Letter of Clarification #1
THE HARRIS CENTER EHR/RCM PROJECT

To: All Vendors

From: Sharon Brauner, C.P.M., A.P.P., Purchasing Manager

Cc: Nina Cook, MBA, CTPM, CPPB, Director of Purchasing

Date: August 20, 2018

RE: Letter of Clarification #1 for THE HARRIS CENTER EHR/RCM PROJECT
Request for Proposal

For the benefit of all Vendors submitting responses and to avoid possible confusion, the Request for Proposal (RFP) documents are clarified as follows. Please note this Letter of Clarification is hereby incorporated into the RFP document.

1. As far as we can tell Meaningful Use certification is not a requirement for mental health. Given that, is MU 2-3 cert still a requirement?
   Answer 1.: MU 2014 EHR certification is a requirement for The Harris Center. We would like to have 2015 certification if possible but not mandatory at this time.

2. Does your center do inpatient and residential treatment?
   Answer 2.: We do residential, but not true inpatient treatment. Our NPC location does a 23 hour observation, but that’s the closest we come to inpatient.

3. I didn’t see a reference to the makeup of clinical staff. For pricing proposals we will need to know how many MD’s/ NP’s and clinical staff?
   Answer 3.: 2278 total people have access to log into Anasazi. Approximately 1600 staff would be Clinical and 102 are physicians (does not include Residents, Contract, or Locums). A percentage of the 2278 number are non-clinical (i.e. Business Office, IT, Admin, Revenue). At this time, it does not appear that we have a list broken out into MD’s/ NP’s and clinical staff.

4. Our pricing is based off of NPR (Net Patient Revenue). I see The Harris Center has an annual budget in excess of $276 million. Could you provide NPR?
   Answer 4.: NPR is $31,108,760.

5. The Harris Center provides services through four service divisions. Could provide how many of these are outpatient? How many are inpatient? How many total inpatient beds?
   Answer 5.: We do not define a single division as inpatient or outpatient.
Residential beds:
180 beds in 12 units (max 30 / unit)
Monitor a variable number of contracted residential beds

Inpatient beds:
No direct management of inpatient beds
Monitor 200 contract hospital and 200 state hospital beds

Division breakdown:
MH - 16 residential beds in a single program, monitor 200 contract and 200 state hospital inpatient beds
CPEP - 74 residential beds in 4 programs, plus a variable number of contracted residential beds
IDD - 30 residential beds in 5 homes, 1 contracted residential bed
Forensics - 60 residential beds in 2 units, planning to expand to 104 beds in the near future

6. Is The Harris Center looking for a single source contract (i.e. Hardware, Third Party Vendors, etc.) or can there be individual contracts with 3rd party vendors?
   Answer 6.: We prefer a single source contract but will entertain options depending on the software solution integration.

7. Is there budget for this EHR project?
   Answer 7.: Yes, we do have a budget for the EHR project.

8. How many providers are in your clinics?
   Answer 8.: We roughly have 339 licensed providers (This does not include the RN’s, LVN’s, LCDC’s, BCBA’s) throughout all our clinics. (100 Prescribers)

9. How many total providers are in your outpatient locations/clinics (MD, NP, PA) and others whose name appears as "provider" on billing?
   Answer 9.: We roughly have 339 licensed providers (This does not include the RN’s, LVN’s, LCDC’s, BCBA’s). There are many more providers that bill under our Agency NPI, such as QMHP, SC, and assistants to the PT, ST and OT therapist.

10. How many providers are in your inpatient locations?
    Answer 10.: We do not define a single division as inpatient or outpatient.
    Residential beds:
    180 beds in 12 units (max 30 / unit)
    Monitor a variable number of contracted residential beds

    Inpatient beds:
    No direct management of inpatient beds
    Monitor 200 contract hospital and 200 state hospital beds
Division breakdown:
MH - 16 residential beds in a single program, monitor 200 contract and 200 state hospital inpatient beds
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11. Ambulatory Clinic Visits
   a. In the 610,000 ambulatory visits you’ve included, are any of these visits solely with a Social Worker?
   b. In the State of Texas, or locally at The Harris Center, are Social Workers considered advanced practice providers?
   c. We roughly calculate volume metrics on visit volume, so I want to ensure I have a clear definition of what types of clinical providers are included in the 610,000 visits?
   d. Likewise, for Outpatient Behavioral Health Visits, what types of clinical providers are considered in the 398k volume metric?
Answer 11.:
   a. The 610,000 ambulatory visits includes physicians, psychologists, nurses, social workers counselors, OTs, SLTs and bachelor’s level clinicians (QMHPs, CMs, RCs, SCs).
   b. NO
   c. See above (The 610,000 ambulatory visits includes physicians, psychologists, nurses, social workers counselors, OTs, SLTs and bachelor’s level clinicians (QMHPs, CMs, RCs, SCs).
   d. RN, LVN, ;PC, LMSW, LCSW, QMHP, OT, PT, and others

12. Inpatient Days
   a. I noted that you’ve included in your RFP reference to several emergency and residential programs. Are these programs, or the 60-bed Mental Health Forensic Services unit, accounted for in the 165 inpatient beds that you contract from UT Harris County Psychiatric Center?
Answer 12.:
   a. NO, The Harris Center directly operates a psychiatric emergency service (~36 beds), a crisis stabilization unit (16 beds), a post hospital crisis residential unit (24 beds), a crisis residential unit (18 beds), a crisis respite unit (~16 beds), a peer respite program (9 beds), a 24 bed permanent supported housing unit and a 60 bed dual diagnosis forensic residential treatment program.

13. The Harris Center identifies an automated dispensing system called Pyxis in Exhibit A, MAR/Reconciliation/Dispense-pickup. Is this the system of choice or would The Harris Center like the vendor to propose another Automated Dispensing System? If not what is the model of the Pyxis system?
Answer 13. : Pyxis system: No new system is necessary. All systems should have a way to interface with Pyxis. Version: MS4000
   a. If a proposal for a new automated dispensing system is an option:
      i. How many locations do you have where you dispense meds? PYXIS is in our hospital location and we have Parata and ScriptPro robots in our clinic
settings. Parata at 2 locations and ScriptPro at the other 2 clinics. For a total of 1 hospital and 4 clinic pharmacy locations

ii. What type of medications are dispensed? Tabs, caps, liquids

iii. How many/volume of the medications are dispensed on a daily basis? At clinics up to about 200 RX’s per day at each location. The hospital dispenses about 300 doses per day, plus about 50 to 100 outpatient RX’s per day

iv. Do any of the medications need to be refrigerated? YES

14. In Exhibit A in Continuity of Care, it is explained that there is use of beds. Will Harris provide how many total locations and total beds?
   Answer 14.: Residential beds: 180 beds in 12 units (max 30 / unit) / monitor a variable number of contracted residential beds
   Inpatient beds: no direct management of inpatient beds / monitor 200 contract hospital and 200 state hospital beds

15. In Exhibit A for the e-Prescribing section, the vendor was unable to identify the number of prescribers and non-prescriber agents, will Harris please provide these numbers? Will The Harris Center also provide the number of EPCS prescribers if this is different?
   Answer 15.: We have 93 prescribers, of whom 69 can currently prescribe controlled substances.

16. Throughout Exhibit A, a patient portal is discussed. Would The Harris Center like the ability to have a kiosk capability within the office where clients can access the portal in the office?
   Answer 16.: Yes, The Harris Center would like for the solution to include kiosk capability.

17. If the vendor proposing has other related solutions being leveraged by other centers in Texas, and this RFP does not have any specific requirements listed that would call for these solutions, can they be offered as optional in a separate document and attached to the RFP? If so, is there any specific format Harris would like to see this in?
   Answer 17.: Yes, you can include the optional information as part of the proposal. There is no specific format required.

18. Exhibit A it states the need to have supervisors access a tool that would allow them to produce reports that allow for supervisors to better monitor areas of deficiency or all them to track quality of patient care and management. How many supervisors does The Harris Center have that would access this level of reporting capability
   Answer 18.: Clinical staff: 1400
   Physicians: 136
   Nurses: 146
   Non-clinical staff: 500
   Contact staff that need access to enter services and view documents: 500

19. In the RFP document within the payment terms section it identifies four milestones that invoices can be issued. (Execution of the agreement, Software Installation, Go Live, Acceptance). Can the vendor propose/request to add additional milestones, where monies would be spread out and due at additional agreed upon milestones during the project that reflect more of when much of the work would be performed?
Answer 19.: Yes, you can submit the additional milestones for review.

20. In Exhibit A, CCDs are requested to be integrated it states having the ability to transfer ADT data. Also identifies the need to interface between lab systems. Exhibit A speaks to immunization control, but not pulling immunization information. Does the Harris Center need/want to pull Immunization? Also pulling Syndromic data isn’t discussed within the RFP, is this a need as well?

Answer 20.: We do want to pull immunization data and may need this to be a 2-way interface with ImmTrac2 in the future (with integrated healthcare). Syndromic data is currently reported manually (the county / state systems do not currently accept electronic reporting).

21. In Exhibit A, The Harris Center identifies both internal and external providers. Will The Harris Center let the vendor know how many external contract provider agencies and external contract providers they have performing services on behalf of Harris, of which Harris needs to manage, receive services, and make payments to? In addition, is there a preferred method Harris has in which they’d like to managed these providers? For example, many organizations offer providers direct licenses into the system for direct data entry. Others prefer their providers submit information via web portal integration leveraging Managed Service technology.

Answer 21.: We currently have over 100 contracted providers (all IDD). We DO NOT want these providers to enter information directly into the system. MH does not have any contracted providers at the moment, but would like the option of having contracted providers enter their data directly in the system in the future.

22. In Exhibit A, it is addressing continuity of care for clients utilizing the county resources such as hospitals, NPC, jail, outpatient and crisis services. How many partners are there? What are the systems being utilized that would require coordination? What are the desired means to share information? Example, file transfer, web services, HL-7, HIE and CCD?

Answer 22.: Our partnerships could be endless but there are main players: HCPC, West Oaks, Harris County Jail EMR, Harris Health, state hospitals, state data, all the medical hospitals in Harris County, HHH, all the private psychiatric hospitals in Harris County. To provide quality of care to patients by gathering their history of medical/psych/quality of care/rehab/cmgmt and coordinating care. The desired means to share information depends upon the solution and compatibility.

23. In Technical and Overall Program Concept, it states that the need to “Coordinate and exchange data with county hospital systems and other internal/external systems.” Will Harris also identify the internal systems that will need to be connected with to exchange data?

Answer 23.: Our partnerships could be endless but there are main players: HCPC, West Oaks, Harris County Jail EMR, Harris Health, state hospitals, state data, and all the medical hospitals in Harris County, HHH, and all the private psychiatric hospitals in Harris County. To provide quality of care to patients by gathering their history of medical/psych/quality of care/rehab/cmgmt and coordinating care. The desired means to share information depends upon the solution and compatibility.

24. When will the Vendors be notified to do Demos, and how many?
Answer 24.: The top three vendors will be notified on Wednesday September 19 2018. The demonstrations will begin on September 24, 2018 to include three sessions/days to include but not limited to Billing/MCO, Technical and Clinical.

25. How many .net developers does the IT Dept. have?
   Answer 25.: Seven

26. What is your implementation timeline?
   Answer 26.: The implementation timelines will be dependent on the solution provided and the vendor that is selected.

27. Demo - will it be scripted by Harris or an overview of Vendors EHR system?
   Answer 27.: Demos should be based on page 10-18 of the RFP and the weighted criteria. "A day in the life of" according to criteria for all services. Provide a process and a workflow for each services. A tentative schedule will be provided to demo vendors when they are notified.

28. Are all of the 339 licenses providers prescribers?
   Answer 28.: The 339 are not all prescribers, they are therapist, social workers, LPC's. Approximately 100 are prescribers.

29. What are the integration requirements?
   Answer 29.: We are at a pivotal point and have several clients that travel in the loop of Harris County like The HARRIS CENTER, Harris County Sheriff Office, JPS, HCPC, Greater Houston Health Connect, and FQHC. We need to communicate with EPIC, Sunrise, Centricity, and Juvenile Custom System.

30. Who are the Interfacing laboratory?
   Answer 30.: Currently it is Clinical Pathology Labs, Emergency Laboratory Services and Hermann Memorial.

31. Concurrent size and growth assessment?
   Answer 31.: 950 Users: Revenue staff are 23 and 927 are Clinical. Goal is to have one solution.

32. Preference to the solution hosted inside or outside our data center?
   Answer 32.: Not at this point. Will look at return on investment.

33. Would you like both (inside and outside) data hosting priced out?
   Answer 33: Yes, if you can do both price both OR if you can only do one, just price out one.

34. Implementation Support will be in house?
   Answer 34: This decision will be made by Executive staff at a later date.

35. Any additional services in future?
   Answer 35.: Substance Abuse
36. Are there any expectations from the patients anticipated?
   **Answer 36.** Possible Kiosk, completing forms, and MU requires a client portal so that is for the patients.

37. Does the jail have access to our system? Do you transfer to the jail or treat patients in the jail.
   **Answer 37.** Our jail staff have access to our system. The jail uses Centricity. Both.

38. Are you trying to replace CPEP system?
   **Answer 38.** CPEP will use the new system.

39. What is your number of facilities?
   **Answer 39.** Currently, the number is 23 facilities in Harris County. Go to The HARRIS CENTER website for detail regarding programs: [www.theharriscenter.org](http://www.theharriscenter.org)

40. Does HCPC use our same system?
   **Answer 40.** HCPC uses Sunrise, however, some of their staff has access to our system and some of our staff has access to their system. It's both ways.

41. Are we looking for guidance from Vendor on implementation (Phased approach or Big Bang)?
   **Answer 41.** Yes, we will look to Vendor for guidance. We are however, looking for the Big Bang implementation with few exception, if any.

42. What 1115 and CCBHC measures we selected?
   **Answer 42.**
   a. M1-105 Tobacco Use: Screening and Cessation  
   b. M1-160 Follow-Up After Hospitalization for MI-7 Day  
   c. M1-160 Follow-Up After Hospitalization for MI-30 Day  
   d. M1-256 Initiation of Depression Treatment  
   e. M1-257 Care Planning for Dual Diagnosis  
   f. M1-264 Vocational Rehabilitation for Pts Schizophrenia  
   g. M1-265 Housing Assessment for Individuals with Schizophrenia  
   h. M1-266 Independent Living Skills Assessment for Individuals with Schizophrenia  
   i. M1-317 Preventative Care: Unhealthy ETOH Use, Screening, and Brief Count  
   j. M1-341 Sub Use Dis: Current Dx of ETOH, Count on Psychosocial and Pharm Options in 12 Mo Report Paid  
   k. M1-342 Time to Initial Evaluation (LPHA Intake)  
   l. M1-390 Time to Initial Evaluation Mean Days (LPHA Intake)  
   m. M1-405 Bipolar and Depression SA Assessment  
   n. M1-146 Preventative Care: Depression, Screening and Tx Planning  
   o. M1-147 Preventative Care: BMI Assessment  
   p. M1-210 Preventative Care: Screening for High BP and Follow-Up  
   q. M1-259 Assignment of PCP to Pts with Schizophrenia  
   r. M1-260 Annual Physical Exam  
   s. M1-261 Assessment for Substance Abuse Problems for Psychiatric Patients  
   t. M1-262 Assessment for Risk to Self/Others
u. M1-263 Assessment of Psychosocial Issues of Psychiatric Pts
v. M1-287 Documentation of Current Medication on the Medical Record
w. M1-319 AMH MDD Suicide Risk Assessment
x. M1-340 Sub Use Dis: Current Dx of Opioid, Count on Psychosocial and Pharm Options in 12 Mo Report Paid

43. Number of inpatient beds including the name of the facility.
   Answer 43.: Inpatient beds:
   - No direct management of inpatient beds
   - Monitor 200 contract hospital and 200 state hospital beds

44. Inventory control for pharmacy?
   Answer 44.: Etreby

45. Annual stats on outpatient and inpatient visits.
   Answer 45.: Ambulatory Visits – (1,240,000+ services, 90,000+ services/month)
   Outpatient rehab visits – (80,000+ services, 5,000+ services/month)
   Visit to an outpatient behavioral health – (525,000+ services, 40,000+ services/month)

46. Do we adjudicate MCO claims?
   Answer 46.: Yes

47. Do we need a GL interface?
   Answer 47.: Yes, preferable if there is an interface between the EHR and ROSS. A good example of this is in the preparation of the CAM report which uses data from both systems.

48. Do we need a lab interface? With which lab companies?
   Answer 48.: No, we do not currently have a lab interface. We DO need to interface with at least Clinical Pathology Laboratories (CPL).

49. Are we looking to replace our pharmacy system? Do we need an interface to our in-house pharmacy system?
   Answer 49.: Clinical Pathology Labs, Emergency Laboratory Services and Hermann Memorial.

50. Which pharmacy automation system(s) do we have?
   Answer 50.: Pyxis system: No new system is necessary. All systems should have a way to interface with Pyxis. Version: MS4000

51. What external systems do we need to interface with?
   Answer 51.: We are at a pivotal point and have several clients that travel in the loop of Harris County like The HARRIS CENTER, Harris County Sheriff Office, JPS, HCPC, Greater Houston Health Connect, and FQHC. We need to communicate with EPIC, Sunrise, Centricity, and Juvenile Custom System.

52. Do we have a data warehouse?
   Answer 52.: Yes, we have a data warehouse.
53. Will we want to convert legacy data? If so, what?
   Answer 53.: We do want to convert legacy data for both the EHR and RCM. We will need to
determine how much is possible based on the ANASAZI database layout and field compatibilities.

54. Do we provide primary care?
   Answer 54.: We currently do not provide primary care, but would like to have the
functionality in the system for future use.

55. Do we need imaging capability?
   Answer 55.: Yes, we would like the capability to scan insurance cards, identification, etc... to
become part of the medical record.

56. How many prescribers do we have? How many can do controlled substances?
   Answer 56.: We have 93 prescribers, of whom 69 can currently prescribe controlled
substances.

57. Do external contractors need access to the system? How are their services/events recorded?
   Answer 57.: Yes. Some enter their own and others provide written data for Harris Center staff
to data enter.

58. What are our expectations for an implementation timeline? For a roll-out strategy?
   Answer 58.: The implementation timelines will be dependent on the solution provided and
the vendor that is selected.

59. Are you looking for a hosted or on premise solution?
   Answer 59.: Yes, if you can do both solutions price both, or if you can only do one, just price
one.

60. Do you want interfaces to be bidirectional?
   Answer 60.: The interfaces will depend upon the solution. We prefer bidirectional if possible.

61. Where do we list examples of CCBHC and 1115 measures capabilities?
   Answer 61.: You can list the examples of CCBHC and 1115 measures capabilities as part of your
proposal with a separate tab.

62. Do you require a project plan?
   Answer 62.: Yes, we would require a comprehensive project plan.

63. When will you go live?
   Answer 63.: The Go-Live date depends upon the selected solution and project plan.

64. Do we have a need to use mobile devices such as tablets or smartphones?
   Answer 64.: Yes, the solution would need to be accessible via mobile devices such as tablets or
smartphones.

65. Do we have a need for offline use?
   Answer 65.: Yes, the solution would need to have offline capabilities.
66. How many outpatient clinics do we have?
   Answer 66.: We do not define a single division as inpatient or outpatient.

   Residential beds:
   180 beds in 12 units (max 30 / unit)
   Monitor a variable number of contracted residential beds

   Inpatient beds:
   No direct management of inpatient beds
   Monitor 200 contract hospital and 200 state hospital beds

   Division breakdown:
   MH - 16 residential beds in a single program, monitor 200 contract and 200 state hospital inpatient beds
   CPEP - 74 residential beds in 4 programs, plus a variable number of contracted residential beds
   IDD - 30 residential beds in 5 homes, 1 contracted residential bed
   Forensics - 60 residential beds in 2 units, planning to expand to 104 beds in the near future

67. Are you looking at a train the trainer model or vendor to train all model?
   Answer 67.: We are looking at the train the trainer model.

68. Harris Stats: (approximate numbers)
   Answer 68.:
   - The Harris Center manages 200 HCPC beds and 200 State hospital beds (not as a provider)
   - We will need the ability to expand the managed beds as HCPC will be adding another 300 beds in the next 3 years.

69. List of the names and locations of your In-Patient Hospitals and the number of beds in each facility.
   Answer 69.: Residential beds:
   180 beds in 12 units (max 30 / unit)
   Monitor a variable number of contracted residential beds

   Inpatient beds:
   No direct management of inpatient beds
   Monitor 200 contract hospital and 200 state hospital beds

   Division breakdown:
   MH - 16 residential beds in a single program, monitor 200 contract and 200 state hospital inpatient beds
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   Forensics - 60 residential beds in 2 units, planning to expand to 104 beds in the near future

70. Number of annual visits in your In-Patient Hospitals.
   Answer 70.: FY2018 to date admissions to CSU = 1211
71. Are you looking for a Scanning/Archiving solution?
   Answer 71.: Yes, we would like the capability to scan insurance cards, identification, etc... to become part of the medical record.

72. We respectfully request a list of the vendors that participated in the pre-proposal conference.
   Answer 72.:

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73. What is the budget for the EHR project for The Harris Center?
   Answer 73.: Yes, we do have a budget for the EHR project.
74. Are you attesting for MU?
   Answer 74.: No we are not.

75. Do you send 270/271’s to a Clearinghouse? If so, which one(s)?
   Answer 75.: No, we have our own in house utility which is used by connecting to TMHP
directly to send and receive the files. We have an inhouse dept. that maintains the
application.

76. Do you need to connect to an HIE? If so, which one(s)?
   Answer 76.: We are in the process of implementing an interface with Greater Houston Health
Connect (GHH).

77. How many versions of the DLA-20 do you use? Example, one for adult, one for children?
   Answer 77.: We use three versions Adult MH, Youth MH (6 – 18), and ID/IDD.

78. A patient portal is discussed throughout Exhibit A. Would The Harris Center like vendors to propose
a kiosk solution that provides clients access to the portal within the offices?
   Answer 78.: Yes, we would like for the vendors to propose a kiosk solution.

79. If the vendor has other related solutions being leveraged by LMHAs in Texas not specifically
mentioned in the RFP can we offer the solutions as optional in a separate document attached to the RFP
response?
   Answer 79.: Yes, you can offer the solutions as optional in a separate document.

80. The Harris Center identifies the use of both internal and external providers in the treatment
plans and prescribing sections of Exhibit A. How many external contract provider agencies and external
contract providers are performing services on behalf of Harris, of which Harris needs to manage, receive
services, and make payments to? In addition, is there a preferred method Harris has in which they’d like
to managed these providers? For example, many organizations offer providers direct licenses into the
system for direct data entry. Others prefer their providers submit information via web portal
integration leveraging Managed Service technology.
   Answer 80.: There are currently 238 staff IDs in Anasazi that do NOT have rights to log in, but
for which clinical activity and caseloads can be recorded. Many of these are contracts, where
multiple staff at a vendor perform services, but for which the contractor aggregates the data.
And we in I.T. don’t know if these contracts really are all still active. Many of them may not
be paid, but are used for tracking purposes only.

81. Please provide a description of the long term care services provided by The Harris Center.
   Answer 81.: Go to The HARRIS CENTER website for detail regarding programs:
www.theharriscenter.org MH Authority does not provide long term care services, utilization
review of State mental health facility beds.

82. Exhibit A states the need to have supervisors access a tool allowing them to produce reports to
better monitor areas of deficiency or allow them to track quality of patient care and management. How
many supervisors does The Harris Center have that would access this level of reporting capability?
Answer 82.: Clinical staff: 1400
Physicians: 136
Nurses: 146
Non-clinical staff: 500
Contact staff that need access to enter services and view documents: 500

83. In Exhibit A, the ability to integrate and send/receive CCDs is requested. There is a requirement for the ability to transfer ADT data and share data through XML and/or bi-directional HL7 transmission. The document also identifies the need to interface between lab systems. Does the Harris Center need/want to pull immunizations? In addition, does The Harris Center desire the ability to pull syndromic data?

Answer 83.: We do want to pull immunization data and may need this to be a 2-way interface with ImmTrac2 in the future (with integrated healthcare). Syndromic data is currently reported manually (the county / state systems do not currently accept electronic reporting).

84. In Exhibit A, it is addressing continuity of care for clients utilizing the county resources such as hospitals, NPC, jail, outpatient and crisis services. How many partners are there? What are the systems being utilized that would require coordination? What are the desired means to share information? Example, file transfer, web services, HL-7, HIE and CCD.

Answer 84.: Our partnerships could be endless but there are main players: HCPC, West Oaks, jail EMR, Harris Health, state hospitals, state data, and all the medical hospitals in Harris County, HHH, and all the private psychiatric hospitals in Harris County. To provide quality of care to patients by gathering their history of medical/psych.quality of care/rehab/cmgmt and coordinating care. The desired means to share information depends upon the solution and compatibility.

85. The number of prescribers and prescribers who prescribe Controlled Substances was discussed during the bidder’s conference. Will The Harris Center also provide the number of non-prescribers who need access to this portion of the system?

Answer 85.: We roughly have 339 licensed providers (This does not include the RN’s, LVN’s, LCDC’s, BCBA’s) throughout all our clinics. (100 Prescribers)

86. Will The Harris Center provide the different programs that you are managing (if any) and the population for each of those programs?

Answer 86.: Go to The HARRIS CENTER website for detail regarding programs: www.theharriscenter.org

87. During the bidders conference it was mentioned that a list of all the locations and number of beds would be provided. Looking back at Q&A from last year, we have calculated 260 beds that The Harris Center is managing and would need to track within your new solution. Please confirm or provide the correct number.

Answer 87.: Residential beds:
180 beds in 12 units (max 30 / unit)
Monitor a variable number of contracted residential beds
Inpatient beds:
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Division breakdown:
MH - 16 residential beds in a single program, monitor 200 contract and 200 state hospital inpatient beds
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Forensics - 60 residential beds in 2 units, planning to expand to 104 beds in the near future

88. What system/current EHR would we be replacing?
   Answer 88.: The Harris Center for Mental Health is using Anasazi.

89. Is a mobile app with availability to document in a disconnected mode a requirement?
   Answer 89.: Yes, the solution would need to be accessible via mobile devices such as tablets or smartphones, and have off line capabilities.

90. Is there a preference for client-server or cloud based solution?
   Answer 90.: Depends upon the solution provided, but cloud base solution preferred.

91. What is the number of prescribers who prescribe for Controlled Substances?
   Answer 91.: We have 93 prescribers, of whom 69 can currently prescribe controlled substances.

92. Does the system allow Payer/Benefit Plans? Please clarify what you mean by allow
   Answer 92.: Are we able to set-up billing rules for a payer under BP that are tied to that payer, with covered services. A good example is Medicaid (payer) would have multiple benefit plans, like Rehab, CM, Professional services, ECI services, IDD SC – and each of these benefit plans would have unique covered services and billing rules/set-up.

93. Does the system have the ability to request checks payable to contractors/vendors, void when needed? Do you wish the software to be able to write a check?
   Answer 93.: Not Currently, Yes we want this functionality.

94. Does the system Run, print, void, and post checks? What is meant by Print Checks EOB / 835 Checks?
   Answer 94.: Not currently, as claims are processed for pay, deny or, placed in pending/review status, we need the system to run, print, post checks along with an Explanation of Benefits. Not sure what 835 checks mean.

95. Can the system Track clients track throughout vast utilization in the county (hospital, NPC, jail, outpatient, and crisis services) and report results? – Please clarify further
   Answer 95.: Does the system have the functionality to provide reports from our partnerships which could be endless but there are main players: HCPC, West Oaks, jail EMR, Harris Health, state hospitals, state data, and all the medical hospitals in Harris County, HHH, and all the
96. In sample contract you include “Termination without Cause.” – Is this a negotiable item?
   Answer 96.: Yes, we will hear your concern but cannot commit to modification of the clause.

97. How many inpatient and residential beds will you be tracking within the system?
   Answer 97.: Residential beds:
   180 beds in 12 units (max 30 / unit)
   Monitor a variable number of contracted residential beds

   Inpatient beds:
   No direct management of inpatient beds
   Monitor 200 contract hospital and 200 state hospital beds

   Division breakdown:
   MH - 16 residential beds in a single program, monitor 200 contract and 200 state hospital inpatient beds
   CPEP - 74 residential beds in 4 programs, plus a variable number of contracted residential beds
   IDD - 30 residential beds in 5 homes, 1 contracted residential bed
   Forensics - 60 residential beds in 2 units, planning to expand to 104 beds in the near future

98. Please list all locations that will be using the new EHR and RCM solution with some sizing statistics, i.e., OP locations – Annual visits, prescribers, etc., Hospital or Inpatient facilities – Number of staffed beds, prescribers, etc.
   Answer 98.:
   - Number of active clients: 25,000+
   - Monthly services: 110,000+
   - Pharmacy info:
   - 14,000 outpatient RX / month filled
   - 15,000+ medication orders each month
   - 1 institutional and 4 outpatient pharmacies
   - automated dispensing systems
   - PYXIS inpatient
   - ScriptPro in 2 Pharmacies & Parata in 2 Pharmacies
   - Ambulatory Visits – (1,240,000+ services, 90,000+ services/month)
   - Outpatient rehab visits – (80,000+ services, 5,000+ services/month)
   - Visit to an outpatient behavioral health – (525,000+ services, 40,000+ services/month)
   - EHR/RCM Access
   - Contact staff to enter services and view documents – 500
   - Full Implementation user access estimate – 2,400
   - Inpatient / residential beds:
   - 81 residential as a provider and 30 Contract
   - 18 inpatient CSU beds
   - Total Staff: 2,400 approx.
IT team - 46
Clinical staff - 1400
Physicians - 93 (68 EPCS – do controlled substance)
Nurses - 146
Non-clinical staff - 500
MCO (Managed Care Organization) (we are not the provider):

99. You ask about data migration from the legacy system, could you further expand on the systems and the type of data migration expected, i.e., de-duplicated demographic data, for RCM – Balance Forward Only.

Answer 99.: We do want to convert legacy data for both the EHR and RCM. We will need to determine how much is possible based on the ANASAZI database layout and field compatibilities. No claims data will be migrated from current system and all outstanding claims and A/R generated out of the current system will be processed/closed out using the current system.

100. Need a breakdown of employee counts by specific disciplines (i.e., prescribers, nurses, PT/OT/ST, pharmacists, etc.). See Page 17 of RFP for a general description of the organization’s workforce (as provided by the client), but no specifics.

- **Sizing and Growth Estimates**
  
  Our current concurrent user base is around 900, has never peaks above 950, during normal clinic hours (8 am through 5 pm) weekdays. 24 hour units create approximately 100 users. Total named user count is approximately 1900, EHR and RMS

  Answer 100.: We roughly have 339 licensed providers (This does not include the RN’s, LVN’s, LCDC’s, and BCBA’s). There are many more providers that bill under our Agency NPI, such as QMHP, SC, and assistants to the PT, ST and OT therapist.

101. Need a general understanding if there is an expectation that Harris’ employees will be involved in the training/implementation process (i.e., a TTT type model) or is they are looking more for a vendor-led solution.

Describe capabilities and offerings regarding training and implementation:

- **Training options i.e. in person, onsite, offsite, e-learning, etc.**
- Levels of training i.e. beginner, specialized by function, advanced, etc.
- Implementation services approach and philosophy
- Implementation methodology

Answer 101.: We are looking for a train the trainer solution. We’re interested in a combination of onsite, offsite, and e-learning. The levels of training will vary depending upon the role of the staff.

102. The RFP refers to “25 facilities throughout Harris County.” Can you identify where training would take place? Is it anticipated that training would take place at each facility or employees would come to a centralized location for training? What type of training space is available?

Answer 102.: We are looking for a train the trainer solution. We have designated training space available with and without computers.
103. Can you provide further information on what type of data you wish to interface to in the various forensic environments? From your matrix: “What is the system’s ability to interface with forensic systems, and criminal justice environments (jail, court, probation, parole, etc.)?”

Answer 103.: Our partnerships could be endless but there are main players: HCPC, West Oaks, jail EMR (GE Centricity), Harris Health, state hospitals, state data, and all the medical hospitals in Harris County, HHH, and all the private psychiatric hospitals in Harris County. To provide quality of care to patients by gathering their history of medical/psych/quality of care/rehab/cmgmt and coordinating care. The desired means to share information depends upon the solution and compatibility.

104. Would The Harris center consider allowing for an extension of the due date by 14 days?

Answer 104.: No, the schedule cannot be changed.

105. During the bidders conference it was discussed that The Harris Center would like to have the proposers provide optional solutions with examples from other LMHAs and whitepapers describing the various optional and proposed solutions in one area. Would The Harris Center like the optional solutions after the optional pricing page and the whitepapers and examples for the proposed solutions at the end of the proposal?

Answer 105.: Yes, you can offer the solutions as optional in a separate document.

106. For the requirement for e-Prescribing and integration with other pharmacies, can vendors assume that all external pharmacies utilize SureScripts certified information systems and exchange will be done via the SureScripts network? Or can the Harris Center provide additional information about whether it anticipates some data exchange would need to happen via HL7 exchange?

Answer 106.: Yes, and depends upon the selected solution but we would like to have HL7 exchange functionality as an option.

107. For the requirement for Early Childhood Intervention, can additional information be provided about the method/format of the electronically interface requirement?

Answer 107.: You will need an SFTP client, which needs to be configure to connect to dar0ft01.dars.state.tx.us on port 22. Your account is for SFTP/SCP only so you must use a client that supports SFTP or SCP.

All data file names submitted to DARS ECI must use the following specifications:

Data file name specs: {3-digit Program Code}_UploadData_{Date Data File Submitted}

Example: 001_UploadData_083012.csv

DARS IR(Information Resources) will generate error files with the following file naming specifications:

Error file name specs: {3-digit Program Code}_Error_Output_{Date Error File Generated}

Example: 001_Error_Output_083012.err

108. For the requirement for clinical tasking & messaging, in particular, notifying external providers, can vendors assume that, for all external care providers, the Harris Center has an existing relationship/BAA in place and all would adhere to the same method/format of data exchange (e.g., the method of exchange could be standardized and all external care providers would follow/meet the Harris Center’s standard)?
Answer 108.: Yes, that is a correct assumption.

109. Does the Harris Center wish to follow a single, master treatment/care plan for individual clients or multiple treatment/care plans for individual clients by separate client program/service enrollment? Is there any other unique workflow or clinical process which the Harris Center follows for treatment/care plans?

Answer 109.: Single master treatment plan.

110. Who are the primary Payors for the Harris Center?

Answer 110.: TMHP, CMS, Amerigroup, Optum, Texas Children Health Plan, Beacon, Community Health Choice, Superior, and Molina. Hospitals, residential treatment locations, apartment complexes, ALFs, housing – anyone in future (have done outpatient services or therapy etc.)

111. How many direct submit EDI transaction sets does the Harris Center currently do and requires from its new EHR vendor? Is it Harris Center’s desire is to receive and process EDI from external providers using systems (e.g., receive 837s, remit 835s)? If so, will external providers follow a single, standard claim format?

Answer 111.: Yes, Yes, Monthly Average numbers: 225 claim batches sent (about 40,000 claims), 650 checks received, 575 file transaction for 270/271.

112. Please provide the total number of NPIs under which the Harris Center bills to third party payers (e.g., rendering, group, facility, etc.).

Answer 112.: The Harris Center uses 2 Facility/Agency NPI, 1 Group NPI, 435 rendering NPI

113. Does the Harris Center you have a desired total duration of the implementation project period (e.g., less than 1 year, longer than 1 year, etc.)?

Answer 113.: The implementation timelines depends upon the selected solution.

114. Does the Harris Center have defined implementation goals or implementation deliverables?

Answer 114.: The Harris Center will work with vendor and internal management team to determine implementation goals or implementation deliverables.

115. Does the Harris Center have a desired roll-out plan? Pilot project, phased roll-out, all at once, etc.?

Answer 115.: The Harris Center will work with vendor and internal management team to determine implementation plan.

116. Has the Harris Center defined their project team and members (e.g., project manager, clinical, billing, QA, IT)?

Answer 116.: Some of the project team and members have been identified.

117. What is the Harris Center’s preferred training methodology - end user vs train-the-trainer?

Answer 117.: We prefer the train the trainer methodology.

118. Is the Harris Center able to provide an approximate number of external providers with whom it requires the vendor to exchange CCDs?

Answer 118.: We currently do not exchange CCDs with any provider at this time. GHH will be the HIE we need to send data to. We need the ability to exchange CCDs with partners who
may not follow standard electronic transmission methods – such as the State Hospitals who utilize an SFTP site (when/if they actually do it).

119. Can the Harris Center provide additional information for the requirement, “does the system provide capability to review billing algorithm behind a claim, as well as maintain insurance company information?”

   **Answer 119.** The ability to look at the billing logic of a claim – such what billing rules the claim tried to use for billing and how it ended up using the rule used for claiming.

120. Can the Harris Center provide additional information for the requirement, “does the system have separate price masters for each entity?”

   **Answer 120.** Separate billing tables should be used for paying and receiving claims. All are negotiated per contract.

121. Can the Harris Center provide additional information for the requirement, “does the software track choice process per consumer of external providers, and reselections as they occur?”

   **Answer 121.** The service provider can be selected by the patient—we need to tie the patient to a specific service provider that maybe contracted out for one service and internal for another service....or even if the patient choses outside provider for all link them to that provider and we pay them.

122. Can the Harris Center provide additional information (specifically, regarding “disallowed “process) for the requirement, “does the software Auto disallow of authorizations?”

   **Answer 122.** The system needs to have the functionality to Auto disallow of authorizations when a certain set of business rules have not been met.

123. Can additional information be provided related to data warehousing functionality?

   **Answer 123.** The Data Warehouse has 2 main functions. The first function is to integrate the information/data coming from different data sources. The second function is to separate the data in the live data sources from the data in the actual data warehouse, which is used for reporting and data analysis.

124. What is the anticipated volume of data in GBs (especially, typical size in GBs of X-Ray images) to be scanned into the system on a total per-client basis or total annual basis?

   **Answer 124.** We do not currently scan X-Ray images into Anasazi, but would like for the proposed solution to have this functionality available.

125. Does the Harris Center anticipate data needing to be migrated only from its current EHR system or from other sources, such as the internally developed databases?

   **Answer 125.** We do want to convert legacy data for both the EHR and RCM. We will need to determine how much is possible based on the ANASAZI database layout and field compatibilities. NO internally developed databases

126. Is the following list an acceptable list of client data to be migrated into the new system, or can additional detail be provided?

   a. Client data migration entities:
b. Client Demographics

c. Client Financial Information (Payers, Family income, Guarantor, Family size)

d. Client Medical Conditions and Diagnostic Data

e. Client Allergies • Client Medications • Client Labs/Results

f. Client Appointment History and Scheduled Appointments

g. Client Vitals

h. Client Balance Forward Information

i. Client Treatment Plan

   Answer 126.: The eight items listed in question #126 are typically the information desirable for migration. We do want to convert legacy data for both the EHR and RCM. We will need to determine how much is possible based on the ANASAZI database layout and field compatibilities. No claims data will be migrated from current system and all outstanding claims and A/R generated out of the current system will be processed/closed out using the current system. Cost will play a large part on how much is migrated. It also important to remember that today the paper chart is the main record. We anticipate the paper chart to follow the client for historical information for a period of time after go-live.

127. Billing data migration - Regarding billing data to be migrated, can vendors assume that no claims data will be migrated from current system and all outstanding claims and A/R generated out of the current system will be processed/closed out using the current system (assuming both systems will remain operational in parallel for some transition period)?

   Answer 127.: Yes, that is a correct assumption.

128. Custom assessment instruments/forms – Does the Harris Center anticipate migrating data from custom forms developed in their current system?

   Answer 128.: If possible that would be beneficial.

129. What EHR system(s) is the Harris Center currently running on?

   Answer 129.: The Harris Center is currently using Anasazi.

This Letter of Clarification #1 is hereby incorporated in the RFP document and shall supersede any previous specification or provision in conflict with the Letter of Clarification #1. All responding Vendors are directed to respond accordingly. Vendors are required to add this Letter of Clarification #1 to the original RFP document.