360 which will interface with Centricity in through a bi-directional interface. The go-live date is yet to be determined. Current OMS 6.11 has Interfaces with a) DTS (Data Transfer) for OMS, Centricity b) Western Union c) Paper Clip d) Keefe Commissary.

**C.5.23.6** DOC CIPS- http://www.kalos-inc.com

Pharmacy software version is CIPS 9 and there is no interface currently. Integration with GE Centricity, OMS, Automate Dispensing System and eMAR shall be required.

**C.5.24** **Data Quality Assurance**: The contractor and subcontractors shall maintain all health services information in DOC information systems to the highest standards of accuracy, integrity, inter-system consistency (data derived from JACCS, and in Centricity, CIPS, and eMAR, and, external medical records, if any, shall be consistent), and with all required security. The contractor shall be responsible for accounting for any apparent variances in data quality. If data quality lapses are identified, the contractor shall submit in writing to the contract administrator and contracting officer an approved plan to address identified gaps and lapses. The contractor shall address these within specified time-period. Liquidated damages may result if the contractor fails to address the issues in a timely manner per approved plan.

**C**.5.24A The contractor shall provide new and updated forms and templates on the EMR at the request of the Medical Director, with forms available within three weeks of the Medical Director's request, and at no charge to the District, based on Medical Director's discussions with OHSA.

**C.5.25** **HIV COUNSELING, TESTING, REFERRAL, AND DISCHARGE PLANNING (CTRD)**

**C.5.25.1** Automatic HIV CTRD services is a vital program in DOC. The goal is to:

**C.5.25.2** Assess the prevalence of HIV disease within the DOC resident community;

**C.5.25.3** Continue and improve upon the existing HIV prevention program that supports reduction of HIV transmission and encourages individual, group and community level behavior change;

**C.5.25.4** Increase the number of residents who know their status;

**C.5.25.5** Formulate HIV policies and programs that address the needs of all sectors of the correctional community;

**C.5.25.6** Maximize the utilization of human, technological and other resources necessary to prevent HIV transmission; and

**C.5.25.7** Ensure that high quality HIV services are delivered in a timely and culturally appropriate manner.

**C.5.25.8** District will provide the contractor condoms, upon request, at no expense to the contractor.

**C.5.25.9** The contractor shall be responsible for health education supplies, ensuring all staff performing HIV testing are qualified and trained to deliver services and have signed confidentiality statements.

**C.5.25.10** The contractor shall provide all residents HIV counseling and testing at the time of intake, with the following exceptions:

**C.5.25.11** If there is a documented HIV test in the EMR that occurred within 120 days of their current intake,

**C.5.25.12** If the resident refuses,

**C.5.25.13** If the resident provides documentation or self-report of HIV diagnosis, or,

**C.5.25.14** If the resident is a weekender who has been tested at least once.

**C.5.25.15** The contractor shall provide HIV CTRD at intake, sick call and upon resident's release.

**C.5.25.16** The contractor shall use 4$^{th}$ Generation HIV Testing as recommended by CDC and approved by DC Health. The contractor shall provide counseling to those who refuse testing and document in the EMR. **DC Health will supply the testing kits.**

**C.5.25.17** The contractor shall ensure HIV positive residents receive primary medical care, including medications and case management, and shall refer them to behavioral health services, if applicable.

**C.5.25.18** The contractor shall create an HIV education plan. The contractor shall inform infected persons of their status, available medical services, case management services, and other appropriate treatment programs within and outside of DOC at the time of resident encounter.

**C.5.25.19** The contractor shall comply with the HIV CTRD program in accordance to DOC Program Manual 6000.1, Medical Management. .

**C.5.25.20** The contractor shall provide the following prior to the resident's release: 1) medications and 2) referrals to substance abuse treatment and counseling programs, as appropriate.

**C.5.25.21** RESERVED.

**C.5.25.22** The contractor shall implement a quality assurance program, as required by CDC, based on Quality Assurance Guidelines for Testing Using Rapid HIV Antibody Tests waived under Clinical Laboratory Improvement Amendments of 1988, and may be revised.

**C.5.25.23** The contractor shall develop treatment plan recommendations to be incorporated into a discharge plan for each HIV infected resident. The contractor shall attempt to contact recently released persons who were tested but released prior to availability of test results to communicate any new HIV+ status information if their serology is positive.

**C.5.26 SUBSTANCE ABUSE**

**C.5.26.1** The contractor shall provide behavioral health and medical services to all residents with substance use disorders. Specifically, the contractor shall provide an evidence- based/best practices adherent Medication Assisted Treatment program to treat addicted residents. Contractor shall provide MAT to residents who enter the facility on MAT continuing the form of MAT they were on as resident prefers. Contractor shall initiate Suboxone/Methadone for eligible residents and provide treatment and counseling (including Cognitive Behavioral Therapy as able) and medical detoxification for drug and alcohol dependence to addicted residents as best practice indicates. Contractor shall use NIDA/Assist Screening Tools at intake. Contractor shall have appropriate licenses, protocols and policies for initiating MAT for new patients. Contractor shall include description of both medical initiation and detoxification policies in its operations manual.

**C.5.26.2** The contractor shall coordinate its services with the DOC Residential Substance Abuse Treatment program. DOC RSAT model views substance abuse through the lens of chronic disease and provides residents timely and prompt access to medical and behavioral health education, treatment and linkages that support their successful re-entry into society. The contractor shall coordinate services with local and regional alcohol and drug treatment programs identified by RSAT Director. The contractor's services shall include provisions for substance abuse education as requested by RSAT...and

provision of MAT for eligible RSAT residents referred by RSAT per established protocol.

**C.5.26.3** The contractor shall comply with Opioid Treatment Program (in accordance with DOC Program Manual – 6000.1, Medical Management, and the Substance Abuse Mental Health Services Administration and its designated accrediting organization. The contractor shall provide a proposal for optimal OTP according to national best practices recommendations regarding Medication Assisted Treatment as previously described.

**C.5.26.4** The contractor shall run the SUD Focused Men's and Women's Therapeutic Housing Units as described in C.5.20.

## C.5.27 DISCHARGE PLANNING

**C.5.27.1** The contractor shall provide internal and external discharge planning to facilitate continuity of care for all residents. The contractor shall provide treatment information, and medications, as needed, to the resident upon release, or transfer to the HWH. The contractor shall work with DBH staff, DOC staff and resident. The contractor's discharge plans shall include follow-up care to medical, dental and mental health providers as needed. The contractor shall link resident to other necessary wrap-around services including, but not limited to, housing, the US Veterans'Affairs Agency, the Social Security Administration (SSA), and Court Services and Offender Supervision Agency.

**C.5.27.2** The contractor shall provide an IDTP for all residents upon intake, as described in C.5.7.1.12 of this RFP. The contractor shall document IDTP in the EMR.

**C.5.27.3** The contractor shall provide treatment recommendations for all residents diagnosed with a chronic or behavioral health disease, prior to their release. The contractor shall document this in the EMR.

**C.5.27.4** The contractor shall provide the following to each resident upon release:

**C.5.27.5** Treatment plans shall contain diagnosis, medication regimen, and an appointment to a medical provider of the resident's choice in the resident's neighboring community or other provider of resident's choice;

**C.5.27.6** Medications prescribed and issued as described in Section C.5.22;

**C.5.27.7** Culturally appropriate educational literature related to the resident's condition written in a manner that the resident can comprehend;

**C.5.27.8** The contractor shall exchange information with the Department of Behavioral Health/DOC Liaisons on-site and community providers that is required to provide continuity of care and facilitate discharge planning.

**C.5.27.9** The contractor's Medicaid certified enroller shall enroll all eligible residents at CTF/CDF, assist residents to complete Medicaid enrollment applications within five days of hospital discharge, and assist residents to complete Medicaid applications, as applicable, at final discharge from the DOC facilities. Some applications may have been started at a hospital if residents were in inpatient status for over 24 hours.

**C.5.28 HOSPITAL SERVICES**

**C.5.28.1** The contractor shall refer residents who require care exceeding the resources available at the CDF or CTF in emergency cases to hospital(s). Within 24 hours of an resident's transfer to a hospital, the contractor shall submit in writing to DOC's Medical Director his or her rationale for the hospital referral--clearly indicating resident's medical needs and facility's capabilities.

**C.5.28.2** The contractor shall subcontract with a minimum of three local hospitals. The contractor shall make timely referrals, based upon the severity of the problem. The contractor shall ensure that the appropriate documentation accompanies all residents transferred for hospital services. The contractor shall ensure that a physician, nurse practitioner, or physician assistant approves all referrals prior to the transfer of an resident.

**C.5.28.3** In the event, after reviewing transfer documentation, should the DOC Medical Director deem the contractor did not adhere to the guidelines and hospitalization was not required to serve the resident's medical needs, the contractor may be cited for unnecessary transfer of resident. In addition, failure to adhere to guidelines may result in poor performance evaluation of the contractor's services.

**C.5.28.4** Upon hospital discharge, the contractor shall return the resident to his or her designated location and administer necessary on-site medical services.

**C.5.28.5** The contractor shall discuss status of hospitalized patients with DOC Medical Director on at least a weekly basis, with a particular focus on when resident may be transferred back to CTF/CDF.

**C.5.28.6** The contractor shall provide appropriate utilization management and review of all hospital referrals.

**C.5.28.7** The contractor shall obtain a report or discharge summary for patients returning from an off-site facility, to include emergency room services, in-patient hospital discharges, and clinic visits- within two weeks of the resident's discharge from that facility. The contractor shall incorporate discharge summary and offsite visit documentation into the EMR.

**C.5.28.8** The contractor shall coordinate continuity of care for each admission and discharge (e.g., having appropriate medication, housing assignment and discharge summary).

**C.5.28.9** The contractor shall bear responsibility for the full cost of transporting all residents to an off-site location for non-911 hospital services.

**C.5.28.10** The contractor shall not be responsible for the cost of hospital services provided to Federal residents (C.3.56) housed at CDF and CTF. The contractor shall provide DOC Federal Billing Unit with all non-emergency offsite specialty requests, prior to scheduling an appointment. The FBU will identify federal versus local (District) residents. Once identification is established, and referral is approved, the contractor shall make the appointment. Emergency room visits do not require pre-authorization. FBU will provide billing information that will allow off-site providers to bill Federal agencies.

**C.5.28.11** The contractor shall be financially responsible for all inter-facility/hospital ambulance transfers and may recoup their direct costs upon authorization of the CA. The contractor shall report all inter-facility transports to the CA (F.3.37).

**C.5.28.12** The contractor shall be financially responsible for all in-patient hospitalization of residents. The CA will authorize reimbursement payments per Sections B.3.1.2, B.3.2.2, B.3.3.2, B.3.4.2, and B.3.5.2.

**C.5.28.13** When medically appropriate, The contractor shall transport special conveyance emergencies to the emergency room as directed by the District of Columbia FEMS.

**C.5.28.14** The contractor shall be responsible for cost of all residents under the custody of DOC who are admitted to a hospital. HWH residents admitted to the hospital that DOC remands back to the CDF or CTF, shall at that time, be the contractor's responsibility as outlined under C.5.28 "Hospital Services."

**C.5.28.15** The contractor shall be responsible for aggressively ensuring all hospital admissions are assessed for readiness to return to a DOC facility in a timely manner. The contractor shall discuss the discharge dispositions status on all outposts daily with the DOC's Medical Director or designee.

## C.5.29 CENTRAL CELL BLOCK (TRIAGE) CLINIC (CCBC)

**C.5.29.1** The contractor shall staff CCBC with a qualified Nurse Practitioner, Physician, or Physician's Assistant licensed to conduct medical and behavioral health screens in the District of Columbia's CCB Clinic as well as assess and treat arrestees for a variety of medical or behavioral health concerns 24 hour a day, seven days a week, including holidays. The contractor's nurse practitioner, physician or physician assistant shall possess a current DC license, current Drug Enforcement Administration (DEA, C.3.41) license in good standing, prescribing privileges, and current Cardiopulmonary Resuscitation (CPR) certification. The District prefers 3-4 years of experience in ambulatory care or in care giving correctional setting.

**C.5.29.2** The contractor shall provide non-urgent medical assessment, treatment and stabilization services, including first aid, cardiopulmonary resuscitation. The contractor as well as DOC will work together in arranging 911 services for arrestees (e.g. whatever entity first responds to a MERT in the facility is responsible for communicating the need for 911 to the CCB Central Command Center).

**C.5.29.3** The contractor shall staff the CCBC with a qualified nurse practitioner, physician, or physician assistant 24 hours per day, seven days a week.

**C.5.29.4** The contractor shall contact the District of Columbia FEMS for transfers to emergency rooms for emergency care beyond the CCBC scope of services. For non-emergencies, DOC will transport arrestees to the hospital emergency room. The contractor shall not be financially responsible for any transportation costs for arrestees.

**C.5.29.5** District will be financially responsible for all 911 transportation costs for arrestees**.** Arrestee shall be financially responsible for all non-emergency transportation costs between CCBC and emergency room.

**C.5.29.6** The contractor shall not be responsible for the cost of arrestees' emergency room visits or hospitalization.

**C.5.29.7** The contractor shall only be responsible for in-patient hospital costs if custody status changes from arrestee to committed resident. The contractor shall be responsible for resident in-patient hospital costs until discharge.

**C.5.29.8** The contractor shall be financially responsible for all inter-hospital ambulance transfers for residents.

**C.5.29.9** The contractor (MD, PA or NP) shall identify each encounter into the DOC Electronic Excel spreadsheet: "DOC CCBC Patient Encounter Form."

**C.5.29.10** The contractor shall administer emergency dose of medication(s) to arrestees. The contractor shall replenish medication stock to maintain par-levels.

**C.5.29.11** The contractor shall inventory, document and replenish contents of first aid kits after each use.

**C.5.29.12** The contractor shall provide CA with "CCBC Metrics" report, as described in Section C.5.41 Reporting.

**C.5.29.13** The contractor shall provide all materials and supplies necessary to carry out the delivery of services under the contract. Contractor shall conduct inventory for expiration dates for supplies and medications and submit to OHSA as requested.

**C.5.29.14** The District will be responsible for the cost of local telephone services in the CCBC.

**C.5.29.15** The contractor shall be prohibited from use of personal cellular telephones inside the CCBC.

**C.5.29.16** DOC will provide two (2) computer stations, printer and copy machine.

## C.5.30 HALFWAY HOUSE

**C.5.30.1** The contractor shall provide discharge planning to include clinic appointments as described in C.5.14 for residents transferred to the District of Columbia Halfway House at the following locations and any new or substitute locations established during the life of the contract:

**C.5.30.3**

Reynolds & Associates (Fairview)
1430 G Street, NE
Washington, D.C. 20002
Typical ADP: 8 Females

**C.5.30.4** The contractor shall conduct medical and or behavioral health clearance evaluation/re-evaluation for residents prior to their transfer to the HWH, incorporate HWH transfers into the discharge planning process as described in C.5.27, and issue medications as described in C.5.22.

**C.5.30.5** The contractor shall ensure that HWH residents, upon discharge from CTF or CDF, have an initial outpatient medical appointment scheduled by the contractor. The contractor shall schedule the appointment in a manner that is amenable to the HWH resident's schedule. In the event that HWH residents require behavioral health and dental appointments, those outpatient appointments shall also be scheduled prior to leaving DOC facilities. HWH residents are responsible for providing their own transportation arrangements and after the initial outpatient clinical appointment scheduled by the contractor, any subsequent outpatient appointments will be made by each HWH resident.

## C.5.31 MEDICAL DISASTER PLAN

The contractor shall participate in planning drills and implement the following procedures pertaining to the delivery of Comprehensive Health Care Services in the event of a disaster such as fire, storm, epidemic, riot, strike or mass arrests. The contractor shall implement the following elements of the Medical Disaster Plan:

**C.5.31.1** Communications system;

**C.5.31.2** Recall of key staff;

**C.5.31.3** Assignment of health care staff;

**C.5.31.4** Establishment of command post;

**C.5.31.5** Safety and security of patient and staff areas;

**C.5.31.6** Use of emergency equipment and supplies;

**C.5.31.7** Establishment of a triage area;

**C.5.31.8** Use of ambulance services;

**C.5.31.9** Transfer of injured to outside hospitals;

**C.5.31.10** Evacuation procedures; and,

**C.5.31.11** Practice drills.

## C.5.32 SAFETY AND SECURITY

**C.5.32.1** The contractor shall initiate, maintain and supervise safety precautions and programs related to services provided under the contract. The contractor shall take all necessary precautions for the safety of its employees and other persons who may be affected thereby. The contractor shall remedy all damage, injury or loss to any property caused, directly or indirectly, in whole or in part, by the contractor, any subcontractor or anyone directly or indirectly employed by the contractor or subcontractor.

**C.5.32.2** The contractor and its personnel shall be subject to and shall comply with all security regulations and procedures of the DOC to include but not limited to all items as described in C.2 Applicable Documents. Violation of these regulations may result in an employee's denial of access into DOC Facilities.

**C.5.32.3** All of the contractor's staff providing services at DOC shall complete pre-service and annual training in a timely manner and complete in-service training provided by the Center for Professional Development and Learning (CPDL) at DOC each year. CPDL will schedule the contractor's personnel in coordination with the CA. The contractor shall also comply with procedures for annual renewal of ID badges for DOC facilities on an annual basis prior to the expiration date on each personnel member's badge.

## C.5.33 MEDICAL PERSONNEL, TRAINING AND STAFFING PLAN (F.3.43)

**C.5.33.1** The contractor shall propose and maintain a staffing complement necessary to ensure provision of comprehensive services under this contact on a 24/7 hours a day, seven days a week (including holidays) basis. The staffing plan may be adjusted, from time to time, based on changing population numbers and needs with the contract administrator and contracting officer's prior written approval. Should the contractor personnel normally assigned to provide comprehensive

health care services not be available, the contractor shall receive advance written approval of CA prior to replacement of key personnel.

**C.5.33.2** The contractor shall include, as a part of the staffing plan, a written job description for each member of health care staff, which clearly delineates assigned responsibilities. The contractor may choose to provide a staffing plan which represents a mixture/blend of 12-hour shift for medical providers and 8-hour shift for Monday to Friday administrative personnel; or 8-hour shifts for all staff. The contractor shall propose a staffing plan resulting in "best value" to the District. The contractor shall fully justify proposed staffing plan, based on service scope, workloads, accreditation requirements and peer jail patterns. The District reserves the right to re-negotiate staffing levels and associated price adjustments (to include cost savings) with the contractor to meet the minimum need for service.

**C.5.33.3** RESERVED

**C.5.33.4** The contractor shall submit revised staffing plan for medical records to CA for approval within 30 days of integrated information system implementation as described in Section C.5.22.25 and F.3.43.

**C.5.33.5** The contractor's and any subcontractor's staff shall comply with all current and future state, federal, and local laws and regulations, court orders, department rules, policies, and procedures. All of the contractor's and all the subcontractor's staff who provide services at DOC facilities shall comply with DOC's timekeeping system required procedures (F.3.10).

**C.5.33.6** The contractor shall recruit, interview, hire, train and supervise all health care and administrative staff. The contractor shall maintain a sufficient number of personnel to provide all services required in the contract. All health care staff provided by the contractor shall be licensed, certified, or registered, as appropriate, in their respective areas of expertise, as required by applicable District law and accepted standard of medical, dental, and behavioral health practices. Any and all personnel of the contractor shall be required to pass a background investigation conducted by DOC as a requisite for initial and continued employment If during OHSA audits, contractor staff found not to be in compliance with employment requirements, those staff will be barred entrance immediately until compliance demonstrated.

**C.5.33.7** The contractor shall ensure adequate staff coverage 24- hours per day, seven days a week, including holidays.

**C.5.33.8** The contractor shall be responsible for ensuring that all new health care personnel are provided with orientation regarding on-site security and medical practices. All clinical individuals hired for positions under the proposed contract shall attend DOC's 40 hours of initial pre-service training after having been cleared through a background check and drug testing, and 16 hours of continuing education training annually thereafter. As necessary, The contractor

shall backfill positions during continuing education training to ensure adequate staffing levels are maintained to execute operations.

**C.5.33.9** The contractor shall maintain current Cardiopulmonary Resuscitation (CPR) certification for applicable employees. The contractor's primary urgent care providers shall maintain current ACLS certifications. The contractor shall submit monthly updates to CA, or upon request, documentation of the following: 1) current CPR or ACLS-certification, as applicable, 2) current Tuberculosis and Hepatitis-B screening, 3) current licensing and certification prior to attending DOC's 40 hours initial pre-service, and annual in-service training. The contractor shall be responsible for any expense required for off-site training. The District will provide: pre-service/in-service training, (initial) drug screening and background check.

**C.5.33.10** The contractor employees shall be subject to random drug testing conducted by DOC. Random drug testing of all contractor's employees will be performed at DOC's expense. The District may bar contractor's employees from providing services on this contract for refusal of drug tests or positive drug tests.

**C.5.33.11** The District reserves the right of approval for all contractor's hiring of employees working within a DOC facility. The District reserves the right to ban or remove any personnel from DOC facilities at any time, and, will advise the contractor and the contracting officer in writing.

**C.5.33.12** The contractor shall not perform any of its corporate functions and tasks at the expense of DOC by using contract-mandated positions or budgeted direct service positions approved by the CA to satisfy health care program administrative responsibilities. The contractor shall provide for necessary corporate responsibilities such as submission of payroll documents and timekeeping, corporate personnel functions, and any accounts payable tasks to be performed through sources outside of direct service hours defined in the approved staffing plan.

**C.5.33.13** The contractor shall be responsible for credentialing and certification of its staff, this includes subcontractors who provide tele-healthcare services. The contractor shall maintain and certify valid and current licenses and certifications as required for all health care providers and make available monthly, or upon request, to the CA.

**C.5.33.14** Medical Professional Staff: The contractor shall utilize all applicable District regulations and the standards of ACA and NCCHC for Medical Professional Staff appointments. The contractor shall validate and certify credentials of all Medical Professional Staff appointed at DOC through either a primary or secondary source and submit these to the CA prior to pre-service training. The contractor shall reconfirm and recertify credentials annually and a record of the credentialing activity shall be maintained as part of each employee's personnel file. The contractor shall provide hard copies to OHSA. Credentialing is defined as the process by which an applicant's training, degrees conferred, certification by specialty societies, state and other licenses, teaching positions,

appointments and other professional experience is confirmed or reconfirmed. The contractor shall provide proof of credentialing and certification to the CA within five business days of request.

**C.5.33.15** Non-Medical Professional Staff: The contractor shall use a process whereby applicants carry the burden to produce information for proper evaluation of competence, character, health status, ethics, and other qualifications. The contractor shall review, certify and make available to the CA, upon request, the validity of licenses or certifications of non-medical professional staff. All dieticians shall have current/active credentials for professional dietitian services accepted by the District.

**C.5.33.16** The contractor shall ensure the fulfillment of any and all Medical Staff privilege requirements at participating hospital(s).

**C.5.33.17** The contractor shall maintain personnel files on all contract employees. The contractor shall provide these records promptly to the CA upon request. These files shall include but not be limited to copies of current professional licenses, privileges, proof of professional certification, evaluations, and salary/payroll records (C.5.43.7, F.3.8).

**C.5.33.18** The contractor shall warrant that all persons assigned by it to perform the work requirements herein will be employees of the contractor or subcontractor approved by DOC, and shall maintain all required licenses to perform the work required herein. The contractor shall submit proof of licensure to the Office of Health Services Administration upon hire and monthly updates thereafter, or upon request. The contractor shall include an identical provision, covering required licenses and full qualification for work assigned, in any contract with any approved subcontractor selected to perform work hereunder. Any personnel requirements per this contract shall not be changed unless approved, in advance, by the contracting officer in writing. Staffing shall include any individuals named in the contractor's proposal at the level of effort proposed, except in cases whereby the contracting officer has approved a change. The contractor and all of its employees/subcontractor shall be at least 21 years of age to be eligible to provide services in any DOC facilities.

**C.5.33.19** The contractor shall establish a plan to replace any employee unavailable to provide services on this contract. The CA will review and approve the plan.

**C.5.33.20** The CA will give written notice to the contractor and CO of anyone removed from a DOC facility within 24 hours. In the event of removal of any of the contractor's employees, the contractor shall be responsible for ensuring no interruption of services occurs as a result of the removal. In addition, the contractor shall be responsible for replacing the employee immediately.

**C.5.33.21** The contractor shall verbally notify the CA of any actual or impending administrator or medical director vacancy by the close of the next calendar day after the contractor receives written notice of the vacancy. Within five calendar

days of the verbal notification, The contractor shall also notify the CA in writing regarding the impending or anticipated vacancy (F.3.9).

**C.5.33.22** The contractor shall not use any residents in positions related to the delivery of any services for any reasons whatsoever. DOC restricts the use of residents to housekeeping and maintenance functions.

**C.5.33.23** The contractor shall utilize the DOC timekeeping system, Time-clock Plus. The contractor shall have three (3) weeks after the provision of services to begin to use the DOC timekeeping system. All data captured by the system is the property of DOC and is subject to random audit. Failure to utilize Time-clock may compromise the security of DOC Facilities and therefore may result in non-compliant staff being subsequently banned from entrance into DOC facilities (F.3.10).

**C.5.33.24** RESERVED

**C.5.33.25** The contractor staff shall be up to date on all Continuing Education (CE) requirements as applicable. The contractor shall provide CE (C.3.26) and CME (C.3.29) courses for its staff at its own expense. DOC assumes no responsibility in assuring the provision of any CE/CME courses.

**C.5.34 KEY PERSONNEL- DIVERSION, REASSIGNMENT, AND REPLACEMENT**

**C.5.34.1** Key personnel specified in the contract are considered to be essential to the work being performed hereunder. Prior to diverting any of the specified key personnel for any reason, the contractor shall notify the CA at least 30 calendar days in advance and shall submit justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact upon the contract. The contractor shall obtain written approval of the CA for any proposed substitution of key personnel. The contractor's written justification shall provide explanations and justification of the removal as well as the contractor's plan to temporarily and permanently fill the position. The contractor shall not reassign these key personnel or appoint replacements without prior, express, written permission from the CA. The contractor shall promptly provide a qualified replacement as described in section C.5.33.1, to the satisfaction of the DOC for any person so removed. It is preferred that all key personnel are NCCHC Certified Correctional Health Professionals and have undergone Trauma Informed Care training.

**C.5.34.2** No personnel shall be returned to duty without the prior written approval of the CA.

**C.5.35 KEY PERSONNEL:**

Persons occupying the following positions are designated key personnel:

**C.5.35.1** Medical Director;

**C.5.35.2** Behavioral Health Director;

**C.5.35.3** Health Services Administrator;

**C.5.35.4** Director of Nursing;

**C.5.35.5** Pharmacy Director;

**C.5.35.6** Infection Control Coordinator;

**C.5.35.7** The contractor shall not bind any of its employees, or those under contract with the contractor, to any agreement, which would inhibit, impede, prohibit, restrain, or in any manner restrict employees or independent contractors in or from accepting employment with any subsequent medical care provider in the District of Columbia or the District of Columbia Government.

**C.5.36** **KEY PERSONNEL QUALIFICATIONS**:

**C.5.36.1** The contractor's Medical Director shall possess and maintain a current D.C. medical license, DEA, and Controlled Dangerous Substance (CDS) licenses; five years' experience in a correctional setting is greatly preferred.

**C.5.36.2** The contractor's Behavioral Health Director shall possess and maintain a current D.C. license, and a minimum of three years in behavioral health administration, with a minimum of three years in a correctional setting is preferred.

**C.5.36.3** The contractor's Health Services Administrator shall possess and maintain a current bachelor's degree in nursing or health related field; and a master's degree in business, policy, nursing or health related field; minimum of five years supervisory experience in a correctional setting is preferred.

**C.5.36.4** The contractor's Director of Nursing shall possess and maintain a current D.C. license, bachelor's degree in nursing (master's preferred), and a minimum of five years clinical experience with supervisory experience; a minimum of five years' experience in acute care or a correctional setting is preferred.

**C.5.36.5** The contractor's Pharmacy Director shall possess and maintain a current D.C. license and registration, and a pharmacy degree from a pharmacy school accredited by American Council of Pharmaceutical Education (ACPE), master's degree in a health-related field is preferred, as is a minimum of five years of supervisory experience in a clinical or correctional setting.

**C.5.36.6** The contractor's Infection Control Coordinator shall possess a degree in health-related field minimum of five years of experience in a clinical or correctional setting is preferred.

## C.5.37 PEER REVIEW, UTILIZATION MANAGEMENT, MEDICAL RECORDS, SUPPLIES, AND EQUIPMENT

### C.5.37.1 PEER REVIEW (F.3.11)

The contractor shall provide a practitioner peer review program (Section F.3.11 Deliverables) consisting of at least four hours of on-site practitioner time every three months to conduct chart reviews of a statistically valid sample of practitioner staff in the areas listed below. The contractor shall review each of the areas listed below at least quarterly based on the District's fiscal year. The contractor shall provide a copy of the peer review reports to the CA by the 10th day of the following quarter:

**C.5.37.1.1** Sick Call;

**C.5.37.1.2** Infirmary Admissions;

**C.5.37.1.3** Hospitalization Referrals;

**C.5.37.1.4** Specialty Referrals;

**C.5.37.1.5** Prescribing Patterns;

**C.5.37.1.6** Ancillary Service Utilization;

**C.5.37.1.7** Infectious Disease;

**C.5.37.1.8** Chronic Care Clinic;

**C.5.37.1.9** Mortality and Morbidity;

**C.5.37.1.10** Dental Care;

**C.5.37.1.11** Behavioral Health.

### C.5.37.2 UTILIZATION MANAGEMENT

**C.5.37.2.1** The contractor shall provide a system that evaluates medical necessity of in-patient and outpatient referrals/services; tracks all requests for offsite services; monitors and communicates with offsite providers; and manages costs.

**C.5.37.2.2** The contractor shall review the health care status of residents referred off-site for in-patient and out-patient care to ensure that number of such referrals and the duration of care is medically appropriate.

**C.5.37.2.3** The contractor shall submit a monthly report to the CA on hospitalization care that details the number of referrals, date of care, duration of care, appropriateness of care, payment rates and diagnostic category of care. The contractor shall also include in its Hospitalization report, in-patient admission, discharge diagnosis and length of stay as described in attachment J.22.

**C.5.37.2.4** The contractor shall meet with DOC at least once a month to review issues surrounding Comprehensive Health Care Services, including utilization, projections, and other components to coordinate care. The contractor shall address, at a minimum, the following matters at the monthly meetings:

**C.5.37.2.5** Utilization of Comprehensive Health Care Services;

**C.5.37.2.6** Access to Comprehensive Health Care Services;

**C.5.37.2.7** Quality of Comprehensive Health Care Services;

**C.5.37.2.8** Formulating or revising appropriate projection plans for Comprehensive Health Care Services;

**C.5.37.2.9** Review the appropriateness of current funding and future funding;

**C.5.37.2.10** Review utilization of high-cost services, average length of stays, and one-day admissions;

**C.5.37.2.11** Infirmary Utilization;

**C.5.37.2.12** Necessity of Offsite Referrals;

**C.5.37.2.13** Appropriateness of Emergency and Hospital Admissions;

**C.5.37.2.14** Appropriateness of Prescription Patterns;

**C.5.37.2.15** Compliance with Metrics; and,

**C.5.37.2.16** Data quality and any other issues raised by the contractor or DOC.

## C.5.37.3 MEDICAL RECORDS

**C.5.37.3.1** The contractor shall utilize DOC EMR, and, when necessary, a back-up hard copy record system to document all health care services provided to residents.

**C.5.37.3.2** The contractor shall submit plan within 60 days of contract award to scan all patient related hard copy documents into EMR in support of DOC's effort to create a paperless medical record system. Contractor shall include timeline to scan patient related hard copy documents into the appropriate patient's EMR, among other tasks.

**C.5.37.3.3** Contractor shall scan all medically related safe cell forms into the EMR within 48 hours form changed or resident discharged from safe cell.

**C.5.37.3.4** The contractor shall maintain a complete, accurate standardized problem-oriented electronic medical record for all residents in accordance with standards and prevailing medical regulations for confidentiality, retention, and access. The contractor shall submit for approval, by the CA, any proposed changes in medical record forms used currently prior to making changes. The contractor shall be financially responsible for desired changes to existing or development of new forms per meeting with DOC on necessity of form change. The contractor shall submit the new form (approved by DOC) to its IT vendor within 48 hours. The contractor's new form shall be on-line and functional within three weeks from date it is submitted to IT/software form vendor. All resident medical records are the property of the District. The contractor, upon reasonable notice to the District and consistent with applicable federal and District laws and regulations and DOC policies and procedures regarding the privacy and confidentiality of patient records, shall have timely and reasonable access to residents records to inspect or duplicate at the contractor s expense, any individual chart or record produced or maintained by the contractor personnel to the extent necessary to (i) meet responsibilities to residents for whom the contractor has provided services; (ii) respond to any Government or payor audits; (iii) assist in the defense of any malpractice or other claims to which chart or record may be pertinent; and (iv) for any other legitimate business purpose, consistent with residents confidentiality and to the extent permitted by law. Contractor shall hire a Health IT expert with experience with current EMR, eMAR and pharmacy systems, 1.0 FTE.

**C.5.37.3.5** The contractor shall comply with local and federal law, rules and regulations, including without limitation the Health Insurance Portability and Accountability Act (HIPAA) and relevant DOC Program Statements regarding confidentiality of health information. The contractor shall comply with DOC Program Manual 1300.3 Health Information Privacy, and District HIPAA policies regarding the transfer, information safeguards, access, amendment, authorization, minimum necessary determinations, identity and authority verification, restricted use, disclosure and accounting of personally identifiable health information. The contractor shall obtain signed consent forms from residents as required. Signed consent forms shall be placed in the resident's medical record.

**C.5.37.3.6** The contractor shall organize and maintain medical records in the format outlined in DOC Program Manual: 6000.1 Medical Management.

**C.5.37.3.7** In the event the EMR is inoperable, the contractor shall maintain a hard copy record for all residents in accordance with DOC policies and procedures. The contractor shall scan the hard copy record into the appropriate patient electronic medical record within two business days after the EMR is restored.

The contractor shall store all hard copies in a safe, secured area so that these are easily retrievable upon request.

**C.5.37.3.8** The contractor shall not remove any patient related documents from a DOC facility without prior written consent from the CA or DOC Medical Director.

**C.5.37.3.9** The contractor shall submit a re-engineering plan to implement a fully operational integrated information system after DOC completes an upgrade of its OMS. The contractor shall submit plan within 60 days of contract award or OMS upgrade implementation date, whichever is later (F.3.12).

**C.5.37.3.10** The contractor shall implement a paperless system within 12 months of completion of systems reengineering or contract award (whichever is appropriate).

**C.5.37.3.11** The contractor shall be responsible for all costs associated with developing preferred EMR templates and forms.

**C.5.37.3.12** The contractor shall submit a revised staffing plan for CA approval within 30 days of integrated system.

## C.5.37.4 CLINICAL AND ADMINISTRATIVE SUPPLIES AND EQUIPMENT

**C.5.37.4.1** The contractor shall provide all materials and supplies necessary to carry out the delivery of services under the contract- with the exception of supplies and maintenance agreements required for the TCGRx medication packaging machine. The contractor is responsible for ordering supplies from TCGRx that DC DOC shall pay for.

**C.5.37.4.2** The contractor shall be responsible for all telephone services in the medical services area except for CCBC.

**C.5.37.4.3** Cellular telephones shall be prohibited inside DOC apart from official Contractor issued cellular phones for the contractor's key personnel.

**C.5.37.4.4** The contractor shall provide cellular telephones and service to its key personnel. The contractor shall abide by DOC policies in effect for such devices.

**C.5.37.4.5** The contractor shall be responsible for purchasing all DOC approved cleaning products required to promote cleanliness in the medical areas of CDF and CTF. Such supplies include but are not limited to, hand soap and sanitizer, paper towels and disinfectant. DOC approved items are listed in H.11 and H.12.

## C.5.37.5 MEDICAL EQUIPMENT

**C.5.37.5.1** The Medical Equipment Inventory List of current equipment (Attachments J.26 and J.27) availability and operability will be provided to the contractor by the CA at the time of contract award to document equipment available and location. During the first quarter of each District FY, the contractor shall submit to the CA, an updated equipment inventory schedule to include but not limited to; model, serial number, new equipment purchased, repairs, warranties, maintenance, room numbers and facility locations.

**C.5.37.5.2** The contractor shall maintain medical equipment and monitor for operability in accordance with manufacturer's recommendations. The contractor shall replace all equipment in accordance with industry recommended standards. The contractor shall provide reports to CA of major repairs or replacements. The contractor shall obtain from the CA written authorization to repair or replace any equipment prior to replacement or repair (F.3.18).

**C.5.37.5.3** Upon contract expiration or termination, all equipment used on-site, or purchased for DOC facilities by the contractor shall become the property of DOC. The contractor shall surrender all equipment to the DOC in the same condition in which it was initially provided, except for ordinary wear and tear, and loss or damage by flood, fire or other perils covered by extended coverage insurance. All equipment removed from the facility for disposal will be inventoried by security and processed by DOC warehouse at CDF.

**C.5.37.5.4** The contractor shall pay for any IT items related to healthcare broken in the course of service provision or by its staff. DOC will work with various health systems vendors on securing a repair, but the contractor shall be responsible for cost of repair.

**C.5.37.5.5** The contractor shall not use, loan, or rent to a third party any government-furnished equipment, except with prior, written permission of the CA. The contractor shall not, without consent of the CA, move equipment specified in this contract outside the CDF and CTF.

**C.5.37.5.6** The contractor shall not produce, store or use DOC facilities, equipment or inventories for other company-owned or contract operations, or for other individuals, groups or organizations without prior written consent of the CA.

**C.5.38 TELEMEDICINE** (F.3.19)

**C.5.38.1** Telemedicine is the remote diagnosis and treatment of patients by means of telecommunications technology.

**C.5.38.2** The contractor shall continue the fully tested and functional telemedicine system (F.3.19) in the DOC facilities using existing DOC equipment from the date of contract award. The contractor shall strive to ensure that clinical application includes initial patient evaluations, diagnosis (tele-diagnosis), and consultation (tele-consultation).

**C.5.38.3** The contractor shall utilize telemedicine where appropriate. The contractor shall provide specialty service provider evaluations via telemedicine for resident population.

**C.5.38.4** The contractor shall provide the CA with the names and credentials and proof that staff operating the telemedicine system receive the appropriate and ongoing training. The contractor shall also provide the CA proof that the staff receives training in the advances of telecommunications technology and external issues influencing its use within five days of receiving training.

**C.5.38.5** Telemedicine is expected to reduce avoidable off-site clinic appointments by utilizing offsite providers to conduct consultations which otherwise requires a referral to a local hospital or clinic for services. The contractor shall maintain and provide to the CA monthly, documentation of off-site clinic appointments avoided through use of telemedicine.

**C.5.38.6** The contractor shall comply with applicable NCCHC and ACA guidelines for telemedicine technology in corrections.

## C.5.39 ACCESS CONTROL

**C.5.39.1** The contractor shall ensure DOC in-house and contract technical staff have access to all areas of CDF and CTF Medical Units.

**C.5.39.2** DOC shall control access to all systems and applications housed within DOC's jurisdiction. In addition, DOC reserves the right to restrict or deny access rights of any contractor staff found or suspected to be in violation of DOC's and the District's e-mail and internet policies. DOC will provide the contractor with policy statements. The contractor shall sign all policy agreements in these areas before being granted access privileges. The contractor shall work through the CA for resolution of any issues that may arise from this requirement.

**C.5.39.3** DOC shall have unabridged, unannounced and immediate access to all of the contractor's DOC based service/treatment sites, records, data, reports and personnel for conducting on-site audits, including the contractor's treatment and administrative cost records and those of any subcontractor associated with this contract. Except in emergency situations, DOC will not exercise these rights in a manner that interferes with ongoing medical treatment activities.

## C.5.40 GRIEVANCES

**C.5.40.1** The contractor shall have an resident grievance system for all medical, dental and behavioral health related complaints. At a minimum, the contractor's grievance process shall adhere to NCCHC policy J-A-11 and DOC PS 4030.1, Resident Grievance Procedures. This policy shall include both formal and informal complaints. In addition to general requirements, the contractor established grievance process shall include:

**C.5.40.2** Informing all intakes, the contractor shall adhere to DOC's Resident Grievance Process;

**C.5.40.3** Responding to grievances – in writing- within 15 business days from date of receipt;

**C.5.40.4** Providing DOC with a copy of each grievance and its resolution (F.3.39);

**C.5.40.5** Maintaining an electronic grievance log which captures the complaint and its resolution by complaint area; and,

**C.5.40.6** Presenting findings associated with grievances during quality assurance meetings to include members from DOC and the contractor to review trends and reoccurring grievance areas.

**C.5.41 REPORTING (F.3.31)**

**C.5.41.1** All data collected and managed by the contractor on behalf of DOC shall be the property of the District. The contractor shall apply accepted best practice for database management and data quality assurance to ensure the validity of data collected. All data collected and recorded by the contractor are subject to audit. Inconsistencies identified in data quality or (electronic) records keeping may result in questioning of the contractor's clinical practices.

**C.5.41.2** The contractor shall maintain all records in electronic form using modern databases and data quality maintenance and support procedures, as well as standard off-the-shelf software for reporting, such as Microsoft Office or a comparable product. Facilities and agencies external to DOC may require both electronic and hard-copy printouts of resident medical records. The contractor shall make available such records to external facilities when authorized to do so by the CA, while maintaining compliance with H.15, HIPAA.

**C.5.41.3** The contractor shall provide reports as referenced in C.5.41 of this RFP to the CA no later than the 10th business day of each month and as specified in Section F.3.

**C.5.41.4** The contractor shall also provide reports as required by ACA, NCCHC and DOC's incident-reporting guidelines, particularly those related to resident assaults on other residents and staff, fights, and physical altercations.

**C.5.41.5** The contractor shall prepare ad-hoc reports as requested by DOC and submit to CA within three business days or as specified.

**C.5.41.6** The contractor shall enter all medical data related to incidents directly into the DOC electronic medical record including but not limited to certain incidents, such as assault, sexual assault, suicide attempts, resident injury and other incidents. The contractor shall capture and record all examination results

including photographs of injuries taken by DOC staff within 30 minutes of examination. The contractor shall provide silhouettes in electronic form with injuries clearly marked and noted. The contractor shall perform complete examination of residents, as well as occasional record keeping related to staff injuries (emergency care/stabilization or first-aid with a record of referral to private physician).

**C.5.41.7** The contractor shall provide the following reports, including those mentioned in C.5.41.8 through C.5.41.17 which are specified in Appendix J22:

**C.5.41.8** DOC-IHSA 1.1 Clinical Metric Report-collects demand and output metrics required to manage health services performance. In addition, this report consists of six supplemental reports as described below in C.5.41.9 through C.5.41.14 (F.3.28 - F.3.38);

**C.5.41.9** DOC-IHSA 1.1.a Infirmary Care Report-details granular level of data collection required to complete DOC-IHSA 1.1 each month (F.3.28);

**C.5.41.10** DOC-IHSA 1.1.b In-Patient Hospital Report-details granular level of data required to complete DOC-IHSA 1.1 each month (F.3.25);

**C.5.41.11** DOC-IHSA 1.1.c Offsite Specialty Care Report-details granular level of data collection required to complete DOC-IHSA 1.1 each month (F.3.26);

**C.5.41.12** DOC-IHSA 1.1.d AIDS Drug Assistance Program - details granular level of data required to complete DOC-IHSA 1.1 each month;

**C.5.41.13** DOC-IHSA 1.1.e Dental Care Report- details granular level of data required to complete DOC-IHSA 1.1 each month (F.3.32);

**C.5.41.14** DOC-IHSA 1.1.f Central Cell Block Clinic Report – details granular level of data required to complete DOC-IHSA 1.1 each month (F.3.29);

**C.5.41.15** DOC-IHSA 1.2 Financial Metrics – represents per member per day costs by various service lines. Collects service delivery metrics required to manage resident health services performance in addition, this report consists of two (2) supplemental reports noted below in C.5.41.16 through C.5.41.17 (F.3.30);

**C.5.41.16** DOC-IHSA 1.2.b Supplemental Service Listing provides a list of services required to complete DOCIHSA 1.2 each month (F.3.32);

**C.5.41.17** DOC-IHSA 1.3 Performance Metrics – collects efficiency of service delivery metrics required to manage resident health services performance (F.3.33);

**C.5.41.18** ACA Performance-Based Standards for Adult Local Detention Facility, Fourth Edition. ACA Metrics reflect national accreditation standards (F.3.35);

**C.5.41.19** In order to enable the District to monitor the effectiveness and extent as well as any challenges to achieving care continuity, the contractor shall report on a

monthly basis the following three metrics in addition to all metrics required in Appendix J22 attached:

**C.5.41.20**. The distinct count of individuals released from DOC to the community in the past 90 days who received services at a provider's community- based clinic or clinic in the provider's broader network (F.3.50);

**C.5.41.21**. The distinct count of individuals released from DOC to the community in the past 180 days who received services at a provider's community- based clinic or clinic in the provider's broader network (F.3.50);

**C.5.41.22**. The distinct count of individuals released from DOC to the community in the past 365 days who received services at a provider's community- based clinic or clinic in the provider's broader network (F.3.50);

DOC will provide a list of DCDCs of individuals who were released to the community to enable the contractor to report the above. The above metrics should be submitted along/concurrently with all the monthly reports required in Appendix J22 and detailed in the preceding text.

**C.5.41.23** For each metric, DOC shall provide the contractor with data source, related targets/benchmarks, and counting/sampling procedures which the contractor shall follow. Unless authorized by CA, the contractor deviation from established procedure may result in liquidated damages.

**C.5.41.24** The contractor shall submit a substantive root cause analysis and corrective action plan to CA for approval within ten days for all metrics which fall ten percent outside target/benchmark (F.3.36).

**C.5.41.25** DOC will audit the contractor's provision of quality health care consistent with ACA, NCCHC, Federal and District regulatory standards, as noted in the DOC Performance Improvement Tool" (PI, C.3.88). DOC may utilize this tool to conduct independent or joint audits with the contractor.

**C.5.41.26** All reports described in C.5.41, may be found in Attachment J.22 Metrics Reports.

**C.5.41.27** The District reserves the right at any time during contract period to add new reports and delete or amend reports listed in Section C.5.41.

**C.5.41.28** The contractor shall provide to the CA a telephone number and an email address available on a 24 hour a day, seven days a week basis, accessible to courts and residents' legal representatives, to receive alerts, concerns about resident health, mental health, and dental health. The communications shall be noted in the patient's electronic medical record. The contractor shall acknowledge receipt and follow up, in a manner compliant with HIPAA and other federal and local privacy law, on an expedited basis as needed, not to exceed 24 hours after receipt of notifications. The contractor shall keep the emails and responses, and a log of all phone messages received, and responded to (if the caller provides contact information), and the general content of each phone message received and response provided. The log shall

contain the time each message was received and response sent and the name of the person who received the message and the name of the person who sent the response. The contractor shall make the log available to the CA upon request (C.5.43.34, F.3.49).

**C.5.42 TB SCREENINGS AND READINGS FOR DOC EMPLOYEES**

The contractor shall provide adequate clinicians LPN, RN, PA, NP or MD to conduct services as follows:

**C.5.42.1** Each clinician shall participate in a mandatory one-hour DOC orientation session. The orientation session shall be held at a place, time and date to be determined. If a clinician has completed the comprehensive DOC orientation within the past year, this shall replace the one-hour DOC orientation session and no additional orientation session is required.

**C.5.42.2** The contractor's Clinician shall administer TST test, which includes planting of Tuberculin on the DOC employees CDF, 1901 D Street SE Washington, DC 20003 on the second floor as outlined by a mutually agreeable schedule.

**C.5.42.3** The contractor's Clinician shall read TST test results for DOC employees at the CDF 1901 D Street SE Washington DC 20003 on the second floor. The clinician shall be available on each day and at each shift during a mutually agreeable schedule.

**C.5.42.4** The contractor's Clinician shall administer TST test, which includes planting of Tuberculin on the DOC employees at the CTF, 1900 E Street SE, Washington, DC 20003, on the second floor as outlined by a mutually agreeable schedule.

**C.5.42.5** The contractor's Clinician shall read TST test results for DOC employees at the CTF, 1900 E Street SE, Washington DC 20003 on the second floor. The clinician shall be available on each day and at each shift during a mutually agreeable schedule.

**C.5.42.7** The contractor's Clinician shall administer TST test, which includes planting, and reading of Tuberculin on the DOC employees at CCB, 300 Indiana Ave N.W. Washington DC 20001 on the first floor. The clinician shall be available on each day and at each shift for the assigned hours as outlined by a mutually agreeable schedule.

**C.5.42.9** All information shall be recorded on a DOC Employee Tuberculosis Screening form and electronically in the designated TB database.

**C.5.42.10** The contractor shall schedule the dates for the above activities for a two-week period prior to April 14th each year, at which date the entire project must be complete and a summary document must be submitted to DOC OHSA. The contractor shall discuss anticipated dates of project with DOC/OHSA by April

14th of each year at the very latest to ensure an agreed upon time of duration and need to alert staff at least two weeks prior to anticipated start date.

**C.5.42.11** The contractor shall ensure that each clinician shall clear the DOC background check and urine drug test prior to orientation, and that all clinicians, providers, and subcontractors provide proof of licensure annually to the Office of Health Services Administration.

**C.5.43 REQUIRED DELIVERABLES**

**C.5.43.1** The contractor shall provide the following deliverables (see F.3 for delivery format and due dates):

**C.5.43.2** Draft Quality Management Plan (F.3.1);

**C.5.43.3** Final Quality Management Plan (F.3.2);

**C.5.43.4** Infection Control Plan (F.3.4);

**C.5.43.5** Revised Pharmacy Staffing Plan (C.5.22.25, F.3.6);

**C.5.43.6** Project Work Plan and Initiation Plan (F.3.7);

**C.5.43.7** Personnel files on all employees, inclusive of the contractor, which include but are not limited to written job description which clearly delineates assigned responsibilities; documentation of current CPR certification; orientation, pre-service, annual, and job specific training records; tuberculosis and Hepatitis-B screening/testing; and staff licensing, credentialing and certification and written verification of each as applicable (C.5.33.17, F.3.8).

**C.5.43.8** Peer Review Results (C.5.37.1, F.3.11);

**C.5.43.9** Paperless System (C.5.37.3.10, F.3.12);

**C.5.43.10** Revised Staffing Plan for Medical Records(F.3.43);

**C.5.43.11** Equipment Schedule (F.3.15);

**C.5.43.12** Test Plan of Medical Operation Related Interfaces (F.3.16);

**C.5.43.13** Telemedicine System (C.5.45.28, F.3.19);

**C.5.43.14** Telemedicine Evaluation Report (F.3.20);

**C.5.43.15** All Reports mentioned in Appendix J.22 (F.3.22);

**C.5.43.16** DOC-IHSA 1.1 Clinical Metric Report (C.5.41.8, F.3.23);

**C.5.43.17** DOC-IHSA 1.1.a Infirmary Care Report (F.3.24);

**C.5.43.18** DOC-IHSA 1.1.b In-Patient Hospital Report (F.3.25);

**C.5.43.19** DOC-IHSA 1.1.c Offsite Specialty Care Report (F.3.26);

**C.5.43.20** DOC-IHSA 1.1.d AIDS Drug Assistance Program (ADAP);

**C.5.43.21** DOC-IHSA 1.1.e Dental Care Report (F.3.28);

**C.5.43.22** DOC-IHSA 1.1.f Central Cell Block Clinic Report (CCBC), (C.5.41.14, F.3.29);

**C.5.43.23** DOC-IHSA 1.2 Financial Metrics (C.5.41.15, F.3.30);

**C.5.43.24** DOC-IHSA 1.2.a Data by Provider Report (F.3.31);

**C.5.43.25** DOC-IHSA 1.2.b Supplemental Service Listing (F.3.32);

**C.5.43.26** DOC-IHSA 1.3 Performance Metric. (F.3.33);

**C.5.43.27** Continuity of Care Metrics (F.3.34);

**C.5.43.28** ACA Performance-Based Standards (F.3.35);

**C.5.43.29** Substantive Root Cause Analysis and Corrective Action Plan for Metrics Missing Targets by Greater Than 10% (F.3.36);

**C.5.43.30** Inter-facility Transports Report (C.5.28.11, F.3.37);

**C.5.43.31** Yearly Comprehensive Actual Cost Inpatient Hospitalization Report (F.3.38);

**C.5.43.32** The contractor shall collect data and deliver to the CA the Monthly Reports specified in Attachment J.22 (F.3.22);

**C.5.43.33** Implement all onsite specialty clinics (C.5.18) within 6 months after contract award (F.3.5).

**C.5.43.34** Telephone and email connectivity for resident health status (C.5.41.28, F.3.49).

## C.5.44 ACCREDITATION

Contractor shall maintain NCCHC and ACA Accreditation for DOC (C.5.6.4) during reaccreditation every three years (F.3.3).

## C.5.45 INCLUSIVE SERVICES

**C.5.45.1** Contractor shall provide comprehensive health care services at the CDF and the CTF in accordance with this contract requirement, standards of the AMA, ACA, NCCHC, HRSA, DHHS, DOC Program Statements, and District law. Contractor Comprehensive Medical, Behavioral Health and Dental Services shall include but not be limited to:

**C.5.45.2** Receiving screenings prior to housing assignment;

**C.5.45.3** Intake assessments for residents at the time of intake;

**C.5.45.4** Sick call, urgent care, chronic care, and onsite and offsite specialty care services;

**C.5.45.5** Utilization management for in-patient hospitalization, offsite specialty care, and all onsite care to include infirmary care, specialty clinics, chronic care, and sick call;

**C.5.45.6** Twenty-four hour (including holidays) emergency dental and urgent care services;

**C.5.45.7** Behavioral health services delivered through a Trauma Informed Care lens including crisis management, suicide management, acute and persistent in-house behavioral health unit and chronic behavioral health and substance use treatment for all eligible residents;

**C.5.45.8** Maintaining ACA and NCCHC accreditation (F.3.3);

**C.5.45.9** Adhering to infection control program in accordance with the CDC, OSHA guidelines, and DOC PS;

**C.5.45.10** Managing Pharmacy distribution and control, to include release Medications;

**C.5.45.11** HIV CTRD;

**C.5.45.12** Medication Assisted Treatment and Medical detoxification for drug and alcohol addictions and coordination with the DOC RSAT program; provide medical and SUD Therapeutic Housing. Comprehensive medical and Mental health services to the men and women SUD therapist housing unit to include the use of certified addictions and Peer Navigation.

**C.5.45.13** Discharge planning. Residents shall receive an Initial Discharge Treatment Plan prior to their housing assignment. The contractor shall provide discharge and treatment plan and medications (as necessary) prior to an resident's release.

**C.5.45.14** Contractor shall begin using DOC timekeeping system within three weeks of award of contract (F.3.10).

**C.5.45.15** Contractor shall coordinate with DOC in conducting medical disaster drills.

**C.5.45.16** Contractor shall maintain minimum staff requirements at the DOC approved staffing plan levels for CDF and CTF 24 hours a day, including holidays.

**C.5.45.17** Contractor shall be responsible for credentialing and certification of its staff.

**C.5.45.18** Contractor shall make immediate notification of any changes to key personnel.

**C.5.45.19** Contractor shall be responsible for all clinical and administrative supplies.

**C.5.45.20** Contractor shall be responsible for all telephone services, to include key personnel cellular phones.

**C.5.45.21** Contractor shall provide reports as outlined in C.5.41 – Reporting Section.

**C.5.45.22** Contractor shall accommodate all on-site specialty clinics within six months from start date (F.3.5).

**C.5.45.23** Contractor shall be responsible for costs of preferred changes to Centricity forms development upon approval of DOC.

**C.5.45.24** Contractor shall enter all data in health applications in accordance with DOC specifications.

**C.5.45.25** Contractor shall, at its expense, integrate DOC's EMR, CIPS, automated dispensing system and eMAR with OMS.

**C.5.45.26** The contractor shall provide Test and Delivery of Medical Operation Related Interfaces (F.3.16, F.3.17) 1 copy Electronic/Hard copy to CA one week before testing and delivery (F.3.17).

**C.5.45.27** The contractor shall repair or replace medical equipment (C.5.23.5.2) as applicable (F.3.18).

**C.5.45.28** The contractor shall implement a fully tested and functional telemedicine system within 12 months of information systems reengineering or contract award (as appropriate) (C.5.38, C.5.43.13, F.3.19).

**C.5.45.29** The contractor shall provide for DOC Incident Reporting (F.3.21).

## C.5.46 SUBCONTRACTED SERVICES

**C.5.46.1** The contractor shall be responsible for subcontracted services to be performed at the time required by DOC, at no additional expense to the District., during extenuating circumstances such as court proceedings.

## SECTION D: PACKAGING AND MARKING

**D.1** The packaging and marking requirements for this contract shall be governed by clause number (2), Shipping Instructions-Consignment, of the Government of the District of Columbia's Standard Contract Provisions for use with Supplies and Services Contracts, dated July 2010 (Attachment J.1).

## SECTION E: INSPECTION AND ACCEPTANCE

**E.1** The inspection and acceptance requirements for this contract shall be governed by clause number five Inspection of Supplies AND clause number six , Inspection of Services of the Government of the District of Columbia's Standard Contract Provisions for use with Supplies and Services Contracts, dated July 2010 (Attachment J.1).

# SECTION F: PERIOD OF PERFORMANCE AND DELIVERABLES

## F.1 TERM OF CONTRACT

The term of the contract shall be for a period of one base year from date of award specified on the cover page of this contract to December 31, 2025.

## F.2 OPTION TO EXTEND THE TERM OF THE CONTRACT

**F.2.1** The District may extend the term of this contract for a period of four option periods, or successive fractions thereof, by written notice to the Contractor before the expiration of the contract; provided that the District will give the Contractor preliminary written notice of its intent to extend at least thirty (30) days before the contract expires. The preliminary notice does not commit the District to an extension. The exercise of this option is subject to the availability of funds at the time of the exercise of this option. The Contractor may waive the thirty (30) day preliminary notice requirement by providing a written waiver to the Contracting Officer prior to expiration of the contract.

**F.2.2** If the District exercises this option, the extended contract shall be considered to include this option provision.

**F.2.3** The price for the option period shall be as specified in the Section B of the contract.

**F.2.4** The total duration of this contract, including the exercise of any options under this clause, shall not exceed five (5) years.

## F.3 DELIVERABLES

The contractor shall perform the activities required to successfully complete the District's requirements and submit each deliverable to the CA identified in section G.9 in accordance with the following:

| | Deliverable | Quantity | Format/Method of Delivery | Due Date |
|---|---|---|---|---|
| 1.<br>C.5.43.2<br>C.5.16.3 | Draft Quality Management Plan | 1 copy | Electronic copy to CA | Within 60 days of contract award |
| 2.<br>C.5.43.3<br>C.5.16.3 | Final Quality Management Plan | 1 copy | Electronic copy to CA | Within 90 days of contract award |
| 3.<br>C.5.44 | Maintain NCCHC and ACA Accreditation | As Needed | Accreditation | During reaccreditation every three years |

| | Deliverable | Quantity | Format/Method of Delivery | Due Date |
|---|---|---|---|---|
| 4.<br>C.5.43.4 | Implement Infection Control Plan | 1 copy | Electronic copy to CA | Upon commencement of services |
| 5.<br>C.5.18<br>C.5.45.22 | Implement all onsite specialty clinics | N/A | N/A | 6 months after contract award |
| 6.<br>C.5.22.25 | Revised pharmacy staffing plan | 1 copy | Electronic copy to CA | within 30 days of any future system enhancement |
| 7.<br>C.5.43.6 | Project work plan which includes an initiation plan prior to implementation and status reporting | 1 copy | Electronic Copy to CA | After Transition if any and prior to providing contractual services |
| 8.<br>C.5.33.17<br>C.5.43.7 | Personnel files on all employees, inclusive of the contractor, which include but are not limited to written job description which clearly delineates assigned responsibilities; documentation of current CPR certification; orientation, pre-service, annual, and job specific training records; tuberculosis and Hep-B screening/testing; and staff licensing, credentialing, and certification and written verification of each as applicable. | 1 file per employee | Electronic to CA | Upon Request |
| 9.<br>C.5.33.21 | Verbal and written notification to CA of any actual or impending administrator or medical director vacancy. | 1 copy | Hard and Electronic copy to CA | Within 24 hours after knowledge of potential vacancy. |
| 10.<br>C.5.33.5<br>C.5.33.23<br>C.5.45.14 | Utilize DOC timekeeping system | N/A | N/A | Within 3 weeks of contract award |
| 11.<br>C.5.37.1<br>C.43.8 | Peer Review Results | 1 copy | Electronic copy to CA | Quarterly-Fiscal Year |

| | Deliverable | Quantity | Format/Method of Delivery | Due Date |
|---|---|---|---|---|
| 12.<br>C.5.37.3.9 | Re-engineering plan–paperless system | 1 copy | Electronic copy to CA | Within 60 days of contract award |
| 13.<br>C.5.23.3 | Implement software/application interfaces with upgraded OMS | N/A | N/A | As determined by DOC (based on new OMS process) |
| 14. | RESERVED | N/A | N/A | N/A |
| 15.<br>C.5.43.11 | Submit Equipment Schedule to CA | 1 copy | Hard copy to CA | Annually |
| 16.<br>C.5.43.12 | Test Plan of Medical Operation Related Interfaces | 1 copy | Electronic/Hard copy to CA | Before commencement of services. |
| 17.<br>C.5.45.26 | Test and Delivery of Medical Operation Related Interfaces | 1 copy | Electronic/Hard copy to CA | One week before testing and delivery |
| 18.<br>C.5.45.27 | Repair or replacement of medical equipment | N/A | Electronic/Hard copy to CA | As applicable |
| 19.<br>C.5.38<br>C.5.43.13<br>C.5.45.28 | Implement a fully tested and functional telemedicine system | N/A | N\A | Within two months of contract award. |
| 20.<br>C.5.43.14 | Telemedicine Evaluation Report | 1 copy | Electronic copy to CA | Within 60-days after 1-year implementation of telemedicine. |
| 21.<br>C.5.45.29 | DOC Incident Reporting | 1 copy | Hard copy to CA | Per incident requiring reporting |
| 22.<br>C.5.43.32 | All Reports mentioned in Appendix J.22 | 1 copy | Electronic copy to CA | 3rd business day of the beginning of the month. |
| 23.<br>C.5.41.8 | DOC-IHSA 1.1 Clinical Metric Report | 1 copy | Electronic copy to CA | 3rd business day of the beginning of the month. |
| 24.<br>C.5.41.9<br>C.5.43.17 | DOC-IHSA 1.1.a Infirmary Care Report | 1 copy | Electronic copy to CA | 3rd business day of the beginning of the month. |
| 25.<br>C.5.43.18 | DOC-IHSA 1.1.b In-Patient Hospital Report | 1 copy | Electronic copy to CA | 3rd business day of the beginning of the month. |

| | Deliverable | Quantity | Format/Method of Delivery | Due Date |
|---|---|---|---|---|
| 26.<br>C.5.41.11 | DOC-IHSA 1.1.c Offsite Specialty Care Report | 1 copy | Electronic copy to CA | 3rd business day of the beginning of the month. |
| 27. | RESERVED | | | |
| 28.<br>C.5.43.21 | DOC-IHSA 1.1.e Dental Care Report | 1 copy | Electronic copy to CA | 3rd business day of the beginning of the month. |
| 29.<br>C.5.41.14<br>C.5.43.22 | DOC-IHSA 1.1.f Central Cell Block Clinic Report (CCBC) | 1 copy | Electronic copy to CA | 3rd business day of the beginning of the month. |
| 30.<br>C.5.41.15<br>C.5.43.23 | DOC-IHSA 1.2 Financial Metrics | 1 copy | Electronic copy to CA | 3rd business day of the beginning of the month. |
| 31.<br>C.5.43.24 | DOC-IHSA 1.2.a Data by Provider Report | 1 copy | Electronic copy to CA | 3rd business day of the beginning of the month. |
| 32.<br>C.5.41.16<br>C.5.43.25 | DOC-IHSA 1.2.b Supplemental Service Listing | 1 copy | Electronic copy to CA | 3rd business day of the beginning of the month. |
| 33.<br>J.22<br>C.5.41.17<br>C.5.43.26 | DOC-IHSA 1.3 Performance Metrics ( | 1 copy | Electronic copy to CA | 3rd business day of the beginning of the month. |
| 34.<br>C.5.43.27 | Continuity of Care Metrics | 1 copy | Electronic copy to CA | 3rd business day of the beginning of the month. |
| 35.<br>C.5.41.18,<br>C.5.43.28 | ACA Performance-Based Standards | 1 copy | Electronic copy to CA | 3rd business day of the beginning of the month. |
| 36.<br>C.5.41.24,<br>C.5.43.29 | Submit substantive root cause analysis and corrective action plan for metrics missing targets by greater than 10%. | 1 copy | Electronic copy to CA | 15th day of the beginning of the month. |
| 37.<br>C.5.28.11<br>C.5.43.30 | Inter-facility Transport Reports | 1 copy | Electronic copy to CA | 15th day of the beginning of the month. |
| 38.<br>C.5.43.31 | Yearly Comprehensive Actual Cost Inpatient Hospitalization Report | 1 copy | Electronic copy to CA | Annually, within 30 days after each fiscal year (September 30th) end |
| 39.<br>C.5.40.4 | A copy of each grievance and its resolution | 1 copy | Electronic copy to CA | Within 5 business days after resolution |

| | Deliverable | Quantity | Format/Method of Delivery | Due Date |
|---|---|---|---|---|
| 40.<br>H.9.3<br>H.13.7 | Fully executed copies of all subcontracts | 1 copy | Electronic copy to CO, CA, DC Auditor, Director DSLBD | Within 21 days of date of award |
| 41.<br>H.9.4 | Quarterly Subcontracting Compliance Report | 1 copy | Electronic copy to CO, CA DC Auditor, Director DSLBD | 15th day of the beginning of the following quarter |
| 42.<br>C.5.1.1.5 | An Operations Manual that includes procedures, protocols and methodologies for treatment; a description of treatment programs; nursing care procedures for infirmary care; | 1 copy | Electronic/Hard copy to CA | Before commencement of services. |
| 43.<br>C.5.1.1.6 | Final Staffing Plan | 1 copy | Electronic/Hard copy to CA | Before commencement of services. |
| 44.<br>C.5.1.1.7 | Quality Management Program Manual approved by the CA | 1 copy | Electronic/Hard copy to CA | Within 90 days after the award |
| 45.<br>C.5.1.1,<br>C.5.1.2 | 45.Transition Plan approved by the CA | 1 copy | Electronic/Hard copy to CA | Within 30 days after the award |
| 46.<br>C.5.14.4 | Provide residents with Patient Education and nutritional/dietary counseling as needed. | As Needed | TBD | TBD |
| 47.<br>C.5.18.10 | Retain Dialysis Quality Improvement Plan, monthly productivity statistics and quality performance results | Upon DOC request | Electronic/Hard copy to CA | TBD |
| 48.<br>C.5.21.8.13 | Documented Behavioral Health Rounds on a weekly basis on the Restrictive Housing Units; | Upon DOC request | Electronic/Hard copy to CA | TBD |
| 49.<br>C.5.41.28,<br>C.5.43.34 | Log of incoming telephone messages/requests and outgoing | Upon DOC request | Electronic | At commencement of services. |

| | Deliverable | Quantity | Format/Method of Delivery | Due Date |
|---|---|---|---|---|
| | responses, if any, on telephone line operated by the contractor. | | | |
| 50.<br>C.5.41.20<br>C.5.41.21<br>C.5.41.22 | Reports on individuals released from custody. | One copy to CA | Electronic | At commencement of services. |
| 51.<br>C.5.16.3 | Laboratory Facilities' Quality Improvement Plan which the contractor must submit and retain according to C.5.16.3. | 1 copy | Electronic copy to CA | TBD |
| 52.<br>C.5.16.3 | Monthly productivity statistics and quality performance results | 1 copy | Electronic copy to CA | By the 7th day of the following month |

**F.4** The contractor shall submit to the District, as a deliverable, the report described in section H.6.6 that is required by the 51% District Residents New Hires Requirements and First Source Employment Agreement. If the contractor does not submit the report as part of the deliverables, final payment to the contractor shall not be paid pursuant to section G.5.1.

**F.5 Review and Approval of Deliverable Documents**

The contractor shall submit to the CA for review and approval all Deliverables using the following procedures:

a. Submit each Deliverable identified in the *Table of Deliverables* (at section F.3) by the Due Date stated in that Table;

b. The contractor must identify each Deliverable (on its first page) by date and version – and must include on every subsequent submission of that Deliverable the new submission date and successive, serial version numbers (*e.g.*, "V.2");

c. The CA shall review the Deliverable within five business days (unless a greater number of *Initial Review* days is stated in the *Deliverable* column of the Table) and return it to contractor either approved (with minor comments or without comments) or disapproved subject to corrections identified in the CA's return transmittal;

d. Within three days or a reasonable, shorter period stated by the CA, the contractor shall correct and return to the CA for further review a disapproved Deliverable; and

e. The CA shall approve or disapprove the resubmitted Deliverable as provided in paragraph c, above. Upon final approval, in his transmittal, the CA will state his approval and identify the date and version number of the approved Deliverable.

# SECTION G: CONTRACT ADMINISTRATION

## G.1 CONTRACTING OFFICER (CO)

**G.1.1** Contracts will be entered into and signed on behalf of the District only by contracting officers. The contact information for the CO is:

Deborah J. White
Supervisory Contract Specialist/Contracting Officer
Officer of Contracting and Procurement
Department of Corrections
2000 14th St. NW – First Floor
Washington, DC 20009
Telephone: 202-409-0183
Email: deborahj.white@dc.gov

**G.1.2** The CO is the only person authorized to approve changes in any of the requirements of the contract.

**G.1.3** The Contractor shall not comply with any order, directive, or request that changes or modifies the requirements of the contract, unless issued in writing and signed by the CO.

**G.1.4** In the event the Contractor effects any change at the instruction or request of any person other than the CO, the change will be considered to have been made without authority and no adjustment will be made in the contract price to cover any cost increase incurred as a result thereof.

**G.2** CONTRACT ADMINISTRATOR (CA)

**G.2.1** The contact information for the CA is:

***[Name of CA*** To be determined
***Title***
***Agency***
***Address***
***Telephone***
***E-mail address]***

**G.2.2** The CA is responsible for general administration of the contract and advising the CO as to the Contractor's compliance or noncompliance with the contract**.** The CA has the responsibility of ensuring the work conforms to the requirements of the contract and such other responsibilities and authorities as may be specified in the contract. These include:

1. Keeping the CO fully informed of any technical or contractual difficulties encountered during the performance period and advising the CO of any potential problem areas under the contract;

2. Coordinating site entry for Contractor personnel, if applicable;

3. Reviewing invoices for completed work and recommending approval if the Contractor's costs are consistent with the negotiated amounts and progress is satisfactory and commensurate with the rate of expenditure;

4. Reviewing and approving invoices for deliverables to ensure receipt of supplies and services. This includes the timely processing of invoices and vouchers in accordance with the District's payment provisions; and

5. Maintaining all contract correspondence, modifications, records of inspections (site, data, equipment, etc.) and invoices or vouchers.

**G.2.3** The CA shall NOT have the authority to:

1. Award, agree to, or sign any contract, delivery order, or task order. Only the CO shall make contractual agreements, commitments or modifications;

2. Grant deviations from or waive any of the terms and conditions of the contract;

3. Increase the dollar limit of the contract or authorize work beyond the dollar limit of the contract,

4. Authorize the expenditure of funds by the Contractor;

5. Change the period of performance; or

6. Authorize the use of District property, except as specified in the contract.

**G.2.4** The Contractor will be fully responsible for any changes not authorized in advance, in writing, by the CO; may be denied compensation or other relief for any additional work performed that is not so authorized; and may also be required, at no additional cost to the District, to take all corrective action necessitated by reason of the unauthorized changes.

## G.3 INVOICE PAYMENT

**G.3.1** The District will make payments to the Contractor, upon the submission of proper invoices, at the prices stipulated in this contract, for supplies delivered and accepted or services performed and accepted, less any discounts, allowances or adjustments provided for in this contract.

**G.3.2** The District will pay the Contractor on or before the 30th day after receiving a proper invoice from the Contractor.

## G.4 INVOICE SUBMITTAL

**G.4.1** The Contractor shall create and submit payment requests in an electronic format through the DC Vendor Portal, https://vendorportal.dc.gov

**G.4.2** The Contractor shall submit proper invoices on a monthly basis or as otherwise specified in the contract.

**G.4.3** To constitute a proper invoice, the Contractor shall enter all required information into the Portal after selecting the applicable purchase order number which is listed on the Contractor's profile.

## G.5 FIRST SOURCE AGREEMENT REQUEST FOR FINAL PAYMENT

**G.5.1** For contracts subject to the 51% District Residents New Hires Requirements and First Source Employment Agreement requirements, final request for payment must be accompanied by the compliance report or a waiver of compliance.

**G.5.2** The District may impose monetary fines for willful breach of the employment agreement or failure to submit the compliance report.

## G.6 PAYMENT

### G.6.1 PAYMENTS ON PARTIAL DELIVERIES OF GOODS

Unless otherwise specified in this contract, payment will be made on partial deliveries of goods accepted by the District if:

a) The amount due on the deliveries warrants it; or

b) The Contractor requests it and the amount due on the deliveries is at least $1,000 or 50 percent of the total contract price.

### G.6.2 PAYMENTS ON PARTIAL DELIVERIES OF SERVICES

Unless otherwise specified in this contract, payment will be made on partial deliveries of services accepted by the District if:

a) The CO determines that the amount due on the deliveries warrants it; or

b) The Contractor requests it and the amount due on the deliveries is at least $1,000 or 50 percent of the total contract price.

### G.6.3 PARTIAL PAYMENTS

Unless otherwise specified in this contract, payment will be made on partial deliveries of supplies and services accepted by the District if:

a) The amount due on the deliveries warrants it; or

b) The Contractor requests it and the amount due on the deliveries is in accordance with the following:

"Payment will be made on completion and acceptance of each item for which the price is stated in the Schedule in Section B".

c) Presentation of a properly submitted invoice.

**G.6.4**

**LUMP SUM PAYMENT**

The District will pay the full amount due the Contractor after:

a) Completion and acceptance of all work; and
b) Presentation of a properly submitted invoice.

## G.6.5 PAYMENT FOR REIMBURSABLE ITEMS AND SERVICES

Payment for approved reimbursable services provided on an hourly labor rate basis and other items will be made based on submitted, approved documentation, including verified timesheets and receipts. Hourly rates shall be computed by multiplying the appropriate hourly rates in Section B by the number of direct labor hours performed. Fractional parts of an hour shall be payable on a prorated basis. Fixed hourly rates shall be fully loaded and include wages, overhead, general and administrative expenses and profit.

## G.7 ORDERING CLAUSE

**G.7.1** Any supplies and services to be furnished under this contract must be ordered by issuance of delivery orders or task orders by the CO. Such orders may be issued during the term of this contract.

**G.7.2** All delivery orders or task orders are subject to the terms and conditions of this contract. In the event of a conflict between a delivery order or task order and this contract, the contract shall control.

**G.7.3** Delivery orders or task orders may be issued by facsimile or by electronic commerce methods and are considered "issued" when the District sends the order.

## G.8 COST REIMBURSEMENT CEILING

**G.8.1** Cost reimbursement ceiling for this contract is set forth in Sections B.**3.1.2,**. B.**3.2.2,** B.**3.3.2,** B.**3.4.2,** and B.**3.5.2.**

G.8.2 **The costs for performing the cost reimbursement elements of this contract shall not exceed the cost reimbursement ceiling specified** in Sections B.**3.1.2,**. B.**3.2.2,** B.**3.3.2,** B.**3.4.2,** and B.**3.5.2.**

**G.8.3** The Contractor agrees to use its best efforts to perform the work specified in this contract and to meet all of the cost-reimbursable obligations under this contract within the cost reimbursement ceiling.

**G.8.4** The Contractor must notify the CO, in writing, whenever it has reason to believe that the total cost for the performance of the cost-reimbursable elements of this contract will be either greater or substantially less than the cost reimbursement ceiling.

**G.8.5** As part of the notification, the Contractor must provide the CO a revised estimate of the total cost of performing the cost-reimbursable elements of this contract.

G.8.6 The District is not obligated to reimburse the Contractor for costs incurred in excess of the cost reimbursement ceiling specified in Sections B.3.1.2,. B.3.2.2, B.3.3.2, B.3.4.2, and B.3.5.2, and the Contractor is not obligated to continue performance under this contract (including actions under the Termination clauses of this contract), or otherwise incur costs in excess of the cost reimbursement ceiling specified in Sections B.3.1.2,. B.3.2.2, B.3.3.2, B.3.4.2, and B.3.5.2 until the CO notifies the Contractor, in writing, that the estimated cost has been increased and provides a revised cost reimbursement ceiling for performing this contract.

G.8.7 No notice, communication, or representation in any form from any person other than the CO shall change the cost reimbursement ceiling. In the absence of the specified notice, the District is not obligated to reimburse the Contractor for any costs in excess of the cost reimbursement ceiling, whether such costs were incurred during the course of contract performance or as a result of termination.

G.8.8 If a cost reimbursement ceiling specified in Sections B.3.1.2,. B.3.2.2, B.3.3.2, B.3.4.2, and B.3.5.2 is increased, any costs the Contractor incurs before the increase that are in excess of the previous cost reimbursement ceiling shall be allowable to the same extent as if incurred afterward, unless the CO issues a termination or other notice directing that the increase is solely to cover termination or other specified expenses.

G.8.9 A change order shall not be considered an authorization to exceed the applicable cost reimbursement ceiling specified in Sections B.3.1.2,. B.3.2.2, B.3.3.2, B.3.4.2, and B.3.5.2, unless the change order specifically increases the cost reimbursement ceiling.

**G.*8*.10** Only costs determined in writing to be reimbursable in accordance with the cost principles set forth in rules issued pursuant to D.C. Code § 2-355.02 shall be reimbursable.

# SECTION H: SPECIAL CONTRACT REQUIREMENTS

## H.1 HIRING OF DISTRICT RESIDENTS AS APPRENTICES AND TRAINEES

**H.1.1** For all new employment resulting from this contract or subcontracts hereto, as defined in Mayor's Order 83-265 and implementing instructions, the contractor shall use its best efforts to comply with the following basic goal and objectives for utilization of bona fide residents of the District of Columbia in each project's labor force:

**H.1.1.1** At least fifty-one (51) percent of apprentices and trainees employed shall be residents of the District of Columbia registered in programs approved by the District of Columbia Apprenticeship Council.

**H.1.2** The contractor shall negotiate an Employment Agreement with the Department of Employment Services ("DOES") for jobs created as a result of this contract. The DOES shall be the contractor's first source of referral for qualified apprentices and trainees in the implementation of employment goals contained in this clause.

## H.2 DEPARTMENT OF LABOR WAGE DETERMINATIONS

The contractor shall be bound by the Wage Determination No. 2015-4281, Rev. No. 30**,** dated 07/22/2024, issued by the U.S. Department of Labor in accordance with the Service Contract Act, 41 U.S.C. §351 *et seq*., and incorporated herein as Section J.2. The contractor shall be bound by the wage rates for the term of the contract subject to revision as stated herein and in accordance with Section 24 of the SCP. If an option is exercised, the contractor shall be bound by the applicable wage rates at the time of the option. If the option is exercised and the CO obtains a revised wage determination, the revised wage determination is applicable for the option periods and the Contractor may be entitled to an equitable adjustment.

## H.3 PREGNANT WORKERS FAIRNESS

**H.3.1** The contractor shall comply with the Protecting Pregnant Workers Fairness Act of 2016, D.C. Official Code § 32-1231.01 *et seq*. (PPWF Act).

**H.3.2** The contractor shall not:

**(a)** Refuse to make reasonable accommodations to the known limitations related to pregnancy, childbirth, related medical conditions, or breastfeeding for an employee, unless the contractor can demonstrate that the accommodation would impose an undue hardship;

**(b)** Take an adverse action against an employee who requests or uses a reasonable accommodation in regard to the employee's conditions or privileges of employment, including failing to reinstate the employee when the need for reasonable accommodations ceases to the employee's original job

or to an equivalent position with equivalent:

**(1)** Pay;

**(2)** Accumulated seniority and retirement;

**(3)** Benefits; and

**(4)** Other applicable service credits;

**(c)** Deny employment opportunities to an employee, or a job applicant, if the denial is based on the need of the employer to make reasonable accommodations to the known limitations related to pregnancy, childbirth, related medical conditions, or breastfeeding;

**(d)** Require an employee affected by pregnancy, childbirth, related medical conditions, or breastfeeding to accept an accommodation that the employee chooses not to accept if the employee does not have a known limitation related to pregnancy, childbirth, related medical conditions, or breastfeeding or the accommodation is not necessary for the employee to perform her duties;

**(e)** Require an employee to take leave if a reasonable accommodation can be provided; or

**(f)** Take adverse action against an employee who has been absent from work as a result of a pregnancy-related condition, including a pre-birth complication.

**H.3.3** The contractor shall post and maintain in a conspicuous place a notice of rights in both English and Spanish and provide written notice of an employee's right to a needed reasonable accommodation related to pregnancy, childbirth, related medical conditions, or breastfeeding pursuant to this chapter to:

**(a)** New employees at the commencement of employment;

**(b)** Existing employees; and

**(c)** An employee who notifies the employer of her pregnancy, or other condition covered by this chapter, within 10 days of the notification.

**H.3.4** The contractor shall provide an accurate written translation of the notice of rights to any non-English or non-Spanish speaking employee.

**H.3.5** Violations of the PPWF Act shall be subject to civil penalties as described in the Act.

**H.4 UNEMPLOYED ANTI-DISCRIMINATION**

**H.4.1** The contractor shall comply with the Unemployed Anti-Discrimination Act of 2012, D.C. Official Code § 32-1361 *et seq*.

**H.4.2** The contractor shall not:

**(a)** Fail or refuse to consider for employment, or fail or refuse to hire, an individual as an employee because of the individual's status as unemployed; or

**(b)** Publish, in print, on the Internet, or in any other medium, an advertisement or announcement for any vacancy in a job for employment that includes:

**(1)** Any provision stating or indicating that an individual's status as unemployed disqualifies the individual for the job; or

**(2)** Any provision stating or indicating that an employment agency will not consider or hire an individual for employment based on that individual's status as unemployed.

**H.4.3** Violations of the Unemployed Anti-Discrimination Act shall be subject to civil penalties as described in the Act.

**H.5 51% DISTRICT RESIDENTS NEW HIRES REQUIREMENTS AND FIRST SOURCE EMPLOYMENT AGREEMENT**

Delete Article 35, 51% District Residents New Hires Requirements and First Source Employment Agreement, of the Standard Contract Provisions dated July 2010 for use with District of Columbia Government Supplies and Services Contracts and substitute the following Section **H.6 51% DISTRICT RESIDENTS NEW HIRES REQUIREMENTS AND FIRST SOURCE EMPLOYMENT AGREEMENT** in its place:

**H.6 51% DISTRICT RESIDENTS NEW HIRES REQUIREMENTS AND FIRST SOURCE EMPLOYMENT AGREEMENT**

**H.6.1** For contracts for services in the amount of $300,000 or more, the contractor shall comply with the First Source Employment Agreement Act of 1984, as amended, D.C. Official Code § 2-219.01 et seq. (First Source Act).

**H.6.2** The contractor shall enter into and maintain during the term of the contract, a First Source Employment Agreement (Employment Agreement) with the District of Columbia Department of Employment Service's (DOES), in which the contractor shall agree that:

(a) The first source for finding employees to fill all jobs created in order to perform the contract shall be the First Source Register; and

(b) The first source for finding employees to fill any vacancy occurring in all jobs covered by the Employment Agreement shall be the First Source Register.

**H.6.3** The contractor shall not begin performance of the contract until its Employment Agreement has been accepted by DOES. Once approved, the Employment Agreement shall not be amended except with the approval of DOES.

**H.6.4** The contractor agrees that at least 51% of the new employees hired to perform the contract shall be District residents.

**H.6.5** The contractor's hiring and reporting requirements under the First Source Act and any rules promulgated thereunder shall continue for the term of the contract.

**H.6.6** The CO may impose penalties, including monetary fines of 5% of the total amount of the direct and indirect labor costs of the contract, for a willful breach of the Employment Agreement, failure to submit the required hiring compliance reports, or deliberate submission of falsified data.

**H.6.7** If the contractor does not receive a good faith waiver, the CO may also impose an additional penalty equal to 1/8 of 1% of the total amount of the direct and indirect labor costs of the contract for each percentage by which the contractor fails to meet its hiring requirements.

**H.6.8** Any contractor which violates, more than once within a 10-year timeframe, the hiring or reporting requirements of the First Source Act shall be referred for debarment for not more than five (5) years.

**H.6.9** The contractor may appeal any decision of the CO pursuant to this clause to the D.C. Contract Appeals Board as provided in **clause 14. Disputes**, in Section I.11.

**H.6.10** The provisions of the First Source Act do not apply to nonprofit organizations which employ 50 employees or less.

## H.7 RESERVED

## H.8 FAIR CRIMINAL RECORD SCREENING

**H.8.1** The contractor shall comply with the provisions of the Fair Criminal Record Screening Amendment Act of 2014, effective December 17, 2014 (D.C. Law 20-152) (the "Act" as used in this section). This section applies to any employment, including employment on a temporary or contractual basis, where the physical location of the employment is in whole or substantial part within the District of Columbia.

**H.8.2** Prior to making a conditional offer of employment, the contractor shall not require an applicant for employment, or a person who has requested consideration for employment by the contractor, to reveal or disclose an arrest or criminal accusation that is not then pending or did not result in a criminal conviction.

**H.8.3** After making a conditional offer of employment, the contractor may require an applicant to disclose or reveal a criminal conviction.

**H.8.4** The contractor may only withdraw a conditional offer of employment, or take adverse action against an applicant, for a legitimate business reason as described in the Act.

**H.8.5** This section and the provisions of the Act shall not apply:

(a) Where a federal or District law or regulation requires the consideration of an applicant's criminal history for the purposes of employment;

(b) To a position designated by the employer as part of a federal or District government program or obligation that is designed to encourage the employment of those with criminal histories;

(c) To any facility or employer that provides programs, services, or direct care to, children, youth, or vulnerable adults; or

(d) To employers that employ less than 11 employees.

**H.8.6** A person claiming to be aggrieved by a violation of the Act may file an administrative complaint with the District of Columbia Office of Human Rights, and the Commission on Human Rights may impose monetary penalties against the contractor.

## H.9 SUBCONTRACTING REQUIREMENTS

### H.9.1 Mandatory Subcontracting Requirements

**H.9.1.1** Unless the Director of the Department of Small and Local Business Development (DSLBD) has approved a waiver in writing, for all contracts in excess of $250,000, at least 35% of the dollar volume of the contract shall be subcontracted to qualified small business enterprises (SBEs).

**H.9.1.2** If there are insufficient SBEs to completely fulfill the requirement of paragraph H.9.1.1, then the subcontracting may be satisfied by subcontracting 35% of the dollar volume to any qualified certified business enterprises (CBEs); provided, however, that all reasonable efforts shall be made to ensure that SBEs are significant participants in the overall subcontracting work.

**H.9.1.3** A prime contractor that is certified by DSLBD as a small, local or disadvantaged business enterprise shall not be required to comply with the provisions of sections H.9.1.1 and H.9.1.2.

**H.9.1.4** Except as provided in H.9.1.5 and H.9.1.7, a prime contractor that is a CBE and has been granted a proposal preference pursuant to D.C. Official Code § 2-218.43, or is selected through a set-aside program, shall perform at least 35% of the contracting effort with its own organization and resources and, if it subcontracts, 35% of the subcontracting effort shall be with CBEs. A CBE prime contractor that performs less than 35% of the contracting effort shall be subject to enforcement actions under D.C. Official Code § 2-218.63.

**H.9.1.5** A prime contractor that is a certified joint venture and has been granted a proposal preference pursuant to D.C. Official Code § 2-218.43, or is selected through a set-aside program, shall perform at least 50% of the contracting effort with its own organization and resources and, if it subcontracts, 35% of the subcontracting effort shall be with CBEs. A certified joint venture prime contractor that performs less than 50% of the contracting effort shall be subject to enforcement actions under D.C. Official Code § 2-218.63.

**H.9.1.6** Each CBE utilized to meet these subcontracting requirements shall perform at least 35% of its contracting effort with its own organization and resources.

**H.9.1.7** A prime contractor that is a CBE and has been granted a proposal preference pursuant to D.C. Official Code § 2-218.43, or is selected through a set-aside program, shall perform at least 50% of the on-site work with its own organization and resources if the contract is $1 million or less.

**H.9.2 Subcontracting Plan**

If the prime contractor is required by law to subcontract under this contract, it must subcontract at least 35% of the dollar volume of this contract in accordance with the provisions of section H.9.1 of this clause. The plan shall be submitted as part of the proposal and may only be amended after award with the prior written approval of the CO and Director of DSLBD. Any reduction in the dollar volume of the subcontracted portion resulting from an amendment of the plan after award shall inure to the benefit of the District.

Each subcontracting plan shall include the following:

(1) The name and address of each subcontractor;
(2) A current certification number of the small or certified business enterprise;

(3) The scope of work to be performed by each subcontractor; and
(4) The price that the prime contractor will pay each subcontractor.

**H.9.3 Copies of Subcontracts**

Within 21 days of the date of award, the contractor shall provide fully executed copies of all subcontracts identified in the subcontracting plan to the CO, CA, District of Columbia Auditor and the Director of DSLBD (F.3.40).

**H.9.4 Subcontracting Plan Compliance Reporting** (F.3.41)

**H.9.4.1** If the contractor has a subcontracting plan required by law for this contract, the contractor shall submit a quarterly report to the CO, CA, District of Columbia Auditor and the Director of DSLBD. The quarterly report shall include the following information for each subcontract identified in the subcontracting plan:

(A) The price that the prime contractor will pay each subcontractor under the subcontract;
(B) A description of the goods procured or the services subcontracted for;
(C) The amount paid by the prime contractor under the subcontract; and
(D) A copy of the fully executed subcontract, if it was not provided with an earlier quarterly report.

**H.9.4.2** If the fully executed subcontract is not provided with the quarterly report, the prime contractor will not receive credit toward its subcontracting requirements for that subcontract.

**H.9.5 Annual Meetings**

Upon at least 30-days written notice provided by DSLBD, the contractor shall meet annually with the CO, CA, District of Columbia Auditor and the Director of DSLBD to provide an update on its subcontracting plan.

**H.9.6 Notices**

The contractor shall provide written notice to the DSLBD and the District of Columbia Auditor upon commencement of the contract and when the contract is completed.

**H.9.7 Enforcement and Penalties for Breach of Subcontracting Plan**

**H.9.7.1** A contractor shall be deemed to have breached a subcontracting plan required by law, if the contractor (i) fails to submit subcontracting plan monitoring or compliance reports or other required subcontracting information in a reasonably timely manner; (ii) submits a monitoring or compliance report or other required subcontracting information containing a materially false statement; or (iii) fails to meet its subcontracting requirements.

**H.9.7.2** A contractor that is found to have breached its subcontracting plan for utilization of CBEs in the performance of a contract shall be subject to the imposition of penalties, including monetary fines in accordance with D.C. Official Code § 2-218.63.

**H.9.7.3** If the CO determines the contractor's failure to be a material breach of the contract, the CO shall have cause to terminate the contract under the default provisions in **clause 8 of the SCP, Default.**

## H.10 NON-PROFITS EXEMPT FROM SUBCONTRACTING

**H.10.1** Subcontracting Requirements, pursuant to D.C. Official Code § 2.218.02 and § 2-218.46, non-profit organizations are exempt from the 35% subcontracting requirement.

**H.10.2** Non-profit organizations are required to submit a subcontracting plan with their proposal and shall type "NON-PROFIT EXEMPT" before their company name in the Beneficiary Information box.

**H.10.3** Contractors claiming the non-profit exemption shall provide verification of their non-profit status as an attachment to the subcontracting plan.

## H.11 ENVIRONMENTALLY PREFERABLE JANITORIAL PRODUCTS

### H.11.1 Environmentally Preferable Product Goals

**H.11.1.1** The District is seeking contractor to provide environmentally preferable and effective janitorial products that support the District's environmentally preferable purchasing (EPP) contracting initiative.

**H.11.1.2** Environmentally preferable products are products and services that have a lesser or reduced effect on human health and the environment when compared with competing products or services that serve the same purpose. This comparison considers the life cycle of the product from raw material acquisition, production, manufacturing, packaging, distribution, re-use, operation, maintenance and disposal.

### H.11.2A Environmentally Preferable Janitorial Products

Janitorial products subject to the requirements of this clause include the following:

All-purpose cleaner
Bathroom cleaner
Bathroom deodorizers
Bathroom disinfectant
Bathroom hand cleanser/soap
Carpet cleaner
Chrome and brass cleaner/polish
Floor stripper/finish
Furniture polish
General degreaser
General disinfectant
Glass/window cleaner
Graffiti remover
Gum remover
Lime and scale remover
Solvent spotter
Urinal deodorizers/cleaner
Wood floor (wax/cleaner/finish)

### H.11.3 Prohibited Cleaning Products

Janitorial products with the following ingredients shall not be used because they pose an unacceptable risk to the person using the product, building occupants and the environment:

Alkylphenol Ethoxylates
Benzyl Alcohol
CFC-22; Chlorodifluoro Methan
Coconut Oil; Diethanolamine
Diethanolamine
HCFC-142b
Lauric Acid Diethanolamine
Methyl Chloroform; 1,1,1,-TCE
Methyl Ethyl Ketone
Naphthalene
Nitrilotriacetic Acid
Paradichloro benzene
Perchloroethylene
Tetrachloroethylene
Toluene
Tributyl Tin
Trichlorethylene

**H.11.4 Janitorial Product Health and Environmental Requirements**

Contractor shall only use janitorial products during the performance of this contract that meet the following requirements:

**H.11.5 Skin and Eye Irritation**

**H.11.5.1** This attribute refers to janitorial cleaning supplies containing chemicals that are either mildly or strongly irritating to the skin or eyes. These substances are either highly alkalinic or acidic.

**H.11.5.2** Contractor shall use products with a pH between 7.2 and 7.8 which are acceptable alkaline levels.

**H.11.6 Food Chain Exposure**

**H.11.6.1** This attribute refers to ready-to-use cleaning products containing ingredients that are consumed by smaller aquatic plants and animals that increase in concentration through the food chain.

**H.11.6.2** Contractor shall use products when the bio-Concentration factor (BCF) measured are less than 1,000.

**H.11.7 Air Pollution Potential**

**H.11.7.1** This attribute refers to janitorial products containing volatile organic compounds (VOC) that could form smog once in the atmosphere, thereby causing irritation of the eyes, nose, throat, lungs and asthma attacks.

**H.11.7.2** Contractor shall not use products containing VOC in concentrations that exceed 10 percent of the weight of the product.

**H.11.8 Fragrances**

**H.11.8.1** This attribute refers to products containing fragrances that are added to the formulation to improve an odor or to mask an offensive odor. This attribute does not include natural odors associated with cleaning agents (e.g. a lemon odor).

**H.11.8.2** The contractor shall not use products containing fragrances that are added to the formulation to improve an odor or to mask an offensive odor.

**H.11.9 Dyes**

**H.11.9.1** This attribute refers to dyes that have been added to a formulation to enhance or change the product's color.

**H.11.9.2** Contractor shall use products without dyes.

**H.11.10 Minimizing Exposure to Concentrates**

**H.11.10.1** This attribute refers to the possibility that an end-user of a product could be exposed to a concentrated form of the product, thereby exposing the end-user to a greater health risk than that caused by exposure to the ready-to-use product.

**H.11.10.2** If possible, contractor shall use products that are not in a concentrated form.

**H.11.10.3** If contractor uses products in a concentrated form, it must be a part of a system by which chemicals are only transferred between closed containers, thereby reducing the risk of harm to the end-user.

**H.11.11 Packaging Reduced/Recyclable**

**H.11.11.1** If possible, contractor shall use products that are in reusable, refillable, or recyclable containers or are otherwise made from recycled content products.

**H.11.11.2** No products shall be delivered in aerosol cans.

**H.11.11.3** All products must be available in non-aerosol containers such as ready-to-use pump action sprays, air-charged refillable containers or spray bottles.

**H.11.12 Product Safety**

**H.11.12.1** Contractor shall be responsible for:

**H.11.12.1.1** Any damage to personnel, buildings, furniture or equipment directly traceable to their use or transportation of prohibited products;

**H.11.12.1.2** Any spills or leaks that occur during the use or transportation of their products;

**H.11.12.1.3** Evacuating and warning individuals that might be affected by transported; and

**H.11.12.1.4** Paying the cleanup cost for any spills or leaks that occur while they are using or transporting their products.

## H.12 ENVIRONMENTALLY PREFERABLE SOLVENT PRODUCTS

### H.12.1 Environmentally Preferable Product Goals

**H.12.1.1** The District is seeking contractor to provide environmentally preferable and effective solvent products that support the District's EPP contracting initiative.

**H.12.1.2** Environmentally preferable products are products and services that have a lesser or reduced effect on human health and the environment when compared with competing products or services that serve the same purpose. This comparison considers the life cycle of the product from raw material acquisition, production, manufacturing, packaging, distribution, re-use, operation, maintenance and disposal.

### H.12.2 Environmentally Preferable Solvent Products

**H.12.2.1** Solvents are fluids or a mixture of fluids capable of dissolving substances to produce compositions for industrial value.

**H.12.2.2** Solvent products subject to the requirements of this clause include, but are not limited to, the following classes:

**H.12.2.2.1** **Alcohols**: Alcohols are solvents that dissolve substances such as shellacs, vinyls, acrylics, epoxies and silicones.

**H.12.2.2.2** **Aliphatic Hydrocarbons**: Aliphatic hydrocarbons are solvents often found in coatings and insecticides. Commonly used as degreasers and solvents for acrylics and epoxies. Common aliphatics include mineral spirits, paint thinner, petroleum distillates, VM&P Naphtha, kerosene, gasoline and 104ubcontr (all of which are extremely (flammable).

**H.12.2.2.3** **Aromatic Hydrocarbons**: Aromatic hydrocarbons are substances used in printing, fiberglass-reinforced products, glues and veneers. Common aromatics include toluene (toluol), xylene (xylol), coal-tar naphtha, styrene and benzene.

**H.12.2.2.4** **Chlorinated Hydrocarbons**: Chlorinated hydrocarbons are commonly used degreasers, dry cleaning agents, rubber solvents and paint strippers found in coatings, resins and tars. Common chemicals in this class include perchloroethylene, methylene chloride, carbon tetrachloride, methyl chloroform and trichloroethylene.

**H.12.2.2.5** **Glycols**: Glycols, which are water-soluble solvents used as lubricants, are found in cosmetics, coatings, resins and dyes. Glycol ethers include butyl cellusolve (2- butoxyethanol), cellusolve (2-ethoxyethanol), methyl cellusolve (2-methoxyethanol), and cellusolve acetate (2-ethoxyethyl acetate). Most common glycol ethers are combustible.

**H.12.2.2.6** **Esters**: Esters have differing chemical properties depending on their use including methyl formate, ethyl acetate, isopropyl acetate, methyl acetate, secamylacetate, and isoamyl acetate (banana oil).

**H.12.2.2.7** **Ethers**: Ethers are ingredients in dyes, resins, waxes, cellulose nitrate and fuels, including ethyl ether, tetrahydrofuran, dioxane and isopropyl ether.

**H.12.2.2.8** **Ketones**: Ketones are solvents for dyes, resin and waxes that are used to manufacture plastics, synthetic fibers, explosives, cosmetics and medicines. Some examples of ketones include acetone, methyl ethyl ketone, cyclohexanone and isophorone.

**H.12.2.2.9** **Other Solvents**: Other types of solvents include 105ubco, turpentine, dimethylformamide and carbon disulfide.

## H.12.3 SOLVENT ENVIRONMENTAL REQUIREMENTS

Contractor shall avoid the following hazards when using solvent products during the performance of this contract:

### H.12.3.1 Health Hazards

**H.12.3.1.1** Bodily Contact: Contractor shall not use solvent products that irritate or harm the skin, eyes, nose and throat from direct contact with the solvents;

**H.12.3.1.2** Inhalation: Contractor shall not use solvent products that when inhaled causes headaches, nausea, vomiting and dizziness from contact with the solvents; and

**H.12.3.1.3** Ingestion: Contractor shall not use solvent products that if ingested or exposed to for a period of time cause damage to the brain, liver, kidney, respiratory system and nervous systems.

### H.12.3.2 Physical Hazards

**H.12.3.2.1** Flammable materials are substances that shall easily ignite, burn and serve as fuel for a fire. The flash point is the lowest temperature at which a liquid gives off enough vapors which, when mixed with air, can be easily ignited by a spark. The lower the flash point, the greater the risk of fire or explosion.

**H.12.3.2.2** Contractor shall not use solvent products that are a potential fire hazard or have a low flash point. A solvent is flammable and a serious fire hazard if its flash point is below 37.8C (100F).

**H.12.4 Prohibited Solvents**

The following solvent products are recognized by the National Institute for Occupational Safety and Health (NIOSH) as carcinogens, ozone-depleting solvents or as reproductive hazards in the workplace and shall not be used:

Benzene
Trichloroethylene
2-methoxyethanol
Methyl chloride
Chlorinated Fluorocarbon Compounds
Carbon tetrachloride
1,1,2,2-tetrachloroethane
2-ethoxyethanol
Trichlorotrifluoroethane

**H.12.5 Packaging Reduced/Recyclable**

**H.12.5.1** Contractor shall use products that are in reusable, refillable, or recyclable containers or are otherwise made from recycled content products.

**H.12.5.2** No products shall be delivered in aerosol cans.

**H.12.5.3** All products must be available in non-aerosol containers such as ready- to-use pump action sprays, air-charged refillable containers, or spray bottles.

**H.12.6 Product Safety**

**H.12.6.1** Contractor shall be responsible for:

**H.12.6.1.1** Any damage to personnel, buildings, furniture or equipment directly traceable to their use or transportation of prohibited products;

**H.12.6.1.2** Any spills or leaks that occur during the use or transportation of their products;

**H.12.6.1.3 Evacuating and warning individuals that might be affected by any spills or leaks that occur when their products are being used or transported; and**

**H.12.6.1.4 Paying the clean-up cost for any spills or leaks that occur while they are using or transporting their products.**

**H.13 AUDITS AND RECORDS**

**H.13.1** As used in this clause, “records” includes books, documents, accounting procedures and practices, and other data, regardless of type and regardless of whether such items are in written form, in the form of computer data, or in any other form.

**H.13.2** **Examination of Costs**. If this is a cost-reimbursement, incentive, time-and-materials, labor-hour, or price redeterminable contract, or any combination of these, the contractor shall maintain and the CO, or an authorized representative of the CO, shall have the right to examine and audit all records and other evidence sufficient to reflect properly all costs claimed to have been incurred or anticipated to be incurred directly or indirectly in performance of this contract. This right of examination shall include inspection at all reasonable times of the contractor's plants, or parts of them, engaged in performing the contract.

**H.13.**3 **Cost or pricing data**. If the contractor has been required to submit cost or pricing data in connection with any pricing action relating to this contract, the CO, or an authorized representative of the CO, in order to evaluate the accuracy, completeness, and currency of the cost or pricing data, shall have the right to examine and audit all of the contractor's records, including computations and projections, related to:

a) The proposal for the contract, subcontract, or modification;
b) The discussions conducted on the proposal(s), including those related to negotiating;
c) Pricing of the contract, subcontract, or modification; or,
d) Performance of the contract, subcontract or modification.

**H.13.4** **Comptroller General**

**H.13.4.1** The Comptroller General of the United States, or an authorized representative, shall have access to and the right to examine any of the contractor's directly pertinent records involving transactions related to this contract or a subcontract hereunder.

**H.13.4.2** This paragraph may not be construed to require the contractor or subcontractor to create or maintain any record that the contractor or subcontractor does not maintain in the ordinary course of business or pursuant to a provision of law.

**H.13.5** **Reports.** If the contractor is required to furnish cost, funding, or performance reports, the CO or an authorized representative of the CO shall have the right to examine and audit the supporting records and materials, for the purpose of evaluating:

a) The effectiveness of the contractor's policies and procedures to produce data compatible with the objectives of these reports; and,
b) the data reported.

**H.13.6** **Availability.** The contractor shall make available at its office at all reasonable times the records, materials, and other evidence described in clauses H.13.1 through H.13.5, for examination, audit, or reproduction, until three (3) years after final payment under this contract or for any shorter period

specified in the solicitation, or for any longer period required by statute or by other clauses of this contract. In addition:

a) If this contract is completely or partially terminated, the contractor shall make available the records relating to the work terminated until thee (3) years after any resulting final termination settlement; and
b) The contractor shall make available records relating to appeals under the Disputes clause or to litigation or the settlement of claims arising under or relating to this contract until such appeals, litigation, or claims are finally resolved.

**H.13.7** The contractor shall insert a clause containing all the terms of this clause, including this section H.13.7, in all subcontracts under this contract that exceed the small purchase threshold of $100,000, and:

a) That are cost-reimbursement, incentive, time-and-materials, labor-hour, or price-redeterminable type or any combination of these;
b) For which cost or pricing data are required; or,
c) That requires the subcontractor to furnish reports as discussed in H.13.5 of this clause.

## H.14 ADVISORY AND ASSISTANCE SERVICES

This contract is a "nonpersonal services contract". The contractor and the contractor's employees: (1) shall perform the services specified herein as independent contractors, not as employees of the government; (2) shall be responsible for their own management and administration of the work required and bear sole responsibility for complying with any and all technical, schedule, financial requirements or constraints attendant to the performance of this contract; (3) shall be free from supervision or control by any government employee with respect to the manner or method of performance of the service specified; but (4) shall, pursuant to the government's right and obligation to inspect, accept or reject work, comply with such general direction of the CO, or the duly authorized representative of the CO as is necessary to ensure accomplishment of the contract objectives.

## H.15 HIPAA BUSINESS ASSOCIATE COMPLIANCE AGREEMENT CLAUSE

For the purpose of this Business Associate Agreement ("BAA") clause, Department of Corrections**,** a covered component within the District of Columbia's ("District") Hybrid Entity will be referred to as a "Covered Entity" as that term is defined by the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and associated regulations promulgated at 45 C.F.R. §§ 160, 162 and 164 as amended (the "HIPAA Regulations") and **[ INSERT VENDOR INFORMATION]**, as a recipient of Protected Health Information ("PHI") or electronic PHI from Department of Corrections is a "Business Associate" as that term is defined by HIPAA.

Terms used, but not otherwise defined, in this BAA shall have the same meaning as those terms in the HIPAA Regulations.

1. Definitions

a. *Business Associate* means a person or entity, who, on behalf of the District or of an Organized Health Care Arrangement (as defined in this section) in which the Covered Entity participates, but other than in the capacity of a member of the Workforce of the District government or Organized Health Care Arrangement, creates, receives, maintains, or transmits PHI for a function or activity for the District, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 C.F.R § 3.20, billing, benefit management, practice management, and repricing; or provides, other than in the capacity of a member of the Workforce of such Covered Entity, legal, actuarial, accounting, consulting, Data Aggregation (as defined in 45 C.F.R § 164.501), management, administrative, accreditation, or financial services to or for the District, or to or for an Organized Health Care Arrangement in which the District participates, where the provision of the service involves the disclosure of PHI from the District or arrangement, or from another Business Associate of the District or arrangement, to the person. A Covered Entity may be a Business Associate of another Covered Entity.

A Business Associate includes, (i) a Health Information Organization, e-prescribing gateway, or other person that provides data transmission services with respect to PHI to a Covered Entity and that requires access on a routine basis to such PHI; (ii) a person that offers a personal health record to one or more individuals on behalf of the District; (iii) a subcontractor that creates, receives, maintains, or transmits PHI on behalf of the Business Associate.

A *Business Associate* does not include: (i) a health care provider, with respect to disclosures by a Covered Entity to the health care provider concerning the treatment of the individual; (ii) a plan sponsor, with respect to disclosures by a group health plan (or by a health insurance issuer or health maintenance organization, HMO, with respect to a group health plan) to the plan sponsor, to the extent that the requirements of 45 C.F.R § 164.504(f) apply and are met; (iii) a government agency, with respect to determining eligibility for, or enrollment in, a government health plan that provides public benefits and is administered by another government agency, or collecting PHI for such purposes, to the extent such activities are authorized by law; (iv) a Covered Entity participating in an Organized Health Care Arrangement that performs a function, activity or service included in the definition of a Business Associate above for or on behalf of such Organized Health Care Arrangement.

b. *Covered Entity* means a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by 45 C.F.R. §§ 160 and 164. With respect to this BAA, *Covered Entity* shall also include the designated Health Care Components of the District government's Hybrid Entity or a District agency following HIPAA's implementing regulations and best practices.

c. *Covered Functions* means those functions of a Covered Entity the performance of which makes the entity a health plan, health care provider, or health care clearinghouse.

d. *Data Aggregation* means, with respect to PHI created or received by a Business Associate in its capacity as the Business Associate of a Covered Entity, the combining of such PHI by the Business Associate with the PHI received by the Business Associate in its capacity as a Business Associate of another Covered Entity, to permit data analyses that relate to the health care operations of the respective Covered Entities.

e. *Designated Record Set* means a group of records maintained by or for a Covered Entity that are:

i. The medical records and billing records about individuals maintained by or for a covered health care provider;

ii. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

iii. Records used, in whole or in part, by or for the Covered Entity to make decisions about individuals.

f. *Health Care* means care, services, or supplies related to the health of an individual. Health care includes, but is not limited to, the following:

i. Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and

ii. Sale or dispensing of a drug, device, equipment, or other item in accordance with the prescription.

g. *Health Care Components* means a component or a combination of components of a Hybrid Entity designated by a Hybrid Entity in accordance with 45 CFR § 164.105(a)(2)(iii)(D). *Health Care Components* must include non-Covered Functions that provide services to the Covered Functions for the purpose of facilitating the sharing of PHI with such functions of the Hybrid Entity without Business Associate agreements or individual authorizations.

h. *Health Care Operations* shall include (1) conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 C.F.R § 3.20); population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, Effective 10/13/2016

Policy Number III.10.a) contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment; (2) reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities; (3) except as prohibited under 45 C.F.R. § 164.502(a)(5)(i), underwriting, enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of 45 C.F.R. § 164.514(g) are met, if applicable; (4) conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs; (5) business planning and development, such as conducting cost-management and planning related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and (6) business management and general administrative activities of the entity, including, but not limited to: (i) management activities relating to implementation of and compliance with the requirements of this subchapter; (ii) customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that PHI is not disclosed to such policy holder, plan sponsor, or customer.(iii) resolution of internal grievances;(iv) The sale, transfer, merger, or consolidation of all or part of the Covered Entity with another Covered Entity, or an entity that following such activity will become a Covered Entity and due diligence related to such activity; and(v) consistent with the applicable requirements of 45 C.F.R. §164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the Covered Entity.

i. *Hybrid Entity* means a single legal entity that is a Covered Entity and whose business activities include both covered and non-Covered Functions, and that designates Health Care Components, in accordance with 45 C.F.R. § 164.105(a)(2)(iii)(C). A Hybrid Entity is required to designate Health Care Components, any other components of the entity that provide services to the Covered Functions for the purpose of facilitating the sharing of PHI with such functions of the Hybrid Entity without Business Associate agreements or individual authorizations. The District is a Hybrid Covered Entity. Hybrid Entities are required to designate and include functions, services and activities within its own organization, which would meet the definition of Business Associate and irrespective of whether performed by employees of the Hybrid Entity, as part of its Health Care Components for compliance with the Security Rule and privacy requirements under this BAA.

j. *Individual* shall mean the person who is the subject of PHI in accordance with 45 C.F.R. § 160.103. The term *individual* shall also include the

individual's personal representative in accordance with 45 C.F.R. § 164.502(g).

k. *Individually Identifiable Health Information* shall mean information that is a subset of health information, including demographic information collected from an individual; and:

i. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; Effective 10/13/2016 Policy Number III.10.a)

ii. Relates to the past, present, or future physical or mental health or condition of an individual; or the past, present, or future payment for the provision of health care to an individual; and

iii. That identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

l. *National Provider Identifier (NPI)* shall mean the Standard Unique Health Identifier for Healthcare Providers as defined at 42 C.F.R. § 162.406.

m. *Organized Health Care Arrangement* shall mean (1) a clinically integrated care setting in which individuals typically receive health care from more than one health care provider; (2) an organized system of health care in which more than one Covered Entity participates and in which the participating Covered Entities: (i) hold themselves out to the public as participating in a joint arrangement; and (ii) participate in joint activities that include at least one of the following: (a) utilization review, in which health care decisions by participating Covered Entities are reviewed by other participating Covered Entities or by a third party on their behalf; (b) quality assessment and improvement activities, in which treatment provided by participating Covered Entities is assessed by other participating Covered Entities or by a third party on their behalf; or (c) payment activities, if the financial risk for delivering health care is shared, in part or in whole, by participating Covered Entities through the joint arrangement and if PHI created or received by a Covered Entity is reviewed by other participating Covered Entities or by a third party on their behalf for the purpose of administering the sharing of financial risk in accordance with 42 C.F.R. § 160.103.

n. *Personal Representative:* shall mean a person authorized, under District or other applicable law, to act on behalf of the subject of PHI in accordance with 42 C.F.R. § 164.502(g).

o. *Privacy and Security Official:* shall mean the person or persons designated by the District, a Hybrid Entity, who is/are responsible for developing, maintaining, implementing and enforcing the District-wide Privacy Policies and Procedures, and for overseeing full compliance with HIPAA Regulations, and other applicable federal and state privacy laws.

p. *Privacy Officer* shall mean the person designated by the District's Privacy and Security Official or one of the District's covered components within its Hybrid

Entity, who is responsible for overseeing compliance with a Covered Agency's Privacy Policies and Procedures, the HIPAA Regulations and other applicable federal and state privacy laws. Also referred to as the agency Privacy Officer, the individual shall follow the guidance of the District's Privacy and Security Official, and, shall be responsive to and report to the District's Privacy and Security Official on matters pertaining to HIPAA compliance.

q. *Privacy Rule* shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. parts 160 and 164, subparts A and E.

r. *Protected Health Information ("PHI")* means individually identifiable health information, including electronic information ("ePHI"), that is created or received by the Business Associate from or on behalf of the Covered Entity, or agency following HIPAA best practices, which is:

i. Transmitted by, created or maintained in electronic media; or

ii. Transmitted or maintained in any other form or medium;

iii. PHI or ePHI does not include individually identifiable health information: (i) In education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. § 1232g; (ii) In records described at 20 U.S.C. § 1232(g)(a)(4)(B)(iv); (iii) In employment records held by a Covered Entity in its role as employer; and (iv) Regarding a person who has been deceased for more than 50 years.

s. *Record* shall mean any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for a Covered Entity.

t. *Required By Law* means a mandate contained in law that compels an entity to make a use or disclosure of PHI and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits pursuant to 45 C.F.R. § 164.103.

u. *Secretary* means the person serving as Secretary of the United States Department of Health and Human Services (HHS) or any other officer or employee of HHS to whom the authority involved has been delegated.

v. *Security Officer* means the person designated by the Security Official or one of the District of Columbia's designated Health Care Components, who is responsible for overseeing compliance with the Covered Agency's Privacy Policies and Procedures, the Security Rules, and other applicable federal and state privacy law(s). The Covered

Agency's security officer shall follow the guidance of the District's Security Official, as well as the Associate Security Official within the Office of the Chief Technology Officer, and shall be responsive to the same on matters pertaining to HIPAA compliance.

w. *Security Rule* shall mean the Standards for Security of Individually Identifiable Health Information at 45 C.F.R. parts 160, 162 and 164, subpart C.

x. *Unsecured PHI* shall mean PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the U.S. Department of Health and Human Services Secretary in the guidance issue under § 13402(h)(2) of the Health Information Technology Economic and Clinical Health Act (HITECH), enacted at part of the American Recovery and Reinvestment Act of 2009 (ARRA)(Pub.L 111-5, 123 Stat 115), approved February 17, 2009.

y. *Workforce* shall mean employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a Covered Entity or Business Associate, is under the direct control of such Covered Entity, whether or not they are paid by the Covered Entity or Business Associate.

2. Obligations and Activities of Business Associate
Business Associate agrees to comply with applicable federal and District confidentiality and security laws, including, but not limited to the Privacy Rule and Security Rule and the following:

a. Business Associate agrees not to use or disclose PHI or ePHI (other than as permitted or required by this BAA or as Required by Law.

b. Business Associate agrees to use appropriate safeguards and comply with administrative, physical, and technical safeguards requirements described at 45 C.F.R. §§ 164.308, 164.310, 164.312 and 164.316 as required by § 13401 of the Health Information Technology Economic and Clinical Health Act ("HITECH"), enacted as part of the American Recovery and Reinvestment Act of 2009 ("ARRA")(Pub.L 111-5, 123 Stat 115) approved February 17, 2009, to maintain the security of the PHI and to prevent use or disclosure of such PHI other than as provided for by this BAA. Business Associate acknowledges that, pursuant § 13401, Business Associate must comply with the Security Rule and privacy provisions detailed in this BAA. The additional requirements of § 13401of HITECH that relate to security and apply to a Covered Entity shall also apply to Business Associate and shall be incorporated into an agreement between the Business Associate and the Covered Entity. Business Associate shall be directly liable for any violations of this BAA or HIPAA Regulations. A summary of HIPAA Security Standards for the Protection of ePHI, found at Appendix A to Subpart C or 45 C.F.R. Part 164 is as follows:

**Administrative Safeguards**

Security Management Process 164.308(a)(1) Risk Analysis (R)
Risk Management (R)
Sanction Policy (R)
Information System Activity Review (R)
Assigned Security Responsibility 164.308(a)(2) (R)
Workforce Security 164.308(a)(3) Authorization and/or Supervision (A)
Workforce Clearance Procedure
Termination Procedures (A)
Information Access Management 164.308(a)(4) Isolating Health care Clearinghouse Function (R)
Access Authorization (A)
Access Establishment and Modification (A)
Security Awareness and Training 164.308(a)(5) Security Reminders (A)
Protection from Malicious Software (A)
Log-in Monitoring (A)
Password Management (A)
Security Incident Procedures 164.308(a)(6) Response and Reporting (R)
Contingency Plan 164.308(a)(7 Data Backup Plan (R)
Disaster Recovery Plan (R)
Emergency Mode Operation Plan (R)
Testing and Revision Procedure (A)
Applications and Data Criticality Analysis (A)
Evaluation 164.308(a)(8) (R)
Business Associate Contracts and Other Arrangement
164.308(b)(1) Written Contract or Other Arrangement (R)

**Physical Safeguards**
Facility Access Controls 164.310(a)(1) Contingency Operations (A)
Effective 10/13/2016 Policy Number III.10.a)
PAGE 8 of 19
Facility Security Plan (A)
Access Control and Validation Procedures (A)
Maintenance Records (A)
Workstation Use 164.310(b) (R)
Workstation Security 164.310(c) (R)
Device and Media Controls 164.310(d)(1) Disposal (R)
Media Re-use (R)
Accountability (A)
Data Backup and Storage (A)

**Technical Safeguards** (§ 164.312)
Access Control 164.312(a)(1) Unique User Identification (R)
Emergency Access Procedure (R)
Automatic Logoff (A)
Encryption and Decryption (A)

Audit Controls 164.312(b) (R)
Integrity 164.312(c)(1) Mechanism to Authenticate Electronic Protected Health Information (A)
Person or Entity Authentication 164.312(d) (R)
Transmission Security 164.312(e)(1) Integrity Controls (A)
Encryption (A)

c. The Business Associate agrees to name a Privacy and/or Security Officer who is accountable for developing, maintaining, implementing, overseeing the compliance of and enforcing compliance with this BAA, the Security Rule and other applicable federal and state privacy law within the Business Associate's business. The Business Associate reports violations and conditions to the District-wide Privacy and Security Official and/or the Agency Privacy Officer of the covered component within the District's Hybrid Entity.

d. The Business Associate agrees to establish procedures for mitigating, and to mitigate to the extent practicable, any deleterious effects that are known to the Business Associate of a use or disclosure of PHI by the Business Associate in violation of the requirements of this BAA.

e. The Business Associate agrees to report to Covered Entity, in writing, any use or disclosure of the PHI not permitted or required by this BAA or other incident or condition arising out the Security Rule, including breaches of unsecured PHI as required at 45 C.F.R § 164.410, to the District-wide Privacy and Security Official or agency Privacy Officer within ten (10) business days from the time the Business Associate becomes aware of such unauthorized use or disclosure. However, if the Business Associate is an agent of the District (i.e., performing delegated essential governmental functions), the Business Associate must report the incident or condition immediately.
Upon the determination of an actual data breach, and in consultation with the District's Privacy and Security Official, the Business Associate will handle breach notifications to individuals, the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), and potentially the media, on behalf of the District.

f. The Business Associate agrees to ensure that any Workforce member or any agent, including a subcontractor, agrees to the same restrictions and conditions that apply through this BAA with respect to PHI received from the Business Associate, PHI created by the Business Associate, or PHI received by the Business Associate on behalf of the Covered Entity.

g. In accordance with 45 C.F.R §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information

h. Initially, within ten (10) business days following the commencement of this contract, or within ten (10) business days of a new or updated agreement with a subcontractor, the Business Associate agrees to provide the District a list of all subcontractors who meet the definition of a Business Associate. Additionally, Business Associate agrees to ensure

its subcontractors understanding of liability and monitor, where applicable, compliance with the Security Rule and applicable privacy provisions in this BAA.

i. The Business Associate agrees to provide access within five (5) business days, at the request of the Covered Entity or an Individual, **at a mutually agreed upon location, during normal business hours, and in a format** as directed by the District Privacy Official or agency Privacy Officer, or as otherwise mandated by the Privacy Rule or applicable District laws, rules and regulations, to PHI in a Designated Record Set, to Covered Entity or an Individual, to facilitate the District's compliance with the requirements under 45 C.F.R. §164.524.

j. The Business Associate agrees to make any amendment(s) within five (5) business days to the PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R § 164.526 **in a format** [*agency should insert appropriate terms for amendment if applicable*] or as directed by the District Privacy Official or agency Privacy Officer in order to facilitate the District's compliance with the requirements under 45 C.F.R. §164.526.

k. The Business Associate agrees to use the standard practices of the Covered Entity to verify the identification and authority of an Individual who requests the PHI in a Designated Record Set of a recipient of services from or through the Covered Entity. The Business Associate agrees to comply with the applicable portions of the [*Insert Applicable Agency Identity And Procedure Verification Policy*], attached hereto as Exhibit A and incorporated by reference.

l. The Business Associate agrees to record authorizations and log such disclosures of PHI and information related to such disclosures as would be required for the Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528 and applicable District laws, rules and regulations.

m. The Business Associate agrees to provide to the Covered Entity or an Individual, within five (5) business days of a request **at a mutually agreed upon location, during normal business hours, and in a format designated** [*delete bolded material and insert agency appropriate terms if applicable*] by the District's Privacy and Security Official or agency Privacy Officer and the duly authorized Business Associate Workforce member, information collected in accordance with Paragraph (i) of this Section above, to permit the Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528, and applicable District laws, rules and regulations.

n. The Business Associate agrees to make internal practices, books, and records, including policies and procedures, and PHI, relating to the use and disclosure of PHI received from the Business Associate, or created, or received by the Business Associate on behalf of the Covered Entity, available to the Covered Entity, or to the Secretary, within five (5) business days of their request and **at a mutually agreed upon location, during normal business hours, and in a format designated** [*delete bolded material and insert negotiated terms if applicable*] by the District Privacy and Security Official or agency Privacy Officer and the duly authorized Business Associate Workforce

member, or in a time and manner designated by the Secretary, for purposes of the Secretary in determining compliance of the Covered Entity with the Privacy Rule.

o. To the extent the Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 C.F.R Part 164,the Business Associate agrees to comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligation(s).p. As deemed necessary by the District, the Business Associate agrees to the monitoring and auditing of items listed in paragraph 2 of this BAA, as well as data systems storing or transmitting PHI, to verify compliance.

q. The Business Associate may aggregate PHI in its possession with the PHI of other Covered Entities that Business Associate has in its possession through its capacity as a Business Associate to other Covered Entities provided that the purpose of the Data Aggregation is to provide the Covered Entity with data analyses to the Health Care Operations of the Covered Entity. Under no circumstances may the Business Associate disclose PHI of one Covered Entity to another Covered Entity absent the explicit written authorization and consent of the Privacy Officer/Liaison or a duly authorized Workforce member of the Covered Entity.

r. Business Associate may de-identify any and all PHI provided that the de-identification conforms to the requirements of 45 C.F.R. § 164.514(a)-(b) and any associated HHS guidance. Pursuant to 45 C.F.R. § 164.502(d)(2), de-identified information does not constitute PHI and is not subject to the terms of this BAA.

s. If the Business Associate has not submitted the District's Business Associate Questionnaire prior to contract award, the Business Associate shall file the Questionnaire with the Agency Privacy Officer/Liaison or the agency contract administrator within 30 days after contract award. Business Associate shall file and submit an updated Questionnaire to the agency privacy officer/liaison or the agency contract administrator on or before October 1st of each contract year. At the discretion of the agency privacy officer/liaison, business associates with limited access to PHI may be granted a written waiver to file a letter attesting to their HIPAA compliance on or before October 1st of each contract year. A copy of the Business Associate Questionnaire can be located at www.ocp.dc.gov /OCP Solicitations /Required Solicitation Documents.

3. Permitted Uses and Disclosures by the Business Associate

a. Except as otherwise limited in this BAA, the Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, the Covered Entity as specified in the contract, provided that such use or disclosure would not violate Subpart E of 45 C.F.R Part 164 if the same activity were performed by the Covered Entity or would not violate the minimum necessary policies and procedures of the Covered Entity.

b. Except as otherwise limited in this BAA, the Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

c. Except as otherwise limited in this BAA, the Business Associate may disclose PHI for

the proper management and administration of the Business Associate, provided that the disclosures are Required By Law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used, or further disclosed, only as Required By Law, or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it has knowledge that the confidentiality of the information has been breached.

d. Except as otherwise limited in this BAA, the Business Associate may use PHI to provide Data Aggregation services to the Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

e. Business Associate may use PHI to report violations of this BAA or the HIPAA Regulations to the appropriate federal and District of Columbia authorities, consistent with 45 C.F.R. § 164.502(j)(1)-(2).

4. Additional Obligations of the Business Associate

a. Business Associate shall submit a written report to the Covered Entity that identifies the files and reports that constitute the Designated Record Set of the Covered Entity. Business Associate shall submit said written report to the Privacy Officer no later than 30 business days after the commencement of this BAA. In the event that Business Associate utilizes new files or reports which constitute the Designated Record Set, Business Associate shall notify the Covered Entity of said event within 30 days of the commencement of the file's or report's usage. The Designated Record Set file shall include, but not be limited to the identity of the following:

i. Name of the Business Associate of the Covered Entity;

ii. Title of the Report/File;

iii. Confirmation that the Report/File contains PHI(Yes or No);

iv. Description of the basic content of the Report/File;

v. Format of the Report/File (Electronic or Paper);

vi. Physical location of Report/File;

vii. Name and telephone number of current member(s) of the Workforce of the Covered Entity or other District Government agency responsible for receiving and processing requests for PHI; and

viii. Supporting documents if the recipient/personal representative has access to the Report/File.

b. Business Associate must provide assurances to the Covered Entity that it will continue to employ sufficient administrative, technical and physical safeguards, as described

under the Security Rule, to protect and secure (the Covered Entity's) ePHI entrusted to it. These safeguards include:

i. The Business Associate agrees to administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that the Business Associate creates, receives, maintains or transmits on behalf of the Covered Entity.

ii. The Business Associate agrees to report to the Covered Entity any security incident of which it becomes aware, including any attempts to access ePHI, whether those attempts were successful or not.

iii. This BAA may be terminated if the Covered Entity determines that the Business Associate has materially breached the agreement.

iv. The Business Associate agrees to make all policies and procedures, and documents relating to security, available to the Secretary of HHS for the purposes of determining the Covered Entity's compliance with HIPAA.

v. This BAA continues in force for as long as the Business Associate retains any access to the Covered Entity's ePHI.

vi. With respect to the subset of PHI known as electronic PHI (ePHI) as defined by HIPAA Security Standards at 45 C.F.R. §§ 160 and 164, subparts A and C (the "Security Rule"), if in performing the Services, Business Associate, its employees, agents, subcontractors and any other individual permitted by Business Associate will have access to any computer system, network, file, data or software owned by or licensed to Provider that contains ePHI, or if Business Associate otherwise creates, maintains, or transmits ePHI on Provider's behalf, Business Associate shall take reasonable security measures necessary to protect the security of all such computer systems, networks, files, data and software. With respect to the security of ePHI, Business Associate shall: (a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Provider; (b) Ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it; and (c) Report to the Provider any security incident of which it becomes aware.

vii. Business Associate agrees not to electronically transmit or permit access to PHI unless such transmission or access is authorized by this BAA and further agrees that it shall only transmit or permit such access if such information is secured in a manner that is consistent with applicable law, including the Security Rule. For purposes of this BAA "encrypted" shall mean the reversible conversion of readable information into unreadable, protected form so that only a recipient who has the appropriate "key" can convert the information back into original readable form. If the Covered Entity stores, uses or maintains PHI in encrypted form, or in any other secured form acceptable under the security regulations, Covered

Entity shall promptly, at request, provide with the key or keys to decrypt such information and will otherwise ensure that such PHI is accessible by upon reasonable request.

viii. In the event Business Associate performs functions or activities involving the use or disclosure of PHI on behalf of Covered Entity that involve the installation or maintenance of any software (as it functions alone or in combination with any hardware or other software), Business Associate shall ensure that all such software complies with all applicable standards and specifications required by the HIPAA Regulations and shall inform of any software standards or specifications not compliant with the HIPAA Regulations.

c. At the request of the Covered Entity, the Business Associate agrees to amend this BAA to comply with all HIPAA mandates.

5. Sanctions

Business Associate agrees that its Workforce members, agents and subcontractors who violate the provisions of HIPAA or other applicable federal or District privacy law will be subject to discipline in accordance with Business Associate's internal Personnel Policy and applicable collective bargaining agreements. Business Associate agrees to impose sanctions consistent with Business Associate's personnel policies and procedures and applicable collective bargaining agreements with respect to persons employed by it. Members of the Business Associate Workforce who are not employed by Business Associate are subject to the policies and applicable sanctions for violation of this BAA In the event Business Associate imposes sanctions against any member of its Workforce, agents and subcontractors for violation of the provisions of HIPAA or other applicable federal or District privacy laws, the Business Associate shall inform the District Privacy Official or the agency Privacy Officer/Liaison of the imposition of sanctions.

6. Obligations of the Covered Entity

a. The Covered Entity shall notify the Business Associate of any limitation(s) in its Notice of Privacy Practices of the Covered Entity in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect the use or disclosure of PHI by the Business Associate.

b. The Covered Entity shall notify the Business Associate of any changes in, or revocation of, permission by the Individual to the use or disclosure of PHI, to the extent that such changes may affect the use or disclosure of PHI by the Business Associate.

c. The Covered Entity shall notify the Business Associate of any restriction to the use or disclosure of PHI that the Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect the use or disclosure of PHI by the Business Associate.

7. Permissible Requests by Covered Entity Covered Entity shall not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule and Subpart E of 45 C.F.R Part 164 if done by the Covered Entity.)

8. Representations and Warranties.

The Business Associate represents and warrants to the Covered Entity:

a. That it is duly organized, validly existing, and in good standing under the laws of the jurisdiction in which it is organized or licensed, it has the full power to execute this BAA and it, its employees, agents, subcontractors, representatives and members of its Workforce are licensed and in good standing with the applicable agency, board, or governing body to perform its obligations hereunder, and that the performance by it of its obligations under this BAA has been duly authorized by all necessary corporate or other actions and will not violate any provision of any license, corporate charter or bylaws;

b. That it, its employees, agents, subcontractors, representatives and members of its Workforce are in good standing with the District, that it, its employees, agents, subcontractors, representatives and members of its Workforce will submit a letter of good standing from the District, and that it, its employees, agents, subcontractors, representatives and members of its Workforce have not been de-barred from being employed as a contractor by the federal government or District;

c. That neither the execution of this BAA, nor its performance hereunder, will directly or indirectly violate or interfere with the terms of another agreement to which it is a party, or give any governmental entity the right to suspend, terminate, or modify any of its governmental authorizations or assets required for its performance hereunder. The Business Associate represents and warrants to the Covered Entity that it will not enter into any agreement the execution or performance of which would violate or interfere with this BAA;

d. That it is not currently the subject of a voluntary or involuntary petition in bankruptcy, does not currently contemplate filing any such voluntary petition, and is not aware of any claim for the filing of an involuntary petition;

e. That all of its employees, agents, subcontractors, representatives and members of its Workforce, whose services may be used to fulfill obligations under this BAA are or shall be appropriately informed of the terms of this BAA and are under legal obligation to the Business Associate, by contract or otherwise, sufficient to enable the Business Associate to fully comply with all provisions of this BAA. Modifications or limitations that the Covered Entity has agreed to adhere to with regards to the use and disclosure of PHI of any individual that materially affects or limits the uses and disclosures that are otherwise permitted under the Privacy Rule will be communicated to the Business Associate, in writing, and in a timely fashion;

f. That it will reasonably cooperate with the Covered Entity in the performance of the mutual obligations under this Agreement;

g. That neither the Business Associate, nor its shareholders, members, directors, officers, agents, subcontractors, employees or members of its Workforce have been excluded or served a notice of exclusion or have been served with a notice of proposed exclusion, or have committed any acts which are cause for exclusion, from participation in, or had any sanctions, or civil or criminal penalties imposed under, any federal or District

healthcare program, including but not limited to Medicare or Medicaid, or have been convicted, under federal or District law (including without limitation following a plea of *nolo contendere* or no contest or participation in a first offender deferred adjudication or other arrangement whereby a judgment of conviction has been withheld), of a criminal offense related to (a) the neglect or abuse of a patient, (b) the delivery of an item or service, including the performance of management or administrative services related to the delivery of an item or service, under a federal or District healthcare program, (c) fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a healthcare item or service or with respect to any act or omission in any program operated by or financed in whole or in part by any federal, state, or local government agency (d) the unlawful, manufacture, distribution, prescription or dispensing of a controlled substance, or (e) interference with or obstruction of any investigation into any criminal offense described in (a) through (d) above. The Business Associate further agrees to notify the Covered Entity immediately after the Business Associate becomes aware that any of the foregoing representations and warranties may be inaccurate or may become incorrect.

9. Term and Termination

a. *Term.* The requirements of this BAA shall be effective as of the date of the contract award, and shall terminate when all of the PHI provided by the Covered Entity to the Business Associate, or created or received by the Business Associate on behalf of the Covered Entity, is confidentially destroyed or returned to the Covered Entity within five (5) business days of its request. The PHI shall be returned in a format mutually agreed upon by and between the Privacy Official and/or Privacy Officer or their designee and the appropriate and duly authorized Workforce member of the Business Associate.; If it is infeasible to return or confidentially destroy the PHI, protections shall be extended to such information, in accordance with the termination provisions in this Section and communicated to the Privacy Official or Privacy Officer or their designee. The requirement to return PHI to the District at the end of the contract term or if the contract is terminated applies irrespective of whether the Business Associate is also a Covered Entity under HIPAA. Where a Business Associate is also a Covered Entity, PHI provided by the District, or created or received by the Business Associate on behalf of the District, a duplicate of the record may be acceptable if mutually agreed.

b. *Termination for Cause.* Upon the Covered Entity's knowledge of a material breach of this BAA by the Business Associate, the Covered Entity shall either:

i. Provide an opportunity for the Business Associate to cure the breach within a period of ten (10) days(or such longer period as the District may authorize in writing) after receipt of notice from the contracting officer specifying such failure or end the violation and terminate the contract if the Business Associate does not cure the breach or end the violation within the time specified by the Covered Entity; or

ii. Immediately terminate the contract if the Business Associate breaches a material

term of this BAA and a cure is not possible. If neither termination nor cure is feasible, the Covered Entity shall report the violation to the Secretary of HHS.

c. *Effect of Termination.*

i. Except as provided in paragraph (ii) of this section, upon termination of the contract, for any reason, the Business Associate shall return in **a mutually agreed upon format or confidentially destroy** [*delete bolded material and insert negotiated terms and conditions if applicable*] all PHI received from the Covered Entity, or created or received by the Business Associate on behalf of the Covered Entity within five (5) business days of termination. This provision shall apply to PHI that is in the possession of ALL subcontractors, agents or Workforce members of the Business Associate. The Business Associate shall retain no copies of PHI in any form.

ii. In the event that the Business Associate determines that returning or destroying the PHI is infeasible, the Business Associate shall provide written notification to the Covered Entity of the conditions that make the return or confidential destruction infeasible. Upon determination by the agency Privacy Officer/Liaison that the return or confidential destruction of the PHI is infeasible, the Business Associate shall extend the protections of this BAA to such PHI and limit further uses and disclosures of such PHI for so long as the Business Associate maintains such PHI. Additionally, the Business Associate shall:

(1) Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

(2) Return to Covered Entity [or, if agreed to by Covered Entity, destroy] the remaining PHI that the Business Associate still maintains in any form;

(3) Continue to use appropriate safeguards and comply with Subpart C of 45 C.F.R Part 164 with respect to ePHI to prevent use or disclosure of the PHI, other than as provided for in this section, for as long as Business Associate retains the PHI;

(4) Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at [Insert section number related to paragraph (ender "Permitted Uses and Disclosures By The Business Associate"] which applied prior to termination; and

(5) Return to Covered Entity [or, if agreed to by Covered Entity, destroy] the Protected Health Information retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.
The obligations outlined in Section 2. Obligations and Activities of Business Associate shall survive the termination of this contract.

10. Miscellaneous

a. *Regulatory References.* A reference in this BAA to a section in the Privacy Rule means the section as in effect or as amended.

b. *Amendment.* A Covered Entity and Business Associate ("the Parties") agree to take such action as is necessary to amend this BAA from time to time as is necessary for the Covered Entity to comply with the requirements of the Privacy Rule and HIPAA Regulations. Except for provisions Required By Law as defined herein, no provision hereof shall be deemed waived unless in expressed in writing and signed by duly authorized representatives of the Parties. A waiver with respect to one event shall not be construed as continuing, or as a bar to or waiver of any other right or remedy under this BAA.

c. *Survival.* The respective rights and obligations of the business associate under Section 9. Term and Termination of this HIPAA Compliance BAA and Sections 9 and 20 of the Standard Contract Provisions for use with the District of Columbia Government Supply and Services Contracts shall survive termination of the contract.

d. *Interpretation.* Any ambiguity in this BAA shall be resolved to permit compliance with applicable federal and District laws, rules and regulations, and the HIPAA Rules, and any requirements, rulings, interpretations, procedures, or other actions related thereto that are promulgated, issued or taken by or on behalf of the Secretary; provided that applicable federal and District laws, rules and regulations shall supersede the Privacy Rule if, and to the extent that they impose additional requirements, have requirements that are more stringent than or provide greater protection of patient privacy or the security or safeguarding of PHI than those of the HIPAA Regulations.

The terms of this BAA amend and supplement the terms of the contract.. In the event of a conflict between the terms of the BAA and the terms of the contract, the terms of this BAA shall control; provided, however, that this BAA shall not supersede any other federal or District law or regulation governing the legal relationship of the Parties, or the confidentiality of records or information, except to the extent that the Privacy Rule preempts those laws or regulations. In the event of any conflict between the provisions of the contract (as amended by this BAA) and the Privacy Rule, the Privacy Rule shall control.

e. *No Third-Party Beneficiaries*. The Covered Entity and the Business Associate are the only parties to this BAA and are the only parties entitled to enforce its terms. Except for the rights of Individuals, as defined herein, to have access to and amend their PHI, and to an accounting of the uses and disclosures thereof, in accordance with paragraphs (2)(f), (g) and (j) of this BAA, nothing in the BAA gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly, indirectly, or otherwise, to third persons.

f. *Compliance with Applicable Law*. The Business Associate shall comply with all federal and District laws, regulations, executive orders and ordinances, as they may be amended from time to time during the term of this BAA and the contract; to the extent they are applicable to this BAA and the contract.

g. *Governing Law and Forum Selection*. This contract shall be construed broadly to implement and comply with the requirements relating to the Privacy Rule, and other applicable laws and regulations. All other aspects of this contract shall be governed under the laws of the District. The Covered Entity and the Business Associate agree that all disputes which cannot be amicably resolved by the Covered Entity and the Business Associate regarding this BAA shall be litigated before the District of Columbia Contract Appeals Board, the District of Columbia Court of Appeals, or the United States District Court for the District of Columbia having jurisdiction, as the case may be. The Covered Entity and the Business Associate expressly waive any and all rights to initiate litigation, arbitration, mediation, negotiations and/or similar proceedings outside the physical boundaries of the District of Columbia and expressly consent to the jurisdiction of the above tribunals.

h. *Indemnification*. The Business Associate shall indemnify, hold harmless and defend the Covered Entity from and against any and all claims, losses, liabilities, costs, and other expenses incurred as a result or arising directly or indirectly out of or in connection with
(a) any misrepresentation, breach of warranty or non-fulfillment of any undertaking of the Business Associate under this BAA; and
(b) any claims, demands, awards, judgments, actions and proceedings made by any person or organization, arising out of or in any way connected with the performance of the Business Associate under this BAA.

i. *Injunctive Relief*. Notwithstanding any rights or remedies under this BAA or provided by law, the Covered Entity retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of PHI by the Business Associate, its Workforce, any of its subcontractors, agents, or any third party who has received PHI from the Business Associate.

j. *Assistance in litigation or administrative proceedings*. The Business Associate shall make itself and any agents, affiliates, subsidiaries, subcontractors or its Workforce assisting the Business Associate in the fulfillment of its obligations under this HIPAA Compliance BAA and the contract, available to the Covered Entity, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Covered Entity, its directors, officers or employees based upon claimed violation of HIPAA, the Privacy Rule or other laws relating to security and privacy, except where the Business Associate or its agents, affiliates, subsidiaries, subcontractors or its Workforce are a named adverse party.

k. *Notices.* Any notices between the Parties or notices to be given under this BAA shall be given in writing and delivered by personal courier delivery or overnight courier delivery, or by certified mail with return receipt requested, to the Business Associate or to the Covered Entity, to the addresses given for each Party below or to the address either Party hereafter gives to the other Party. Any notice, being addressed and mailed in the foregoing manner, shall be deemed given five business days after mailing. Any notice delivered by personal courier delivery or overnight courier delivery shall be deemed given upon notice upon receipt.

If to the Business Associate, to  If to the Covered Entity, to

| | |
|---|---|
| OCP will enter name of contractor here after the award<br><br>Attention: | District of Columbia Government<br>Department of Corrections<br>1901 E Street, S.E<br>Room A1-133a<br>Washington, DC 2003<br>Attention: Dr. Beth Jordan<br>202-671-2157<br>beth.jordan@dc.gov |

l. *Headings*. Headings are for convenience only and form no part of this BAA and shall not affect its interpretation.

m. *Counterparts; Facsimiles*. This BAA may be executed in any number of counterparts, each of which shall be deemed an original. Facsimile copies hereof shall be deemed to be originals.

n. *Successors and Assigns*. The provisions of this BAA shall be binding upon and shall inure to the benefit of the Parties hereto and their respective successors and permitted assigns, if any.

o. *Severance*. In the event that any provision of this BAA is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this BAA will remain in full force and effect. In addition, in the event a Party believes in good faith that any provision of this BAA fails to comply with the then-current requirements of the Privacy Rule, such party shall notify the other Party in writing, in the manner set forth in Section 10. Miscellaneous, Paragraph k. Notices. Within ten (10) business days from receipt of notice, the Parties shall address in good faith such concern and amend the terms of this BAA, if necessary to bring the contested provision(s) into compliance.

p. *Independent Contractor*. The Business Associate will function as an independent contractor and shall not be considered an employee of the Covered Entity for any purpose. Nothing in this BAA shall be interpreted as authorizing the Business Associate Workforce, its subcontractor(s) or its agent(s) or employee(s) to act as an agent or representative for or on behalf of the Covered Entity.

q. *Entire Agreement*. This BAA, as may be amended from time to time pursuant to Section 10. Miscellaneous, Paragraph b. Amendment, which incorporates by reference specific procedures from the District of Columbia Department of Health Privacy Policy Operations Manual, constitutes the entire agreement and understanding between the arties and supersedes all prior oral and written agreements and understandings between them with respect to applicable District and federal laws, rules and regulations, HIPAA and the Privacy Rule, and any rules, regulations, requirements, rulings, interpretations, procedures, or other actions related thereto that are promulgated, issued or taken by or on behalf of the Secretary of HHS.

## H.16 RESERVED

## H.17 PURCHASES OF IT HARDWARE AND EQUIPMENT

The contractor shall provide only the most current models, components and accessories in new, fully operational, factory sealed condition, with all applicable licenses. The contractor warrants and represents that the equipment is eligible for the manufacturer's normal and extended warranty and support within the United States to Authorized Users. Previously owned, damaged, refurbished, remanufactured, counterfeit, "gray market" or substitute third party items will not be accepted. The offeror shall provide evidence of its authorized reseller agreement or certification with its proposal.

## H.18 PUBLICITY

(See 2010 SCP 33, p.29)

## H.19 FREEDOM OF INFORMATION ACT

(See 2010 SCP 34, p.29**)**

## H.20 SECTION 504 OF THE REHABILITATION ACT OF 1973, as amended.

(See 2010 SCP 38, p.31)

## H.21 AMERICANS WITH DISABILITIES ACT OF 1990 (ADA)

(See 2010 SCP 38, p.31)

## H.22 WAY TO WORK AMENDMENT ACT OF 2006

(See 2010 SCP 38, p.31-32)

## H.23 LIQUIDATED DAMAGES

**H.23.1** DOC is committed to providing quality medical services to those under its custody. For failure to meet the performance standards listed in C.5, contractor shall be subject to a corrective action plan or liquidated damages appropriate to the actual loss experienced by the failure.

## H.24 DISTRICT RESPONSIBILITIES

The Government of the District of Columbia, through the Department of Corrections or the CA, shall provide the following:

**H.24.1 The District shall be responsible for the following:**

**H.24.1.1** Installation and maintenance of all hardware, software and communications infrastructure associated with the delivery of Health Care Services at CDF and CTF; and administration of all databases residing on DOC platforms. DOC shall have unabridged access to these data within the legal confines of HIPAA

requirements. In providing analytical and technology support to the contractor, DOC shall:

**H.24.1.1.1** Ensure workstations have appropriate warranties and service level agreements.

**H.24.1.1.2** Replace computer workstations in accordance with DOC replacement standards.

**H.24.1.1.3** Install and maintain cabling, as well as other communications infrastructure.

**H.24.1.1.4** Install and maintain required servers.

**H.24.1.1.5** Maintain version control of all software and associated licenses.

**H.24.1.1.6** Develop and implement a disaster recovery program.

**H.24.1.1.7** Develop and maintain industry standard procedures to test for back up, data storage, and security.

**H.24.1.1.8** Maintain updated virus protection software.

**H.24.1.1.9** Develop and maintain system documentation.

**H.24.1.1.10** Utilize industry standard procedures to test and accept new applications and databases.

**H.24.1.1.11** Operate a Help Desk during regular business hours, Monday through Friday, 8:30 a.m. 5:00 p.m., and provide 24/7 emergency, on call IT support.

**H.24.1.1.12** Provide the contractor with controlled access to JACCS and other essential DOC systems.

**H.24.1.1.13** Prepare specifications for all new or replacement hardware and software technologies. (F.3.18)

**H.24.1.1.14** Administer password access to the medical information system, specialized health databases, and relevant DOC systems.

**H.24.1.2** Provide adequate clinic space and administrative offices to contractor to allow for adequate delivery of comprehensive care as required by the contract, as more completely described in Attachment J.25.

**H.24.1.3** Identify federally billable residents.

**H.24.1.4** Bear the cost of 911- FEMS services for District employees and visitors.

**H.24.1.5** Bear the cost of transporting residents to offsite scheduled appointments and all non-911 emergency room visits.

**H.24.1.6** RESERVED.

**H.24.1.7** Provide contractor access to the OMS.

**H.24.1.8** Provide contractor access to DOC's program statements.

**H.24.1.9** Provide training on DOC's EMR, as needed.

**H.24.1.10** Provide resident workers to ensure cleanliness of medical areas. Resident workers shall not clean blood spills or handle bio-hazardous items.

**H.24.1.11** Provide a licensed dietician for oversight and monitor the effectiveness and appropriateness of therapeutic diets.

**H.24.1.12** Subject contractor staff to a background investigation, drug testing, pre-service and annual in-service training for initial and continued employment. DOC shall provide these at no cost to contractor.

**H.24.1.13** Provide HIV test kits and condoms.

**H.24.1.14** Provide telemedicine equipment.

**H.24.1.15** Provide a Residential Substance Abuse Program.

**H.24.1.16** Upgrade Centricity EMR and CIPS.

**H.24.1.17** Security control and limitation of resident movement into, from and within the health service area, including physical security of employees, suppliers and other authorized visitors.

## H.24.2 SPACE, EQUIPMENT, SUPPLIES

The District shall provide the space, equipment and furniture currently in place as indicated on the equipment inventory list to be provided to the contractor in Attachments J.26 and J.27. The District shall provide trash collection (except biohazardous waste), building maintenance and building access for telephone services (except the cost of telephone services). Notwithstanding the requirements of C.5.14.1 of this RFP, the District shall provide all current pharmaceuticals, clinical supplies, and standardized DOC forms to contractor at the commencement of the contract period. The District shall provide the medical reporting software, and the Association of State Correctional Administrator's reporting guidelines. Conversely, all medical and administrative equipment, pharmaceutical and clinical supply inventories at the end of the contract period shall become the property of the DOC.

### H.24.3 INFORMATION TECHNOLOGY MANAGEMENT

The District shall provide network infrastructure and management, database administration, help desk, level 3 technical support and liaison with technology vendors. Contractor shall follow district policy and procedure and participate in the development and implementation of system procedures. These include: a) disaster recovery plan; b) proper procedures for back-up, data storage and security; and c) maintaining updated virus protection software.

### H.24.4 TRANSPORTATION

The District shall provide all non-emergency, scheduled medical transportation and security escort services for health services delivery functions, in accordance with prevailing DOC program statements and medical escorts.

### H.24.5 CLEANING

The District shall provide support for cleaning, which includes the use of resident labor, supplies and equipment.

### H.24.6 PEST CONTROL

The District provides environmental services for pest control.

## H.25 CONTRACTOR RESPONSIBILITIES

The contractor responsibilities are as stated in Section C.5.45.

# SECTION I: CONTRACT CLAUSES

## I.1 APPLICABILITY OF STANDARD CONTRACT PROVISIONS

The Standard Contract Provisions for use with District of Columbia Government Supplies and Services Contracts dated July 2010 ("SCP") are incorporated as part of the contract. To obtain a copy of the SCP go to www.ocp.dc.gov, click on Center of Excellence, Required Solicitation Documents, then click on Standard Contract Provisions – 2010.

## I.2 CONTRACTS THAT CROSS FISCAL YEARS

Continuation of this contract beyond the current fiscal year is contingent upon future fiscal appropriations.

## I.3 CONFIDENTIALITY OF INFORMATION

The contractor shall keep all information relating to any employee or customer of the District in absolute confidence and shall not use the information in connection with any other matters; nor shall it disclose any such information to any other person, firm or corporation, in accordance with the District and federal laws governing the confidentiality of records.

## I.4 TIME

Time, if stated in a number of days, will include Saturdays, Sundays, and holidays, unless otherwise stated herein.

## I.5 RIGHTS IN DATA

Delete Article 42, Rights in Data, of the Standard Contract Provisions dated July 2010 for use with District of Columbia Government Supplies and Services Contracts and substitute the following Article 42, Rights in Data) in its place:

**A. Definitions**

1. "Products" - A deliverable under any contract that may include commodities, services and/or technology furnished by or through contractor, including existing and custom Products, such as, but not limited to: a) recorded information, regardless of form or the media on which it may be recorded; b) document research; c) experimental, developmental, or engineering work; d) licensed software; e) components of the hardware environment; f) printed materials (including but not limited to training manuals, system and user documentation, reports, drawings); g) third party software; h) modifications, customizations, custom programs, program listings, programming tools, data, modules, components; and i) any intellectual property embodied therein, whether in tangible or intangible form, including but not

limited to utilities, interfaces, templates, subroutines, algorithms, formulas, source code, and object code.

2. "Existing Products" - Tangible Products and intangible licensed Products that exist prior to the commencement of work under the contract. Existing Products must be identified on the Product prior to commencement of work or else will be presumed to be Custom Products.

3. "Custom Products" - Products, preliminary, final or otherwise, which are created or developed by contractor, its subcontractors, partners, employees, resellers or agents for the District under the contract.

4. "District" – The District of Columbia and its agencies.

**B. Title to Project Deliverables**

The contractor acknowledges that it is commissioned by the District to perform services detailed in the contract. The District shall have ownership and rights for the duration set forth in the contract to use, copy, modify, distribute, or adapt Products as follows:

1. Existing Products: Title to all Existing Licensed Product(s), whether or not embedded in, delivered or operating in conjunction with hardware or Custom Products, shall: (1) remain with contractor or third party proprietary owner, who retains all rights, title and interest (including patent, trademark or copyrights). Effective upon payment, the District is granted an irrevocable, non-exclusive, worldwide, paid-up license to use, execute, reproduce, display, perform, adapt (unless contractor advises the District as part of contractor's proposal that adaptation will violate existing agreements or statutes and contractor demonstrates such to the District's satisfaction) and distribute Existing Product to District users up to the license capacity stated in the contract with all license rights necessary to fully effect the general business purpose(s) of the project or work plan or contract; and (2) be licensed in the name of the District. The District agrees to reproduce the copyright notice and any other legend of ownership on any copies authorized under this paragraph.

2. Custom Products: Effective upon Product creation, contractor hereby conveys, assigns, and transfers to the District the sole and exclusive rights, title and interest in Custom Product(s), whether preliminary, final or otherwise, including all patent, trademark and copyrights. Contractor hereby agrees to take all necessary and appropriate steps to ensure that the Custom Products are protected against unauthorized copying, reproduction and marketing by or through contractor.

**C. Transfers or Assignments of Existing or Custom Products by the District**

The District may transfer or assign Existing or Custom Products and the licenses thereunder to another District agency. Nothing herein shall preclude the contractor from otherwise using the related or underlying general knowledge, skills, ideas,

concepts, techniques and experience developed under a project or work plan in the course of contractor's business.

**D. Subcontractor Rights**

Whenever any data, including computer software, are to be obtained from a subcontractor under the contract, the contractor shall use this clause, **Rights in Data**, in the subcontract, without alteration, and no other clause shall be used to enlarge or diminish the District's or the contractor's rights in that subcontractor data or computer software which is required for the District.

**E. Source Code Escrow**

1. For all computer software furnished to the District with the rights specified in section B.2, the contractor shall furnish to the District, a copy of the source code with such rights of the scope as specified in section B.2 of this clause. For all computer software furnished to the District with the restricted rights specified in section B.1 of this clause, the District, if the contractor either directly or through a successor or affiliate shall cease to provide the maintenance or warranty services provided the District under the contract or any paid-up maintenance agreement, or if the contractor should be declared insolvent by a court of competent jurisdiction, shall have the right to obtain, for its own and sole use only, a single copy of the current version of the source code supplied under the contract, and a single copy of the documentation associated therewith, upon payment to the person in control of the source code the reasonable cost of making each copy.

2. If the contractor or Product manufacturer/developer of software furnished to the District with the rights specified in section B.1 of this clause offers the source code or source code escrow to any other commercial customers, the contractor shall either: (1) provide the District with the source code for the Product; (2) place the source code in a third party escrow arrangement with a designated escrow agent who shall be named and identified to the District, and who shall be directed to release the deposited source code in accordance with a standard escrow arrangement acceptable to the District; or (3) will certify to the District that the Product manufacturer/ developer has named the District as a named beneficiary of an established escrow arrangement with its designated escrow agent who shall be named and identified to the District, and who shall be directed to release the deposited source code in accordance with the terms of escrow.

1. The contractor shall update the source code, as well as any corrections or enhancements to the source code, for each new release of the Product in the same manner as provided above, and certify such updating of escrow to the District in writing.

**F. Indemnification and Limitation of Liability**

The contractor shall indemnify and save and hold harmless the District, its officers, agents and employees acting within the scope of their official duties against any

liability, including costs and expenses, (i) for violation of proprietary rights, copyrights, or rights of privacy, arising out of the publication, translation, reproduction, delivery, performance, use or disposition of any data furnished under this contract, or (ii) based upon any data furnished under this contract, or based upon libelous or other unlawful matter contained in such data.

## I.6 OTHER CONTRACTORS

The contractor shall not commit or permit any act that will interfere with the performance of work by another District contractor or by any District employee.

## I.7 SUBCONTRACTS

The contractor hereunder shall not subcontract any of the contractor's work or services to any subcontractor without the prior written consent of the CO. Any work or service so subcontracted shall be performed pursuant to a subcontract agreement, which the District will have the right to review and approve prior to its execution by the contractor. Any such subcontract shall specify that the contractor and the subcontractor shall be subject to every provision of this contract. Notwithstanding any such subcontract approved by the District, the contractor shall remain liable to the District for all contractor's work and services required hereunder.

## I.8 INSURANCE AF08292023

A. GENERAL REQUIREMENTS. The Contractor at its sole expense shall procure and maintain, during the entire period of performance under this contract, the types of insurance specified below. The Contractor shall submit a Certificate of Insurance to the Contracting Officer (CO) giving evidence of the required coverage prior to commencing performance under this contract. In no event shall any work be performed until the required Certificates of Insurance signed by an authorized representative of the insurer(s) have been provided to, and accepted by, the CO.

The Government of the District of Columbia shall be included in all policies, where applicable and allowable by law, required hereunder to be maintained by the Contractor and its subcontractors (except for workers' compensation and professional liability insurance) as an additional insureds for claims against The Government of the District of Columbia relating to this contract, with the understanding that any affirmative obligation imposed upon the insured Contractor or its subcontractors (including without limitation the liability to pay premiums) shall be the sole obligation of the Contractor or its subcontractors, and not the additional insured. The additional insured status under the Contractor's and its subcontractors' Commercial General Liability insurance policies shall be effected using the ISO Additional Insured Endorsement form CG 20 10 11 85 (or CG 20 10 07 04 **and** CG 20 37 07 04) or such other endorsement or combination of endorsements providing coverage at least as broad and approved by the CO in writing. All of the Contractor's and its subcontractors' liability policies (except for workers' compensation and professional liability insurance) shall be endorsed using ISO form CG 20 01 04 13 or its equivalent so as to indicate that such policies provide primary coverage (without any right of contribution by any other insurance, reinsurance or self-insurance, including

any deductible or retention, maintained by an Additional Insured) for all claims against the additional insured arising out of the performance of this Statement of Work by the Contractor or its subcontractors, or anyone for whom the Contractor or its subcontractors may be liable. These policies shall include a separation of insureds clause applicable to the additional insured.

If the Contractor and/or its subcontractors maintain broader coverage and/or higher limits than the minimums shown below, the District requires and shall be entitled to the broader coverage and/or the higher limits maintained by the Contractor and subcontractors.

B. INSURANCE REQUIREMENTS

1. Commercial General Liability Insurance ("CGL") - The Contractor shall provide evidence satisfactory to the CO with respect to the services performed that it carries a CGL policy, written on an occurrence (not claims-made) basis, on Insurance Services Office, Inc. ("ISO") form CG 00 01 04 13 (or another occurrence-based form with coverage at least as broad and approved by the CO in writing), covering liability for all ongoing and completed operations of the Contractor and under all subcontracts, covering claims for bodily injury, including without limitation sickness, disease or death and mental anguish of any persons, broad form property damage, including loss of use resulting therefrom, personal and advertising injury, and including coverage for liability arising out of an Insured Contract (including the tort liability of another assumed in a contract) and acts of terrorism (whether caused by a foreign or domestic source). Such coverage shall have limits of liability of not less than $1,000,000 each occurrence, a $2,000,000 general aggregate.

   The Commercial General Liability shall be further endorsed to:

   a) To the fullest extent permitted by law, provide additional insured coverage using ISO form CG 2015 0413 (or it's equivalent) to The Government of the District of Columbia
   b) Coverage available to the additional insureds shall apply on a primary and non-contributing basis as respects any other insurance, deductibles, or self-insurance available to the additional insureds
   c) A waiver of subrogation in favor of The Government of the District of Columbia
   d) Any Annual Aggregate shall apply on a per location or per project basis (where applicable)
   e) Defense costs shall be in addition to and not erode the limits of liability

2. Automobile Liability Insurance - The Contractor shall provide evidence satisfactory to the CO of commercial (business) automobile liability insurance written on ISO form CA 00 01 10 13 (or another form with coverage at least as broad and approved by the CO in writing) including coverage for all owned, hired, borrowed and non-owned vehicles and equipment used by the Contractor in connection with work under this agreement, with a minimum combined single limit of $1,000,000 for bodily injury or death and property damage, including loss of use thereof. Such policy or policies of automobile liability insurance shall be written on an "occurrence" (as opposed to a "claims made") basis.

Auto Physical Damage Coverage - The Contractor shall provide auto physical damage insurance to cover "loss" to a covered "auto" or its equipment:

a) Comprehensive - Fire, lightning or explosion; theft; windstorm, hail or earthquake; flood; mischief or vandalism; or the sinking, burning, collision or derailment of any conveyance transporting the covered "auto".
b) Collision Coverage - Caused by: The covered "auto's" collision with another object or the covered "auto's" overturn.

The Commercial Auto Liability policy shall be further endorsed to:

a. To the fullest extent permitted by law, provide additional insured coverage to The Government of the District of Columbia
b. Coverage available to the additional insureds shall apply on a primary and non-contributing basis as respects any other insurance, deductibles, or self-insurance available to the additional insureds
c. A waiver of subrogation in favor of The Government of the District of Columbia
d. Defense costs shall be in addition to and not erode the limits of liability
e. If applicable, include Form CA 99 48 03 06 Pollution Liability - Broadened Coverage for Covered Autos - Business Auto, Motor Carrier and Truckers (or it's equivalent)

3. Workers' Compensation Insurance - The Contractor shall provide evidence satisfactory to the CO of Workers' Compensation insurance in accordance with the statutory mandates of the District of Columbia or the jurisdiction in which the contract is performed.

Employer's Liability Insurance - The Contractor shall provide evidence satisfactory to the CO of employer's liability insurance as follows: $500,000 per accident for injury; $500,000 per employee for disease; and $500,000 for policy disease limit.

The Workers Compensation and Employers Liability shall be further endorsed to:

a) Include a Waiver of Subrogation in favor of The Government of the District of Columbia.
b) Where applicable, include United States Longshore and Harbor Workers Compensation Act (USL&H)
c) Where applicable, include Jones Act Coverage for seamen or crew members on an "if any" basis.

4. Network Security/Privacy (Cyber) Liability Insurance covering acts, errors, omissions, breach of contract, and violation of any consumer protection laws arising out of Contractor's operations or services with a limit of $5,000,000 per claim and in the aggregate. Such coverage shall include but not be limited to, third party and first party coverage for loss or disclosure of any data, including personally identifiable information and payment card information, network security failure, violation of any consumer protection laws, unauthorized access and/or use or other intrusions, infringement of any intellectual property rights (except patent), unintentional breach of contract, negligence or breach of duty to use reasonable care, breach of any duty of

confidentiality, invasion of privacy, or violations of any other legal protections for personal information, defamation, libel, slander, commercial disparagement, negligent transmission of computer virus, or use of computer networks in connection with denial of service attacks. Such coverage shall include regulatory defense and fines/penalties in any jurisdiction anywhere in the world. Such coverage shall include contractual privacy coverage for data breach response and crisis management costs that would be incurred by Contractor on behalf of The Government of the District of Columbia in the event of a data breach including legal and forensic expenses, notification costs, credit monitoring costs, and costs to operate a call center. Contractor shall maintain coverage in force during the term of this Agreement and for an extended reporting period of not less than two (2) years after.

5. Professional Liability Insurance (Errors & Omissions) - The Contractor shall provide Professional Liability Insurance (Errors and Omissions) to cover liability resulting from any error or omission in the performance of professional services under this Contract. The policy shall provide limits of $1,000,000 per claim or per occurrence for each wrongful act and $2,000,000 annual aggregate. The Contractor warrants that any applicable retroactive date precedes the date the Contractor first performed any professional services for the Government of the District of Columbia and that continuous coverage will be maintained or an extended reporting period will be exercised for a period of at least ten years after the completion of the professional services. Limits may not be shared with other lines of coverage.

6. Environmental Liability/Contractors Pollution Liability Insurance - The Contractor shall provide evidence satisfactory to the CO of environmental liability insurance covering losses caused by pollution or other hazardous conditions arising from ongoing or completed operations of the Contractor. Such insurance shall apply to bodily injury, property damage (including loss of use of damaged property or of property that has been physically injured), clean-up costs, transit and non-owned disposal sites. Coverage shall extend to defense costs and expenses incurred in the investigation, civil fines, penalties and damages or settlements. There shall be neither an exclusion nor a sublimit for mold or fungus-related claims. The minimum limits required under this paragraph shall $2,000,000 per occurrence and $2,000,000 in the annual aggregate. If such coverage is written on a claims-made basis, the Contractor warrants that any retroactive date applicable to coverages under the policy precedes the Contractor's performance of any work under the Contract and that continuous completed operations coverage will be maintained for at least ten (10) years or an extended reporting period shall be purchased for no less than ten (10) years after completion.

   The Contractor also must furnish to the CO Owner certificates of insurance evidencing environmental liability insurance maintained by third party transportation and disposal site operators(s) used by the Contractor for losses arising from facility(ies) accepting, storing or disposing hazardous materials or other waste as a result of the Contractor's operations. Such coverages must be maintained with limits of at least the amounts set forth above.

   The Environmental Liability policy shall be further endorsed to include The Government of the District of Columbia as an Additional Insured.

7. Commercial Umbrella or Excess Liability - The Contractor shall provide evidence satisfactory to the CO of commercial umbrella or excess liability insurance with minimum limits of $10,000,000 per occurrence and $10,000,000 in the annual aggregate, following the form and in excess of all liability policies. **All** liability coverages must be scheduled under the umbrella and/or excess policy. The insurance required under this paragraph shall be written in a form that annually reinstates all required limits. Coverage shall be primary to any insurance, self-insurance or reinsurance maintained by The Government of the District of Columbia and the "other insurance" provision must be amended in accordance with this requirement and principles of vertical exhaustion.

8. Medical Professional Liability - The Contractor shall provide evidence satisfactory to the CO of a Medical Professional Liability policy with limits of not less than $1,000,000 each incident and $3,000,000 in the annual aggregate. The definition of insured shall include the Contractor and all Contractor's employees and agents. The policy shall be either (1) written on an occurrence basis or (2) written on a claims-made basis. If the coverage is on a claims-made basis, Contractor hereby agrees that prior to the expiration date of Contractor's current insurance coverage, Contractor shall purchase, at Contractor's sole expense, either a replacement policy annually thereafter having a retroactive date no later than the effective date of this Contract or unlimited tail coverage in the above stated amounts for all claims arising out of this Contract.

9. Sexual/Physical Abuse & Molestation - The Contractor shall provide evidence satisfactory to the CO with respect to the services performed that it carries $1,000,000 per occurrence limits; $2,000,000 aggregate of affirmative abuse and molestation liability coverage. Coverage should include physical abuse, such as sexual or other bodily harm and non-physical abuse, such as verbal, emotional or mental abuse; any actual, threatened or alleged act; errors, omission or misconduct. This insurance requirement will be considered met if the general liability insurance includes an affirmative sexual abuse and molestation endorsement for the required amounts or through a separate stand alone sexual abuse and molestation policy with confirmation there are no exclusions for abuse or assault & battery under the General Liability. So called "silent" coverage or "shared" limits under a commercial general liability or professional liability policy will not be acceptable. Limits may not be shared with other lines of coverage. The applicable policy may need to be submitted to the ORM for compliance review.

C. SUBCONTRACTOR INSURANCE REQUIREMENTS

Any and all subcontractors engaged by Contractor for work under this agreement shall be required to have the same insurance required of Contractor. Should the Contractor wish to propose different insurance requirements than outlined below, then, prior to commencement of work by the subcontractor, the Contractor shall submit in writing the name and brief description of work to be performed by the subcontractor on the Subcontractors Insurance Requirement Template provided to the Office of Risk Management (ORM). ORM will determine the insurance requirements applicable to the subcontractor and promptly deliver such requirements in writing to the Contractor. In either instance, the Contractor must provide proof of the

subcontractor's required insurance prior to commencement of work by the subcontractor.

D. PRIMARY AND NONCONTRIBUTORY INSURANCE
The insurance required herein shall be primary to and will not seek contribution from any other insurance, reinsurance or self-insurance including any deductible or retention, maintained by the Government of the District of Columbia.

E. DURATION. The Contractor shall carry all required insurance until all contract work is accepted by The Government of the District of Columbia and shall carry listed coverages for ten years for construction projects following final acceptance of the work performed under this contract and two years for non-construction related contracts.

F. LIABILITY. These are the required minimum insurance requirements established by The Government of the District of Columbia. However, it is understood that The Government of the District of Columbia does not in any way represent that the insurance or the limits of insurance specified herein are sufficient or adequate to protect your interests or liabilities and will not in any way limit the contractor's liability under this contract.

G. CONTRACTOR'S PROPERTY. Contractor and subcontractors are solely responsible for any loss or damage to their personal property, including but not limited to tools and equipment, scaffolding and temporary structures, rented machinery, or owned and leased equipment. A waiver of subrogation shall apply in favor of The Government of the District of Columbia.

H. MEASURE OF PAYMENT. The Government of the District of Columbia shall not make any separate measure or payment for the cost of insurance and bonds. The Contractor shall include all of the costs of insurance and bonds in the contract price.

I. NOTIFICATION. The Contractor shall ensure that all policies provide that the CO shall be given thirty (30) days prior written notice in the event of cancellation, non-renewal, or material changes to the extent such cancellation or material changes results in Contractor no long complying with the above requirements. The Contractor shall provide the CO with ten (10) days prior written notice in the event of non-payment of premium. The Contractor will also provide the CO with an updated Certificate of Insurance should its insurance coverages renew during the contract. The Government of the District of Columbia may reasonably change the above insurance coverage requirements during the Term by giving Contractor at least 30 days' notice of the change. Contractor must comply, at your expense, and deliver to the CO evidence of compliance before the change becomes effective.

J. CERTIFICATES OF INSURANCE. The Contractor must send to CO, at least 10 days after execution of this Agreement, certificates of insurance evidencing the required insurance coverage and endorsements required herein. Contractor must also provide us with evidence of renewal before the expiration date of each insurance policy. Contractor is responsible for providing us with 30 days advanced written notice if the certificate of insurance by the insurer has been canceled, reduced in

coverage, or otherwise altered. . Certificates of insurance must reference the corresponding contract number. Evidence of insurance shall be submitted to:

**The Government of the District of Columbia**

**And mailed to the attention of:**

Deborah J. White
Supervisory Contract Specialist/Contracting Officer
Officer of Contracting and Procurement
Department of Corrections
2000 14th St. NW – Suite 100C
Washington, DC 20009
Telephone: 202-724-4793
Email: deborahj.white@dc.gov

The CO may request and the Contractor shall promptly deliver updated certificates of insurance, endorsements indicating the required coverages, and/or certified copies of the insurance policies. If the insurance initially obtained by the Contractor expires prior to completion of the contract, renewal certificates of insurance and additional insured and other endorsements shall be furnished to the CO prior to the date of expiration of all such initial insurance. For all coverage required to be maintained after completion, an additional certificate of insurance evidencing such coverage shall be submitted to the CO on an annual basis as the coverage is renewed (or replaced).

K. DISCLOSURE OF INFORMATION. The Contractor agrees that The Government of the District of Columbia may disclose the name and contact information of its insurers to any third party which presents a claim against The Government of the District of Columbia for any damages or claims resulting from or arising out of work performed by the Contractor, its agents, employees, servants or subcontractors in the performance of this contract.

L. CARRIER RATINGS. All Contractor's and its subcontractors' insurance required in connection with this contract shall be written by insurance companies with an A.M. Best Insurance Guide rating of at least A- VII or better (or the equivalent by any other rating agency) and licensed in the District of Columbia.

M. WARRANTIES. When applicable, the Contractor should be named as an additional insured on the applicable manufacturer's/distributer's Commercial General Liability policy using Insurance Services Office, Inc. ("ISO") form CG 20 15 04 13 (or another occurrence-based form with coverage at least as broad). CO should collect, review for accuracy, and maintain all warranties for goods and services.

## I.9 EQUAL EMPLOYMENT OPPORTUNITY

In accordance with the District of Columbia Administrative Issuance System, Mayor's Order 85-85 dated June 10, 1985, the forms for completion of the Equal Employment Opportunity Information Report are incorporated herein as Section J.3.

An award cannot be made to any offeror who has not satisfied the equal employment requirements.

## I.10 ORDER OF PRECEDENCE

The contract awarded as a result of this RFP will contain the following clause:

**ORDER OF PRECEDENCE**

A conflict in language shall be resolved by giving precedence to the document in the highest order of priority that contains language addressing the issue in question. The following documents are incorporated into the contract by reference and made a part of the contract in the following order of precedence:

(1) An applicable Court Order, if any
(2) Contract document
(3) Standard Contract Provisions
(4) Contract attachments other than the Standard Contract Provisions
(5) RFP, as amended
(6) BAFOs (in order of most recent to earliest)
(7) Proposal

## I.11 DISPUTES

Delete Article 14, Disputes, of the Standard Contract Provisions for use with District of Columbia Government Supplies and Services Contracts and substitute the following Article 14, Disputes) in its place:

**14. Disputes**

All disputes arising under or relating to the contract shall be resolved as provided herein.

(a) **Claims by the Contractor against the District**: Claim, as used in paragraph (a) of this clause, means a written assertion by the contractor seeking, as a matter of right, the payment of money in a sum certain, the adjustment or interpretation of contract terms, or other relief arising under or relating to the contract. A claim arising under a contract, unlike a claim relating to that contract, is a claim that can be resolved under a contract clause that provides for the relief sought by the claimant

(1) All claims by a contractor against the District arising under or relating to a contract shall be in writing and shall be submitted to the CO for a decision. The contractor's claim shall contain at least the following:

(i) A description of the claim and the amount in dispute;
(ii) Data or other information in support of the claim;
(iii) A brief description of the contractor's efforts to resolve the dispute prior to filing the claim; and,
(iv) The contractor's request for relief or other action by the CO.

(2) The CO may meet with the contractor in a further attempt to resolve the claim by agreement.

(3) The CO shall issue a decision on any claim within 120 calendar days after receipt of the claim. Whenever possible, the CO shall take into account factors such as the size and complexity of the claim and the adequacy of the information in support of the claim provided by the contractor.

(4) The CO's written decision shall do the following:

(i) Provide a description of the claim or dispute;
(ii) Refer to the pertinent contract terms;
(iii) State the factual areas of agreement and disagreement;
(iv) State the reasons for the decision, including any specific findings of fact, although specific findings of fact are not required and, if made, shall not be binding in any subsequent proceeding;
(v) If all or any part of the claim is determined to be valid, determine the amount of monetary settlement, the contract adjustment to be made, or other relief to be granted;
(vi) Indicate that the written document is the CO's final decision; and
(vii) Inform the contractor of the right to seek further redress by appealing the decision to the Contract Appeals Board.

(5) Failure by the CO to issue a decision on a contract claim within 120 days of receipt of the claim will be deemed to be a denial of the claim, and will authorize the commencement of an appeal to the Contract Appeals Board as provided by D.C. Official Code § 2-360.04.

(6) If a contractor is unable to support any part of its claim and it is determined that the inability is attributable to a material misrepresentation of fact or fraud on the part of the contractor, the contractor shall be liable to the District for an amount equal to the unsupported part of the claim in addition to all costs to the District attributable to the cost of reviewing that part of the contractor's claim. Liability under this paragraph (a)(6) shall be determined within six (6) years of the commission of the misrepresentation of fact or fraud.

(7) Pending final decision of an appeal, action, or final settlement, the contractor shall proceed diligently with performance of the contract in accordance with the decision of the CO.

(b) **Claims by the District against the contractor:** Claim as used in paragraph (b) of this clause, means a written demand or written assertion by the District seeking, as a matter of right, the payment of money in a sum certain, the adjustment of contract terms, or other relief arising under

or relating to the contract. A claim arising under a contract, unlike a claim relating to that contract, is a claim that can be resolved under a contract clause that provides for the relief sought by the claimant.

(1) The CO shall decide all claims by the District against a contractor arising under or relating to a contract.

(2) The CO shall send written notice of the claim to the contractor. The CO's written decision shall do the following:

(i) Provide a description of the claim or dispute;
(ii) Refer to the pertinent contract terms;
(iii) State the factual areas of agreement and disagreement;
(iv) State the reasons for the decision, including any specific findings of fact, although specific findings of fact are not required and, if made, shall not be binding in any subsequent proceeding;
(v) If all or any part of the claim is determined to be valid, determine the amount of monetary settlement, the contract adjustment to be made, or other relief to be granted;
(vi) Indicate that the written document is the CO's final decision; and,
(vii) Inform the contractor of the right to seek further redress by appealing the decision to the Contract Appeals Board.

(3) The CO shall support the decision by reasons and shall inform the contractor of its rights as provided herein.

(4) Before or after issuing the decision, the CO may meet with the contractor to attempt to resolve the claim by agreement.

(5) The authority contained in this paragraph (b) shall not apply to a claim or dispute for penalties or forfeitures prescribed by statute or regulation which another District agency is specifically authorized to administer, settle or determine.

(6) This paragraph shall not authorize the CO to settle, compromise, pay, or otherwise adjust any claim involving fraud.

(c) Decisions of the CO shall be final and not subject to review unless the contractor timely commences an administrative appeal for review of the decision, by filing a complaint with the Contract Appeals Board, as authorized by D.C. Official Code § 2-360.04.

(d) Pending final decision of an appeal, action, or final settlement, the contractor shall proceed diligently with performance of the contract in accordance with the decision of the CO.

## I.12 COST AND PRICING DATA

Delete Article 25, Cost and Pricing Data, of the Standard Contract Provisions dated July 2010 for use with District of Columbia Government Supplies and Services Contracts.

## I.13 CONTINUITY OF SERVICES

**I.13.1** The contractor recognizes that the services provided under this contract are vital to the District and must be continued without interruption and that, upon contract expiration or termination, a successor, either the District or another contractor, at the District's option, may continue to provide these services. To that end, the contractor agrees to:

**I.13.1.1** Furnish phase-out, phase-in (transition) training; and

**I.13.1.2** Exercise its best efforts and cooperation to effect an orderly and efficient transition to a successor.

**I.13.2** The contractor shall, upon the CO's written notice:

**I.13.2.1** Furnish phase-in, phase-out services for up to 120 days after this contract expires and

**I.13.2.2** Negotiate in good faith a plan with a successor to determine the nature and extent of phase-in, phase-out services required. The plan shall specify a training program and a date for transferring responsibilities for each division of work described in the plan, and shall be subject to the CO's approval.

**I.13.3** The contractor shall provide sufficient experienced personnel during the phase-in, phase-out period to ensure that the services called for by this contract are maintained at the required level of proficiency.

**I.13.4** The contractor shall allow as many personnel as practicable to remain on the job to help the successor maintain the continuity and consistency of the services required by this contract. The contractor also shall disclose necessary personnel records and allow the successor to conduct on-site interviews with these employees. If selected employees are agreeable to the change, the contractor shall release them at a mutually agreeable date and negotiate transfer of their earned fringe benefits to the successor.

**I.13.5** Only in accordance with a modification issued by the contracting officer, the contractor shall be reimbursed for all reasonable phase-in, phase-out costs (i.e., costs incurred within the agreed period after contract expiration that result from phase-in, phase-out operations) and a fee (profit) not to exceed a pro rata portion of the fee (profit) under this contract.

## I.14 ESTIMATED QUANTITIES

It is the intent of the District to secure a contract for all of the needs of the designated agencies for items specified herein which may occur during the contract term. The District agrees that it will purchase its requirements of the articles or services included herein from the contractor. Articles or services specified herein have a history of repetitive use in the District agencies. The estimated quantities stated in the RFP reflect the best estimates available. They shall not be construed to limit the quantities which may be ordered from the contractor by the District or to relieve the contractor of his obligation to fill all such orders. Orders will be placed from time to time if and when needs arise for delivery, all charges prepaid, to the ordering agency. The District does not guarantee to order any specific quantities of any item(s) or work hours of service.

## I.15 STATE AND MUNICIPAL AGENCY RIDER CLAUSE.

A. If authorized by the Contractor, the contract may be extended to any public corporation or public agency of any state, county, city, town, or municipality within the United States or its territories ("Participating Agency") to purchase at contract prices in accordance with contract terms.

B. Any Participating Agency utilizing this contract will place its own order(s) with the Contractor. There shall be no obligation on the part of any Participating Agency to utilize the contract.

C. It is the Contractor's responsibility to notify any Participating Agency of the availability of the contract.

D. Each Participating Agency has the option of executing a separate contract with the Contractor. Contracts entered into with a state or municipal agency may contain general terms and conditions unique to that jurisdiction including, by way of illustration and not limitation, clauses covering minority participation, non-discrimination, indemnification, naming the jurisdiction as an additional insured under any required Comprehensive General Liability policies, and venue. If, when preparing such a contract, the general terms and conditions of a Participating Agency are unacceptable to the Contractor, the Contractor may withdraw its extension of the award to that Participating Agency.

E. The District shall not be held liable for any costs or damages incurred by a Participating Agency as a result of any award extended to that Participating Agency by the Contractor.

## I.16 CHANGES

Delete clause 15, Changes, of the Standard Contract Provisions dated July 2010 for use with District of Columbia Government Supplies and Services Contracts and substitute the following clause 15, Changes, in its place:

**15. Changes:**

(a) The CO may, at any time, by written order, and without notice to the surety, if any, make changes in the contract within the general scope hereof. If such change causes an increase or decrease in the cost of performance of the contract, or in the time required for performance, an equitable adjustment shall be made. Any claim for adjustment for a change within the general scope must be asserted within ten (10) days from the date the change is ordered; provided, however, that the CO, if he or she determines that the facts justify such action, may receive, consider and adjust any such claim asserted at any time prior to the date of final settlement of the contract. If the parties fail to agree upon the adjustment to be made, the dispute shall be determined as provided in **clause 14 Disputes**.

(b) The District shall not require the Contractor, and the Contractor shall not require a subcontractor, to undertake any work that is beyond the original scope of the contract or subcontract, including work under a District-issued change order, when the additional work increases the contract price beyond the not-to-exceed price or negotiated maximum price of this contract, unless the CO:

(1) Agrees with Contractor, and if applicable, the subcontractor on a price for the additional work;
(2) Obtains a certification of funding to pay for the additional work;
(3) Makes a written, binding commitment with the Contractor to pay for the additional work within 30-days after the Contractor submits a proper invoice; and
(4) Provides the Contractor with written notice of the funding certification.

(c) The Contractor shall include in its subcontracts a clause that requires the Contractor to:

(1) Within 5 business days of its receipt of notice the approved additional funding, provide the subcontractor with notice of the amount to be paid to the subcontractor for the additional work to be performed by the subcontractor;
(2) Pay the subcontractor any undisputed amount to which the subcontractor is entitled for the additional work within 10 days of receipt of payment from the District; and

(3) Notify the subcontractor and CO in writing of the reason the Contractor withholds any payment from a subcontractor for the additional work.

(d) Neither the District, Contractor, nor any subcontractor may declare another party to be in default, or assess, claim, or pursue damages for delays, until the parties to agree on a price for the additional work.

## I.17 NON-DISCRIMINATION CLAUSE

Delete clause 19, Non-Discrimination Clause, of the Standard Contract Provisions dated July 2010 for use with District of Columbia Government Supplies and Services Contracts and substitute the following clause 19, Non-Discrimination Clause, in its place:

**19. Non-Discrimination Clause:**

(a) The Contractor shall not discriminate in any manner against any employee or applicant for employment that would constitute a violation of the District of Columbia Human Rights Act, effective December 13, 1977, as amended (D.C. Law 2-38; D.C. Official Code § 2-1401.01 *et seq.)* ("Act", as used in this clause). The Contractor shall include a similar clause in all subcontracts, except subcontracts for standard commercial supplies or raw materials. In addition, the Contractor agrees, and any subcontractor shall agree, to post in conspicuous places, available to employees and applicants for employment, a notice setting forth the provisions of this non-discrimination clause as provided in section 251 of the Act.

(b) Pursuant to Mayor's Order 85-85, (6/10/85), Mayor's Order 2002-175 (10/23/02), Mayor's Order 2011-155 (9/9/11) and the rules of the Office of Human Rights, Chapter 11 of Title 4 of the D.C. Municipal Regulations, the following clauses apply to the contract:

(1) The Contractor shall not discriminate against any employee or applicant for employment because of actual or perceived: race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender identity or expression, family responsibilities, genetic information, disability, matriculation, political affiliation, or credit information. Sexual harassment is a form of sex discrimination which is prohibited by the Act. In addition, harassment based on any of the above protected categories is prohibited by the Act.

(2) The Contractor agrees to take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their actual or perceived: race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender identity or expression, family responsibilities, genetic information, disability,

matriculation, political affiliation, or credit information. The affirmative action shall include, but not be limited to the following:

(a) employment, upgrading or transfer;
(b) recruitment, or recruitment advertising;
(c) demotion, layoff or termination;
(d) rates of pay, or other forms of compensation; and
(e) selection for training and apprenticeship.

(3) The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting agency, setting forth the provisions in paragraphs 19(b)(1) and (b)(2) concerning non-discrimination and affirmative action.

(4) The Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment pursuant to the non-discrimination requirements set forth in paragraph 19(b)(2).

(5) The Contractor agrees to send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by the contracting agency, advising the said labor union or workers' representative of that contractor's commitments under this nondiscrimination clause and the Act, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

(6) The Contractor agrees to permit access to its books, records, and accounts pertaining to its employment practices, by the Chief Procurement Officer or designee, or the Director of the Office of Human Rights or designee, for purposes of investigation to ascertain compliance with the Act, and to require under terms of any subcontractor agreement each subcontractor to permit access of such subcontractors' books, records, and accounts for such purposes.

(7) The Contractor agrees to comply with the provisions of the Act and with all guidelines for equal employment opportunity applicable in the District adopted by the Director of the Office of Human Rights, or any authorized official.

(8) The Contractor shall include in every subcontract the equal opportunity clauses, i.e., paragraphs 19(b)(1) through (b)(9) of this clause, so that such provisions shall be binding upon each subcontractor.

(9) The Contractor shall take such action with respect to any subcontract as the CO may direct as a means of enforcing these provisions, including sanctions for noncompliance; provided, however, that in the event the Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the contracting agency, the Contractor may request the District to enter into such litigation to protect the interest of the District.

## I.17. AMERICANS WITH DISABILITIES ACT of 1990 (ADA)

During the performance of the contract, the Contractor and all of its subcontractors shall comply with the ADA. The ADA makes it unlawful to discriminate in employment against a qualified individual with a disability. Contractors providing public transportation shall comply with Title II of the ADA. Contractors providing public accommodations shall comply with Title III of the ADA. Contractors providing telecommunication shall comply with Title IV of the ADA. See 42 U.S.C. § 12101 *et seq*.

## SECTION J: ATTACHMENTS

The following list of attachments is incorporated into the solicitation by reference.

| Attachment Number | Document |
|---|---|
| J.1 | Government of the District of Columbia Standard Contract Provisions for Use with the Supplies and Services Contracts (July 2010) available at www.ocp.dc.gov click on Center of Excellence, Required Solicitation Documents, then click on Standard Contract Provisions – 2010. |
| J.2 | U.S. Department of Labor Wage Determination No.: 2015-4281 Revision No. 30; Date of Revision: 07/22/2024 available at sam.gov |
| J.3A | Equal Employment Opportunity Employer Information Report and Mayor's Order 85-85 available at www.ocp.dc.gov click on Center of Excellence, Required Solicitation Documents, then click on EEO Compliance Documents and OHR EEO Packet |
| J.3B | Equal Employment Opportunity Employer Information Report and Mayor's Order 85-85 available at www.ocp.dc.gov click on Center of Excellence, Required Solicitation Documents, then click on EEO Compliance Documents and EEO Submission Instructions |
| J.4A | Department of Employment Services First Source Employment Agreement available at www.ocp.dc.gov click on Center of Excellence, Required Solicitation Documents, then click on First Source Employment Agreement - Non Construction Only-February 2018 |
| J.4B | Department of Employment Services First Source Employment Agreement and First Source Employment Plan, available at www.ocp.dc.gov click on Center of Excellence, Required Solicitation Documents, then click on Revised First Source Employment Plan Contracts over $5 Million. |
| J.5 | Way to Work Amendment Act of 2006 - Living Wage Notice , available at www.ocp.dc.gov click on Center of Excellence, Required Solicitation Documents, then click on 2023 Living Wage Notice |
| J.6 | Way to Work Amendment Act of 2006 - Living Wage Fact Sheet available at www.ocp.dc.gov click on Center of Excellence, Required Solicitation Documents, then click on 2023 Living Wage Fact Sheet. |
| J.7 | Bidder/Offeror Certifications available at www.ocp.dc.gov click on Center of Excellence, Required Solicitation Documents, then click on Bidder/Offeror Certifications. |
| J.8 | Subcontracting Plan (if required by law) available at www.ocp.dc.gov click on Center of Excellence, Required Solicitation Documents, then click on Subcontracting Plan Form (on dslbd.dc.gov) |
| J.9 | Specialty Care Clinic Attendance; see Section 5.9 of the solicitation in PASS, available as an attachment to the solicitation |
| J.10 | DOC Program Manual:<br>1300.3 Health Information Privacy |

| Attachment Number | Document |
|---|---|
| | https://doc.dc.gov/node/310202 |
| J.11 | DOC Program Statement:<br>2000.2 Retention and Disposal of Department Records<br>*Note: Confidential Attachments to be distributed by DOC staff at the Pre-Proposal Conference*<br>*For Internal Use only, not for the public eye.* |
| J.12 | DOC Program Statement:<br>2420.2 Information Security<br>https://doc.dc.gov/node/311832 |
| J.13 | DOC Program Statement:<br>2920.4 Inspections and Abatement Program<br>https://doc.dc.gov/node/312002 |
| J.14 | DOC Program Statement: 3800.3 ADA/ Communications for Deaf and Hearing, Impaired<br>https://doc.dc.gov/node/1238426 |
| J.15 | RESERVED |
| J.16 | DOC Program Statement: 5010.3 Contraband Control<br>https://doc.dc.gov/node/313682 |
| J.17 | RESERVED |
| J.18 | RESERVED |
| J.19 | DOC Program Manual:<br>6000.1 Medical Management<br>https://doc.dc.gov/node/313722 |
| J.20 | DOC Program Statement: 6050.4 Mandatory Employee Drug and Alcohol Testing<br>*Note: Confidential Attachments to be distributed by DOC staff at the Pre-Proposal Conference*<br>*For Internal Use only, not for the public eye.* |
| J.21 | DOC Program Statement: 6080.2 Suicide Prevention and Intervention<br>https://doc.dc.gov/node/313842 |
| J.22 | Components of the Performance Metrics Reports To Be Submitted Each Month |
| J.23 | CCBC Patient Encounter Form To Be Used by Contractor |

| Attachment Number | Document |
|---|---|
| J.24 | List of Policies and Procedures for the Delivery of Health Care in the Department of Corrections |
| J.25 | CDF and CTF Medical Space<br>*Note: Confidential Attachment to be distributed by DOC staff at the Pre-Proposal Conference* |
| J.26 | Medical and Dental Equipment at Central Detention Facility |
| J.27 | Medical and Dental Equipment at Correctional Treatment Facility |
| J.28 | Average daily population in the mid 1,300. Population Count By Facility; see link in Section C.4.8 |
| J.29 | RESERVED |
| J.30 | Residential Substance Abuse and Treatment (RSAT) Program Statement<br>https://doc.dc.gov/node/313792 |
| J.31 | Resident Length of Stay (LOS); see link in Section C.4.8 |
| J.32 | Cost/Price Disclosure Certification available as an attachment to the solicitation |
| J.33 | Cost Data Requirements Template available as an attachment to the solicitation |
| J.34 | Pharmacy Management Report available as an attachment to the solicitation |
| J.35 | DOC Formulary available as an attachment to the solicitation |
| J.36 | RESERVED |
| J.37 | Hepatitis C and HIV policies available as an attachment to the solicitation |
| J.38 | Compassionate Release available as an attachment to the solicitation |
| J.39 | Out-Patient Referrals available as an attachment to the solicitation |
| J.40 | Overnight Hospital Admissions available as an attachment to the solicitation |

| Attachment Number | Document |
|---|---|
| J.41 | RESERVED |
| J.42 | DOC – USMS IGA available as an attachment to the solicitation |
| J.43 | Sick Call by Provider, Calendar Year 2022 available as an attachment to the solicitation |
| J.44 | Number of Patients in Chronic Care, January 2022 – December 2022 available as an attachment to the solicitation |
| J.45 | Recommended TIC/TAMAR Behavioral Health Programming Curricula available as an attachment to the solicitation<br>Dr. Jordan to provide |
| J.46 | RESERVED |
| J.47 | PowerPoint presentation on the Central Cell Block Clinic |
| J.48 | Suicide Prevention Screening Questionnaire |
| J.49 | Cost Data Template, in addition to J.33 |

# EXHIBIT 1

**THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

| | |
|---|---|
| V.C., et al.<br><br>*Plaintiffs,*<br><br>v.<br><br>DISTRICT OF COLUMBIA<br><br>*Defendant.* | Case No. 1:23-cv-01139-CKK |

**SUPPLEMENTAL BRIEF IN SUPPORT OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION**

Individuals incarcerated in DC Department of Corrections facilities are completely reliant on the medical care provided by the Defendant District of Columbia. Yet Defendant operates a constitutionally inadequate health care system that denies its residents access to basic medical care, including access to medical specialists, prescribed medications, and medical supplies. Since Plaintiffs filed their Motion for Class Certification and Statement of Points and Authorities (ECF No. 8), Plaintiffs' counsel have regularly conferred with residents at Central Detention Facility and Correctional Treatment Facility (collectively, "the Jail") who continue to experience the same failures in the Defendant's correctional health care system that Plaintiffs allege in their Complaint. *See* ECF No. 1. With this supplemental brief, Plaintiffs seek to add seven new class representatives ("Proposed Class Representatives")[1] and submit five additional declarations[2] that demonstrate Defendant's persistent and systemic denial of constitutionally-required medical care to those in its

[1] Plaintiffs put forward A.E., A.G., L.T., V.D., D.M., D.S., and T.W. as Proposed Class Representatives. *See* Exhibits 2-8. While Plaintiffs V.C. and B.L. are no longer incarcerated at the Jail, Plaintiff L.S. intends to continue as a Class Representative.

[2] Plaintiffs submit the declarations of C.M., L.S., D.P., M.S., and Zoé Friedland as further confirmation that the systemic, constitutional deficiencies in medical care at the Jail remain. *See* Exhibits 9-13.

custody. Plaintiffs also submit supplemental declarations from proposed class counsel updating their qualifications and adequacy to represent the proposed Class. Exhibits 14-16. The Court should grant class certification to ensure that Plaintiffs can obtain meaningful relief for all residents at the Jail who are currently or will be impacted by the District's constitutional violations. Should the Court deem it necessary, Plaintiffs respectfully request an oral hearing following completion of the class certification briefing.

## PROCEDURAL BACKGROUND

On April 27, 2023, Plaintiffs filed a motion seeking to certify a class under Federal Rule of Civil Procedure 23(b)(2) comprised of "all people who are or will be incarcerated in DC Department of Corrections facilities who have serious medical needs." ECF No. 8 at 1. After granting two of Defendant's requests for an extension (ECF Nos. 15 & 25), on July 19, 2023, the Court granted the Parties' joint motion to stay briefing on Plaintiffs' Motion for Class Certification. ECF No. 26. Before the Defendant responded to Plaintiffs' Class Certification Motion, on October 2, 2023, this Court granted the Parties' joint motion to refer the case to mediation and stayed the case until February 2, 2024. ECF No. 33. Over the next two years, the case remained stayed as the Parties participated in mediation. However, the Parties' good-faith efforts to resolve the case through mediation were unsuccessful. Plaintiffs therefore submit this Supplemental Brief to add new class representatives, update the qualifications of proposed class counsel, and highlight the continued need for class certification to address widespread deficiencies in the provision of medical care at the Jail.

## LEGAL STANDARD

Under Federal Rule of Civil Procedure 23(a), one or more members of a class may sue as representative parties on behalf of all members if, among other things, the class is "so numerous

that joinder of all members is impracticable." Fed. R. Civ. P. 23(a)(1). Class members' claims must "depend upon a common contention . . . that it is capable of class wide resolution—which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 350 (2011); Fed. R. Civ. P. 23(a)(2). Plaintiffs' claims must also be "typical of the claims . . . of the class," Fed. R. Civ. P. 23(a)(3), and class representatives must "fairly and adequately protect" class interests. Fed. R. Civ. P. 23(a)(4). Finally, certification under Rule 23(b)(2) is appropriate where "(1) the defendant's action or refusal to act [is] generally applicable to the class; and (2) plaintiffs . . . seek final injunctive relief or corresponding declaratory relief on behalf of the class." *Taylor v. D.C. Water & Sewer Auth.*, 241 F.R.D. 33, 47 (D.D.C. 2007); *see also DL v. D.C.*, 860 F.3d 713, 723 (D.C. Cir. 2017).

Courts have the discretion to allow parties to supplement the record of a case, particularly where additional factual material may assist the court in resolving the matter. *See Marsh v. Johnson*, 263 F. Supp. 2d 49, 53 (D.D.C. 2003). As such, Courts in this District have allowed parties to file supplemental briefs in support of motions for class certification. *See, e.g.*, *Robertson et al. v. Dist. of Columbia*, No. 1:24-cv-00656 (D.D.C. Oct. 24, 2025) (Minute Order); *Angelica S. et al. v. U.S. Dep't of Health & Hum. Servs.*, No. 1:25-cv-01405 (D.D.C. Sept. 5, 2025) (Minute Order).

**ARGUMENT**

Plaintiffs incorporate by reference their April 27, 2023, motion in support of class certification. ECF No. 8. In supplementation of the arguments raised and evidence submitted therewith, Plaintiffs state as follows:

1. Healthcare is one of the primary responsibilities the Defendant assumes for the approximately 2,000 people[3] in its custody, and individuals confined to the Jail are entirely dependent on the Defendant for their healthcare needs. During the time the Parties have engaged in mediation, Defendant District of Columbia has continued to evade its legal duties under the Fifth and Eighth Amendments to provide adequate health care.
2. Since the filing of the Complaint, Plaintiffs' counsel has maintained contact with putative class members through frequent visits to the Jail, written correspondence, and video and telephone calls.
3. As Exhibits 2-13 demonstrate, Defendant's unconstitutional behavior persists, raising class-wide questions and necessitating class-wide relief. The Jail regularly fails to identify residents' serious medical conditions, and even after such concerns are identified, fails to provide proper treatment, including necessary medication, medical supplies, diagnostic care, specialty care, and chronic care. For example, as recently as February 2026, a judge in this District granted an individual at the Jail medical furlough to have surgery because the Jail "ignored [his] numerous requests over ten months to be seen by medical staff at the jail; failed to schedule imaging tests and surgery, until the court intervened; and failed to transport [him] to his surgery on time." *United States v. Hodge*, No. 25-CR-204-DLF, 2026 WL 380543, at *3 (D.D.C. Feb. 11, 2026). The Jail did so even though the individual repeatedly "raise[d these] problems with his medical care" to staff. *Id.*
4. As it did at the outset of this litigation, Defendant continues to deprive putative class members of urgently needed medication. For example, A.G., who has anemia and

[3] D.C. Dep't of Corr., *Daily Population Report (Feb. 21–Feb. 27, 2026)*, https://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/The%20Daily%20Population%20Report%20from%20February%2021st%20through%20February%2027th%202026.pdf.

thalassemia, a genetic blood disorder that impacts hemoglobin levels, requires iron pills for her conditions, but has gone weeks without her medication because of the Jail's failure to update her prescription. Exhibit 3, Decl. of A.G. ¶¶ 31-36; *see also* Exhibit 4, Decl. of L.T. ¶¶ 37-39 (describing how L.T. missed her medication for her ulcerative colitis because the Jail failed to refill her prescription); Exhibit 9, Decl. of C.M. ¶¶ 10-12 (describing how, for nearly a year, C.M. missed doses of his prescribed medications for schizophrenia, sleep, anxiety, and diabetes only recently started receiving all of his medication consistently); Exhibit 12, Decl. of M.S. ¶¶ 19-21 (describing how M.S., who has stage five kidney failure, type II diabetes, high blood pressure, and gout, has had difficulty receiving insulin for his diabetes, medication for his kidney failure, and pain medication); Exhibit 7, Decl. of D.S. ¶¶ 4-7 (describing how D.S., who suffers from seizures, high blood pressure, and schizoaffective disorder, does not receive his medications consistently and often misses doses entirely because staff will not wake him up during morning pill call). The Jail has also failed to timely provide nebulizer treatments to T.W., an asthmatic resident who has experienced at least eight asthma attacks in the less than 18 months he has been at the Jail. Exhibit 8, Decl. of T.W. ¶¶ 35-47. Most recently, in January 2026, T.W. was forced to self-treat his asthma by "inhaling steam from the shower in [his] cell for about four hours." *Id.* at ¶ 46.

5. The Jail fails to share information as simple as the names and potential side effects of medication with residents. For example, V.D., who has type II diabetes and hypertension, takes approximately 15-20 pills per day. Exhibit 5, Decl. of V.D. ¶ 6. Yet Jail staff have not informed him of the names of his medications, the conditions for which they are prescribed, their dosages, or their potential side effects. *Id.* at ¶¶ 7-9; *see also* Exhibit 4,

Decl. of L.T. ¶ 40 (noting that L.T. does not receive any prescription instructions or drug facts when she receives her medication on the pill cart).

6. Additionally, putative class members continue to be denied medical supplies that are essential to their mobility and health. C.M. had a traumatic brain injury that causes him to experience seizures, migraines, and extreme light sensitivity. Exhibit 9, Decl. of C.M. ¶ 3. To reduce seizures triggered by his sensitivity to light, C.M. is prescribed tinted glasses. However, it took five months for the Jail to provide C.M. with his glasses. *Id.* at ¶ 7. D.M., who experiences numbness in his legs from Degenerative Disc Disease and Degenerative Bone/Joint Disease, was given a pass to have a cane when he arrived at the Jail in June 2024, which he has renewed several times. Exhibit 6, Decl. of D.M. ¶¶ 2, 8. Most recently, he had a cane pass issued in September 2025. *Id.* at ¶ 8. However, two months later in November 2025, the Jail revoked D.M.'s access to his cane without so much as an explanation, let alone a visit with a doctor. *Id.* at ¶ 9-11. He has not had a cane since November 2025. *Id.* at ¶ 9. As for T.W., who has chronic back pain, the Jail refuses to provide him with a wheelchair despite discharge instructions from George Washington University Hospital instructing the Jail to do so. Exhibit 8, Decl. of T.W. ¶¶ 4-11. As a result, T.W. has missed legal visits, medical appointments, and physical therapy appointments because he cannot physically travel across the Jail to get where he needs to go. *Id.* at ¶¶ 29, 32. L.S., who is completely blind in his right eye and has limited vision in his left eye, returned to the Jail in June 2025. Exhibit 10, Decl. of L.S. ¶¶ 1-6. Despite the nearly two years that have passed since he previously resided at the Jail, he experiences similar issues with accessing his prescribed eye drops and did not receive his prescribed glasses for approximately six months. *Id.* at ¶¶ 8-22.

7. Putative class members continue to frequently miss appointments with medical providers, including specialty providers—if appointments are scheduled at all. For example, A.E., who has metal screws and plates in his neck from a car accident prior to his incarceration, was never taken to a scheduled outside appointment with a neurologist in February 2025. Exhibit 2, Decl. of A.E. ¶ 9. D.P. broke his middle finger in November 2023 when a correctional officer closed a cell door on it. Exhibit 11, Decl. of D.P. ¶¶ 3, 6. Even though an x-ray taken three days later showed that D.P.'s finger was broken, the Jail did not take him to an outside specialist for a month; at that point, a doctor at Howard University Hospital told D.P. there was little he could do because his finger "was already in the process of healing incorrectly." *Id.* ¶¶ 5-7. When L.T. was in her third trimester of a high-risk pregnancy, Jail staff routinely failed to ensure that she saw her outside OBGYN twice a week, as recommended. Exhibit 4, Decl. of L.T. ¶ 14. Additionally, when L.T. was approximately eight months pregnant, she experienced contractions early in the morning and notified a correctional officer. *Id.* at ¶ 16. She continued to notify correctional officers throughout the day until she was eventually taken to the hospital at 6:30 PM, causing an unnecessary delay and a fear that she would go into labor at the Jail. *Id.* After being in extreme pain for multiple days from a broken front tooth, D.M. was forced to pull out part of his own tooth while waiting for a dentist appointment at the Jail. Exhibit 6, Decl. of D.M. ¶¶ 20-24.
8. These are just a few of the many constitutional deficiencies raised by Plaintiffs in their Complaint and corroborated by these additional declarants that cause harm to putative class members at the Jail.

9. As Plaintiffs' Motion for Class Certification explains in depth, and Exhibits 2-12 reinforce, the putative class satisfies all the requirements of Federal Rule of Civil Procedure 23(a). ECF No. 8 at 7-12.
10. Plaintiffs approximate that over 500 people incarcerated at the Jail have serious health conditions, and the class also includes future claimants, making joinder impracticable. *Id.* at 9.
11. The issues faced by Plaintiffs and Declarants raise questions of law and fact common to the class, including whether Defendant operates a constitutionally inadequate health care system. *Id.* at 10-11.
12. The claims of the current and Proposed Class Representatives stem from the same course of conduct, resulting in similar injuries, satisfying typicality. *Id.* at 11-12.
13. Additionally, each of the seven Proposed Class Representatives, along with named Plaintiff L.S., will fairly and adequately represent the interests of the class. Fed. R. Civ. P. 23(a)(4); ECF No. 8 at 12-13. Each possesses a strong interest in this litigation that mirrors the interests of unnamed members of the class, given that they are suffering the same harm (the deprivation of constitutionally adequate health care) and seek the same declaratory and injunctive relief. Each will vigorously prosecute the case.
14. The putative class will be represented by qualified counsel with years of experience in federal class action litigation. *See* Exhibit 15, Supp. Decl. of John Freedman; Exhibit 14, Decl. of Ryan Downer; Exhibit 16, Decl. of Kristin McGough.
15. For purposes of Rule 23(b)(2), Defendant's deficient provision of health care affects all class members, and the single injunction and declaratory judgment requested by Plaintiffs "would provide relief to each member of the class." *Dukes*, 564 U.S. at 360; ECF No. 8 at

13-14. Courts in this Circuit and elsewhere have certified Rule 23(b)(2) classes when incarcerated people challenged generally applicable policies or actions related to the provision of medical care. *See, e.g.*, *Parsons v. Ryan*, 754 F.3d 657, 688-89 (9th Cir. 2014) (certifying a statewide class of individuals incarcerated in Arizona prisons who alleged, *inter alia*, constitutionally deficient medical care); *Postawko v. Missouri Dep't of Corr.*, 910 F.3d 1030 (8th Cir. 2018) (certifying class of "all those individuals in the custody of [Missouri prisons] . . . diagnosed with chronic HCV . . . who are not provided treatment with direct acting antiviral drugs"); Class Cert. Order, *Banks v. Booth*, No. 1:20-cv-00849-CKK, ECF No. 181 (D.D.C. Feb. 18, 2022) (in COVID-19 case, certifying settlement class of those confined in DC DOC facilities at any point between March 30, 2020, and the expiration of the settlement agreement); *Lewis v. Cain*, 324 F.R.D. 159, 169-74 (M.D. La. 2018) (certifying class of individuals confined at Louisiana State Penitentiary where plaintiffs alleged "systemic deficiencies within Defendants' medical healthcare policies and procedures"); *Scott v. Clarke*, 61 F. Supp. 3d 569, 591 (W.D. Va. 2014) (certifying class where plaintiffs alleged "a common course of conduct by Defendants reflecting deliberate indifference to the prisoners' serious medical needs"); *Dean v. Coughlin,* 107 F.R.D. 331, 333 (S.D.N.Y.1985) ("Where a prisoner class seeks to challenge an entire health care system, deliberate indifference to their health needs can be shown . . . by evidence of such systemic deficiencies in staffing, facilities, or procedures that unnecessary suffering is inevitable. Accordingly, the claims of each class member need not be identical to raise common factual and legal questions regarding the adequacy of an entire system.") (citations and internal quotation marks omitted).

## CONCLUSION

For the reasons described above, as well as those set forth in Plaintiffs' Motion for Class Certification, Plaintiffs respectfully request that the Court certify a class pursuant to Federal Rule of Civil Procedure 23(b)(2).

Dated: March 6, 2026

*/s/* John Freedman

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**CERTIFICATE OF SERVICE**

I hereby certify that on March 6, 2026, I electronically filed the foregoing supplemental brief and the attached exhibits using the Court's ECF system, which will send notice of the filing to all counsel of record via email.

/s/ John Freedman

# EXHIBIT 2

**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

V.C., et al.

*Plaintiffs*

v.

District of Columbia

*Defendant.*

No. 1:23-cv-01139

**DECLARATION OF A.E.**

*I, A.E., certify under penalty of perjury that the following statement is true and correct to the best of my knowledge.*

1. I am 23 years old and am currently incarcerated pre-trial in the Central Detention Facility (CDF) run by the District of Columbia Department of Corrections ("the Jail").
2. I have been incarcerated at the Jail since January 23, 2025.
3. On June 15, 2023, I was in a car accident, which resulted in me breaking my neck. Because of this injury, I have metal screws and plates in my neck and am unable to turn my head.
4. I still experience pain and discomfort from this injury. The Jail does not provide me with the medical care I need to alleviate my pain and discomfort.
5. When I first arrived at the Jail, I requested to be placed in the Correctional Treatment Facility's (CTF's) medical unit. I was told I did not qualify for housing in the medical unit and was instead assigned to general population at CDF. I continued to request placement in the medical unit through the grievance process, but did not receive any responses to my grievances. I also spoke to a mental health staff person about this and was told that I could only be placed in CTF if I was paraplegic. Eventually, I was placed in restrictive housing.

6. I spent a couple of weeks in restrictive housing between January and February 2025. While housed there, I received absolutely no medical care, including pain medication.
7. When I wake up each morning, my pain is at a level of seven or eight out of ten. I experience a great deal of stiffness in the morning which is alleviated as I go about my day. I will also get headaches.
8. When I was in the community, I was prescribed Oxycontin and blood thinners for my pain. At the Jail, the only pain medication I receive for my neck is 600 mg of Ibuprofen. Last year, around April 2025, I was not receiving timely refills of my pain medication and went without it for weeks. I filed a grievance on the issue. Now, I have a prescription to keep Ibuprofen in my cell. I take two to three of these painkillers a day, but they do not provide significant relief.
9. Around February 2025, I requested physical therapy and was told that I needed to see a neurologist first. I was scheduled to see a neurologist in February 2025. This appointment was cancelled without reason. After I filed a sick call, the appointment was rescheduled and I saw a neurologist around April 2025.
10. The only physical therapy I received for my injury was in May 2025, approximately four months after I came to the Jail. I received two sessions each week over four weeks, resulting in eight total sessions. These sessions took place at CTF. The limited physical therapy I received provided only slight relief to my neck. After I completed these eight sessions, I never received a physical therapy session again. The physical therapists informed me at my last session that my therapy would be discontinued and could only be extended at the doctor's request. I asked the physical therapists about continuing my therapy, but my request was never addressed.

11. My mattress is the standard mattress given to all residents of the Jail and is only a couple of inches thick. Laying on this mattress causes me significant discomfort. I often try to stay up for as long as possible to avoid laying down and causing myself pain. I requested a double mattress while I was in physical therapy, but I never received a response to my request. I did not file any sick calls or grievances on the issue.
12. Because of the Jail's inability to care for my injury, I continue to experience pain and discomfort that need not exist with proper care. Provision of only Ibuprofen for my pain is insufficient and causes me to suffer unnecessarily.
13. I have been informed of the responsibilities of a class representative, and I am willing to serve in that role, and protect the interests of the class.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge. Executed on March 3, 2026.

A.E.

A.E.

# EXHIBIT 3

**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

V.C., et al.

*Plaintiffs*

v.

District of Columbia

*Defendant*.

No. 1:23-cv-01139

**DECLARATION OF A.G.**

*I, A.G., certify under penalty of perjury that the following statement is true and correct to the best of my knowledge*.

1. I am 33 years old and a resident at the Correctional Treatment Facility (CTF) run by the District of Columbia Department of Corrections ("the Jail"). I have been incarcerated at CTF since June 8, 2023.
2. I have anemia, which is a condition where low hemoglobin levels reduce the ability of blood oxygen transport, and thalassemia, which is a genetic blood disorder that also impacts hemoglobin levels. I was diagnosed with these conditions around April 2022 while I was incarcerated at the Maryland Department of Corrections and had to be taken for emergency blood and iron transfusions at MedStar Harbor Hospital in Baltimore.
3. After my diagnosis, I was prescribed iron pills to take every day. While I was incarcerated at the Maryland Department of Corrections, I consistently received my medication, and I also regularly got my blood work done—approximately every three months—to monitor my iron and hemoglobin levels and to see if my prescription needed to be adjusted.

4. Since arriving at the Jail almost three years ago, I have not received proper medical care for my low iron and hemoglobin levels.
5. When my iron and hemoglobin levels are low, I feel weak, sluggish, light-headed, unusually tired, more irritable, and colder than normal. I also look paler than usual, my fingertips are sometimes white, and the inside of my lower eyelids look white instead of their normal pink color. In addition, when I stand up after sitting, I sometimes feel very dizzy, like I might faint.
6. When I notice these symptoms, I often fill out sick call slips, describing my symptoms, and asking for blood work to be done as soon as possible. I also tell correctional officers that I need to be seen by medical personnel. The correctional officers will call medical, but I am not always seen. I have written several grievances on these issues, but when the Jail responds, they say that I should put in a sick call to get help. When I put in a sick call slip, I am supposed to be seen the next day. There is usually a delay in me being seen or I am ignored entirely and never see medical staff.
7. I consistently keep my wife up to date on my medical condition. When my sick call slips and grievances go ignored and I fear that my condition may be becoming critical, I tell my wife. She has tried contacting the Deputy Warden at CTF multiple times to make sure I receive medical care, but she is typically unable to get a helpful response.
8. Throughout my time in custody of the Jail, I have had issues receiving my medication, being taken to outside medical appointments, and having my blood levels regularly monitored. Because of this inadequate medical care, my symptoms have fluctuated over time, often worsening periodically, and I have also had to have emergency blood transfusions. I am increasingly worried about the impact on my overall health.

*Monitoring Blood Levels, Blood Transfusions, and Outside Appointments*

9. The Jail does not regularly test my blood or monitor my iron and hemoglobin levels. I do not receive routine blood work at the Jail. I only receive blood work after I report the symptoms described in paragraph five.

10. Prior to coming to the Jail and before I was in custody in Maryland, I went to my primary care doctor and they explained that when my hemoglobin level drops below seven, it can be critical, meaning I could go into a coma or pass out, because the oxygen levels in my blood are low, and I may need a blood transfusion quickly. If my hemoglobin level drops below four, it is life threatening.

11. I feel very anxious when my hemoglobin and iron levels are not regularly monitored because I am worried about my condition resulting in the need for additional blood transfusions or causing me to pass out. When I previously had a blood transfusion, I got sick and threw up.

12. The doctors have also not been able to tell me why my hemoglobin and iron levels are low, which increases my anxiety because I am worried it may be something very serious. Jail medical staff and outside medical providers have been worried about internal bleeding, and they have not been able to identify the cause of the internal bleeding.

13. On or about August 18, 2024, I had my first blood and iron transfusions while in custody of the Jail. I was on Unit E4B. Correctional officers told me I looked pale and that my eyes were baggy. I also felt fatigued. I put in a sick call slip requesting blood work and lab work and explaining that I felt weak and fatigued, but I did not get a response. Because I work detail cleaning units, I was able to put in another sick call slip on Unit E4A where I was working. After I put in the second sick call slip, I was taken to medical and then sent to

Howard University Hospital (HUH). At HUH, I received two blood transfusions and one iron transfusion.

14. In approximately late August 2024 or early September 2024, I had an additional iron transfusion at the Jail. It took the medical staff at the Jail approximately seven attempts to insert the intravenous (IV) line in for this infusion. Due to this, my arms were badly bruised and in pain.

15. Around October and November 2025, I was often extremely tired. At one point, I fell asleep in the middle of my trial, and we had to take a break. I believe this extreme fatigue was caused by my low iron and hemoglobin levels— again, because the Jail was not monitoring my iron and hemoglobin levels unless I asked and/or submitted sick calls, I was not being properly treated for these symptoms or getting treatment to prevent them in the first place. During my trial, Judge Berman Jackson informed my defense attorney that I could request a break at any time because I looked so tired, and told my attorney that I could eat chocolate during the trial to keep me awake. It was difficult for me to pay attention during my trial and to consult with my attorney.

16. In December 2025, I was again feeling fatigued, cold, and sluggish. I put in sick call slips requesting lab work and explaining how I was feeling. After, I had lab work done to check my hemoglobin and iron levels. In January, I learned that my hemoglobin level was below eight, meaning it was critical and I needed to be sent out for an emergency iron transfusion. I was not sent out for an emergency iron transfusion because they said I had an upcoming appointment.

17. Because of these results, I was told by Jail medical staff that I was going to be sent out for an iron transfusion in January 2026, but I was not sent out in January.

18. On or about February 11, 2026, I asked Jail medical staff when I would have my appointment with outside medical for a transfusion, and they did not provide me with an update. I told them I felt dizzy, lightheaded, and had a headache. Medical staff took my blood work again, but I did not get the results. The Jail medical staff told me again to wait for my appointment, and that I would not be taken out for an emergency visit.
19. On or about February 18, 2026, I went to see the hematologist at HUH. I thought that the purpose of the appointment was to finally receive the iron transfusion, but I still did not receive one. Instead, the hematologist told me that the Jail did not send along any updated bloodwork or labs, so the last records he had available were from July 2025. The hematologist also said that he had tried to call the "front desk" at the Jail to ask for my updated records but still did not receive them. Because of this, the hematologist was not exactly sure why I had the appointment scheduled and was not able to provide me with specific care.
20. However, the hematologist did explain my hemoglobin condition further to me: he turned on a sink faucet and said that the water rushing out of the faucet is what it is like when I lose a lot of blood, and that transfusions act like a patch—they do not stop the underlying problem.
21. When I was at HUH, they took my blood work to get updated information on my hemoglobin levels. The hematologist told me there would be a follow-up appointment to have the transfusion and ordered IV iron for this.
22. On or about February 19, 2026, I saw the obstetrician-gynecologist (OBGYN) at the Jail, and she suggested I get an IUD or Depo-Provera shot to help with my heavy menstrual

bleeding, which impacts my iron levels. She also told me that my lab results from Howard were even lower than my previous results.

23. On February 25, 2026, a correctional officer on my unit told me that I did not look good and there was a spot on my eye that was yellow and puffy. She called medical and asked if I could be seen. In response, medical said I should put in a sick call slip, and I was not seen. I put in a sick call slip because I continued to feel like I was about to pass out and my sight was blurry.

24. As of the date in signing this declaration, I still do not know when I will receive the next transfusions to address my decreasing blood levels.

*Fibroids*

25. During my visit to HUH in August 2024, I also had a pelvic ultrasound to see if there was any internal bleeding. The doctors told me that they saw a lump on my ovaries, which was a fibroid.

26. The HUH OBGYN explained that it was nothing to worry about though. Instead, the OBGYN told me I will know if the fibroids grow if I continue to be in more pain.

27. Around the end of 2024, I learned from Jail medical staff that there were four fibroids, with at least one about the size of a grape. She told me that they could shrink or grow, but there was nothing that could be done. The Jail medical staff suggested that I should get my uterus removed when I get out of DOC custody.

28. On or about November 21, 2025, I went to the OBGYN at the Jail. We discussed my fibroids and heavy menstrual bleeding and ways to decrease this bleeding. From this conversation, I continued to use progesterone, which I was previously prescribed, to see if it would help.

29. Fibroids run in my family, and I am concerned they may be impacting or causing my low hemoglobin or iron levels. Since finding out I had at least one fibroid, I have asked the Jail OBGYN if I could have an ultrasound to check on the fibroids and see if they might be affecting my hemoglobin or iron levels.

30. The OBGYN at the Jail told me that they would not use the ultrasound machine at the Jail to look at my fibroids so I would have to wait for an outside appointment. I have still not received any follow-up to check on my fibroids.

*Medication Issues*

31. I have a prescription for iron pills that I take for my anemia.

32. However, I have not been given my iron pills consistently at the Jail. I have received doses that do not properly mitigate my symptoms, and there have been instances where I have not received my pills at all.

33. For example, on or about September 2025, while I was receiving my medication by the pill cart, I did not receive my iron pills at all for approximately two weeks. When I asked the morning nurse for my iron pill, they said I had to take it in the evening. Then, when I asked the evening nurse for my iron pill, they said I had to take it in the morning. I put in a sick call slip to see a provider to discuss the missed medication. I went to medical at the Jail to ask why I was not receiving my iron pills, and the nurse there told me that the pills were on backorder, and they had to call the pharmacy. I overheard the nurse talking to the pharmacy on the phone, and the pharmacy said that my prescription expired. Because the Jail did not properly refill my medication on time and I therefore missed taking my medication for two weeks, I was anxious about the impact on my health.

34. In addition, the Jail medical staff instructed me to take my iron pill every other day instead of every day. I believe they decreased the amount of medication I take because they said it takes a while for them to refill my prescription, so it is logistically easier for me to take fewer pills. I believe this lower dosage of medication may also be causing my fluctuating and worsening symptoms.

35. On or about February 11, 2026, the Jail stopped giving me my iron pills and I missed my medication for a few days, despite the decline of my hemoglobin between December and February levels. I put in another sick call slip to get my medication, and I was seen by a provider. After I spoke with the Jail medical staff, I got my medication again.

36. During my appointment on or about February 18, 2026 with the hematologist at HUH, I told him that I was only receiving my iron pills every other day, but I believed I should be taking them every day. He affirmed that I should be getting and taking my iron pills every day at the Jail. I asked him to make a note of this in my records, and he said he would.

*Ignoring Outside Medical Advice and Missing Outside Medical Appointments*

37. I have missed and/or needed to reschedule multiple outside medical appointments while in custody of the Jail.

38. On or about January 13, 2025, I had an outside medical appointment scheduled for further testing, including a colonoscopy. However, the Jail did not give me the preparation drink needed to clear my bowels for the colonoscopy. When we were at HUH, the doctor asked if I had taken the preparation drink. Because the Jail did not give it to me, the appointment had to be rescheduled.

39. This appointment was rescheduled for on or about April 1, 2025, approximately three months after my initial appointment. During this appointment at HUH, I had a colonoscopy

and an endoscopy. The purpose of the endoscopy, as I understood it, was to see if I was bleeding internally, as that would potentially explain my low hemoglobin and iron levels. After this procedure, I was told I was not bleeding internally, and this was ruled out as a potential cause of my condition. Meanwhile, due to the results of the colonoscopy, I was diagnosed with hemorrhoids.

40. Throughout my residency at CTF, the recommendations made by outside doctors to improve my care and my symptoms have also been ignored by the Jail at times.

41. As a result of the visit on or about April 1, 2025, HUH doctors recommended that I change my diet to increase my iron intake because the regular food provided by the Jail does not provide adequate nutrition. I was told by HUH doctors that they would tell the Jail that I need a special diet to help control my iron levels.

42. When I got back to the Jail and asked a nurse about this new diet, they told me that I could only receive the diet recommended by HUH if I changed my religion. I did not feel comfortable making this change when I did not actually need to do so, and I have not received the diet recommended to me by the doctors at HUH.

43. Also arising from the visit on or about April 1, 2025, HUH doctors recommended that I receive an additional mattress and pillow for my gastrointestinal issues to provide additional comfort for my hemorrhoids. When I got back to the Jail and asked about this, they told me that they did not see this recommendation in the notes from HUH, even though the doctors at HUH told me they would make note of it. Nevertheless, after asking about this, an officer at the Jail did give me the recommended mattress and pillow. However, on April 14, 2025, during a shakedown, my extra mattress and pillow were taken away. I never received another extra mattress or pillow.

44. Despite my numerous ongoing medical issues, I continue to advocate for my own health and those around me so residents can receive proper treatment and medical care.

45. I have been informed of the responsibilities of a class representative, and I am willing to serve in that role, and protect the interests of the class.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge. Executed on MARCH 5, 2026.

A.G.

A.G.

# EXHIBIT 4

**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

V.C., et al.

Plaintiffs

v.

District of Columbia

Defendant.

No. 1:23-cv-01139

**DECLARATION OF L.T.**

*I, L.T., certify under penalty of perjury that the following statement is true and correct to the best of my knowledge.*

1. I am 22 years old and am currently incarcerated in the Correctional Treatment Facility (CTF) run by the District of Columbia Department of Corrections ("the Jail"). I have been incarcerated at the Jail since February 2024.
2. I have an autoimmune disease called ulcerative colitis, meaning I have ulcers in my colon. These ulcers can start bleeding, causing flare ups, which are trigged by food, stress, or other deviations from routine. When I experience flare ups, my ulcerative colitis is severe, and I suffer from extreme stomach pain, fatigue, diarrhea, vomiting, and discolored, runny, and bloody stool, all of which also causes weight loss.
3. When I arrived at the Jail, I was 24 weeks pregnant. My pregnancy was considered high-risk because of my ulcerative colitis.
4. Since arriving at the Jail over two years ago, I have received inadequate medical care for my pregnancy and for my ulcerative colitis.

*Pregnancy*

5. Before I came to the Jail, my OBGYN told me that my daughter was measuring small because of my ulcerative colitis and therefore my pregnancy was considered high risk.

6. Due to my high-risk pregnancy, I needed to be medically monitored to ensure that my baby and I were healthy. However, at the Jail, I did not receive accurate information about or proper medical care for my pregnancy, including my prenatal care, labor and delivery, and post-partum care.

7. During my first month at the Jail, I saw an obstetrician gynecologist (OBGYN) only once, and that was after submitting a sick call slip. Before I was incarcerated, I was informed by my OBGYN in the community that I needed to have a glucose test to screen for gestational diabetes. I submitted a sick call to request this test. After completing the test, I also had to ask for the results. I was told the result was 72% but was not provided with any explanation or context for what that number meant.

8. This was only the start, as I continued to navigate my pregnancy with little information and improper medical care. As a first-time mom, words cannot express the confusion, anxiety, and hurt I felt at the lack of information and the inadequate care I received at the Jail throughout my pregnancy.

9. To prepare for my delivery, I asked correctional officers, medical staff, my case manager, and my former criminal attorney questions about giving birth while in custody. My primary concerns were my prenatal care, labor and delivery, breastfeeding, and postpartum care. In response to my questions and concerns, I was provided with incorrect information or no answer at all.

10. For example, late in my pregnancy I learned I was supposed to be receiving a prenatal tray that had larger portions, fresh fruit, fresh vegetables, and a snack. I only started receiving the prenatal tray when I was 37 weeks pregnant after my civil attorney, Chelsea Sullivan, advocated on my behalf, and, even then, I did not receive the tray or the snack consistently.
11. During postpartum, Ms. Sullivan also advocated for me to receive the prenatal tray to provide additional nutrients and calories while breastfeeding. I received the tray only for a week and a half after giving birth, even though I continued to pump for approximately two and a half months.
12. This pattern of learning that I was supposed to be receiving a certain level or type of care that the Jail was not providing me also extended to the way they shackled me over the course of my pregnancy. In my second trimester, I was shackled at my wrists and ankles to be transported to a court appearance. While in a Jail hallway, I saw that there was a poster on the wall, which explained that there should not be any restraints around my ankles. According to the Jail's policy, leg irons and belly chains are prohibited from being used at any point during pregnancy, handcuffs secured in front may be used only during the first and second trimesters of pregnancy, and no restraints at all can be used during the third trimester of pregnancy or during postpartum recovery. I pointed the poster out to the correctional officer accompanying me and told them I was pregnant. They asked how many weeks I was and still proceeded to shackle me and to refuse to remove my ankle restraints, even after I explained I was in my second trimester.
13. This kind of treatment was not unusual for officers at the Jail. In fact, at times, correctional officers did not believe I was pregnant, despite having access to my medical records.

14. Because I was high risk, the OBGYN at Washington Hospital Center told me I was supposed to be seen by an outside OBGYN twice a week in my third trimester. I was not taken to these appointments consistently and often missed them.

15. For example, on or about May 13, 2024, I was taken to a holding cell at approximately 5:30 a.m. I was told I was going to be taken to an outside medical appointment, but approximately four hours later, I was taken back to my cell instead.

16. In the beginning of May 2024, when I was approximately eight months pregnant, I began having pre-term contractions and notified a correctional officer in the morning. After nothing was done, I again notified a correctional officer around 1:30 p.m. in the afternoon. I was not taken to the hospital until approximately 6:30 p.m. Although the pain turned out to be Braxton Hicks contractions, the impediment in getting to the hospital made me worry about a potential delay when I did go into labor. When I came back to the Jail, a Lieutenant came up to my unit and told me he heard what happened and did not know I was pregnant.

17. During my third trimester, I was taken to my outside OBGYN at Washington Hospital Center. At this appointment, officers refused to allow my doctor to assess my baby using a fetal monitor. Instead, my doctor was forced to admit me to the hospital in order to use the fetal monitor, which caused a long delay—I ended up being at the hospital for approximately six hours; my office appointments usually last less than an hour.

18. In early June 2024, I was told by Jail medical staff that I had to be induced but they would not tell me the date.

19. On June 7, 2024, I was induced at Washington Hospital Center. By this point, I had been told by Jail officials that my mother-in-law was allowed to be with me in the room during labor and delivery. Having a support person with me made me feel more confident about

my labor and delivery, since I would not be alone. However, when I was going into labor, the correctional officers did not initially permit my mother-in-law to enter the delivery room. It was not until then-Deputy Warden Vick intervened that my mother-in-law was allowed to enter the room. Even then, my mother-in-law had difficulty coming in and out of the room throughout my labor and delivery and was also asked to leave entirely after I gave birth.

20. After I was induced, there was at least one male correctional officer in the room with me before I gave birth.

21. On June 8, 2024, at 9:06 p.m., I delivered my daughter with two correctional officers in the room. Even though my mother-in-law, nurses from Washington Hospital Center, and I asked them to leave the room, they refused.

22. Three hours after giving birth, I moved to the postpartum unit, and a new shift of correctional officers came. One of the new officers attempted to shackle me to the bed. My mother-in-law and I informed the officers that Jail policy forbids shackling during postpartum. The correctional officer then called then-Deputy Warden Vick to confirm the policy for the officers. After this confirmation, I was not shackled to the bed. However, three days later, I was handcuffed when I left the hospital.

23. Before I was discharged, I requested that my daughter leave first, so I could be sure that my baby was safely in the custody of my mother-in-law. The process of saying goodbye to my daughter was traumatic. After receiving news that I was allowed to watch my daughter discharged, I was then told that I could no longer watch her. There was confusion and back-and-forth between me, my family, hospital security, and Jail correctional officers about

how I could say goodbye. This added to my already great amount of anxiety, stress, and sadness. It was one of the worst moments of my life.

24. Upon returning to the Jail, I submitted a sick call slip requesting counseling for postpartum depression and I told the Jail OBGYN. I never received a response to my sick call slip and was never seen by anyone from medical or psychology about this issue.

25. After delivering my daughter, I knew I wanted to breastfeed her. Being able to breastfeed was extremely important to me because I knew it was the healthiest way for my daughter to receive food and nutrition, along with the benefits of bonding and connection. When I initially asked about breastfeeding at the Jail, I was told I was allowed to and would receive a breast pump and a small refrigerator-freezer to store expressed breast milk. I was not provided with any other key logistical information, such as how and when my milk would be sent to my daughter, what supplies I would receive, or how I would clean my bottles and pumping supplies.

26. I breastfed at the Jail for three months after giving birth. Throughout this time, I was not provided with the proper postpartum care nor with the resources I needed to breastfeed.

27. When I was discharged from the hospital after giving birth, Washington Hospital Center gave me a breast pump, pads, ice packs, and witch hazel spray. However, within days, I ran out of witch hazel spray and pads. When I requested more witch hazel spray and/or pads, I had difficulty receiving more. I told Ms. Sullivan about the issue with supplies, and it was not until Ms. Sullivan followed up with DOC's General Counsel that I was able to get more. The Jail did not supply me with postpartum supplies such as nipple cream, wipes, or ice packs. Although they did provide me with nursing pads, they were not large enough.

28. The Jail also did not give me any cleaning products for my bottles. I was forced to use hand soap and my bath towel to clean the bottles and breast pump.

29. During this postpartum period, I shared a cell on Medical Unit 82 at CTF with another individual who was postpartum and also pumping breast milk. There was only one power outlet in our cell, so we had to take turns using it to pump. We also shared one small freezer to store our breast milk. This made it harder to pump and properly store our breast milk.

30. I was told by the Jail that I would receive a cooler to transport my breast milk to my daughter during visitation, but I never got one. This meant that the only way I was able to transport my milk to my daughter was by using a trash bag and giving it to her and my mother-in-law during their visits. The trash bags would often not be large enough to fit all the milk, and they would often rip and thaw over the course of our visits, which I know is not how my milk should have been safely transported. In addition, I sometimes had to borrow milk storage bags from my cellmate because I did not consistently receive these supplies from the Jail.

31. Being on the medical unit to breastfeed meant that I did not have access to programming or education, and it limited my recreation time to two hours. I wanted to join the Georgetown Scholars program but was told I could not participate in the education department at the Jail because I was on the medical unit. Due to these restrictions, my mental health worsened.

32. During a follow-up appointment with the OBGYN at the Jail, I again requested to receive counseling for postpartum depression. Despite this request, the OBGYN did not address my concerns, and I did not get an appointment with a psychologist or counselor. After approximately three months of breastfeeding, although I had intended to continue, the

restrictions on programming in Medical Unit 82, combined with the lack of adequate support, supplies, nutrition, and care at the Jail, made it too difficult for me to continue, and I was forced to stop.

33. I moved back to a unit with the general population at the Jail in late August 2024.

34. My entire pregnancy (prenatal care, giving birth, and postpartum) was one of the most traumatic experiences in my life. Because I did not receive the level of care needed for a high-risk pregnancy while at the Jail, I was incredibly worried not only about my own health, but also my daughter's health.

*Other Medical Concerns*

35. In August and September 2024, I suffered a severe flare up of my ulcerative colitis. I experienced diarrhea 6-10 times a day and threw up 2-3 times a day. I also experienced unbearable stomach pain, worse than contractions, blood in my stool, and fatigue. Over the course of 21 days (August 27–September 17, 2024), I lost approximately 14 pounds. During this time, I put in three sick calls detailing my symptoms and requesting care. When I was finally able to see a doctor at the Jail, they gave me medication to help with the pain.

36. Since fall 2024, I have started to see a gastrointestinal (GI) doctor at Washington Hospital Center for my ulcerative colitis. On at least two occasions, I have missed these appointments because Jail staff brought me too late, so I did not receive treatment.

37. To help treat my ulcerative colitis, I should receive a 7-dose supply of mesalamine once a week to keep on me. I also receive and take azathioprine every night by the pill cart. However, there have been times when I have missed my dosages entirely because the Jail has not provided me with my medication.

38. In these instances, I ask the Jail staff member who distributes the medication why I am not receiving mine. They tell me it is because my medication is expired and/or needs to be refilled, and I should put in a sick call to ask for that to happen. Over the past year, I have submitted multiple sick calls about missing my medication and needing a refill. For example, on December 23, 2025, I submitted a sick call saying that I needed a refill of azathioprine. I have also filed at least one grievance on this issue. In response to the grievance, someone from the pharmacy asked what medicine I needed to refill, and he did so on my behalf. In response to the sick calls, I eventually get my medication, but I have not received any kind of written response or notice of when the prescription should be refilled. Sometimes, it takes three or four days before I start receiving my medication again.
39. Because I do not know when my prescription is scheduled to run out and when it needs to be refilled, it is only after I miss doses that I know it is time for a refill. A refill only happens after I put in a sick call.
40. When I do receive my medication, I am not provided with any prescription instructions or drug facts. My medication comes by the pill cart in a cup with my name on it—there is nothing else to indicate what medication is being given to me: there is no dosage information, no side effects, and no drug name. This information is necessary to ensure that I am taking my correct dose and understand what medication I am receiving and ingesting. Since I do not receive this information with my pills, I get worried that I do not always have the correct information or that I may be given the wrong pill entirely.
41. For example, around January 2025, I was taking azathioprine in the morning when the Jail brought it to me. After taking the medication, I often threw up and felt lightheaded. I told the GI doctor at Washington Hospital Center about these symptoms, and he informed me

that this was probably due to taking the medication in the morning, and he noted that I should start receiving it at night instead. After a few days during which the Jail continued to bring my medication in the morning, I wrote a sick call asking for my medication to be brought to me at night instead. After the Jail started to bring me azathioprine at night, I stopped experiencing these side effects.

42. In early 2026, I was given medication from the pill cart that I thought was not mine because there were more pills in the cup than I typically receive. I told the Jail staff member who gave me the pills that I was not sure if it was the right medication, and he dug around the pill cups until he realized that he had given me the wrong medication. He had accidentally given me medication from a pill cup of someone with a similar last name to mine. Taking incorrect medication can be a serious problem (in addition to the problem of missing my own medicine), and it worries me that I am not provided with the necessary information—or potentially even the correct medication—for my medical care.
43. I continue to advocate for my own health and those around me so residents can receive proper treatment and medical care.
44. I have been informed of the responsibilities of a class representative, and I am willing to serve in that role and protect the interests of the class.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge. Executed on 2 March Second, 2026.

L.T.

# EXHIBIT 5

**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

V.C., et al.

*Plaintiffs*

v.

District of Columbia

*Defendant.*

No. 1:23-cv-01139

**DECLARATION OF V.D.**

*I, V.D., certify under penalty of perjury that the following statement is true and correct to the best of my knowledge.*

1. I am 60 years old and am currently incarcerated at the Correctional Treatment Facility run by the District of Columbia Department of Corrections ("the Jail").
2. I have been incarcerated at the Jail since June 12, 2025.
3. I have a history of heart failure and an irregular heartbeat.
4. In 2023, I suffered a stroke. I walk with a cane due to the stroke's lasting effects on my mobility. The stroke also impaired my vision, affected my ability to write, and gave me a speech impediment.
5. I have Type II diabetes and hypertension, as well as other chronic medical conditions.
6. I take approximately 15-20 pills per day to treat my various conditions.
7. Despite asking Jail staff many times for information about my medications, I am not sure which medications I take, for which conditions, and in what dosages. I have also not been informed of potential side effects or long-term effects of the medications.

8. I have repeatedly asked medical staff at the Jail to provide me with a list of the prescription medications that I am on, but they have refused. I have also put in sick call slips to try and find out this information, but I still have not been able to get any answers.
9. I have also requested bloodwork to assess the effects of my medications on my health, but medical staff have ignored my requests.
10. I experience negative side effects from my various medications, including numbness and tingling in my left arm and groin, vision distortion, and fluid retention. These side effects started around the same time I started taking these medications when I came to the Jail in June 2025.
11. The side effects from my various medications bring me discomfort and distress. The fact that I am unable to access information about my medications makes me feel anxious and disempowered.
12. I also suffer from Substance Use Disorder ("SUD"). I am committed to achieving sobriety and am eager to participate in the Jail's Residential Substance Abuse Treatment program ("RSAT").
13. My SUD has been known to Jail staff and documented in my institutional medical records since I arrived at the Jail. Even though I was flagged for evaluation by the medication-assisted treatment ("MAT") team upon my arrival, I have not received MAT, nor have I been able to participate in RSAT.
14. I have repeatedly asked Jail staff and my case manager about RSAT. I have also submitted a request to participate in RSAT on my institutional tablet. My case manager has repeatedly told me that I am on a waiting list, but has offered no other information about how or when I can access the program.

15. On January 8, 2026, I submitted a complaint to my case manager about the fact that I have not been enrolled in RSAT. I was told that the RSAT waiting list is "very long" and that there is no guarantee I will get into the program.
16. I have seen other residents—who arrived at the Jail after I did—enter the RSAT program. I do not understand why I have not had access to it, and I worry I will not be able to participate in this program before I am transferred to the federal Bureau of Prisons. In the meantime, I am not receiving any other forms of treatment for my SUD. I need help and a reliable support system in my recovery.
17. My stroke impaired my vision, causing me to need a new prescription for my glasses. However, I have not been evaluated for new glasses despite repeatedly asking for an appointment. As a result, I am forced to use my old pair of glasses, which is inadequate. Portions of my vision are distorted and blurry, especially in my left eye, making it difficult to read and go about my daily tasks.
18. I was supposed to see an ophthalmologist on or around January 22, 2026, but Jail staff marked me as a no-show and claimed that I refused the appointment, even though I never did. I have still not seen an eye doctor since my arrival at the Jail, despite submitting several sick call slips.
19. I do not have access to adequate mental health care at the jail. My access to therapy has been inconsistent, and the mental health providers at the Jail frequently discuss residents' private health information with other residents. I have not had access to mental health appointments for approximately the past three weeks, despite submitting sick call slips.
20. Medical care at the Jail is generally slow and inconsistent. My sick call slips are either ignored, or I have to wait two to three weeks to see a doctor after submitting a sick call. If

other health issues arise during the waiting period, Jail staff do not permit me to address them in the appointment; instead, they demand that I submit a separate sick call and wait another two to three weeks for help.

21. Doctors at the Jail have also dismissed my medical concerns related to my high blood pressure. According to my chronic care doctor, Dr. Ojiako, I am supposed to have my blood pressure checked two or three times a week, but this has not happened consistently, even after I submit sick call slips.

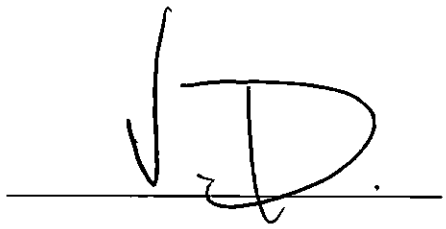
22. When I raise concerns with medical staff about my high blood pressure, they often send me back to my cell without checking it or following up. For example, on February 6, 2026, I had my blood pressure taken and it was very high. The doctor's assistant sent me back to my room to sit down and said my blood pressure would be measured again, but the doctor did not follow up or check on me to confirm that my blood pressure had decreased to normal levels.

23. On February 25, 2026, around 5:00 A.M., I was called up to medical for a blood pressure check after submitting a sick call slip. My blood pressure was 153 over 108, which is very high. They told me that I would be called back up to medical to have it re-checked. Instead, I was taken back to my cell and was never brought back.

24. I am suffering ongoing harm from the Jail's disregard for my medical care and the lack of treatment I have received.

25. I have been informed of the responsibilities of a class representative, and I am willing to serve in that role and protect the interests of the class.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge. Executed on February 26, 2026.



V.D.

# EXHIBIT 6

**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

| | |
|---|---|
| V.C., et al.<br>*Plaintiffs*<br>v.<br>District of Columbia<br>*Defendant.* | No. 1:23-cv-01139 |

**DECLARATION OF D.M.**

*I, D.M., certify under penalty of perjury that the following statement is true and correct to the best of my knowledge.*

1. I am 52 years old and am currently incarcerated pre-trial in the Central Detention Facility run by the District of Columbia Department of Corrections ("the Jail"). I have been incarcerated at the Jail since June 11, 2024.
2. I have Degenerative Bone/Joint Disease (DJD) and Degenerative Disc Disease (DDD) in my spine, meaning the cushioning discs in my back and the cartilage in my joints are slowly breaking down. The discs towards the bottom of my back are the ones that cause the most pain and the most numbness.
3. As a result of these conditions, I live with both chronic pain in my back and recurring numbness in my fingers, toes, and feet.
4. Every day, there is a throbbing pain along my spine. On a scale from one to ten, I would describe this pain as a four or five. Multiple times a day, I also experience a brief, sharp pain in my back, hands, and feet. On the same scale, this pain is around a nine. Since arriving at the Jail, the sharp pain has been happening more often. Starting around October

2025, the pain became so severe that it wakes me up multiple times a night. Because of the pain, I have not slept through the night since around the end of 2025.

5. In addition to the pain, if I sit, stand still, or lay down for more than a few minutes, I experience numbness in my fingers and toes. As a result, I spend each day constantly moving. When I feel numbness in my fingers, I wiggle my fingers to prevent the numbness from spreading and to relieve the pain. When I feel this in my toes, I often move my feet, reposition myself, or walk in place to try to prevent further numbness or pain. These tricks normally help in the moment but do not prevent the numbness from happening again.

*Cane Pass*

6. The chronic pain and recurring numbness have affected my mobility for years. If I stand up quickly, I risk losing feeling in my legs and collapsing. I cannot run or jump. I have fallen multiple times over the years, so I try to move slowly and carefully. Around 2011, when I was incarcerated in the Eastern Correctional Institution in Maryland, I fell for the first time because of the numbness in my feet. I did not know my foot was numb at the time, so when I tried to walk, I could not feel my foot and fell to the ground. Afterwards, the medical staff at the Eastern Correctional Institution provided me with a cane and told me that I had to keep the cane with me at all times. The officers enforced this rule and required me to keep it with me every day. After leaving the Eastern Correctional Institution in 2015, I was using a cane to help me walk on most days.

7. Around 2017 or 2018, when I was incarcerated in the Maury Correctional Institution in North Carolina, I had my worst fall. I had been standing for a few minutes and did not know my feet had gone numb, so when I reached for a basketball rolling by me and took two steps, I fell. I did not have my cane with me at the time. When I fell, I hit my face on

the ground and lost consciousness. I have permanent scaring on my face from that injury and the surgeries that followed.

8. When I arrived at the Jail in June 2024, I was given a cane pass, which permitted me to use a cane throughout the Jail. Since arriving, I renewed my cane pass several times because I understood all cane passes to expire after one year and I still needed my cane to walk, as my mobility had not improved. My most recent cane pass was issued about five and a half months ago, on September 19, 2025.

9. Around November 2025, when I asked for my cane at the control unit as usual, correctional officers said they do not have my cane. I have not had a cane since then.

10. Since November 2025, I have requested a cane numerous times during appointments with Jail medical personnel. My requests have been either ignored or denied. In December 2025, at an appointment to discuss potential back surgery, one of the doctors at the Jail told me that I do not need a cane. He did not explain why he thought that and when I tried to say why I needed one, he brushed me off and would not listen or discuss it.

11. My health and my mobility have not improved since I arrived at the Jail in June 2024; they have only gotten worse. I do not know why I am being denied access to a cane, despite having a cane pass. I fear that I will fall and injure myself again while living at the Jail without a cane.

*Surgery*

12. The Jail has also ignored or denied my repeated requests for surgery for my DJD and DDD.

13. Since 2011, I have tried both physical therapy and pain management, but neither has been very successful. Since arriving at the Jail, I have participated in physical therapy several

times. For pain management, I receive gabapentin along with over-the-counter pain medications like Tylenol or Advil. Despite this, I am still in constant pain.

14. Prior to and after arriving at the Jail, I have had multiple doctors recommend considering surgery to address my DDD and DJD because years of physical therapy and pain management remained unsuccessful. In conversations with medical personnel at the Jail, I expressed interest in moving forward with the surgery and was told I would be referred to an outside appointment with a surgeon.

15. In early 2025, I had a consultation with a surgeon at Howard University Hospital ("HUH") to discuss a surgical procedure for my DDD. The surgeon told me if I did not have the procedure, I would be in a wheelchair soon. We discussed continuing physical therapy and pain management in the meantime; when I left, I expected a date for the procedure to be set within the next six weeks.

16. Approximately eight weeks after the consultation, Jail medical personnel informed me that the request for surgery was denied. I was not given any explanation about why it was denied. I still do not know why the procedure was denied.

17. Since then, I have submitted approximately ten to fifteen sick call slips about my DDD and chronic pain in an attempt to see a surgeon again.

18. I have been told by numerous Jail medical personnel that they have submitted new referrals for me to see a surgeon. Most recently, the Jail Chronic Care doctor told me he submitted a referral request in early February 2026. Despite this, I have not seen a surgeon for this procedure since May 2025.

19. On February 17, 2026, I was woken up by staff at or around 6am and was instructed to dress for an outside doctor's appointment that day. I was not told what the appointment

was for, but I was only waiting for an appointment about my back surgery, so I assumed that was the appointment. Within an hour, correctional staff returned to my cell and told me the appointment was cancelled. They provided no information as to why. I still have not received any information about what the appointment was, why it was cancelled, or if it has been re-scheduled.

*Dental Care*

20. In addition, the Jail has also dismissed my requests for dental care and complaints of severe tooth pain. Towards the end of March 2025, I began experiencing intense headaches as a symptom of a sinus infection. While taking antibiotics, I continued to suffer from these headaches, and I would clench my teeth to cope with the pain. I believe this ultimately caused one of my right, front teeth to break into two pieces.

21. One of the two pieces was broken at a significant angle and as a result, stuck out of my mouth so that I could not close it. That day, I spoke to a correctional officer on my unit who told me he would call the medical staff to tell them I had an emergency. After his phone call, he told me that I had to submit a sick call slip, which I understood to mean that this would be considered a routine medical request rather than an emergency. I submitted a sick call slip and waited in extreme pain for multiple days. At times, I hit my head against the wall to distract myself from the pain. It was the worst pain I have experienced.

22. On April 3, 2025, I was supposed to have a dental appointment for my broken tooth. However, the Jail staff informed me that my scheduled dental appointment was cancelled because my appointment was not an emergency and the dentist needed to treat someone in pain, instead. My appointment was rescheduled for April 8, 2025. I still could not close my mouth without experiencing extreme pain.

23. The next day, when I heard the dentist was in my unit, I wanted to speak with her about my broken tooth. When I approached her, she would not discuss it and repeatedly told me I needed to wait for my rescheduled appointment.
24. Two days later, on April 5, I could no longer bear the pain, so I pulled out the protruding piece of my tooth. Quickly, the pain became more manageable, so I was no longer in extreme pain while I continued waiting for another few days. On April 8, I attended my rescheduled appointment, and the dentist removed the remaining piece of my tooth.
25. In my experience, medical personnel are dismissive of pain and continuously cancel or postpone appointments, delaying access to medical care. I am frustrated by the lack of medical attention and the pain I have experienced because of it.
26. I have been informed of the responsibilities of a class representative, and I am willing to serve in that role and protect the interests of the class.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge. Executed on March 3, 2026.

D.M.

# EXHIBIT 7

**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

| | |
|---|---|
| V.C., et al.<br>*Plaintiffs*<br>v.<br>District of Columbia<br>*Defendant.* | No. 1:23-cv-01139 |

**DECLARATION OF D.S.**

*I, D.S., certify under penalty of perjury that the following statement is true and correct to the best of my knowledge.*

1. I am 39 years old and am currently incarcerated pre-trial in the Central Detention Facility run by the District of Columbia Department of Corrections ("the Jail"). I have been incarcerated at the Jail since the end of 2023.
2. I have high blood pressure and experience recurring seizures. Due to head injuries that I sustained as a young adult, I have suffered from recurring seizures since around 2008. At the Jail, I have been prescribed Dilantin, a seizure medication, to help manage this condition.
3. I also have schizoaffective disorder, meaning I sometimes experience hallucinations or hear voices, particularly when I do not have access to my psychiatric medications.
4. As a result of my various mental and physical health conditions, I have multiple prescription medications that I should take daily. I struggle to remember the names of every prescription, but I know I should be taking medication for my seizures, high blood pressure, and schizoaffective disorder, in addition to a few more. Currently, I receive around four

pills in the morning, and four to five pills in the evening. Those pills are given to me together in a small cup, so although I recognize my daily pills, it is difficult for me to know which medication is which.

5. Since arriving at the Jail, I have had inconsistent access to my prescribed medications. For example, when I first arrived at the Jail, in early 2024, I would notice that sometimes I was given more pills than I was prescribed to take. When I told the nurse who gave me my medication that my pills did not look right, she brushed off my concerns and instructed me to take the pills anyways. This occurred approximately ten times in the first few months of 2024. I remember feeling dizzy and sleeping more than I normally do during this time.
6. I am supposed to receive my prescription medications twice a day, when Jail medical staff visit my unit to deliver medication ("pill call"). Pill call happens around 9:30 AM each morning and 7:30 PM each evening. When staff arrive at the unit, they verbally announce that they have arrived for pill call, and the residents in my unit line up to get their medication.
7. One side-effect of my medications is drowsiness. As a result, I am sometimes asleep when staff arrive for pill call and I do not hear them arrive. When that happens, staff do not wake me up and I miss the dose of my medication entirely. This happens approximately two to three times a week.
8. Missing pill call happens to other people on my unit as well. I have watched as medical personnel stand at the end of the hall and call out an individual's cell number two or three times, if that individual has not picked up their pills yet. If someone does not come out of their cell or respond when their cell number is called, medical staff leave the unit and pill call is over. Staff rarely walk to someone's cell to wake them up or see if they heard pill

call being announced. Since early 2024, I have lived on two different units. In both units, I have watched at least one person miss their medication during pill call nearly every day.

9. I have talked to the correctional staff on my unit after waking up and realizing I missed pill call. They do not call the medical staff back to the unit or help me access my medication. I have submitted multiple grievances and sick call slips about this issue, but it has never been resolved.

10. Around the summer of 2024, I also began developing tremors in my hands. At times, my tremors were so severe that they prevented me from participating in daily activities. For example, in the fall of 2025, I could hardly write more than a few words legibly. I felt extremely frustrated when I was unable to send letters to my loved ones or communicate with my lawyers by mail. It was upsetting to feel like I could not control part of my body.

11. In the fall of 2024, when I spoke to Chronic Care doctors at the Jail about my tremors, they expressed a concern that my seizure medication could be causing the tremors, and I was prescribed another medication to reduce my tremors.

12. Throughout the fall and winter of 2025, medical personnel at the Jail have slowly increased the prescription for my tremors. Around the beginning of 2026, my tremors finally became much less frequent and more manageable. I still do not know if the Dilantin, which I am still taking for my seizures, is causing the tremors or is safe for me to be taking. It makes me nervous that I do not know how this may be affecting my health.

13. Despite the challenges I have faced, I do my best to advocate for myself and other residents at the Jail.

14. I have been informed of the responsibilities of a class representative, and I am willing to serve in that role, and protect the interests of the class.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge. Executed on March 4, 2026.

D.S.

# EXHIBIT 8

**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

V.C., et al.

*Plaintiffs*

v.

District of Columbia

*Defendant.*

No. 1:23-cv-01139

**DECLARATION OF T.W.**

*I, T.W., certify under penalty of perjury that the following statement is true and correct to the best of my knowledge.*

1. I am 36 years old and am currently incarcerated in the Correctional Treatment Facility (CTF) run by the District of Columbia Department of Corrections ("the Jail").
2. I have been incarcerated at the Jail since October 5, 2024. Upon admission to the Jail, I was a resident at the Central Detention Facility (CDF), but I have moved between CTF and CDF throughout my incarceration.
3. I am currently housed in Administrative Segregation at CTF. I have been housed in segregation, either at CDF or CTF, since May 2025.
4. I have had ongoing back problems while incarcerated, starting in February 2025. My pain level varies, but it is generally a 7 out of 10. When I lay in certain positions, my legs go numb.
5. My back problems started after I collapsed in my cell from an asthma attack on February 6, 2025, while I was incarcerated at CDF. Subsequent x-rays showed signs of degeneration in my spinal disc, and I was given a one-time dose of Tylenol for lower back pain.

6. On April 23, 2025, while I was incarcerated at CTF, Jail employees confronted me in the strip search room connected to the CTF visiting hall, slammed me on the ground, and assaulted me. I reported increased back pain, lack of sensation in my legs and feet, headache, and dizziness after the incident and was brought to George Washington University Hospital ("GWU Hospital"), where I stayed for six days and received intensive physical therapy.
7. The discharge papers from my hospital stay recommended a follow-up MRI and EMG and concluded that I likely suffered from nerve injury resulting from the assault. GWU Hospital physicians recommended that I receive continued physical therapy with pain management and monitoring for falls and weakness. They also concluded that I would benefit from a manual wheelchair, a rolling walker, a bedside commode, and a shower bench due to my pain and limited mobility and endurance, and recommended neuropathy labs and follow-up outpatient care with GWU Neurology.
8. The hospital providers also prescribed medication for my pain. Despite the prescription, I have not received any pain medication at the Jail since May 2025.
9. The hospital discharged me with a wheelchair to assist with my mobility. Before I was discharged, the prescribing doctor at GWU Hospital called staff at the Jail to ensure that I would be given a wheelchair when I arrived back. Jail staff told the doctor that I would.
10. After I returned from the hospital on April 29, 2025, in a wheelchair, I showed a doctor at the Jail my discharge paperwork. He told me that the Jail would do its own assessment of my condition, even though the Jail does not have its own neurologist on staff, and then put the documents in the shredder. He then gave me walker and told me that, if I couldn't make it down the hallway, I would have to be put on 24-hour lockdown. Afraid of lockdown, I

struggled to the end of the hallway. When I was able to make it, the doctor determined that I didn't need a wheelchair at all, despite what the GWU Hospital providers had said.

11. The Jail has since denied me regular access to a wheelchair, rolling walker, and shower bench to reduce my pain and support my mobility as recommended by the hospital.

12. When I first returned from the hospital, I was provided with a rolling walker, but it did not provide enough support for my legs, which I could hardly use. As a result, I fell at least twice when I was in Medical Unit 82 at CTF.

13. For example, on April 30, 2025, I fell in the communal shower while trying to use my walker. I was lying on the floor for approximately two hours in pain. Eventually, Officer Holmes found me and placed me, naked, into a wheelchair with the help of other residents who were not medical staff. They took me back to my cell and threw me onto my bed with a pair of wet boxers. A nurse later came to take my blood pressure and gave me pain medication. I did not receive any additional follow-up appointments from that incident. The entire experience was humiliating.

14. About a week later, on or about May 5, 2025, Jail staff observed me shooting a basketball while standing next to my walker on Medical 82. They claimed that I had been actively playing basketball and running and up and down the court.

15. About a week later, I slipped and fell in my cell while trying to use the bathroom. The floor in my cell was wet because the toilet was leaking. I reported the leak to Officer Holmes, who told me to pack up and get ready to leave my cell. A Lieutenant came and took me to see a doctor in the medical unit, who said I needed an x-ray. I was told I needed to be taken over to CDF for the x-ray. Lieutenant Camlin escorted me to R&D. As I got off the elevator at R&D, the wheels of my walker got stuck and I fell down. I experienced immediate,

severe pain. Lieutenant Camlin pulled me out of the elevator and told me to get up. He called medical staff, who put me in a restraint chair and took me back to medical to see a physician's assistant named Fekadu Jiru. Mr. Jiru told the staff that nothing was wrong with me, and that he had just seen me "running on camera at the gym." I was taken to CDF, where officers lifted me out of my chair, cuffed me, and threw me into a body scanner, insisting that I could walk. The officers then took me to South 1 and threw me into a cell. I stayed at CDF for the next six months.

16. As the months went by, Jail medical staff continued to deprive me of regular access to a wheelchair or any type of walking support, even though physicians at GWU Hospital had recommended that I use a wheelchair and despite the fact that I experienced acute, persistent pain, had limited mobility, and fell down several times.

17. During this time, my criminal attorneys filed multiple requests with the court to compel the Jail to provide me with a wheelchair to attend legal visits and court hearings and transfer me to a different facility that could properly care for me.

18. On May 26, 2025, my state criminal attorney filed an emergency motion in D.C. Superior Court for my release to home confinement or to a hospital for a medical evaluation of my ability to walk. *See* Emergency Mot. For Release or Immediate Transfer to Hosp. for Med. Eval., *United States v. Whack*, No. 2024 CF1 010033 (D.C. Super. Ct. May 26, 2025).

19. In response, the D.C. Superior Court ordered the Jail to schedule a follow-up neurology appointment for me, consistent with my discharge papers from my GWU Hospital stay. *See United States v. Whack*, No. 2024 CF1 010033 (D.C. Super. Ct. June 27, 2025).

20. I was taken to GWU Hospital for a neurology appointment on the morning of July 28, 2025; however, the Jail failed to get me to my appointment on time, and I missed it.

21. The appointment was rescheduled for September 11, 2025, five months after I was discharged. The neurologist recommended that I have another MRI and an EMG (which was also recommended when I was discharged from the hospital but never done). My discharge papers from the visit specifically ordered that I have access to a wheelchair and continued physical therapy.

22. Still, the Jail refused. On September 18, 2025, my attorney in my D.C. Superior Court case filed another motion to release me on home confinement or to provide appropriate medical care. *See* Mot. for Release on Home Confinement, or in the Alternative, to Order DOC to Provide the Appropriate Medical Care, *United States v. Whack*, No. 2024 CF1 010033 (D.C. Super. Ct. Sept. 18, 2025).

23. On October 2, 2025, after my federal criminal attorney filed an emergency motion for my transfer to another facility, the D.C. District Court issued an Order strongly recommending that the U.S. Marshals Service transfer me to a facility "that can accommodate [my] request for a wheelchair during detention." *See* Consent Order, *United States v. Whack*, No. 1:25-cr-213 (EGS), ECF No. 41 (D.D.C. Oct. 2, 2025).

24. Despite all of these motions and court orders, I still did not receive a wheelchair or get transferred to a facility where I can receive adequate medical care.

25. On December 1, 2025, I finally had an appointment at GWU Neurology to receive an EMG test, eight months after the GWU Hospital providers recommended one. No one at the Jail has reviewed my EMG results with me, and I am still not sure what they said.

26. On or around December 23, 2025, I received a follow-up MRI of my middle and lower back, eight months after my GWU Hospital discharge. The MRI confirmed that I have wear and bulging of some of my spinal discs and narrowing of the pathway where one of the

nerves in my lower back exits my spine. The neurologist recommended that I have constant access to a wheelchair and that I participate in physical therapy.

27. Still, the Jail refuses to provide me with consistent access to a wheelchair. Currently, I am only permitted to use a wheelchair to travel to and from medical appointments, not for daily use.

28. At all other times, I am required to walk with a cane, even though the specialist who did my EMG told me that using the cane will worsen my condition by putting acute pressure on my nerves and increasing my fall risk. The cane also gives me splinters in my hands.

29. Without a wheelchair, I have difficulty traversing long distances to get to legal visits and to attend court. I have missed legal visits with my attorneys to prepare for my criminal cases and in-person court hearings due to the lack of a wheelchair.

30. I have also had to be physically dragged by guards to attend legal visits, which is painful and humiliating. Jail staff have, at times, forced me to crawl on the floor to leave my cell.

31. It is difficult for me to retrieve meals in my cell due to mobility issues and cell size; in order to reach the food, I put my mattress on the ground by the door and sleep on the floor.

32. I have missed at least eight medical appointments, including appointments at the Jail and outside appointments, since November 2025 because correctional officers refused to escort me with a wheelchair.

33. I have submitted multiple grievances to the Jail related to wheelchair access, but the problem has not been resolved. For example, I submitted a grievance on August 19, 2025, describing my lack of care since my April hospitalization, including the fact that I had no access to a wheelchair, had not been taken to see a neurologist, and was confined to my cell for 24 hours a day, being treated “like an animal.” On September 2, 2025, the Jail

responded to my grievance, saying "scheduled for medical appointment in the community for a neurology appointment" and providing no other explanation. When I submitted another grievance related to my medical care later that month, the Jail marked it as "resolved" and cited to the grievance from August, even though I still didn't have access to a wheelchair and my medical problems persisted.

34. Despite the recommendations of the GWU Hospital and Neurology physicians, I also have not had consistent access to physical therapy at the Jail. I have missed several appointments because I was physically unable to get myself to them, and guards refused to provide me with a wheelchair. This has forced me to attempt self-guided physical therapy in an effort to reduce my pain.
35. In addition to these back issues, I suffer from chronic asthma. I have experienced asthma symptoms and had asthma attacks since I was a small child. Cigarette smoke is a trigger for me and has caused me to have multiple asthma attacks at the Jail.
36. Historically, when I have had asthma attacks, I require immediate treatment with a nebulizer, which is a medical device that turns liquid medication into a mist that I inhale into my lungs.
37. I have also historically used an inhaler to manage my day-to-day asthma symptoms.
38. Since arriving at the Jail, I have had at least eight asthma attacks.
39. When I experience an asthma attack, it feels like my chest is closing up, and I struggle to breathe.
40. The Jail has provided me with Albuterol and Symbicort inhalers, but they are not strong enough to provide help when I am having an asthma attack. When that happens, I need nebulizer treatments.

41. Around December 2024, I had a severe asthma attack and was taken to medical. I needed treatment from a nebulizer, but staff told me they could not find the key to the room that the nebulizer was in. I had to wait approximately three hours before I was able to use the nebulizer.

42. On February 6, 2025, I collapsed in my cell from an asthma attack and became nonresponsive. I had been telling officers that I couldn't breathe for hours beforehand, but they ignored me. When I woke up, I was placed on a stretcher and taken to medical, where I finally received a nebulizer treatment.

43. My most recent asthma attack occurred in early January 2026, while I was incarcerated at CTF. I could not breathe, move, or stand.

44. I notified Officer Ewalen, who was working on my unit at that time, that I could not breathe and that I was having an asthma attack. After ignoring me for about thirty minutes, he came to my cell and asked me to stand up. I was too weak to do so and explained, again, that I was having an asthma attack. He told me, "If you can talk, you can breathe."

45. A few minutes later, Officer Ewalen told me that he spoke to medical and that they told him I have no history of asthma, which can't be true. My lifelong struggle with asthma is recorded in my medical records, and I have received chronic care for it.

46. I was not seen by medical until the next day. I was forced to self-treat the asthma attack by inhaling steam from the shower in my cell for about four hours. I was afraid for my life.

47. On January 3, 2026, I submitted a grievance related to this incident. I received a response on January 28, 2026, with the explanation that "there was no evidence of a medical emergency at the time of the incident," but that "corrective action" would be taken against the staff member involved. No corrective action has been taken to my knowledge.

48. In general, medical staff at the Jail are nonresponsive to, and dismissive of, my requests for care. My sick call requests often go unanswered, and correctional officers ignore my cries for help when I am experiencing pain or asthma symptoms. Staff here seem to believe that my conditions aren't real or valid.

49. Correctional officers have said to me, "Since you put a lawsuit on us, we are going to do everything we can to make you uncomfortable." I have no pending individual litigation against the Jail, D.C. DOC, or any of its staff.

50. I have been informed of the responsibilities of a class representative, and I am willing to serve in that role and protect the interests of the class.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge. Executed on 3-3-2026, 2026.

TW

T.W.

# EXHIBIT 9

**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

V.C., et al.

*Plaintiffs*

v.

District of Columbia

*Defendant.*

No. 1:23-cv-01139

**DECLARATION OF C.M.**

*I, C.M., certify under penalty of perjury that the following statement is true and correct to the best of my knowledge.*

1. I am 49 years old and am currently incarcerated pre-trial in the Central Detention Facility (CDF) run by the District of Columbia Department of Corrections ("the Jail").
2. I have been incarcerated at the Jail since May 2025.
3. I am a military veteran. During my military service, I suffered a traumatic brain injury from an accident involving a flash grenade. As a result of my traumatic brain injury, I experience seizures, migraines, and extreme light sensitivity.
4. I have a well-documented history of mental health issues in the military and am on a 100% disability rating from the Department of Veteran Affairs. A 100% disability rating is reflective of the severity of my documented disability. The percentage represents how much my disability decreases my overall health and ability to function, with 100% being the highest possible rating.
5. My seizures are triggered by my migraines so, as long as I am able to manage my migraines, I am not at imminent risk of having a seizure. When I have a seizure, I fall onto

the ground and shake uncontrollably for several minutes. During such a seizure, I am at risk of hurting myself. I also experience myoclonic seizures, which are short, shock-like muscle spasms. I experience myoclonic seizures, or "jerks", several times a day. These "jerks" result in brief interruptions of my daily tasks, such as speaking and eating.

6. When I was in the community, I took medication for my migraines. I also wore a hat and tinted medical glasses prescribed by the Department of Veteran Affairs every day, including while indoors, to block out light and reduce the chance of triggering a migraine through exposure to light.

7. When I arrived at the Jail, it took approximately five months for me to receive my prescription tinted glasses, despite my defense attorney turning them in to the Jail's medical staff approximately two months after I arrived at the facility. The Jail provided no reason for the delay in giving me my glasses. Between July and August 2025, I submitted three grievances asking for my glasses and received no responses to my grievances. I did not receive my glasses until around September 2025.

8. During the five months I was without my tinted glasses at the Jail, I experienced four seizures that resulted in me collapsing and losing total control of my body. During these seizures, I did not receive any assistance from staff. After one of these seizures, my cellmate informed me that staff watched me seize, but did not do anything to assist me. When I was done seizing, I was put on a stretcher and taken to medical, where I would only have my blood pressure checked and not receive any substantive care. During one of these episodes, a correctional officer incorrectly accused me of substance abuse and going through withdrawals.

9. Although I now have my prescription tinted glasses, I still experience myoclonic seizures as the lighting in the Jail is especially harsh, and I am unable to wear additional eye protection, such as a hat. I experience the "jerks" consistently throughout each day.
10. I am prescribed medication for migraines, schizophrenia, sleep, anxiety, and diabetes. I took medications for all of these conditions prior to my incarceration at the Jail.
11. The Jail has failed to consistently provide me with my medications. While in the community, I would take Gabapentin for my migraines. I last received a dose of Gabapentin from the Jail some time last summer. Since arriving at the Jail, I have never received my schizophrenia medication. This significantly increases my mental stress and hinders my ability to think clearly, impacting my decision-making skills, especially in tense situations. I did not start receiving my sleep and anxiety medications until around November 2025, approximately 6 months into my incarceration at the Jail. Before I started receiving my sleep and anxiety medications, I would be unable to sleep most nights and was constantly extremely anxious.
12. I am also diagnosed with diabetes and took two forms of insulin in the community: a long-lasting insulin that I took daily and a fast-acting insulin that I took as needed when my blood sugar levels would spike. I did not start receiving insulin at the Jail until January 2026, eight months after I arrived at the facility. At the Jail, I only receive long-lasting insulin, despite having a prescription for fast-acting insulin as well and having been in need of it on multiple occasions. When I have needed fast-acting insulin and have asked medical staff for assistance, I have been denied that medication. I have never been given a reason for these denials.

13. I have filed at least four grievances on issues with my medication since I arrived at the Jail. Most of my grievances do not receive a response. When my grievances are addressed, facility staff claims that they are not responsible for the processes handled by medical staff and, therefore, cannot help me find a solution.
14. The Jail has also failed to take care of my other medical needs. For example, I injured both of my legs during my military service and was prescribed braces for both of my knees by the Department of Veteran Affairs, which I wore when I was in the community. At the Jail, I wear a knee brace on my right leg and need a brace for my left knee. I have never received the second brace, despite having a prescription.
15. I also use a cane as a walking aid due to the injuries to my legs. However, I am unable to effectively use my cane because staff uses an especially restrictive cuffing technique on me when I am taken to court and outside appointments or when I was previously housed in restrictive housing. This method of shackling makes it so that I cannot hold my cane and put weight on it. Accordingly, I struggle to move when I am shackled.
16. Finally, despite my well-documented history of mental health issues, I have not received mental healthcare since I arrived at the Jail. I have not requested to see a mental health provider because the Jail's lack of responsiveness to my other medical needs makes me feel that such a request would not be productive. The ongoing issues related to my care at the Jail are exacerbating my mental health issues, such as my anxiety and schizophrenia. I feel my mental health is deteriorating because I often feel stressed out and “on-edge”, and I am very concerned about it.
17. I have filed sick call slips and grievances on all of the medical and mental health issues that I have experienced and continue to experience at the Jail, but I see no improvement

from the facility in providing me reasonable and adequate care. This denial of care is not only frustrating to me, but I worry about how my health with be impacted long-term by this neglect.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge. Executed on March 3, 2026.

C.M.

# EXHIBIT 10

**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

| | |
|---|---|
| V.C., et al.<br><br>Plaintiffs<br><br>v.<br><br>District of Columbia<br><br>Defendant. | No. 1:23-cv-01139 |

**SUPPLEMENTAL DECLARATION OF L.S.**

*I, L.S., certify under penalty of perjury that the following statement is true and correct to the best of my knowledge.*

1. I am 48 years old and am currently incarcerated pre-trial in the Central Detention Facility run by the District of Columbia Department of Corrections ("the Jail"). I have been incarcerated at the Jail since June 2025. Previously, I was incarcerated at the Jail from July 2019 until May 2023.
2. On April 25, 2023, I signed a declaration that accompanied the motion for class certification in this case.
3. I have several eye conditions, including posterior synechiae and an irregular left pupil with impaired movement. I am completely blind in my right eye. I have limited vision in my left eye.
4. My vision issues began after I suffered a gunshot wound to the face in 2001. Following a series of treatments at Washington Hospital Center's eye clinic, I was able to see relatively well without any further medical interventions. In approximately 2020, while I was incarcerated, my vision began to deteriorate significantly. At that time, the eye

doctor at the Jail noted that my left pupil was closed and my eyes were dry. They prescribed me Atropine drops, lubricating drops, and I had an eye exam for prescription glasses.

5. Atropine eye drops enlarge the pupil in my left eye and allow me to see as well as a person with 20/70 vision. Glasses further correct the vision in my left eye, and the drops and glasses together allow me to see as well as someone with 20/30 vision.
6. Without the drops or glasses, my vision is extremely blurry, and I am not able to see well. I have trouble orienting myself, struggle to move around my cell, and bump into people and objects.
7. My eye conditions are permanent. I will never regain any vision in my right eye, nor will the vision in my left eye improve to the extent that I will no longer require medication or glasses to be able to see.
8. When I was arrested in June 2025, I was wearing glasses, but the police took them. The day that I was processed into the Jail, I saw a medical provider and told that person about my eye issues, and that I required both Atropine drops and glasses.
9. The provider told me that I had to see the eye doctor before I could have my eye drops or any glasses.
10. When it had been about a month and I had not yet seen the eye doctor, I submitted two sick call slips asking about an appointment with the eye doctor and my glasses. In response to the sick call slip(s), a nurse came to my cell and told me that the appointment is likely to take a while because the eye doctor has a long waiting list.
11. I did not see the eye doctor until the very end of September 2025, three months after I arrived at the Jail.

12. When I was able to see the eye doctor at the Jail, it was the same doctor that I saw in 2022 and 2023 when I was previously incarcerated. She remembered me.
13. After an examination, the doctor ordered glasses for me and prescribed my Atropine drops. I understood that the prescription was written for two drops per day and had two refills. As far as I am aware, no follow-up or subsequent appointment was scheduled.
14. A couple of days after my appointment, I received a bottle of Atropine drops to keep with me in my cell. Because of my prior experience with the Jail failing to refill my Atropine on time, I did not use the Atropine as prescribed. Instead, I rationed the bottle because I was not confident I would be able to get a refill when it ran out, and I was afraid to be both without glasses and without my Atropine drops.
15. Normally, when I run out of a prescription at the Jail, and the provider has given me refills, I can give the empty medication packaging to one of the nurses or technicians passing out medication on the unit ("the pill cart"), and they will submit the medication to be refilled.
16. When the Atropine bottle began to get low, I requested a refill through the pill cart. However, the individual on the pill cart told me that they could not submit the medication for a refill, and that I would have to submit a sick call slip to see the eye doctor again.
17. I submitted a sick call slip requesting a refill of my Atropine drops as requested, but I have not seen the eye doctor a second time.
18. I am regularly called to medical to talk to another provider about my participation in the Medication-Assisted Treatment (MAT) program.

19. In December 2025, while I was with that provider, I asked about a refill for my Atropine drops. That provider wrote me another prescription, but said that for any additional drops, I will have to see the eye doctor again.
20. Given the length of time it took me to get my first eye doctor appointment, I have also been rationing my second bottle of Atropine drops. I only use one drop every couple of days.
21. As I said previously, without my eye drops and without my glasses, everything looks cloudy, and I cannot read. I bump into things, including other people, and often trip when I walk.
22. I finally received my glasses in late December 2025. With my glasses, but without daily Atropine drops, the world is less cloudy, and I can read if I can get very close to the paper or sign I am trying to see. But, I still cannot see as well with just my glasses as I can with both the drops and my glasses.
23. Because of the dangerous nature of the Jail's environment, I try to self-isolate as much as possible for my own safety. Because my vision loss significantly impedes my awareness of impending or developing threats to my safety, I take a more extremist approach to this isolationism when I cannot use both the Atropine drops and wear my glasses. This means that I spend as much time in my cell and away from others as possible.
24. In addition to informing staff at the Jail about my eye conditions, when I was processed into the Jail in June 2025, I also informed medical personnel that I wanted to see the dentist. I was instructed to put in a sick call slip if I wanted to address those issues.
25. In June 2025, I put in a sick call slip asking for a dentist appointment. At the time, I only had ten teeth. I did not see the dentist for approximately one month. When I finally saw

the dentist, I explained that I had been told by two dentists in the community that my remaining teeth should be pulled and I should be fitted for dentures or implants. The dentist at the Jail agreed that five of my remaining ten teeth needed to be extracted. At that point, I asked the dentist at the Jail about pulling my remaining teeth and being fitted for dentures.

26. In September 2025, the dentist at the Jail extracted one of my remaining teeth, leaving me with nine. The dentist indicated that I needed my remaining teeth extracted and complete dentures.

27. When I was incarcerated at the Jail in February 2023, a dental provider told me that they would only order dentures for individuals who will be incarcerated at the Jail for at least six additional months. When I asked about dentures in July 2025, the dental provider asked me how long I thought I would be at the Jail. I told him I thought I would be here for at least six more months. The provider then told me that dentures were only available to individuals who will be incarcerated at the Jail for an additional year.

28. At no point—not in February 2023 nor in July 2025—did anyone at the Jail explain how Jail personnel determine whether a person will be incarcerated for six or twelve additional months.

29. I have been informed of and understand the responsibilities of a class representative, and I am willing to continue to serve in that role and protect the interests of the class.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge. Executed on 2-18-, 2026.

L.S.

# EXHIBIT 11

**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

V.C., et al.

*Plaintiffs*

v.

District of Columbia

*Defendant.*

No. 1:23-cv-01139

**DECLARATION OF D.P.**

*I, D.P., certify under penalty of perjury that the following statement is true and correct to the best of my knowledge.*

1. I am 49 years old and am currently incarcerated post-sentencing in the Central Detention Facility (CDF) run by the District of Columbia Department of Corrections ("the Jail").
2. I have been incarcerated at the Jail since June 14, 2023.
3. On November 22, 2023, on my way to a visit, a correctional officer closed a cell door on the middle finger of my left hand. The door was closed on my finger for only a few seconds, but my finger immediately began bleeding and became swollen. I yelled when the injury occurred, and another resident witnessed the incident, but I received no immediate medical attention for my injury. Instead, staff told me to go to my visit, and I complied.
4. A few hours after the injury, I requested a grievance form from a correctional officer on my unit but did not receive one until approximately one week later.
5. Three days after my finger was injured, on November 25, 2023, after requesting medical attention for my injury to a correctional officer, I was finally taken to medical to get an x-ray of my finger. I was told I would get the results of my x-ray within 24 hours. I instead

got my results about a month later on December 21, 2023 at an appointment with medical staff at CDF.

6. The x-ray results showed that my finger was broken. As a result, the Jail's medical staff said they were going to take me to see an outside provider. Two hours later, but about a month after the injury, I was taken to the emergency room at Howard University Hospital.
7. The doctors at Howard University Hospital determined that they could not do anything to fix my finger because it was already in the process of healing incorrectly. They expressed that they could only fix my finger if it was broken again.
8. Around January 2024, the nail on my injured finger loosened and started to fall off. Any contact with the nail and the top of my finger caused immense pain, so I wore a glove to minimize contact with my finger. A week later, the nail fell off completely and grew back two months later. I filed several grievances on the issue, all of which were denied.
9. I no longer experience any pain in my finger, but I still experience some discomfort and swelling. I am unable to close my finger fully when making a fist with my hand. Because I am left-handed and this injury is on my dominant hand, it has impacted my ability to grip objects and write for long periods of time. I am a barber at the Jail and struggle to cut hair. Finally, I am an electrician by trade and am concerned that this injury will impact my ability to make a living once I return to the community.
10. The Jail's failure to provide me with reasonable and timely attention to my injury has resulted in long-term damage with significant impacts on my function.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge. Executed on March 3, 2026.

D.P.

D.P.

# EXHIBIT 12

**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

V.C., et al.

*Plaintiffs*

v.

District of Columbia

*Defendant.*

No. 1:23-cv-01139

**DECLARATION OF M.S.**

*I, M.S., certify under penalty of perjury that the following statement is true and correct to the best of my knowledge.*

1. I am 61 years old and am currently incarcerated in the Correctional Treatment Facility (CTF) run by the District of Columbia Department of Corrections ("the Jail").
2. I have been incarcerated at the Jail since November 29, 2023.
3. I have stage 5 kidney failure.
4. I have type II diabetes that has damaged my nerves and blood vessels.
5. I suffer from high blood pressure and gout.
6. As a result of my conditions, I experience constant pain, burning, numbness, and tingling in my hands, fingers, and feet. I also feel tired and weak almost all the time.
7. All of my fingers, except for my thumbs, are turning black because of neuropathy and poor circulation.
8. My conditions have gotten worse and worse during my time at the Jail.
9. Staff at the Jail have known about these conditions since I arrived.
10. I have been hospitalized several times since I have been incarcerated at the Jail.

11. From July 24, 2025, to August 2, 2025, I was hospitalized at Howard University Hospital (HUH) after my feet swelled and I became too weak to walk. I started dialysis treatment at the hospital.
12. On August 2, 2025, shortly after I was discharged from HUH, I was readmitted for nausea, vomiting, and high blood pressure.
13. Less than two weeks later, on or about August 11, 2025, I was transported to Urgent Care at Cedar Hill Regional Medical Center after I lost consciousness and became unresponsive for several minutes while being taken to see my lawyer at CTF. While I was at the hospital, I experienced more stomach pain and vomiting.
14. November 2025, I was hospitalized again for nearly two weeks at HUH due to internal bleeding that caused me to vomit blood.
15. I have continued to grow weaker and suffer increased pain, burning, and numbness in my hands and feet in the months since my last hospital visits.
16. When I first arrived at the Jail in late 2023, I told jail staff that, shortly before I was incarcerated, my kidney failure had progressed from Stage 4 to Stage 5, and I needed to be evaluated for dialysis treatment. But I didn't start dialysis until nearly two years later, during my July 2025 hospitalization.
17. Since then, I have dialysis treatments three times per week at the Jail.
18. I use a wheelchair to get around because my kidney failure makes it difficult to walk. I have been using the wheelchair for about six months. At first, the wheelchair they gave me was broken. About a month and a half later, they gave me a better one.
19. Before I got my wheelchair, I had trouble accessing my medication, including insulin for my diabetes and pills for my kidney failure. Jail staff would ask me to walk from my cell

to the medical unit, which is about the distance of three city blocks, which I could not do. I missed doses of my medications on multiple occasions.

20. Even when I have had some access to medication, my access to pain medication has been inconsistent. My dose often changes with no explanation from Jail staff. For example, I have gone weeks without Gabapentin, even though the staff here know I need it.

21. Currently, I am receiving Percocet for pain, but I cannot tolerate it. It makes me nauseas and causes me to vomit. I remain in constant pain.

22. On or around January 14, 2026, I went to see a vascular surgeon at HUH for the pain and numbness in my fingers. However, the doctor I was supposed to see, Dr. Rose, was not even working that day. I waited about three hours until officers took me back to the Jail.

23. On or around January 29, 2026, I had a consultation with an orthopedic specialist at HUH. The physician told me that I would need to amputate my left ring finger because my kidney disease and diabetes have progressed to the point where the tissue in my finger has died. My fingers and are turning black as my condition progresses.

24. On February 19, 2026, I had my left ring finger partially amputated at Howard University Hospital.

25. I fear that I will need to amputate more of my fingers in the future if my condition continues to progress.

26. I have put in many sick call slips related to my pain and lack of care. Often, when I submit sick calls, a staff member will come to my cell and explain to me that I have neuropathy, but they will not do a proper check-up. Usually, they will just stand outside my cell and tell me that I have neuropathy without examining me at all. In the meantime, my health continues to decline.

27. I have experienced significant delays in access to medical care that have allowed my condition to worsen and have caused severe and unnecessary suffering. This has continued even though I have submitted over ten sick call slips and have complained to medical staff.
28. Additionally, my sister has contacted Jail officials multiple times about my urgent and life-threatening conditions and lack of proper care. Still, I continue to decline and to fear for my wellbeing.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge. Executed on February 26, 2026.

M.S.

# EXHIBIT 13

**THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

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|---|---|
| V.C., et al.<br><br>*Plaintiffs,*<br><br>v.<br><br>DISTRICT OF COLUMBIA<br><br>*Defendant.* | Case No. 1:23-cv-01139-CKK |

**DECLARATION OF ZOÉ FRIEDLAND**

1. My name is Zoé Friedland. I am currently a Supervising Staff Attorney in the Special Litigation Division at the Public Defender Service for the District of Columbia ("PDS").
2. This declaration serves as a supplement to the Declaration of Emily Voshell previously submitted in support of Plaintiffs' Motion for Class Certification. *See* ECF No. 8-6.
3. At the request of the Plaintiffs' counsel in this underlying action, I surveyed PDS attorneys about the number of clients on whose behalf they have brought to the attention of judges issues related to the D.C. Jail's failure to provide adequate medical care over the past two years.
4. Based on that survey, my understanding is that, over the past two years, PDS attorneys have brought the D.C. Jail's mismanagement of at least eighteen (18) clients' medical needs to the attention of judges.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge. Executed on March 6, 2026 in Washington, D.C.

Zoe Friedland

Zoé Friedland

# EXHIBIT 14

**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

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| V.C. *et al.*<br><br>Plaintiffs,<br><br>v.<br><br>DISTRICT OF COLUMBIA<br><br>Defendant. | Case No. 1:23-cv-1139 |

**DECLARATION OF RYAN DOWNER IN SUPPORT OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION**

I, Ryan Downer, declare as follows:

1. I am over the age of 18. I make this declaration based on my own personal knowledge.

2. I am a member of the bar of this Court and one of the attorneys for the Plaintiffs and putative class members in this matter.

3. I am the Legal Director at the Washington Lawyers' Committee for Civil Rights and Urban Affairs ("the Committee") and co-counsel along with my colleagues Chelsea Sullivan, Ayesha Ahsan, and Natalie Geismar in the above-captioned matter.

4. I am presenting this declaration to supplement Jacqueline Kutnik-Bauder's declaration filed on April 27, 2023, in support of Plaintiffs' Motion for Class Certification. *See* ECF No. 8-5. Given the departure of Ms. Kutnik-Bauder, Dennis Corkery, Kristin McGough, and Laura Graham from the Committee, this declaration supplements the Washington Lawyers' Committee's qualifications to serve as class counsel.

5. The Washington Lawyers' Committee for Civil Rights and Urban Affairs works to create legal, economic, and social equity, primarily through strategic litigation and related public

policy advocacy, with a primary focus on racial justice. For the last 50 years, the Committee has been on the cutting edge of civil rights advocacy in the region, bringing precedent-setting litigation to address discrimination. Almost all of the Committee's cases are impact cases, which means they affect a large number of people, and some of them are class action cases.

6. Prior to joining the Committee in 2023, I was the Director of Litigation at Civil Rights Corps, a non-profit civil rights organization based in Washington, D.C. In that capacity, I oversaw and litigated a full docket that included dozens of class action lawsuits and other complex litigation challenging inequality in the criminal legal system.

7. During my time at Civil Rights Corps, I served as counsel and participated in the litigation of several class actions or putative class actions. These include: *Graff v. Aberdeen Enterprizes II, Inc.*, 4:17-cv-606 (N.D. Okla. 2017); *Hernandez v. City of Houston*, 4:16-cv-03577 (S.D. Tex. 2016) (constitutional challenge to pre-trial incarceration without probable cause findings); *Fant v. City of Ferguson*, 4:15-cv-253 (E.D. Mo. 2015) (*Bearden* challenge to discriminatory fines and fees regime); *Torres v. Collins*, 20-cv-00026 (E.D. Tenn. 2020) (*Bearden* challenge to bail practices); *Parga v. Tulsa County*, 18-cv-0298 (N.D. Okla. 2018) (same); and *Seth v. McDonough*, 8:20-cv-01028 (D. Md. 2020) (constitutional challenge to jail's COVID-19 response).

8. Before Civil Rights Corps, I was counsel at Relman, Dane & Colfax, a civil rights firm in Washington, D.C., for six years. Prior to that, I served as an assistant counsel and Skadden Fellow at the NAACP Legal Defense Fund, Inc. in New York City. In both positions, I litigated complex federal civil rights cases, including class actions. Two of these class actions— *Thompson v. Dep't of Housing and Urban Dev.* and *Lewis v. City of Chicago*—resulted in groundbreaking precedent and multimillion dollar settlements benefitting the plaintiffs.

9. I also previously served as a law clerk on the United States Court of Appeals for the Sixth Circuit.

10. I am a member in good standing of the state bars of New York and the District of Columbia and am admitted to practice in several federal district and appellate courts, including this Court.

11. I graduated from New York University School of Law in 2008 and received a Bachelor of Arts degree from Harvard University in 2004.

12. Other Committee staff who will be working on this matter also have experience in civil rights and class action litigation.

13. Chelsea Sullivan, also counsel for Plaintiffs in this matter, is Associate Counsel at the Committee, where she works on matters pertaining to prisoners' rights, disability rights, and education. Ms. Sullivan has worked on the underlying matter since joining the Committee in September 2023. In addition to the underlying matter, Ms. Sullivan represents plaintiffs and class members in *Robertson v. District of Columbia*, 1:24-cv-00656 (D.D.C. 2024) (class action certified in challenging discrimination under the IDEA, Section 504, and DCHRA on behalf of students with disabilities) and plaintiffs and putative class members in *District of Columbia Council of the Blind v. District of Columbia*, 1:25-cv-01694 (class action complaint challenging disability discrimination on behalf of individuals who are blind and/or low vision). Ms. Sullivan previously assisted with settlement enforcement in *Scott et al. v. Robinson*, No. 3:12-cv-36 (W.D. Va.) (class action complaint for declaratory and injunctive relief regarding medical care treatment at Fluvanna Correctional Center for Women).

14. Ms. Sullivan is admitted to practice before this Court and the United States Court of Appeals for the District of Columbia Circuit. She graduated from George Washington

University Law School in 2023 and received a Bachelor of Arts degree from Saint Louis University in 2017.

15. Natalie Geismar, also counsel for Plaintiffs in this matter, is an Equal Justice Works Fellow at the Committee, where she works on matters pertaining to prisoners' rights. Ms. Geismar has worked on the underlying matter since joining the Committee in September 2025. Ms. Geismar is admitted to practice before this Court. She graduated from Yale Law School in 2025 and received a Bachelor of Arts degree from Washington University in St. Louis in 2019.

16. The Committee has been involved in this matter since its inception and has devoted significant time and resources to investigating the facts that gave rise to this litigation, drafting pleadings and the Motion for Class Certification, and becoming familiar with the issues. It is well positioned to devote substantial resources to this litigation going forward. The Committee is not receiving reimbursement from the individual plaintiffs or class members in this case and does not have conflicts of interest that would impede its ability to fairly and adequately represent the Plaintiff Class in this matter.

17. The Washington Lawyers' Committee has the resources to zealously represent the Plaintiff Class and is prepared to pursue this case through to its resolution. The Washington Lawyers' Committee has partnered with skilled co-counsel at Arnold & Porter Kaye Scholer LLP and Winston & Strawn LLP. Co-counsel at these law firms bring extensive experience in federal class action litigation, alongside substantial subject-matter expertise and monetary resources.

18. If appointed as Class Counsel, the Washington Lawyers' Committee will continue to zealously pursue this case on behalf of the class and will expend the resources necessary to ensure that the interests of the class are served well.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 6th day of March, 2026.

Ryan Downer

# EXHIBIT 15

**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

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|---|---|
| V.C. *et al.*<br><br>Plaintiffs,<br><br>v.<br><br>DISTRICT OF COLUMBIA<br><br>Defendant. | Case No. 1:23-cv-1139 |

**SUPPLEMENTAL DECLARATION OF JOHN A. FREEDMAN**

I, John A. Freedman, state as follows:

1. I am over the age of 18. I make this declaration based on my own personal knowledge.

2. I am the Senior Pro Bono Counsel at Arnold & Porter Kaye Scholer LLP ("Arnold & Porter") and supervise the Arnold & Porter team on this matter. I previously submitted a declaration in support of class certification on April 27, 2023. This declaration supplements my experience as class counsel.

3. Arnold & Porter is an Am Law 100 firm with nearly 1,000 lawyers working fourteen offices in the United States, Europe, and Asia. In the last five years, Arnold & Porter has litigated over 100 class actions and other cases involving aggregate claims.

4. I am a 1995 graduate of the Harvard Law School and received my Bachelor's degree from Williams College in 1991. Following my clerkship with Hon. Walter Jay Skinner in the District of Massachusetts, I joined Arnold & Porter in 1996. Prior to assuming my current role in 2020, I was a partner in our litigation department starting in 2002. I was admitted to practice before this Court in 1998 and am currently admitted to practice before many federal trial and appellate courts.

5. Throughout my career, I have specialized in class action and other complex litigation involving a wide variety of commercial and civil rights issues. In the last several years, I have served as counsel for putative or certified classes in *Claros, et al. v. Nastos Construction, Inc.*, D.D.C. No. 1:09-cv-01888*, Little v. WMATA,* D.D.C. No. 1:14-cv-01289, *Cote v. Wal-Mart Stores*, D. Mass. No. 15-Civ.12945; *S.A. v. Trump*, N.D. Cal. 3:18-cv-3539, *Emami v. Mayorkas*, N.D. Cal. No. 18-cv-01587; *Costa v. Barzon*, D.D.C. 1:19-cv-3185, *Black Lives Matter D.C. v. Trump*, D.D.C. No. 1:20-cv-1469; *Svitlana Doe et al. v. Noem*, D. Mass No. 1:25-cv-10495; and *Wilkins et al. v. City of Chicago*, D. Ill. No. 23-cv-4072. I have also litigated class actions and class certification issues in federal district courts throughout the country, including *In re Municipal Derivatives Antitrust Litigation* (S.D.N.Y); *In re SafeNet. Inc. Securities Fraud Litigation* (S.D.N.Y.); and *In re Qwest Communications Int'l Securities Litigation*, 396 F. Supp. 2d 1178 (D. Colo. 2004). I also have extensive experience litigating civil rights claims, including claims concerning carceral institutions and provision of medical care to incarcerated and committed persons, including *Vail et al. v. Dunleavy et al*, D. Alaska No. 3:25-cv-00086; *Disability Rights North Carolina v. North Carolina Department of Health and Human Services et al.*, M.D.N.C. No. 1:24-cv-335; *Garrett v. Commonwealth of Virginia et al.*, E.D. Va. No. 3:20-cv-986; *Johnson v. McCowan et al.*, W.D. Va. No. 7:20-cv-582; *Beaty v. Dunn et al*, M.D. Ala. No. 2:20-cv-279; and *Holley v. Foxx et al.*, D. Md. No. 8:17-cv-3141.

6. Because of the years of experience in handling civil rights class actions and individual cases, I believe that the Arnold & Porter team, together with our experienced co-counsel at the Washington Lawyers' Committee and Winston & Strawn, will fairly and adequately represent the interests of the class proposed to be certified in this case. In particular, the attorneys

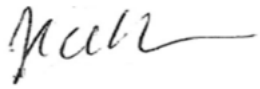
handling this case have knowledge of the applicable laws in this area and are qualified, experienced, and generally able to conduct the litigation of this case.

7. Arnold & Porter attorneys participated in investigating the facts that gave rise to this litigation, drafting pleadings and the Motion for Class Certification, are familiar with the issues, and are in a position to devote substantial resources to this litigation going forward. Arnold & Porter is representing the class *pro bono* and is not receiving reimbursement from the individual plaintiffs or class members in this case.

8. I do not anticipate any reason that class members would dispute the adequacy of Arnold & Porter's representation, and I am aware of no conflicts of interest between Arnold & Porter and any members of the class.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 6th day of March, 2026.



John A. Freedman

# EXHIBIT 16

**THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

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| V.C., et al.<br><br>*Plaintiffs,*<br><br>v.<br><br>DISTRICT OF COLUMBIA<br><br>*Defendant.* | Case No. 1:23-cv-01139-CKK |

**DECLARATION OF KRISTIN L. MCGOUGH**

I, Kristin L. McGough, state as follows:

1) I am over the age of 18, and I make this declaration based on my own personal knowledge.

2) I am the Pro Bono Counsel – Civil Rights at Winston & Strawn LLP (Winston & Strawn).

3) Winston & Strawn is an Am Law 100 firm with just under 1,000 lawyers in 14 offices throughout North America, South America, and Europe. In the last five years, Winston & Strawn has litigated over 350 class action lawsuits.

4) I have worked at Winston & Strawn since 2024. Winston & Strawn has a robust pro bono practice, a substantial portion of which is dedicated to prisoners' rights matters brought under 42 U.S.C § 1983. I supervise and manage all of the firm's § 1983, criminal defense, and other criminal legal system-adjacent matters.

5) Prior to joining Winston & Strawn, I was the Supervising Counsel for the Prisoners Rights team at the Washington Lawyers' Committee for Civil Rights and Urban Affairs (the Committee), where I lead the Committee's efforts, which included both individual impact and class-action litigation, to enforce the civil rights and civil liberties of individuals incarcerated both locally and in the federal Bureau of Prisons.

6) Prior to joining the Committee, I spent nearly ten years in private practice, focused largely on public defense work as a Criminal Justice Act attorney in DC Superior Court.

7) I have tried 20 cases before a jury and approximately 75 bench trials.

8) In addition to my work on this case, I currently serve as counsel for the putative class in *Barde et al. v. Dixon et al.*, 4:25-cv-00463-AW-MAF (N.D. Fla.). While I was at the Committee, I also worked on behalf of the certified class in *Scott et al. v. Robinson et al.*, 3:12-cv-00036-NKM-JCH (W.D. Va.).

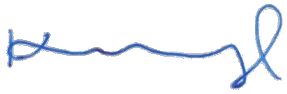
9) I received my J.D. from The Catholic University of America Columbus School of Law in 2008. I also hold a Master's Degree in Evidence-Based Social Work from the University of Oxford (2005), and a bachelor's degree from The College of William and Mary (2004). I was first admitted to the Maryland Bar in 2008, and I was admitted to practice before this Court in 2011. I am also a member of the DC Bar and the Bars of a variety of other federal district and appellate courts.

10) I participated in the investigation that gave rise to this litigation, as well as the inception of the litigation itself, including drafting pleadings and the motion for class certification. My transition to Winston & Strawn did not interrupt my work on this matter. I have personally interviewed dozens of individuals who have been affected by the unconstitutional medical care at the DC Department of Corrections.

11) I have been and remain familiar with the issues in this case, and Winston & Strawn is in a position to devote substantial resources to this litigation going forward. Winston & Strawn is representing the individual plaintiffs and the putative class pro bono, and is not receiving reimbursement from the individual plaintiffs or class members in this case.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed this 6th day of March 2026.



Kristin L. McGough

**THE ITE T TE I T I T T**
**THE I T I T MBI**

V.C., et al.

*Plaintiffs,*

v.

DISTRICT OF COLUMBIA

*Defendant.*

Case No. 1:23-cv-01139-CKK

**E E TI I TI M TI E E T I E**
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THIS MATTER is before the Court on Plaintiffs' Motion for Leave to File a Supplemental Brief in Support of Plaintiffs' Motion for Class Certification. For the reasons set forth in Plaintiffs' Motion and for good cause shown, Plaintiffs' motion is **TE** . The Clerk is directed to file the Supplemental Brief that is attached to Plaintiffs' Motion for Leave to File a Supplemental Brief in Support of Plaintiffs' Motion for Class Certification.

It is further **E E** that Defendant may file a response to Plaintiffs' Supplemental Brief in Support of Plaintiffs' Motion for Class Certification within 14 days of the Clerk docketing Plaintiffs' Brief.

Dated this ____ day of March, 2026.

Judge Colleen Kollar-Kotelly
United States Senior District Judge

Copies to all counsel of record.