

SEMI-STATEWIDE ENTERPRISE HEALTH RECORD

Request for Procurement (RFP) September 20, 2021

Addendum 1, November 10, 2021

California Mental
Health Services
Authority (CALMHSA)



Request for Proposal

Semi-Statewide Enterprise Health

Record

Applications due by 5:00pm PST on Monday, November 15, 2021

Addendum 1, November 10, 2021

CalMHSA RFP for Semi-Statewide Enterprise Health Record



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1. RFP Summary

1.1 Overview

In California, the Medi-Cal (aka Medicaid) benefit for physical health care and mild/moderate mental health treatment is managed by Managed Care Health Plans (MCPs), while Specialty Mental Health and Substance Use treatment benefits are “carved out” and managed separately by county government. Under this model, each of California’s 58 counties is responsible for administering a Medi-Cal Managed Care Plan that provides specialty mental health benefits (e.g., a Mental Health Plan (MHP)), and can additionally opt into administering a Drug Medi-Cal Organized Delivery System (DMC-ODS) Plan that provides substance use treatment services (note: beneficiaries living in counties that do not opt into DMC-ODS receive Drug Medi-Cal State Plan benefits). County Plans administer these benefits and are responsible for the treatment, which they provide through a combination of county-operated and subcontracted provider networks, under the direction of the California Department of Health Care Services (DHCS). Although there is variation among County Plans, for the purposes of this Request for Proposals (RFP), we will assume that each county is administering both an MHP and a DMC-ODS Plan and refer to these two Plans together as Behavioral Health Plans (BHPs).

Given this structure, California County BHPs fill multiple roles. As Plans, BHPs manage the Medi-Cal benefit: they oversee provider networks by managing contracts, verifying eligibility, authorizing services, adjudicating claims, aggregating, and reporting performance data to the State and holding ultimate responsibility for regulatory and contractual compliance of the Plans’ operations. As Treatment Providers, county operated programs perform all necessary clinical and administrative functions common to the behavioral health market, including coordinating care with other healthcare providers and often operating multiple levels of care from general outpatient through intensive 24-hour services. As Government Entities, BHPs provide prevention, early intervention and outreach services, partner closely with other county departments such as Child Welfare, Probation, Social Services and Homeless Services. As holders of responsibility for an expanded array of safety net services, County BHPs are accountable to a wide array of stakeholders and as such have added data and performance management needs. Given this plurality of roles, BHPs are realizing the limitations of their current Electronic Health Records (EHRs) to fully support all their operational needs across their business enterprise.

1.2 Market Size

California represents the largest public behavioral health treatment system of any state in the country by a significant margin. According to DHCS Medi-Cal enrollment data, 34% of California’s estimated 39.7 million residents are enrolled in Medi-Cal and these enrollees comprise more than 25% of the population within 49 of the 58 counties. According to a 2018 report published by the California Health Care Foundation, 4.2% of adult Californians live with a serious mental illness and 7.6% of children in California have been identified as having a serious emotional disturbance. Regarding substance use, about 8.5% of Californians met criteria for a substance use disorder according to a 2018 report published by the California Health Care Foundation. Of the Californians who have been identified as having a substance use disorder, 12% have received treatment. Additionally, according to the National Survey on Drug Use and Health (NSDUH), 45% of people with a substance use disorder have a co-occurring mental health disorder. In total, the public behavioral health spending in California is approximately \$7B annually. With a conservative estimate of 3% of this amount being spent on Electronic Health Records (EHRs) for the counties and their contract providers, California represents



an enormous market opportunity for Health Information Technology (HIT) vendors offering a viable solution to the market.

As stated above, many of the County BHPs are dissatisfied with their current EHRs and are actively seeking new solutions. According to the “2019-2020 Medi-Cal Specialty Mental Health Statewide Annual Report” published by the California External Quality Review Organization (CalEQRO) “It appears that the [Mental Health Plans MHPs are becoming acutely aware of the limitations of their existing Health Information Systems (HIS) as more of them have started pursuing newer systems in the past three years. Most notably, CalEQRO has found during its Fiscal Year 2019-20 reviews a surge in the number of MHPs actively searching for a new system and those having selected a new system, but not in implementation yet... As DHCS requirements continue to shift, an increasing number of MHPs (24) now have plans to change their system”. Additionally, CalMHSA has performed direct market surveys across all California County BHPs to confirm demand within the market. Of the 36 distinct county organizations that responded, 50% (18) stated that they are either “Strongly Likely” or “Definitely” seeking a new EHR within the next three years.

Beyond the near-term demand this data indicates, there are additional variables that suggest the true market for an effective solution for the California market may be much larger. First, while only a subset of the 58 County BHPs is currently seeking new solutions, if a HIT vendor is successful in implementing a solution that address the unique California market, additional counties have expressed interest in moving towards a collaborative system like that outlined in the ensuing document. Secondly, non-county contract entities provide greater than 50% of the mental health services and more than 80% of the substance use treatment services to Medi-Cal beneficiaries in California. In some counties the contractors utilize a given county’s EHR, while others purchase their own EHRs. In making their selections, these contract providers look for solutions that best align with county operations. A subset of these contractors operates in multiple counties, making a collaborative system desirable.

The initial opportunity for this RFP consists of approximately 20 counties and an estimated 12,000 users. As stated previously, successful implementation, adoption, and satisfaction amongst these 20 counties would likely drive the solution adoption appetite amongst the remaining counties and end users that CalMHSA members represent.

1.3 Who We Are/Our Mission Statement

The California Mental Health Services Authority (CalMHSA) is a Joint Powers Authority (JPA) providing California counties with an independent administrative and fiscal intergovernmental structure. We are a member-serving organization focused on supporting and enhancing the public behavioral health system that provides treatment for the most vulnerable individuals in our state. We provide counties a flexible, efficient, and effective administrative/fiscal structure focused on collaborative partnerships and pooling efforts, with an emphasis on the development and implementation of common strategies, programs, and solutions. We are committed to innovation, equity, and data-driven decision-making. CalMHSA has a history of leading successful multi-county projects and large-scale state projects. Our member counties opt into specific projects to solve key business needs.



1.4 System Requirements Background

Historically, the California behavioral health market was governed by several unique requirements related to Medi-Cal billing and these requirements presented a barrier to entry for many HIT vendors.

Starting with the introduction of the Health Insurance Portability and Accountability Act (HIPAA) and continuing with the implementation of subsequent federal and industry efforts to standardize codes sets, electronic data interchanges, interoperability standards, etc., California has moved to adopt industry standard approaches and tools. With the upcoming implementation of the state’s California Advancing and Improving Medi-Cal (CalAIM) initiative, it is expected that the last of the elements that made the California county behavioral health market difficult for new HIT vendors will be phased out.

Given the ongoing evolution of the California county behavioral health requirements, HIT vendors responding to this request for proposal should presume that the requirements of these BHPs are essentially in alignment with industry standards or are moving decidedly in that direction. It is the hope of CalMHSA and its partner county organizations that the evolution of the needs of California BHPs towards industry standard requirements and associated functions will attract more HIT vendors into the market.

Although the implementation of CalAIM will continue the adoption of industry standards as it relates to billing code sets, Electronic Data Interchanges (EDIs), Interoperability, and other technical elements, given the breadth of operations undertaken by County BHPs, the requirements of California county BHPs may be different from that previously experienced by HIT vendors. In other words, this RFP seeks a solution that supports not only the relatively narrower scope of an EHR, but the enterprise-wide needs of county entities that serve as behavioral health providers, Medi-Cal Plan administrators, and county government partners. As a mechanism to identify the entire breadth of the requirements of these organizations, and thus the requirements included in the request for proposal, the proposed solution is referred to within as an “Enterprise Health Record”.

1.5 Document Overview

Despite the expansive scope of operations performed by the County BHPs, the activities of these organizations are based upon regulatory requirements, clinical best practices, or guidelines that are largely common across the 58 counties. As such, with the implementation of a shared Enterprise Health Record, CalMHSA and its partner counties will establish common workflows to support the majority of the business operations. While it is expected that there will be variation to support county-specific needs, most of the operations and thus, system requirements, are common across the implementation of the solution, and are described within this document.

This document is structured to describe these shared requirements and the workflow(s) that are to be established to support them. As such, the following categories are covered in order:

- 1) **System-Wide Requirements** – In this section, the requirements that are foundational to the solution are described. In most instances, all subsequent functions described in the following sections presume that the system-wide requirements are available. Thus, in the following sections there will be references back to several of these core requirements.
- 2) **Care Coordination Requirements** – A significant portion of the operations of County BHPs extend beyond providing treatment to clients. As such, functions and data associated with activities that occur



prior to a client being admitted for treatment need to be supported by the Enterprise Health Record. The requirements are described in terms of care coordination workflows established across all partner entities.

- 3) **Treatment Episode Requirements** – Once clients have been admitted for treatment, the functions and data collection associated with treatment activities need to be supported by the Enterprise Health Record. The requirements associated with treatment activities are described in terms of treatment episode workflows established across all partner County BHPs.
- 4) **Supplementary Treatment Requirements** – In addition to the functions and workflows associated with on-boarding potential clients and actively treating established clients, there are several additional activities performed by County BHPs that are supplementary to these workflows. Examples include supporting clients as they transition between programs with different levels of care or performing non-client “activities” such as community outreach. County BHPs are responsible for these and other related activities that need to be supported by the proposed Enterprise Health Record.
- 5) **Medi-Cal and Other Health Coverage Claims Processing Requirements** - County BHPs are responsible for producing claims for their treatment activities and additional activities to all responsible payors. The requirements associated with Medi-Cal and Other Health Coverage claims processing are described based upon known and yet-to-be finalized requirements determined by CalAIM payment reform initiatives. Since these requirements are not fully defined by DHCS, they may be updated as needed.
- 6) **Supplementary Claims Processing Requirements** – As a consequence of CalAIM payment reform initiatives, most of the revenue cycle management activities will align with industry standard medical billing requirements and processes. However, there are still requirements that are additional (e.g., reimbursement for community outreach services) or unique to California (e.g., Treatment Authorization Requests (TAR) for inpatient psychiatric services). These requirements will need to be supported by the proposed Enterprise Health Record.
- 7) **State Reporting Requirements** – Across care coordination, treatment, and claims processing activities there are several reporting requirements dictated by state, federal, and/or other entities. These reporting requirements are described after the user workflows since collecting the data to support these reports usually occurs in parallel with the care coordination, treatment, and claims processing activities.
- 8) **Sub-Contractor Provider Management Requirements** – As previously identified, County BHPs operate both as a provider of care as well as a Plan managing a network of contract providers. The requirements associated with supporting a county’s operations as a Plan are presented after the user workflows associated with care coordination, treatment, billing, and state reporting because in many instances, clinical documentation requirements, Medi-Cal claiming requirements, and/or reporting requirements dictate that the information collected by contract providers need to align with the requirements and workflows established by the County BHP and in many instances, must be collected within the county Enterprise Health Record.



- 9) **Client/Patient Portal** – A fully integrated client portal is expected to be part of the Enterprise Health Record solution sought through this RFP.

Within each section of this document, each activity is described narratively to provide context. High-level requirements are presented, and wherever possible, use cases are offered to add additional clarity. Though written responses to this RFP will not allow prospective vendors to validate their solution against these use cases, when vendors are selected for on-site demonstrations, these scenarios, and the requirements upon which they are based will be covered.

Throughout this document, the functions required to address the needs of the California market are represented as though they are supported within one system/application. It is understood that the breadth of these requirements will most likely require the integration of several separate applications to create one Enterprise Health Record solution. As such, CalMHSA is requesting that vendors develop their own approach to addressing the total requirements and describe such approach in their response. **Regardless of the approach proposed by a vendor in their response, their proposal will be judged based upon their ability to meet the requirements identified as described in the “Use Case” scenarios provided throughout this RFP.**

2. Project Scope of Work

2.1 Scope of Requirements

The needs of California County BHPs are unique because of the breadth of their operations and responsibilities. As previously identified, these organizations fulfill many roles. California County BHPs are direct providers of care, they are Managed Care Plans responsible for establishing and maintaining a network of providers (aka “contract providers”), they adjudicate/manage claims from their contract providers, they aggregate service data from both contracted and directly operated (county) program, submit aggregated claims to the Department of Health Care Services (Medi-Cal), and they aggregate data to submit for satisfy state reporting requirements.

Additionally, the number and breadth of stakeholders to whom California County Behavioral Health organizations are answerable extends beyond the typical requirements faced by other healthcare organizations. As a government agency responsible for the treatment of millions of California residents and as the steward of billions of dollars in annual funding, such organizations are under a higher level of scrutiny from many stakeholder groups. Given these conditions, an enterprise health system deployed by a California BHP must provide extensive accessibility to all data collected within an Enterprise Health Record for real-time reporting and advanced analytics.

Many HIT vendors offer robust solutions intended to meet the needs of behavioral healthcare providers. Other HIT vendors offer solutions to support insurance companies and managed care organizations to oversee their provider networks, process authorization requests, and adjudicate claims from care providers. And others offer specialized solutions to support functions such as eligibility verification, referral management, care coordination, interoperability, etc. **It is important that vendors intending to respond to this RFP understand that the “Enterprise Health Record” being sought by CalMHSA, and its partner agencies needs to provide all these functions either within one system or through multiple systems so tightly integrated that they appear to be one system. Regardless of the approach proposed by a vendor in their response, their proposal will be**



judged based upon their ability to meet the requirements identified as described in the “Use Case” scenarios provided throughout this RFP.

2.2 System – Wide Requirements

In this section, the requirements that are foundational to the Enterprise Health Record solution are described. In most instances, all subsequent functions in the following sections presume that the system-wide requirements are available. Thus, in ensuing sections there will be references back to several of these core requirements.

2.2.1 Office of the National Coordinator for Health Information Technology (ONC) Certified

The solution proposed by vendors responding to this RFP must have attained certification under the Office of the National Coordinator for Health Information Technology (ONC) Health IT (Information Technology) Certification Program. Furthermore, responding vendors need to commit to continuing certification efforts under the 21st Century Cures Act “Final Rule” as well as future reporting programs implemented by ONC through their Conditions and Maintenance of Certification requirements.

Because the 58 County BHPs are classified as Managed Care Plans, the proposed Enterprise Health Record will need to comply with Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access Final Rule CMS-9115-F (Federal Register :: Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers)

2.2.2 Cloud Based

The Enterprise Health Record should be cloud-based and meet the following criteria:

High-Level Requirements:

- All tiers of the Enterprise Health Record (i.e., application tier and database tier) will be hosted on cloud-based infrastructure within cloud instances.
- Uses responsive web design with the ability to adapt easily across all devices (i.e., desktop, laptop, mobile, etc.)
- Provides the ability to function consistently across multiple browsers (i.e., Edge, Chrome, Safari)
- Is compliant with Health Insurance Portability and Accountability Act (HIPAA), Protected Health Information (PHI), Personally Identifiable Information (PII) and other modern security standards including being compliant with Federal Risk and Authorization Management Program (FedRAMP) “moderate” standards to include a third-party assessment of the security standards to ensure compliance
- User sessions protected through continuous secure sockets layer (SSL) encryption
- Complies with Americans with Disabilities Act (ADA) and Web Content Accessibility Guidelines (WCAG) v2.x or latest



- Seamlessly scalable to accommodate future growth
- Ability to scale up/down on demand using self service
- High availability region pair architecture
- Ability to store three copies of your data in one pair member
- Will store an additional three “split mirrored copies” will be at least 300 miles away geographically
- Closer architecture (Availability Zones) that provides for keeping resources closer together for improved performance while at the same time avoiding any single points of failure
- Provide controls to be able to support a multi-tenant architecture with features like Role Based Access Control to provide application-level security
- Provides broad network access, supports resource pooling, and supports measured service
- Subject to regular penetration testing
- Meets National Institute of Standards and Technology (NIST) definition of “Cloud”

2.2.3 Production, Test, and Development Environments

To support the ongoing operation of the Enterprise Health Record, as well as provide mechanisms to sustain training, testing, and development activities, it is expected that the solution delivered will support multiple fully functional environments. At the very least, CalMHSA and its partners will expect three (3) environments: Production, Test and Development.

High-Level Requirements:

- Three full and separate environments will be deployed and supported by the vendor under the terms of maintenance and/or subscription agreements
- Costs as identified in the vendor’s proposal will represent the inclusion of these three environments
- Each of the three environments will be fully functional application/database environments complete with all associated elements (e.g., databases, Master Patient Index (MPI), Enterprise Master Patient Index (eMPI), Application Programming Interface (APIs), etc.)
- Patch/Update/Maintenance releases will be able to be loaded separately in each environment such that these updates will be able to be loaded into “Test” before being deployed into “Production”
- The “Test” and “Development” environments will be able to be over-written with a copy of the “Production” system to support testing and training activities
- The activity of over-writing the “Test” or “Development” systems will be covered under the support and/or maintenance agreement with the vendor
- After an over-write of the “Test” and/or “Development” system it is expected that the applications and associated elements (e.g., databases, MPI, eMPI, APIs, etc.) of the “Test” and “Development” environments will be fully functional



- The “Test” and “Development” environments will have the same, fully functional security measures to meet HIPAA, PHI, PII and other modern security standards including FedRAMP
- Tools to de-identify (i.e., scramble) data about clients and/or potential clients will be provided

2.2.4 Highly Accessible Data Architecture and Reporting Tools

One of the challenges that California county behavioral health organizations have historically encountered is the inability to extract data from their existing electronic health records to effectively produce operational reports and other data analysis. Based upon performance concerns, it is understood that complex data analytics or reporting should not be performed against the database associated with the Production environment of the Enterprise Health Record. As such to support complex data analysis, in addition to the database(s) associated with the application environment(s), it is expected that the “Highly Accessible Data Architecture” solution will include mechanisms to seed and maintain a cloud-hosted data warehouse external to the application.

High-Level Requirements:

- **Enterprise Application Requirements**
 - Database tier will be hosted on the cloud
 - Database will adopt a normalized relational data model connected by unique referential integrity
 - The base/core Enterprise Health Record will be delivered with a full data schema, data dictionary, and entity relationship diagram
 - The Enterprise Health Record will provide mechanisms to produce updated data schema, data dictionary, and entity relationship diagram to support tables added to the system through application configuration tools
 - The Enterprise Health Record will auto generate a unique identifier for every record in every table (including tables added through the application configuration tools)
 - The Enterprise Health Record Database will save add/update date/time and user identification in all tables to support traceability and audit trails
 - Database will allow for the addition of new indexes to base/core tables as well as tables added to the system through application configuration tools
 - Database management system will support standard connection management tools or other native connectors such as web services, Open Data Base Connectivity (ODBC), Object Linking and Embedding Data Base (OLE DB), Java Data Base Connectivity (JDBC), etc.
 - Using the available connection management tools, the database should support data extraction and reporting using Structured Query Language (SQL)
 - Using the available connection management tools, the database should support reports deployed within the application as well as external to the application



- The Enterprise Health Record should support the deployment of custom reports within the application. There should be no restrictions on the tables, data, or reporting logic used when creating operational reports delivered through the application
- When reports are executed from within the cloud-based Enterprise Health Record application, the report and all associated data need to be protected while in transit between the cloud-based application and the user's device/workstation
- The Enterprise Health Record should provide version control of all custom reports deployed through the application such that users will always access/execute the current version of any report that is deployed via the application
- External database access will be controlled through the Enterprise Health Record's user security tools
- The Enterprise Health Record will provide record-level security based upon Client Consent to control access to data by individual users
- The Enterprise Health Record will support other database level requirements as defined in later sections of this document
- **Cloud-Hosted Data Warehouse Requirements**
 - Data warehouse database and servers to be provided by the vendor
 - Data warehouse database and servers are to be cloud-hosted
 - Data at rest and data in transit will be protected using appropriate encryption or other security measures to meet HIPAA, PHI, PII and other modern security standards including FedRAMP
 - Tools to manage the initial seed of the data warehouse should include:
 - The ability to select all or specific data tables from the Enterprise Health Record for inclusion in the data warehouse
 - Tables created in the data warehouse database should replicate the data schema of the source Enterprise Health Record database
 - The initial process to seed the tables in the data warehouse database should include all records in the tables selected for inclusion from the source Enterprise Health Record database
 - The data warehouse tools should allow the organization to establish scheduled refreshes of the data from the source Enterprise Health Record database
 - Scheduled refreshes of the data from the source Enterprise Health Record database must be able to be completed within an eight (8) hour period. This requirement will remain even as the amount of data within the source Enterprise Health Record database increases
 - Scheduled refreshes of the data from the source Enterprise Health Record database can either be full "drop" of all data in the selected tables or supported through an incremental data set comprised of records that were added/edited/deleted in the Enterprise Health Record since the previous data warehouse load/refresh



- The initial process to seed the tables in the data warehouse database should include all records in the tables selected for inclusion from the source Enterprise Health Record database
- Subsequent scheduled updates to the data warehouse should only include records that were added, edited

Use Cases

First Use Case: Using the application configuration tools available within the Enterprise Health Record, the agency has created a form/screen to capture “Next of Kin” information. Subsequently, the organization needs to produce a “Face Sheet” to be printed out for any client that is admitted for treatment. The “Face Sheet” will be a combination of data that is collected both in base/core forms/screens, as well as forms/screens built using the application configuration tools. The assignment to create the report is assigned to a technical resource at CalMHSA.

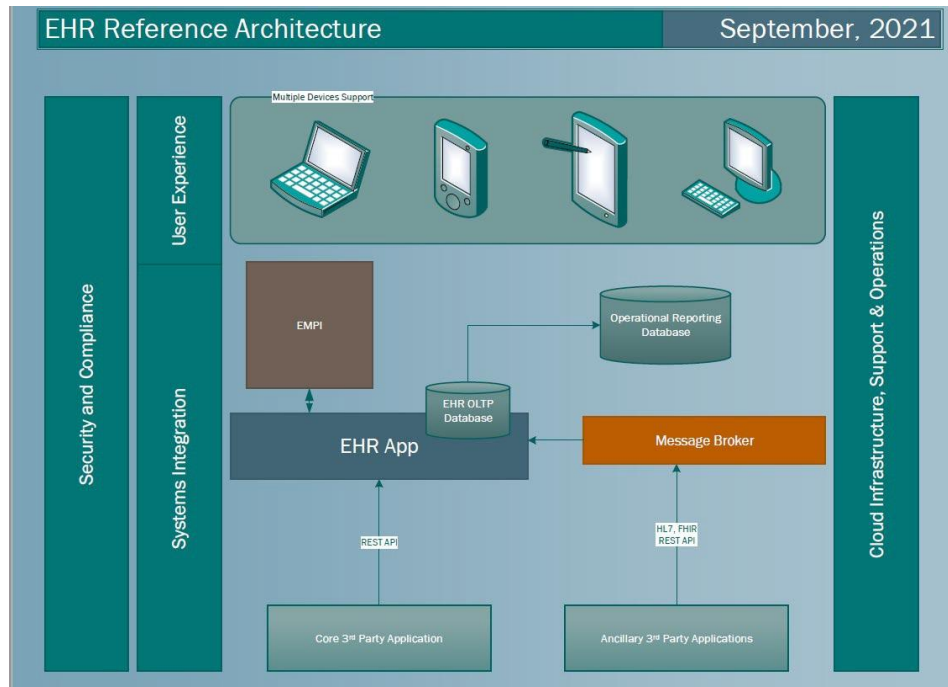
The assigned staff needs resources to understand the data structure of the entire system, core/base forms as well as those created through application configuration tools. The staff member needs access to the report development tool provided with the Enterprise Health Record. The staff member needs to assign themselves access to all appropriate data tables. The staff member needs to apply SQL programming to create the necessary report. One of the most important elements to the SQL programming is selection logic to assure that only users/staff to whom a client(s) has provided consent can the client’s information. Once developed and operational, the report needs to be assigned to users of the Enterprise Health Record so that they can run it from within the application as part of their daily operations.

Later, additional requirements for the report are provided. The staff who developed the report makes appropriate edits and then deploys the new/updated version for the users.

Second Use Case: CalMHSA is asked by an external stakeholder to compile metrics across all partner counties regarding admissions to Mental Health and Substance Use programs over the past 2 years where “Homelessness” is identified as one of the items on clients’ Problem Lists. It is anticipated that this data will need to be consolidated, drilled down upon, and sliced and diced. As such, CalMHSA decides to use their Tableau Analytics tool against the data warehouse to create interactive dashboards. The CalMHSA developer first attempts to confirm that the tables required for the effort are available in the data warehouse. In doing so, they identify that a table with necessary data is not available in the data warehouse. Therefore, CalMHSA needs to add this table to the regularly scheduled extract and assure that the data for the entire data warehouse is updated each night.

2.2.5 Integration Tools – Standard Healthcare APIs and System Open Architecture

As a by-product of both industry requirements and unique needs within the California market, it is expected that the Enterprise Health Record being proposed will support a wide breadth of interoperability/integration mechanisms. It is anticipated that the basis for all integration tools will be the Fast Healthcare Interoperability Resources (FHIR) but the unique requirements and data payload for some functions (e.g., State reporting) are such that other mechanisms may need to be employed. Regardless of the requirements, it is the expectation that the Enterprise Health Record will leverage standard tools such as web services and not rely upon proprietary mechanisms.



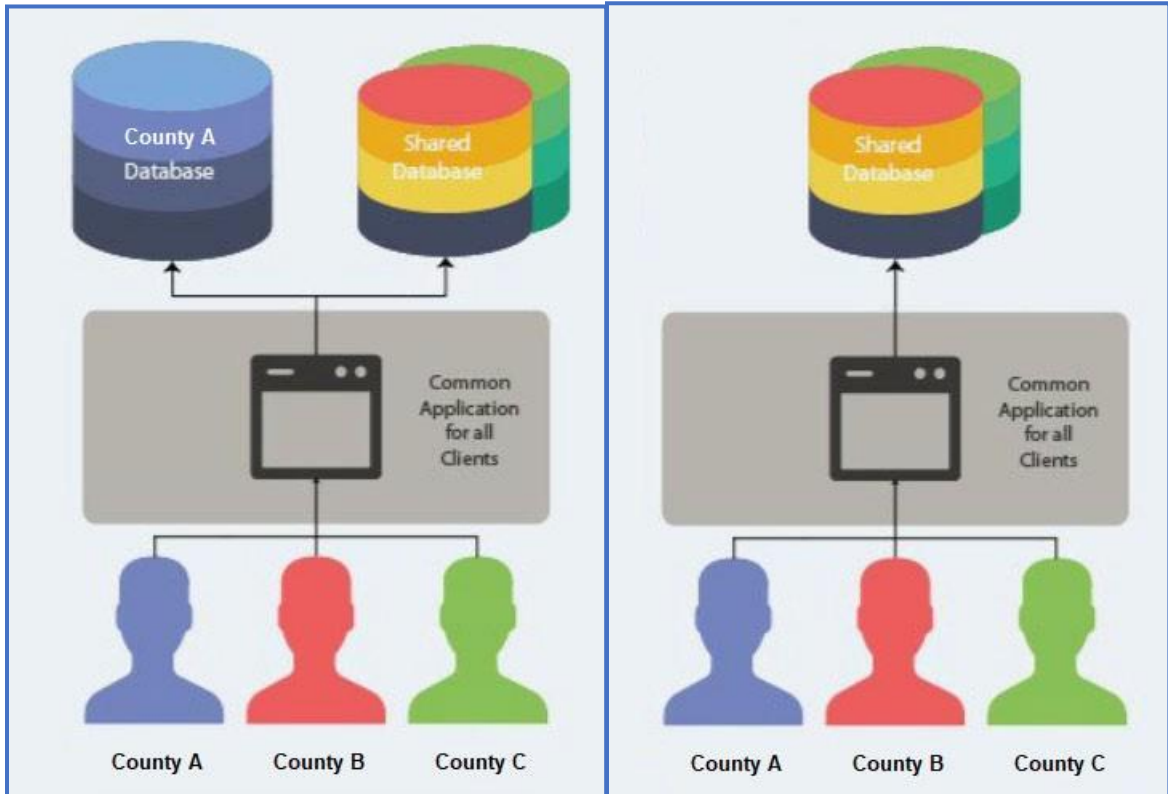
High-Level Requirements:

- The Enterprise Health Record APIs should support both Representational State Transfer (REST) and Simple Object Access Protocol (SOAP)
- The Enterprise Health Record APIs should support JavaScript Object Notation (JSON) but also speak healthcare vocabulary through Health Level Seven (HL7)
- The Enterprise Health Record should support the current and future Fast Healthcare Interoperability Resources (FHIR) standards
- The Enterprise Health Record should support current and future interoperability standards defined through the Office of the National Coordinator for Health Information Technology (ONC) Health IT Programs (e.g., ONC Cures Act Final Rule)
- Using the provided APIs, the Enterprise Health Record should support the ingestion of data from outside sources for any data input form: Core/Base forms as well as those created using provided Application Customization Tool
- In addition to the support of APIs by the Enterprise Health Record, the solution proposed by the vendor should include Integration Server/Suite to expose and manage APIs with external sources

2.2.6 Multi-County Installation

This RFP seeks an Enterprise Health Record solution that can be deployed as one system but implemented across multiple County agencies. In this design, it is anticipated that each environment (Production, Test, Development) will either be a separate/unique instance of the application with partitions, or multitenant architecture.

Multi-County Installation Examples



While on the surface this requirement may seem like a technical architectural issue, regulations around confidentiality (e.g., Code of Federal Regulations (CFR 42)) and the requirements associated with Client Consent Management as outlined in this document require focused design within the application, database, and system architecture to ensure compliance.

Responding vendors are encouraged to develop and propose a viable strategy that meets the following requirements:

High-Level Requirements:

- Core system functionality within the application will be consistent across all counties
- Application Issues/reported bugs will be able to be addressed with system-wide patches
- Application-level logic will comply with Privacy and Security requirements (e.g., CFR 42) data so that users within one county are not able to see data associated with other counties (With the exception of the MPI)
- Data Management tools will be applied or available to assure that Privacy and Security requirements (e.g., CFR 42) can be enforced through any reporting or data extraction tools



- Application-level logic to ensure client-specific data access within each partition/tenant/county will be managed based upon the “[Client Consent Management](#)” requirements
- Within data records stored in the database, columns need to be available that would allow reports and other data extraction tools to ensure client-specific data access within each partition/tenant/county will be managed based upon the “[Client Consent Management](#)” requirements
- Data partitioning will need to be supported throughout the database(s) used by the solution so that reports only pull data from the data source for which the user running the report has access
- County-specific configuration including application logic configured through registry settings, the ability to create data input forms and associated tables (some to be shared across multiple counties), the ability to define dynamic user interface logic within screens/forms to improve documentation compliance, etc. should be supported
- If separate databases are employed as a mechanism to separate county data, with the exception of custom configuration via provided application configuration tools, all core/base data tables will need to be normalize
- If separate databases are employed as a mechanism to separate county data, the assignment of “Unique ID” values to records within the different databases cannot be duplicated thus causing issues when aggregating data across multiple/all counties
- Regardless of the system architecture employed, all integration tools associated with inbound APIs will support the accurate classification of inbound data to assure it is stored in the correct county partition/table/etc.

[Use Cases](#)

First Use Case: An application error/bug is reported. The vendor has provided a maintenance release or patch to address the issue. CalMHSA should be able to load this update into the Test environment. How would CalMHSA confirm that the update is available for testing in any/all county sub-systems?

Second Use Case: User from County A logs into the Enterprise Health Record and admits/enrolls a client into one of the County’s directly operated treatment programs. They enter a diagnostic profile for the client and complete a progress note. Subsequently, a user associated with County B logs into the Enterprise Health Record. The user from County B should see the client’s demographic information and their unique client identifier (aka Patient ID/MRN) within the MPI. While they are logged into the Enterprise Health Record, the user from County B should not be able to see any information related to the admission/enrollment, diagnosis, or progress note for this client.

Third Use Case: CalMHSA is asked to build a report that allows for a list of admissions based upon start/end date parameters and deploy it in all counties sub-systems. During testing, the CalMHSA developer needs to confirm that admissions from County A do not appear on the report when it is executed from within County B’s sub-system.



Fourth Use Case: The client was admitted to one of County A’s directly operated programs. In this county’s sub-system there are users who are associated with Contract Provider Agencies. When these users run the admission report, they should only see admissions that have occurred to their Contract Agency’s program(s).

Fifth Use Case: County C and County D have partnered to conduct a special study. To support this, they ask CaIMHSA to create a specific questionnaire and deploy it only to their application sub-systems. After a month, they study is broadened to include County A and County B. Six months later the data from the entire study needs to be analyzed using analytics and benchmarking tools. How does CaIMHSA access the data for this questionnaire for all four counties? How is the data for the different counties identified so that it can be grouped or selected by County? What are the Unique_ID values for each record in the table(s) for this questionnaire? Are there any duplications/overlaps across the different counties?

Sixth Use Case: The study has been a success and the state wants to implement this questionnaire statewide and they want the four counties who have been running the project to take the lead in collecting the data and analyzing the results across the entire state. As such the State has launched a website with the questionnaire and the data from completed questionnaires that needs to be consumed by the Enterprise Health Record through an inbound API and available for the analysis already created with the analytics and benchmarking tools.

2.2.7 Application Configuration Tools

This RFP seeks an Enterprise Health Record solution that allows an organization to design custom data input forms/screens with associated data tables as well as edit existing core application forms to add new/custom data fields.

High-Level Requirements

- These functions should provide application configuration tools (e.g., templates, drag and drop page elements, etc.) such that custom data input forms can be developed and deployed without the need for programming resources
- Custom data input forms should support common data elements such as free-text, scrolling free-text, date, time, single-select discrete elements (pull-down), single-select discrete elements (radio button), multi-select discrete elements (Check boxes), integer, table look-up, etc.
- Custom data input forms should allow for the definition of various characteristics for each field (e.g., Required/not required) including the ability to assign logic to trigger subsequent events within the form and/or elsewhere in the system
- Custom data input forms should support single record and multi-iteration tables
- Custom data input forms should support the entry of records across multiple entities such as Client, Potential Client, Case/Contact, User, Staff, Program, etc.
- Custom data input forms should support episode-specific and non-episodic data collection requirements



- All tables and forms created through the tools provided will be fully supported by core application functions (e.g., User Account Security)
- All tables and forms created through the application configuration tools provided will support the data security standards associated with the [Consent Management](#) requirements as described in this document
- The application configuration tools should support standard development methodology wherein the development is performed in the “Development” environment, promoted to the “Test” environment, and then deployed to the “Production” environment
- The vendor’s application configuration tools should be supported under the support, maintenance, and/or subscription agreement between CalMHSA and the vendor. It is not expected that the custom developed forms/screens be supported, but the tools and any issues created because of bugs/errors in the tools should be supported
- Any custom data input forms and associated tables should not be over-written or otherwise negatively impacted by application patches, updates, or maintenance efforts
- Once created through the application configuration tools, all custom data input forms and their associated screens will integrate with and support all system-wide requirements identified in this document. These include but are not limited to:
 - Inclusion in the application environment hosted in the Cloud
 - Promotion/Deployment of the custom developed form and associated data table across all County installations of the system
 - Inclusion in the over-write of “Test” and “Development” environments with “Production”
 - High availability of the data table within the application database and access through ODBC and/or other connection management tools
 - Inclusion of the custom developed data tables through tools intended to product application database data dictionaries, entity relationship diagrams, etc.
 - Inclusion of the custom developed data tables in the tools designed to seed and maintain the “Data Warehouse”
 - Support of all “[Dynamic User Interface](#)” requirements within the application forms/screens developed using the vendor supplied tools
 - Support of API and integration tools such that external systems can access (i.e., Get) data collected via the custom developed forms/screens and data can be added to the custom developed table (i.e., Post or Put)
 - Support the data security standards associated with the “Consent Management” requirements as described in this document
 - Support the “Workflow Definition and Application Functions” as described in this document
- The application configuration tools should allow the update/edit of core/base application forms to include
 - The addition of new data elements
 - The removal of non-required, existing data elements



- Ability to make current non-required fields required
- Ability to assign logic to forms and specific fields to trigger subsequent events within the form and/or elsewhere in the system
- Any dictionaries created for single-select or multi-select discrete value should support the definition of cross-references to other discrete value data dictionary

2.2.8 Dynamic User Interface

This RFP seeks an enterprise health solution that is cloud-based and as such, provides a dynamic user interface such technologies allow. It is acknowledged that the term “Dynamic” is subjective. As such the vendors are invited to showcase examples of what they believe are unique features of their user interface that align with the requirements identified below.

High-Level Requirements

- Forms/Screens in the application should dynamically grow to show additional fields or information without the need to navigate to or launch a different form/screen
- Based upon the completion of, or values selected in various field, the forms/screens should support:
 - Conditionally adding new fields to the form
 - Making certain fields required or not required
 - Pre-populating subsequent fields
 - Performing mathematical calculations to support scoring within the form
 - Present warnings or additional guidance to users
- The user interface should allow the forms for different records to be seamlessly combined to efficiently support common tasks
- When separate forms/records are combined, the application should not require that common data elements be repeated
- Sometimes certain assessments or documentation is initiated by one user but is completed by another
 - Forms should be able to be partially completed and sorted in a draft format to be completed by different/subsequent staff
 - CaIMHSA should be able to create reports to identify partially completed forms/records

Use Cases

First Use Case: To support effective assessment of new clients, CaIMHSA and its partner agencies create a “Universal Psychosocial Assessment” using the application configuration tools provided within the Enterprise Health Record. In this assessment there are several clarifying questions that are gender specific. For five fields that should be included when the client is identified as “Female”, two of these should be required with the other three being optional. For the four fields that need to be included if the client is identified as “Male”, three of them need to be required while one is optional.



Second Use Case: Suicidal ideation is a common problem for clients being treated by the county BHPs. As such they have elected to use the “Columbia Suicide Severity Rating Scale” (<https://suicidepreventionlifeline.org/wp-content/uploads/2016/09/Suicide-Risk-Assessment-C-SSRS-Lifeline-Version-2014.pdf>) tool. Factors related to suicide and self-harm can present themselves at any point during treatment and so CalMHSA created the “Columbia Suicide Severity Rating Scale” as a separate form to be completed anytime a client presents indicators for self-harm. Within the “Universal Psychosocial Assessment” designed by CalMHSA there are questions focused on self-harm indicators. Based upon the client’s answers to these questions, CalMHSA wants the fields associated with the “Columbia Suicide Severity Rating Scale” to be appended to the bottom of the “Universal Psychosocial Assessment” without any user effort (i.e., screen refresh) when indications of suicidality are identified.

Third Use Case: As a way to determine potential suicidal ideation, CalMHSA included the first two questions from the “Columbia Suicide Severity Rating Scale” within the “Universal Psychosocial Assessment” form. As such, the questions “Within the past 1 month has the client wished they were dead?” and “Within the past 1 month has the client experienced non-specific active suicidal thoughts?” exist both in the “Columbia Suicide Severity Rating Scale” and the “Universal Psychosocial Assessment” forms. In the situations where the “Columbia Suicide Severity Rating Scale” is appended to the bottom of the “Universal Psychosocial Assessment” when indications of suicidality are identified, these fields (and others such as “Date of Assessment” are duplicative. As such, CalMHSA would like the user experience (UX) to suppress the duplicate fields, but upon filing, use the one field to seed both data records.

Fourth Use Case: The “Columbia Suicide Severity Rating Scale” has several complex relationships between fields. For example, if the client indicates that they have attempted suicide in the past, then the “Most Recent Attempt Date”, “Most Lethal Attempt Date”, and “Initial/First Attempt Date” fields should become required.

Fifth Use Case: The “Columbia Suicide Severity Rating Scale” is a complex questionnaire that requires developed interviewing skills. As such CalMHSA wants to assure that the form can be started by one user, saved in draft, and then completed by a different user.

Sixth Use Case: Medication Management is a common appointment/visit type for psychiatrists and Psychiatrists are the highest cost staffing category within each agency. As such, to make the doctor’s experience in the system efficient as possible, CalMHSA wants to create one form/screen that combines the ability to enter a progress note for the visit, review past lab results, enter new outpatient lab orders, review current prescriptions, add/discontinue prescriptions, review add/edit client problem list, and book new appointments.

2.2.9 Integration of External Scripts

One of the core system functions anticipated to be required to configure the enterprise health record to meet workflow and user experience requirements is the capability to integrate External Scripts with hooks/triggers within the application. While it is anticipated that the “[Application Configuration Tools](#)” previously described will provide a level of programming logic within the application, it is common that organizations encounter the limits that such features provide. As such, it is an expectation that the enterprise health record will provide API (e.g., Web Services) to integrate the solution with external programming scripts hosted on an accessible external web server. By allowing organizations to write custom scripts, host those scripts external to the



system, and then, based upon activities/triggers in the enterprise health record, have those scripts called/run allows an organization to extend the capabilities of their enterprise solution without vendor development.

High-Level Requirements

- Provide API (e.g., Web Service) that will allow the integration of both core and custom forms with external programming scripts
- Support of hooks to reference and call external scripts based upon the following events
 - Form/Screen Load
 - Activation or Completion of a Field
 - Form/Record Submission
 - Post Record Filing

First Use Case: When completing a Progress Note, there are several variables that if not met, the charge should be non-billable to Medi-Cal. For example, for SUD programs, if an initial “Substance Use Assessment” (aka ASAM) has not been complete, the service associated with a Progress Note should be non-billable.

The “Progress Note” form in question is universal so CalMHSA decides to create a script that upon form submission, will review the Treatment Program (to determine if it is an SUD program), and then selectively review the “Substance Use Assessment” records to verify that such a completed record is on file for this client/episode. If a completed “Substance Use Assessment” is present, then the record is filed, but if this record is not present, then the system will change the Service Code to a non-billable code.

Second Use Case: Some of the programs using the enterprise health record have requested that CalMHSA create a “Discharge Summary” data input form. A discharge summary is a handover document that explains to any other healthcare professional why the client was admitted, what has happened to them during care, and all the information that they need to pick up the care of that patient quickly and effectively.

Using the “[Application Configuration Tools](#)” CalMHSA has developed a “Discharge Summary” form comprised of several large free-text fields. In order to expedite the creation of the ‘Discharge Summary’ CalMHSA wants to create a script that will be executed when a user enters the form. This script will be designed to extract data from several tables to pull information related to different clinical data collected throughout the client’s episode of care and prepopulate this information in the various text fields in the “Discharge Summary” form.

2.2.10 Workflow Definition and Application Functions

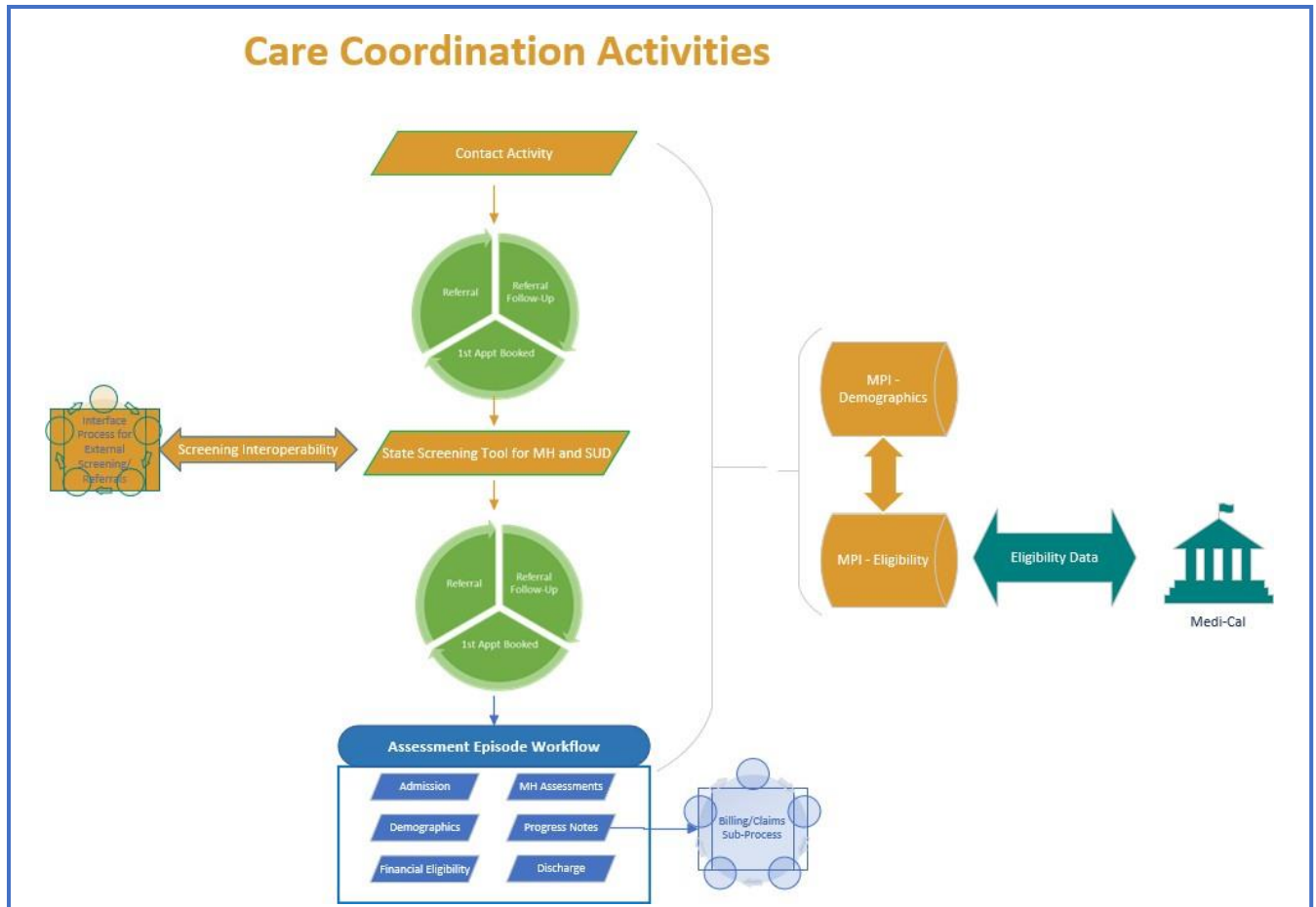
As previously identified, California agencies have many different use cases where the data across multiple activities need to be linked to support an association based upon business and clinical workflows. To implement and assure the data integrity/linking within the data records, the system needs to provide application logic through which the business and clinical workflows are defined, and the users are guided to comply with these established standards.

These workflows are being defined by CalMHSA in anticipation of the implementation of the Enterprise Health Record. To support the workflows being defined by CalMHSA and its partner agencies, it is required that the



proposed Enterprise Health Record will provide workflow management capabilities that support the business and clinical workflow processes.

Business/Clinical Workflow Example



High-Level Requirements

- The ability to identify forms/activities/records that may be required to be completed as a by-product of the entry/completion of a previous activity/record. (i.e., Define within the system logic that would indicate that a “Referral” record would be required following the completion of a “Contact Activity”)
- The ability to define logic within the application that determines what subsequent activity/form/record is to be completed based upon characteristics of the previous/triggering activity/record. (i.e., Based upon the “Disposition Type” of a “Contact Activity” the application understands that the next appropriate activity is a “Screening” record, rather than a “Referral”)
- The ability to define logic within the application that determines the person/group responsible for completing the subsequent activity/form/record. (i.e., The “Referral” based upon the “Contact Activity” should be assigned to a specific person or group for follow-up)



- The ability to define logic within the application that determines whether certain records should be assigned to an individual (i.e., a specific user or clinician) or a group (i.e., The assignment to complete a “Screening” as a by-product of a “Contact Activity” should be assigned to the specific user whereas an assignment to complete a “Referral” as a by-product of a different “Contact Activity” should be assigned to a user group)
- A dynamic user interface such that based upon the selections of values in fields, the application will add to the form/screen, without the need for re-processing, additional fields associated with the creation of a separate record type. (i.e., Since the user selected a particular value while completing a Screening, the system prompts the user to complete a corresponding Referral record)
- In instances where the system is creating/filing two records via one form/screen, the application should provide logic to minimize the need for the user to complete duplicative fields (i.e., If the system is presenting the user a form/screen through which they are entering a Screening and a Referral, the date and time values initially entered by the user should be applied to both records)
- The ability to support work queues for forms/activities/records that need to be completed based upon the entry/completion of a previous activity/record. The table(s) associated with this function should be reportable so that custom reports can be developed with the data. (i.e., Support a/several table(s) that stores records that identify tasks which need to be completed)
- The ability to produce lists via reports and interactive screens within the application of incomplete/outstanding activities/records in a work queue. (i.e., Provide a list of all the “Screenings” that based upon previous actions, are pending entry/completion. To support reporting of historical data, the records should not be temporary or transient)
- The ability to produce interactive worklists for each user displaying the list of pending/outstanding activities/forms/records for which they are either directly assigned or assigned as a by-product of their involvement in a group. The “interactive” nature of these worklists should allow the user to select an outstanding item from the list, thus launching the form through which the outstanding activity/record could be completed
- Tasks in work queues assigned to an individual or a group should be able to be re-assigned
- As records are created within each table, the relationship between the individual records needs to be supported as described in the “Linking of Records in Data Tables” section of this document

[Use Cases](#)

(It is important to note that the functions/design described below do not need to be provided exactly as described. Rather the described functions/design are intended to provide context to the underlying workflow requirement)

First Use Case: A potential client calls the “Access Center” during regular business hours. The county staff member initiates a “Call Activity” record to document details of the activity. Based upon the information shared by the potential client, the staff member determines that a Mental Health Screening is warranted. This organization happens to have one or more qualified staff available for warm hand-offs for “walk-ins” or people



in crisis. Based upon the “Disposition Type” of the “Call Activity” record, the staff member identifies a specific clinician to be assigned to complete the screening. The clinician is informed of a client on the phone awaiting a screening. He/she logs into the Enterprise Health Record and their work queue is presented with this to-do in the list. They select this assignment, and the system presents a form which is a combination of information from the “Call Activity” record, information regarding the assignment to their work-queue, and the “Mental Health Screening” form to be completed. They pick up the line where the potential client is on hold and together, they complete the “Mental Health Screening”. Upon completion, when the record is filed it is assigned a unique identifier in its native table (Screen_ID). Additionally, depending upon the “Disposition Type” selected by the clinician when completing the “Mental Health Screening”, the system may create/add a corresponding record in the “Work Queue” table. If this happens, then the unique identifier assigned to the “Mental Health Screening” (Screen_ID) is also stored, thus creating a link between the two records.

Second Use Case: A client calls the agency after hours. Based upon the information collected during the “Call Activity” it is indicated that a “Mental Health Screening” should be performed. The organization is not staffed where a clinician is immediately available. Within the “Call Activity” form, the user selects a “Disposition Type” that indicates that the client should be referred to a clinician for follow-up when a “Mental Health Screening” would be completed.

Based upon the “Disposition Type” selected, the dynamic user interface expands the form/screen. The new fields presented to the user are associated with the creation of a “Referral” record. It is transparent to the user that they are now completing two different records. Within the “Referral” information being complete, the user identifies a “Group” as the party responsible for following up on the referral.

The next working day, a clinician who is a member of the “Group” assigned to the referral logs into the Enterprise Health Record. In their work-queue they see the pending assignment. The clinician selects the assignment from the work queue and a form is presented to them that contains display-only fields that show some information from the “Call Activity” and “Work Queue” records. In the form there are also blank fields in which the clinician is able enter data to create a “Referral Follow-Up” record. They attempt to call the client, but do not establish contact. They select a “Disposition Type” that indicates an attempt was made. When the screen/form is filed, a subsequent record is created in the work-queue table which keeps the assignment in the worklist for the members of the identified group.

Later, a different clinician selects the assignment from their work queue. The system launches a form displaying information from the “Call Activity” information, from the previous “Referral Follow-Up”, and information about the “Work Queue” assignment. They are also presented blank fields for them to record the information associated with this referral follow-up attempt. This time they are successful in contacting the client. They select a “Disposition Type” for the “Referral Follow-Up” that indicates the client is prepared to complete a “Mental Health Screening” with the clinician. The dynamic user interface expands the form/screen to present the fields associated with the “Mental Health Screening”.

The clinician and the potential client complete all the questions/fields. Based upon the screening, it indicates that the client should be further assessed. As the clinician completes the form, they select a “Disposition Type” for the “Mental Health Screening” indicating that the potential client should be Referred to an appropriate program for an assessment. The clinician also identifies a “Group” who should be responsible for completing



the next step in the workflow. As a by-product of filing the form, a record is created in the “Referral Follow-Up” table, the “Mental Health Assessment” form, and the “Work Queue” table. Within each of these records, the unique identifier associated with the preceding activity is also stored.

Third Use Case: Later that afternoon, a user associated with the “Group” to whom the referral was assigned logs into the Enterprise Health Record. A task to follow-up on the referral is presented via the application in their work queue. They select the assignment and are presented a form/screen which is a combination of information from the “Mental Health Screening” record, information regarding the “Referral”, information about the work-queue assignment, and blank fields associated with performing a “Referral Follow-Up”. Upon review of all the information, the staff member realizes that their program is not appropriate for this client’s needs. The user selects “Reassign Referral” in the “Referral Disposition” field for the “Referral Follow-Up” and identifies a different “group”. This action creates a “Referral Follow-Up” record and a new record, assigned to the different “Group” in the “Work Queue”. Within each of these records, the unique identifier associated with the preceding activity is also stored.

A task to follow-up on the Referral is presented via the application in the work queue for all users assigned to the new group identified. The first staff member available selects the “Referral Follow-Up” task from their queue in the application. They are presented a form which is a combination of information from the “Mental Health Screening” record, the “Referral”, the assignment to the group’s work-queue, and fields associated with performing a “Referral Follow-Up”. They contact the potential client who agrees to book an appointment to come into the program for an assessment. The user selects “Book Appointment” in the “Disposition Type” for the “Referral Follow-Up” and the dynamic user interface of the application expands the form/screen so that the user is presented with fields associated with booking an appointment. Together they identify a viable date/time for the client to meet with a clinician for a full assessment. This action creates an “Appointment” record and a new record in the “Work Queue”. Each record is assigned a unique identifier in their respective tables. The unique identifier for the “Referral Follow-Up” is stored with the “Appointment” record.

2.2.11 Data Hierarchy

Within any application designed to support the operations of an organization, the systems' design is organized around a hierarchy of data entities. For example, the base/core design of the Client Relationship Management (CRM) application, Salesforce, supports sales operations based upon the inherent hierarchical relationship of "Campaigns", "Accounts", "Contacts", "Leads", "Opportunities", etc. It is important to note that the data entities employed define characteristics of an organization (e.g., Accounts) as well as people (e.g., Contacts). With this, structure systems such as Salesforce are able to reflect that the whole of an organization is the relationship of entities, the people who work within them, and the activities performed by these people within. Once these entities are established in an application, appropriate data selection, grouping, reporting is easily supported.

Similarly, Electronic Health Records (EHR) are also designed with an inherent organizational structure intended to support the operations of healthcare provider organizations. CalMHSA has identified that due to three factors, the data hierarchy associated with both the Organization and the Personnel associated with each organization extended beyond the capabilities of most Electronic Health Records (EHR) currently available within the market.



1. Electronic Health Records do not provide the appropriate/needed levels/types within the hierarchy of both the Organization and the Personnel
2. Electronic Health Records do not store information about Organizational levels or Personnel in historical records to support reporting requirements in an evolving landscape
3. Electronic Health Records do not always support the relationship between Personnel and their roles within the different Organizational levels. The support of these relationships historically has been a particular challenge

Based upon these challenges, the solution proposed by the vendor will need to address each of these data hierarchy issues both as it pertains to the definition of Organizational Entities/Levels, to the definition of Personnel, and to the relationship (current and historic) of Personnel within the Organizational Entities/Levels.

2.2.12 Organizational Data Hierarchy

There exists within the established rules and regulations which govern the delivery of behavioral health services in California an existing hierarchy. For mental health services, to document and manage all the providers the state maintains a “Online Provider System (OPS)”. Within this system, the service providers (County and Contractor) are categorized as “Legal Entities” and/or “Providers”. The term “Legal Entity” applies to a corporation, individual, or county that directly owns a facility offering public mental health services. The term “Provider” applies to those facilities delivering mental health services.

Within Substance Use programs a similar hierarchy also exists. As such, the Enterprise Health Record would need to support the following hierarchical entities/levels:

- Organization – This is the organization within the county that has been established to support the Mental Health and/or Substance Use operations
- Department –There are many obligations that require the categorization/grouping of data into either Mental Health or Substance Use. Requirements such as CFR 42 privacy regulations necessitate such a categorization/grouping for counties who manage both these departments under one “Organization”,
- Site/Legal Entity – Applies to a corporation, individual, or county that directly owns a facility offering public mental health services
- Program/Provider - Applies to those facilities delivering mental health services

Additionally, based upon common reporting requirements and ad-hoc requests from both government organizations and advocacy stakeholders, the data/characteristics defined for different levels in the organization need to be historical. It is common for a request for information to be received related to information about a Program/Provider as it existed 2-3 years ago. Given this reality, the Enterprise Health Record must store the important information for each organizational level in multiple historical records.

While the specific approach and terminology within the Enterprise Health Record may differ from the terms used in this document, the system needs to support the following requirements to support appropriate collection and categorization of data collected within the organizational entities:



High-Level Requirements

- At least the four following hierarchical entities/levels need to be supported without the need for additional development or configuration:
 - Organization (In this case the County Behavioral Health Organization)
 - Department (In CA this would be Mental Health Department and/or Drug Medi-Cal Organized Delivery System (DMC-ODS))
 - Site/Legal Entity
 - Program/Provider
- Within each hierarchical entity/level, information will need to be stored in a single-row primary table coupled with a multi-row historical table. Most of the characteristics/data collected for each level/entity will be collected within the historical, subordinate records
- When historical, subordinate records of an entity are being created, the application should allow the defaulting forward of data from the most recent historical record
- To establish the hierarchical nature of the different entities, as new records are created within each entities/level, the system should include a field where the parent/senior record is required to be identified (i.e., As a "Site" is added, the user should be required to identify its corresponding "Department")
- To establish the hierarchical nature of the different entities, each record in the corresponding data tables should include a data column where the Unique_ID for the identified/corresponding parent/senior record is stored
- All table(s) associated with each entity/level should be indexed and otherwise optimized for reporting purposes
- In order to support future requirements, within the application, for each of the parent and subordinate records, the system should allow the addition of new data collection fields (e.g., single-select dictionary fields) within the core/base forms through which these entity records are created and maintained
- The application configuration tools should allow CaIMHSA to create data input forms/screens and associated data tables using these entities as the basis for the data records
- The inclusion/support of the described entities/levels are not just for data aggregation/reporting. Instead, inherent application business rules should be supported. For example:
 - Billing rules by payor/guarantor should be able to be defined for one/multiple programs
 - Only the "Legally Allowed CPT Codes" defined for a "Site" should be available for use as a clinician/practitioner enters a Progress Note
 - Do not allow entry of service/charges against a "Program" that fall outside the date of a contract Start/End Date
- Application-level logic to ensure client-specific data access within each entity/level will be managed based upon the "Client Consent Management" requirements



- Within data records stored in the database, columns need to be available that would allow reports and other data extraction tools to ensure client-specific data access within each entity/level will be managed based upon the “Client Consent Management” requirements

Use Cases

First Use Case: One of the contract providers who work with County “A” has been experiencing a great deal of change. Within the last three years, they have had three different offices as their primary mailing address and they have had four different people in the role of “Director”. But throughout the ups and downs there are some elements that have remained consistent. For example, their Legal Entity number, the organization’s Federal Tax ID, and their website address have remained constant. How can the Enterprise Health Record support all these changes?

Second Use Case: “Caring Tree” is a private mental health and substance use provider that has been a contractor with County “A” for years. “Caring Tree” has grown substantially through the years and as a byproduct of this growth they have decided to divide their mental health operations and substance use operations into separate corporations. As of July 1, 2022, the substance use programs are now to be a part of the new corporation “Recovery Tree”. This corporation has a new NPI Number, a new Federal Tax ID, new Legal Entity # assigned by the state, and each has a new Provider # from the state. How can the Enterprise Health Record support all these changes?

Third Use Case: An influential state politician has decided to make homelessness an important component of their campaign to run for Governor. This politician claims that large amounts of money and resources are being provided to County Behavioral Health organizations, but these resources are not increasing the availability of services. To respond, the Counties on CalMHSA’s Enterprise Health Record have produced reports identifying how many Providers/Programs currently provide services specifically focused on homelessness. Furthermore, they provide the office hours of these organizations as a mechanism to show availability and adequacy. The politician modifies their argument to claim that the issue is historic and systemic under the last four years of the present Governor’s administration. The Counties want to produce similar reports for the previous four years to respond.

Suggested Data Elements

Organization - Single Record					
Field	Data Type	Character Length	Required	Other Characteristics	Indexed
Org_ID	varchar	10	Y		Y
Data entry date	date	10	Y	mm/dd/yyyy	Y
Data Entry Time	Integer	6	Y	hhmmss	Y
Active/Deactive	varchar	1	Y		
Organization Name	varchar	80	Y		
Data Entry User ID	varchar	10	Y		
Data Entry Username	varchar	80	Y		



User Access Value	varchar	1	Y	Calculated/transient field	
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Organization - Historical/Multi-Iteration Record(s)

Org_HX_ID	varchar	10	Y		Y
Org_ID	varchar	10	Y		Y
Effective Date	Date	10	Y	mm/dd/yyyy	
End Date	Date	10		mm/dd/yyyy	
Org Street Address 1	varchar	80			
Org Street Address 2	varchar	80			
Org Address City	varchar	80			
Org Address State	varchar	40			
Org Address County - Code	varchar	40		Look-Up Against County Dictionary	
Org Address County - Value	varchar	40		Look-Up Against County Dictionary	
Org Address Zip	Integer	5		Look-Up Against Zip Code Dictionary	
Org Primary Phone	Phone	12			
Org Secondary Phone	Phone	12			
Org Fax	Phone	12			
Organization Number	varchar	10	Y		Y
Data entry date	date	10	Y	mm/dd/yyyy	Y
Data Entry Time	Integer	6	Y	hhmmss	Y
Data Entry User ID	varchar	10	Y		
Data Entry Username	varchar	80	Y		
User Access Value	varchar	1	Y	Calculated/transient field	

Department – Single Record

Field	Data Type	Character Length	Required	Other Characteristics	Indexed
Dept_ID	varchar	10	Y		Y
Org_ID	varchar	10	Y		Y
Data Entry Date	date	10	Y	mm/dd/yyyy	
Data Entry Time	Integer	6	Y	hhmmss	
Active/Deactive	varchar	1	Y		
Data Entry Username	varchar	80	Y		
Data Entry User ID	varchar	10	Y		



MH_SUD_Code	varchar	10	Y	Single Select Dictionary	
MH_SUD_Value	varchar	40	Y	Single Select Dictionary	
User Access Value	varchar	1	Y	Calculated/transient field	

Legal Entity (aka Site) – Single Record					
Field	Data Type	Character Length	Required	Other Characteristics	Indexed
Site_ID	varchar	10	Y		Y
Dept_ID	varchar	10	Y		Y
Data Entry Date	date	10	Y	mm/dd/yyyy	
Data Entry Time	time	6	Y	hhmmss	
Effective Date	date	10	Y	mm/dd/yyyy	
Data Entry Username	varchar	80	Y		
Data Entry User ID	varchar	10	Y		
End Date	date	10	Y	mm/dd/yyyy	
Active/Deactive	varchar	1	Y		
User Access Value	varchar	1	Y	Calculated/transient field	

Legal Entity (aka Site) - Historical/Multi-Iteration Record(s)					
Site_HX_ID	varchar	10	Y		Y
Site_ID	varchar	10	Y		Y
Effective_Date	Date	10	Y	mm/dd/yyyy	
End_Date	Date	10	N	mm/dd/yyyy	
Site Office Start Time	time	6	Y	hhmmss	
Site Office Start End	time	6	Y	hhmmss	
Office Hour Days	varchar		Y	Multiple values, Look-up Against Dictionary	
NPI Number	varchar	10	Y		
Taxonomy Code	varchar	15	Y		
Site Street Address 1	varchar	80			
Site Street Address 2	varchar	80			
Site Address City	varchar	80			
Site Address State	varchar	40			



Site Address County - Code	varchar	40		Look-Up Against County Dictionary	
Site Address County - Value	varchar	40		Look-Up Against County Dictionary	
Site Address Zip	Integer	5		Look-Up Against Zip Code Dictionary	
Site Primary Phone	Phone	12			
Site Secondary Phone	Phone	12			
Site Fax	Phone	12			
Certification Start Date	date	10	Y	mm/dd/yyyy	
Certification End Date	date	10	Y	mm/dd/yyyy	
Legally Allowed CPT Codes	varchar		Y	Look up against Procedure Code Table	
Certified Modes - Code	varchar			Single Select Dictionary	
Certified Modes - Value	varchar			Single Select Dictionary	
Legal Entity - Code	varchar			Look-Up Against Legal Entity Table	
Legal Entity - Value	varchar			Look-Up Against Legal Entity Table	
Data Entry Username	varchar	80	Y		
Data Entry User ID	varchar	10	Y		
Data Entry Date	date	10	Y	mm/dd/yyyy	
Data Entry Time	time	6	Y	hhmmss	
User Access Value	varchar	1	Y	Calculated/transient field	

Program (aka Provider #) - Single Record					
Field	Data Type	Character Length	Required	Other Characteristics	Indexed
Program_ID	varchar	10	Y		Y
Site_ID	varchar	10	Y		Y
Data Entry Date	date	10	Y	mm/dd/yyyy	
Data Entry Time	Integer	6	Y	hhmmss	
Data Entry Username	varchar	80	Y		
Data Entry User ID	varchar	10	Y		
Program Name	varchar	80			
Program Number	varchar	10			Y
User Access Value	varchar	1	Y	Calculated/transient field	



Program (aka Provider #) - Historical/Multi-Iteration Record(s)					
Field	Data Type	Character Length	Required	Other Characteristics	Indexed
Program_HX_ID	varchar	10	Y		Y
Program_ID	varchar	10	Y		Y
Data Entry Date	date	10	Y	mm/dd/yyyy	
Data Entry Time	time	6	Y	hhmmss	
Data Entry Username	varchar	80	Y		
Data Entry User ID	varchar	10	Y		
Effective Date	date	10	Y	mm/dd/yyyy	
End Date	date	10	Y	mm/dd/yyyy	
Program Tax ID	time	6	Y	hhmmss	
Program Setting- Code	varchar	10	Y	Single Select Dictionary (Inpatient/Outpatient/Day Treatment)	
Program Setting- Value	varchar	40	Y	Single Select Dictionary (Inpatient/Outpatient/Day Treatment)	
Program Type- Code	varchar	10	Y	Single Select Dictionary (Screening/Assessment/Treatment)	
Program Type- Value	varchar	40	Y	Single Select Dictionary (Screening/Assessment/Treatment)	
Program Street Address 1	varchar	80			
Program Street Address 2	varchar	80			
Program Address City	varchar	80			
Program Address State	varchar	40			
Program Address County - Code	varchar	40		Look-Up Against County Dictionary	
Program Address County - Value	varchar	40		Look-Up Against County Dictionary	
Program Address Zip	Integer	5		Look-Up Against Zip Code Dictionary	
Program Primary Phone	Phone	12			
Program Secondary Phone	Phone	12			
Program Fax	Phone	12			
Place of Service - Code	varchar	10	Y	Single Select Dictionary (Standard HCFA/837 Values)	
Place of Service - Value	varchar	40	Y	Single Select Dictionary (Standard HCFA/837 Values)	
Contractually Allowed CPT Codes	varchar			Look up against Procedure Code Table, Multiple Values	
System of Care - Code	varchar			Multiple Select Dictionary	
System of Care - Value	varchar			Multiple Select Dictionary	



Strategic Initiative Group - Code	vvarchar			Multiple Select Dictionary	
Strategic Initiative Group - Value	vvarchar			Multiple Select Dictionary	
Program Group - Code	vvarchar			Multiple Select Dictionary	
Program Group - Value	vvarchar			Multiple Select Dictionary	
System of Care - Code	vvarchar			Multiple Select Dictionary	
System of Care - Value	vvarchar			Multiple Select Dictionary	
Contract Start Date	date	10	Y	mm/dd/yyyy	
Contract End Date	date	10	Y	mm/dd/yyyy	
Legally Allowed CPT Codes	vvarchar		Y	Look up against Procedure Code Table	
OSHPD Program - Code	vvarchar	2		Single Select Dictionary (Yes/No)	
OSHPD Program - Value	vvarchar	3		Single Select Dictionary (Yes/No)	
Require Principal Procedure Code for OSHPD - Code	vvarchar	2		Single Select Dictionary (Yes/No)	
Require Principal Procedure Code for OSHPD - Value	vvarchar	3		Single Select Dictionary (Yes/No)	
State Report Type - Code	vvarchar	10	Y	Single Select Dictionary (CSI/CalOMS/MHSA/None)	
State Report Type - Value	vvarchar	40	Y	Single Select Dictionary (CSI/CalOMS/MHSA/None)	
County ID CalOMS	vvarchar	40			
Provider ID CalOMS	vvarchar	40			
DMC-ODS Cost Report Program Code	vvarchar	40			
CalOMS Type of Service - Code	vvarchar	10		Single Select Dictionary based upon CalOMS Data Dictionary	
CalOMS Type of Service - Value	vvarchar	40		Single Select Dictionary based upon CalOMS Data Dictionary	
CalOMS No Activity - Code	vvarchar	10		Single Select Dictionary based upon CalOMS Data Dictionary	
CalOMS No Activity - Value	vvarchar	40		Single Select Dictionary based upon CalOMS Data Dictionary	
MHSA Provider Number	vvarchar	40			
FSP Program ID	vvarchar	40			

2.2.13 Personnel Data Hierarchy

Similar to the requirements associated with the “Organizational Data Hierarchy” previously described, multi-faceted requirements associated with the personnel who work for the county behavioral health organizations and/or their Contract Providers exist. Many of the data aggregation and reporting requirements that exist for each of the organizations extend all the way to the individual staff/clinician who was responsible for performing various functions within the organization.



Based upon different functions or data reporting requirements, an individual will need to be viewed and supported differently in the system. Firstly, a person will be a “user” of the system. The entity of “User” will need to support security provisions across the application and the database. General security provisions will be based upon privileges assigned by the organization when the user account is created. But since clinical data is regulated under laws such as CFR 42, privileges associated with viewing clinical data will be determined based upon Consent provided by the client (“Consent Management” is covered later in this document) and clinicians’ ability to maintain and access a “Caseload” of client (“[Caseload Management](#)” is covered later in this document). Regardless of the specifics of any particular individual’s security access in the system, it is important that the characteristics of that individual as a “user” be stored in a data table that can be reported against using ODBC compliant (or similar) tools.

In addition to maintaining individuals as “Users”, the Enterprise Health Record will need to separately support defining some staff as “Clinicians”. For the purposes of this document, the term “Clinicians” refers to users of the system who are credentialed and licenses to provide treatment and perform other clinical functions in service of the clients. Within this request for proposal, it is required that the Enterprise Health Record support clinicians both in terms of the standard functions within an EHR (Clinical Documentation, Appointment Scheduling, Service/Charge Entry, Claims Creation, etc.) as well as provide full credentialing capabilities (Payer Enrollment, License Verifications, etc.).

Within a county behavioral health organization there will be “users” of the enterprise health system. A sub-set of this group will be “clinicians”. But there is also a third entity of the organization which will be comprised of “staff” that are neither clinicians nor users of the system. These staff members may not participate in client activities, but their contributions do support the overall mission of the organization and the cost associated with their positions are incorporated in different reporting metrics. For example, a California behavioral health agency may get a request from an advocacy group asking for information related to the total number of staff involved in programs focused on the issue of homelessness. Given such a request, if the Enterprise Health Record only supported the definition of users and clinicians, these staff members would not be included in the metrics. As such, this request for proposal, it is required that the Enterprise Health Record support “staff” as a reporting entity.

As such, the Enterprise Health Record would need to support the following entities/levels:

- User – This entity is where the person is assigned Log-In criteria to access the Enterprise Health Record. Basic privileges to enter forms and access data from tables is assigned here.
- Clinician – A sub-set of the “Users”, “Clinicians” are credentialed and licenses to provide treatment and perform other clinical functions in service of the clients. The system will need to support all standard EHR and Practice Management/Billing functions as well as provide Credentialing capabilities. Additional security determined through “Caseload Management” and client “Consent Management” should be available.
- Staff – These are people that work within the behavioral health organization but do not use the Enterprise Health Record. Data about these people, their characteristics (e.g., cost) and their contribution to the operations of the organization are important.



Additionally, based upon common reporting requirements and ad-hoc requests from both government organizations and advocacy stakeholders, the data/characteristics defined for different Users, Clinicians, and Staff need to be historical. It is common for a request for information to be received related to information about a User, Clinicians, and Staff as it existed 2-3 years ago. More common is the fluid nature of Given this reality, the Enterprise Health Record must store the important information for each organizational level in multiple historical records.

Finally, the relationship of the Users, Clinicians, and Staff within the Organizational Entities/Levels needs to be recorded and supported historically within the system. It is common for a person to leave a County directly operated program in the middle of the year and take a position within one of the Contract Provider Agencies of the County. In this situation, when sunning a report of headcount, capacity, and other metrics, the data records should be available historically to reflect that individual's employment within both Sites/Legal Entities within the same reporting period.

In general, "User" and "Clinician" management are common requirements and thus are supported in the core functionality of electronic health records. The requirements that are somewhat unique to California behavioral health organizations are:

High-Level Requirements

- At least the four following hierarchical entities/levels need to be supported without the need for additional development or configuration:
 - User – This entity is where the person is assigned Log-In criteria to access the Enterprise Health Record. Basic privileges to enter forms and access data from tables is assigned here
 - Clinician – A sub-set of the "Users", "Clinicians" are credentialed and licensed to provide treatment and perform other clinical functions in service of the clients. The system will need to support all standard EHR and Practice Management/Billing functions as well as provide Credentialing capabilities. Additional security determined through "Caseload Management" and client "Consent Management" should be available
 - Staff – These are people that work within the behavioral health organization but do not use the Enterprise Health Record. Data about these people, their characteristics (e.g., cost) and their contribution to the operations of the organization are important
- Within each hierarchical entity/level, information will need to be stored in a single-row primary table coupled with a multi-row historical table. Most of the characteristics/data collected for each level/entity will be collected within the historical, subordinate records
- When historical, subordinate records of an entity are being created, the application should allow the defaulting forward of data from the most recent historical record
- To establish the hierarchical nature of the different entities, as new records are created within each entity/level, the system should include a field where the parent/senior record is required to be identified
- To establish the hierarchical nature of the different entities, each record in the corresponding data tables should include a data column where the Unique_ID for the identified/corresponding parent/senior record is stored



- All table(s) associated with each entity/level should be indexed and otherwise optimized for reporting purposes
- To support future requirements, within the application, for each of the parent and subordinate records, the system should allow the addition of new data collection fields (e.g., single-select dictionary fields) within the core/base forms through which these entity records are created and maintained
- The application configuration tools should allow CaIMHSA to create data input forms/screens and associated data tables using these entities as the basis for the data records
- The inclusion/support of the described entities/levels are not just for data aggregation/reporting. Instead, inherent application business rules should be supported. For example:
 - Billing rules by payor/guarantor should be able to be defined for one/multiple clinicians
 - Only the "Legally Allowed CPT Codes" defined for a credentialing level should be available for use as a clinician/practitioner enters a Progress Note
 - Do not allow entry of service/charges against a "Program" that falls outside the date of employment for the clinician
- “User” Entity Requirements
 - Ability to create and manage individual user accounts that include:
 - Screen/Form Security Privileges
 - Read Only
 - Read and Edit
 - Read, Edit and Add
 - Database Table Access
 - Across all County data sets
 - For select County Data Sets
 - Support all HIPAA security standards (e.g., Automatic Time-Out)
 - Password terms
 - Other
- “User Group” Management
 - Ability to define security privileges and apply them across multiple users
 - It is preferred that the “User Groups” could be implemented/managed across all the counties implemented on the shared enterprise system
- “Clinician” Entity Requirements
 - Clinician Core System Functions
 - Support the definition of clinicians on multiple levels.
 - The first level is information about the person that is universal (e.g., Gender, Languages, Personal Demographics, etc.)



- The second level is information about the clinician based upon their employment/relationship with a program. This will be information that may be variable based upon their employment with the program
 - The system must support multiple historical records for a clinician at this level
- Logic that restricts users from associating clinician to records if the clinician was not actively employed at the time the activity was performed
- Record qualifying characteristics such as gender, language, and race/ethnicity to be used as search criteria for appointment scheduling (e.g., Client only wants to see Spanish speaking clinician)
- Support information associated with the clinician as a network provider who provides services to clients which are then billed to the County (More information provided in the “Managed Care Services” section of this document)
 - Historical records that include
 - Effective date
 - End date
 - Allowable services – the services that this clinician is allowed to provide and thus would be covered by the County
 - Service fees – the contract rates that the County has agreed to pay the Contract Provider for the services performed by the clinician
 - Office address
 - Office hours and ADA accessibility of office location (Network Adequacy)
 - Support information to produce claims for billable services
 - Specialty and/or Coverage Categories to be cross referenced against Benefit Plan criteria to determine insurance coverage for billing
 - National Provider Identification (NPI) Number
 - Taxonomy Code
 - Federal Tax ID
- Clinician Credentialing Requirements –Each record should have effective/end dates and allow for the organization to record the credentialing information for all clinicians. Credentialing information shall include:
 - License(s) and/or registration(s) held – Including effective dates, license number, etc.
 - Certification(s) attained – Types, Awarding body, Effective dates
 - Specialty information
 - Malpractice Insurance (if applicable) – Including effective dates, Policy number, Limits of coverage, etc.
 - Current Drug Enforcement Administration identification number
 - National Provider Identifier (NPI)



[For additional details regarding Credentialing and Re-Credentialing requirements, please see State Reporting Requirements & Regulations Spreadsheet [California Mental Health Services Authority | Multi-County EHR \(calmhsa.org\)](#)]

- “Staff” Entity Requirements
 - Support the definition of Staff on multiple levels.
 - The first level is information about the person that is universal (e.g., Personal Demographics, etc.)
 - The second level is information about the Staff member based upon job/role within the organization. This will be information that may be variable based upon their employment
 - The system must support multiple, historical records for a staff member at this level. Data to be supported at this level should include:
 - Effective Date
 - End Date
 - Job Title
 - Department
 - Employee Status
 - Office Hours
 - Office Address
 - Office Telephone
 - Cell Phone
 - Manager – This should allow the selection of an existing record from this same “Staff” table
 - Cost Center
 - Cost/Salary

Use Cases

First Use Case: A clinician is hired by one of the Contract Provider Agencies. They attend training and it is time to have them added to the electronic health record. How is the following information recorded/supported?

- Clinician’s Specialty
- Service/Procedure Codes that the Clinician is allowed to perform
- Clinician’s association with
 - Site/Legal Entity
 - Program/Provider
- NPI
- Office Hours/Availability
- Privileges to Forms/Functions in the system

Second Use Case: Before being assigned any clients the new clinician decides to log into the system to confirm their log-in works and refresh their memory of the training. When they attempt to access clinical information what information would they see considering they have not been assigned clients to their caseload.



Third Use Case: A clinician who has worked at a County Mental Health program has attained an advance degree and receive new/higher licensure. Within three months of these achievements, they receive a job offer from one of the County Contract Provider and decides to take the position. They maintain their user account in the Enterprise Health Record, but they need their profile as a clinician and their affiliation with the Site/Legal Entity and Program/Provider updated. As a result of this move, the network adequacy data indicating the total office hours available in the year has changed for both the organization they left (decreased), as well as the organization they joined (increased).

Fourth Use Case: An influential state politician has decided to make homelessness an important component of their campaign to run for Governor. This politician claims that large amounts of money and resources are being provided to County Behavioral Health organizations, but these resources are not increasing the availability of services. To respond, the Counties on CalMHSA's Enterprise Health Record have produced reports identifying:

- Total Number of Programs/Providers focused on homelessness
- Total Number of Staff employed within these programs
- Total cost of Staff within these programs
- Percentage of staff in these programs who are clinicians
- Total number of hours available across these programs for client treatment for the past two complete fiscal years

2.2.14 Consent Management

Consent management is another common requirement within the healthcare industry that has unique and expanded elements within California behavioral health organizations. The core of Consent Management is the ability to record a client's wishes with regard to which people and which organizations can view/access their clinical information. Given the expanded operations of California county behavioral health organizations, both the information that is collected within the system and the number of people and organizations with whom it might be shared is much wider in scope.

- As identified, there is a large number of activities and associated data that is collected for clients and potential clients that extend outside of typical treatment information
- As identified, California county behavioral health organizations operate both mental health and substance use programs. Based upon current regulations (e.g., CFR 42) client information cannot be shared across these programs (mental health/substance use) without consent
- Across the Mental Health and Substance Use departments, there are programs that are directly operated by the county, and there are others which are associated with Contract Providers. Consent provided to county programs can be applied across all counties directly operated programs whereas consent for contract providers is exclusive to that program/organization
- As with all other healthcare providers, California behavioral health organizations perform billing for services rendered and thus release of information/consent for these outside payors would need to be supported

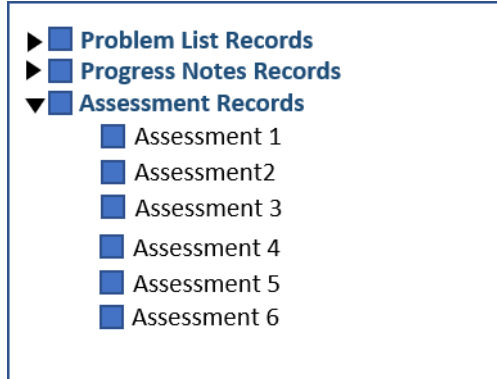


- As with other healthcare providers, the potential for electronic exchange of information through the establishment of industry standard or proprietary interoperability would need to be incorporated in the Consent Management functions within the Enterprise Health Record

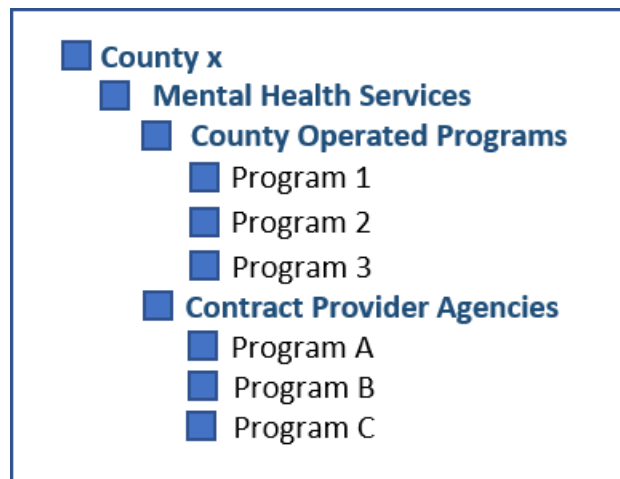
While this request for proposal welcomes any approach that addresses the core requirements identified above, the following high-level requirements are what CalMHSA believes is necessary:

High-Level Requirements

- As discussed later in this document, the Enterprise Health Record needs to support both clients (individuals who are or have received treatment by the county or one of its contract providers) as well as potential clients (individuals who are engaging with the county but who have not graduated to a point where they are receiving treatment. The Consent Management function needs to be able to be supported for both these “Clients” as well as for the “Potential Clients”
- Client Consent Management tools should be available both in the Enterprise Health Record, as well as the associated patient portal
- Consent Management functions should provide a mechanism for the legal language around “consent” to be reviewed by the client through the enterprise application, through the patient portal, via a requested print-out, or through a .pdf document to be e-mailed to the client
- Consent Management should collect an electronic signature from the client associated with the consent provided
- Consent Management should support multiple, historic consent records for each client
- Consent Management will be based upon an “Opt-Out” approach such that the default will be that by providing consent, the client is allowing all information to be shared with all programs, clinicians, and/or outside entities
- Throughout the Enterprise Health Record there will be many different records. As such, each form/screen in the Enterprise Health Record should be able to be categorized into different groups/types. This would allow clients to provide consent for types of data rather than for specific records. (For example, a client would be able to consent to share “Assessments” which would include all records that were entered through screens/forms that were identified as “Assessments”)



- Throughout the Enterprise Health Record there will be many different programs, contract providers, organizations with whom the county may share data (electronically and otherwise). These different entities should be able to be tagged/grouped. This grouping would allow clients to provide consent for types of entities rather than for specific organizations
- Once the records (or record group(s)) that the client consent to share have been identified, the client can then specify the organization/program/entity with whom then consent to share these records



- Based upon the consent provided or withheld by the client, the system should employ mechanism to assure that only those programs, payors, entities, or individual staff/clinicians for whom the client has provided consent can see the selected types of data/records through all functions in the system. This includes but is not limited to:
 - Data viewed through the application screen/forms
 - Data viewed through reports
 - Data sent to payors/guarantors
 - Data exchanged with interoperability partners



- The system should employ mechanism within the various system data tables such that when a data extraction report/routine is executed, that privilege/access to data records for the user running the report will be evaluated based upon consent provided/withheld by the client
- The system should employ mechanisms within the various API Tools such that when a data extraction routine is executed, that privilege/access to data records for the user running the API will be evaluated based upon consent provided/withheld by the client

Use Cases

First Use Case: A client is admitted into an “Assessment Episode” to be evaluated for potential Mental Health treatment. There are indications that the client may also have Substance Use challenges, but they are not ready to face these issues. During their on-boarding, the client is able to use the “Consent Management” function in the Enterprise Health Record to review the terms of consent. The documentation is long, and the client does not really understand what is being asked of them. They electronically sign the “consent” in the system as-is thus providing consent so that all users, in all programs can see all their records. Because the documentation was so long, the client has a copy of the documentation sent to their e-mail.

Second Use Case: During the “Assessment Episode” it was determined that the client was suffering from an extreme anxiety disorder. They agree to be referred to a Contract Provider for treatment. During the admission process for the “Treatment Episode” the client is more sensitive to what “Consent” means having read the documents they had the Enterprise Health Record previously e-mail to them. At this point, the client decides that they want to update their Consent profile. During this update, they provide consent only to the Contract Provider Agency who is currently treating them, as well as the clinician with whom they worked during their initial “Assessment Episode”

Third Use Case: The client’s treatment is proceeding well and through their counseling they realize that to truly address their issues they need to also face their substance use challenges. They are admitted to a “Assessment Episode” and eventually referred to a different Contract Provider who can provide treatment at the appropriate level of care needed. During their Admission to their Outpatient Substance Use Provider, they update their Consent profile so that their Mental Health Provider can see clinical data associated with their Substance Use treatment, and vice versa.

Fourth Use Case: A County operated program happens to share office space with the Substance Use Contract Provider Agency treating the client. A County staff member is returning from lunch, and they see the client leaving the building and recognize them as one of their neighbors. Curiosity gets the better of the staff member and they go looking in the system to see what they can find out about the neighbor/client. They try accessing data through the application as well as through reports external to the system but because they are not part of any organization that the client has consented to provide access, the staff member cannot view any clinical information about either the client’s Mental Health or Substance Use data.

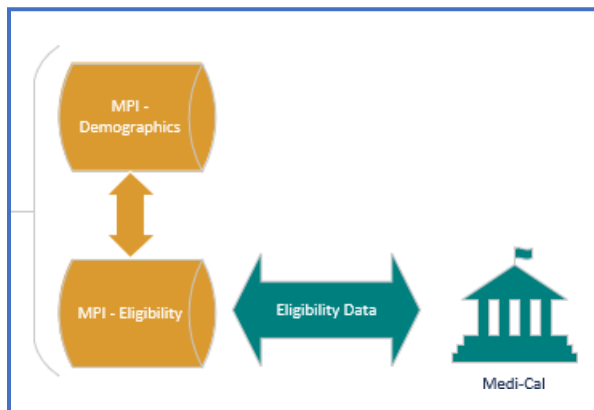
2.2.15 Master Patient Index

A Master Patient Index (MPI) is an electronic database that assigns a unique identifier to each individual, so they are represented only once across the entire organization. The MPI aims to accurately match and link records by uniquely identifying individuals. Because the unique identification of individuals involves the use of



personal identifying information, Master Patient Indexes store demographic data and, in some implementations, act as the primary source of truth for all client demographic data.

This RFP seeks an enterprise health solution that can be deployed as one system (one application code-set) implemented across multiple County Agencies. While the overwhelming majority of information entered into the Enterprise Health Record will be separated/partitioned the proposed solution should include a Master Patient Index (MPI) that will span across all counties and their clients.



Since the majority of clients that are treated by the county behavioral health organizations are Medi-Cal beneficiaries, this RFP seeks a solution whose MPI offers enhanced functionality that includes the ability to support Health Care Eligibility information and verification. As quasi-extensions of California’s Department Healthcare Services (Medi-Cal), the county behavioral health organizations’ operations are closely aligned and dictated by the Medi-Cal eligibility of its clients. As such, the master patient index to be implemented is expected to be both a shared database of client demographic data as well as a database of Medi-Cal eligibility. Throughout this document, these two functions

of the MPI are referred to as: “MPI-Demographics” and “MPI-Eligibility”.

As it relates to the “MPI-Eligibility”, there are two mechanisms associated with Health Care Eligibility verification that are expected to be addressed. The primary of these two mechanisms is known as the Medi-Cal Eligibility Data System (MEDS) and is unique to California. The MEDS information is a statewide database of current and historical Medi-Cal eligibility records. Each month, a sub-set of the MEDS data is made available to each California county behavioral health organization. This data is made available to each County in a file called the “Monthly MEDS Extract File” (MMEF). (It is important to note that while the “MEDS” file and “MMEF” files are different in content and format, the terms are synonymously used within county behavioral health organizations.) The MMEF file is a flat file with fixed-length records formatted in a proprietary format. In the MMEF file provided is 24 months-worth of historical Medi-Cal eligibility information for each Medi-Cal beneficiaries residing in the County who are actively enrolled in Medi-Cal as of the beginning of the month. Within this file, both eligibility and demographic information is provided. The RFP is seeking a solution that will support the monthly upload of MMEF files for each of the partner county agencies and provide the basis Medi-Cal eligibility functions across the entire Enterprise Health Record.

The second mechanism associated with Medi-Cal Eligibility Verification expected to be supported through the “MPI-Eligibility” solution is the Real-Time HIPAA 270/271 EDI Eligibility and Benefit Inquiry and Response. Since the MMEF file only provides Medi-Cal Eligibility status information as of the beginning of the month, it is necessary to support on-going, real-time verification. In California, beneficiaries of Medi-Cal gain and lose eligibility frequently and thus the only way to validate benefits is to constantly perform real-time inquiries.



Based upon the availability of both the MMEF upload and the Real-Time HIPAA 270/271, the proposed solution would maintain an up-to-date file of Medi-Cal Eligibility for all clients who are within the MPI. To achieve this, the anticipated use-case would be similar to the following:

High-Level Requirements

- The MPI will be comprised of two functions represented by different/associated tables: MPI – Demographics and MPI-Eligibility
 - The MPI – Demographics will manage the assignment of unique patient identifiers across the entire installation and will be a central repository of the demographic’s information for the client
 - The MPI – Eligibility will manage and store the current and historical Medi-Cal Eligibility information for the client. This data will be added/received through the processing of monthly MMEF files and/or the Real-Time 270/271 transactions
- The MPI-Demographics database should be integrated with several options/forms in the Enterprise Health Record including
 - “Contact Activity”
 - “Referral”
 - “Referral Follow-Up”
 - “State Screening Tool”
 - “Admission”
- The MPI-Eligibility solution will support the monthly upload of the MMEF file for participating county agencies. Data uploaded through the MMEF will be the basis of each client’s Medi-Cal eligibility
- When a client presents themselves for treatment at one of the participating county agencies, the Enterprise Health Record will search the MPI – Demographics table(s) to see if the client already exists in the Master Patient Index (has been assigned a Unique Patient Identifier)
- If the client is not currently in the MPI – Demographics, the data used as parameters to search the MPI – Demographics will be used to search the MPI-Eligibility tables that have been seeded by the monthly upload of MMEF files
- If the client exists in the MPI-Eligibility tables, then the system will generate a Real-Time 270 request and process the 271 response to obtain the most up-to-date eligibility information for the client. This new eligibility information will be stored in the MPI-Eligibility tables as the most current eligibility record for the client. The information from the 271 response will also be the basis for a new record being created for the client in the MPI-Demographics database
- If the client does not exist in the MPI-Eligibility tables, then the system will prompt the user for all data elements necessary to generate a Real-Time 270 request. This 270 request will be generated and sent to verify the client’s Medi-Cal Eligibility. The 271 response will be processed by the MPI-Eligibility solution and the eligibility response information will be stored in the MPI-Eligibility tables as the most current eligibility record for the client. The information from the 271 response will also be the basis for a new record being created for the client in the MPI-Demographics database



- Information in the MPI – Demographics tables can be updated. These updates will not update the client’s demographic information in the MPI – Eligibility tables
- Clients that are not Medi-Cal eligible/enrolled may still be treated by the county behavioral health organizations. As such, when adding a client to the MPI, if a link between the record being added to the MPI – Demographics tables and corresponding eligibility records in the MPI-Eligibility tables is not able to be established, the client should still be added to the MPI
- Because characteristics of a client’s Medi-Cal eligibility change frequently throughout each month, the results of each eligibility record provided either via the MEDS file (15 months) or as a result of a real-time 270/271 eligibility request should result in the creation of a unique eligibility record in the MPI-Eligibility table(s)
- The MPI-Eligibility database should be deeply integrated with the Enterprise Health Record functions. This integration will include:
 - Users should be prompted to execute Real-Time 270/271 transactions via the MPI-Eligibility function from within the Enterprise Health Record when any of the following transactions are initiated:
 - Admission
 - Any functions associated with the assignment of Payors/Guarantors/Plans
 - Progress Note/Charge Entry
 - Diagnosis
 - Discharge
 - Claims Process
 - Users should be able to review current Medi-Cal Eligibility Information as well as last 5 eligibility records from within the Enterprise Health Record
 - The function in the Enterprise Health Record that manages the Guarantors/Payors/Coverage for each client will need to be tightly integrated with the MPI-Eligibility table(s) such that as any edit or addition to the MPI-Eligibility table(s) are replicated to the Enterprise Health Record to be used for the billing/claiming process

Use Cases

First Use Case: A potential client calls the County Access Center to inquire about services. They are very open and compliant and happy to share their information. The county staff is able to use their information to see if the client is known to the Master Patient Index. The client does not appear to have a unique PATID/MRN assigned. The system then uses the same information to query the MPI-Eligibility database. There is an eligibility record since the potential client was included in a previous MMEF file uploaded for a neighboring county. The user selects that record, and the MPI-Eligibility system sends a 270 record to verify Medi-Cal eligibility. The system uses the demographic data from the eligibility record to seed the MPI-Demographics. The Access Center employee confirms the demographics information with the potential client and the MPI-Demographics database assigns the client a unique PATID/MRN. They then move forward to complete the “Contact Activity” record



Second Use Case: A potential client has been working with the county through several Care Coordination activities over the past few months. They have now graduated to the point where they are scheduled to be admitted for an “Assessment Episode”. They arrive and the administrative staff works with the client to complete an admission. During the admission process the user queries the MPI-Demographics and based upon the identifying information provided, they see that a PATID/MRN already exists for the client. Upon selecting the record in the MPI-Demographics database, the MPI-Eligibility system generates and submits a 270 eligibility verification to Medi-Cal. The user is able to update the client’s Demographics information in the MPI-Demographics database, and the client is admitted. Although the client had already had a record in the MPI-Demographics database, this is their first episode in this particular county. As such the Enterprise Health Record identifies this as “episode #1” for this client, in the county.

The staff continue the intake process by entering into the Enterprise Health Record details provided by the client regarding their Payor/Guarantor information.

The client meets with the clinician who initially focuses on the potential Mental Health issues by completing a series of Assessments and an Assessment Progress Note within the client’s episode in the Enterprise Health Record. When the client is leaving, the admin staff book the client a new appointment for additional Assessment activities. While they are booking the appointment, the admin staff are able to view the last 5 eligibility records for the client in the MPI-Eligibility database. Unfortunately, the 271 response they received from their earlier 270 indicate that the client’s Medi-Cal coverage had lapsed. The admin staff provide the client information as to how to re-establish their eligibility and ask that they do so prior to the next appointment.

Third Use Case: On the scheduled date, the client arrives and upon check-in, the Enterprise Health Record allows the admin staff to run a new Real-Time 270 eligibility inquiry to Medi-Cal. They receive back a 271 response indicating the client’s Medi-Cal Eligibility is effective. The client meets with the clinician. The clinician documents their interaction in the Assessment Progress Note.

Later, the billing department within the County initiates the process to create claims based upon completed Progress Notes. During this process, the Enterprise Health Record compares the “Date of Service” values from these two Assessment Progress Notes against the historical Medi-Cal eligibility information stored in the MPI-Eligibility database and determines that the because the client was not covered by Medi-Cal on the date of their first appointment, it is not billable, but the second visit/charge is. The system creates an 837P claim for Medi-Cal for the second appointment/charge.

[Suggested Data Elements](#)

MPI_Patient Demographics			
Column	Type	Length	Notes
Unique_client_ID	integer	15	To be assigned by MPI
County_DB_Unique_ID	varchar	15	This is the join that will provide a link between MPI and County databases
client_name_first	varchar	20	Allow Special characters
client_name_middle	varchar	20	
client_name_last	varchar	30	Allow Special characters



client_name_sffix	varchar	5	
client_name_pfix	varchar	5	
client_name_full	varchar	80	concatenated/full name of client
client_street_addr1	varchar	80	
client_street_addr2	varchar	80	
client_city_addr	varchar	40	
client_state_addr_code	varchar	5	
client_state_addr_val	varchar	40	
client_zip_addr	varchar	10	Allow special character "-"
client_county_addr_code	varchar	5	
client_county_addr_val	varchar	40	
client_home_phone	phone	14	formatting to support standardized phone number
client_cell_phone	phone	14	
client_work_phone	phone	14	
client_prim_language_code	varchar	5	
client_prim_language_val	varchar	40	
client_sex_orient_code	varchar	5	
client_sex_orient_val	varchar	40	
client_preferred_name	varchar	80	
client_primary_lang_code	varchar	5	
client_primary_lang_val	varchar	40	
client_race_code	varchar	5	
client_race_val	varchar	40	
client_ethnic_origin_code	varchar	5	
client_ethnic_origin_val	varchar	40	
client_marital_stat_code	varchar	5	
client_marital_stat_val	varchar	40	
client_alias1	varchar	80	
client_alias2	varchar	80	
client_alias3	varchar	80	
client_alias4	varchar	80	
client_alias5	varchar	80	
other_unq_ID1	varchar	15	
other_unq_ID2	varchar	15	
other_unq_ID3	varchar	15	
other_unq_ID4	varchar	15	
other_unq_ID5	varchar	15	
other_unq_ID6	varchar	15	
other_unq_ID7	varchar	15	
other_unq_ID8	varchar	15	
other_unq_ID9	varchar	15	
other_unq_ID10	varchar	15	
other_unq_ID11	varchar	15	
other_unq_ID12	varchar	15	
other_unq_ID13	varchar	15	
other_unq_ID14	varchar	15	
other_unq_ID15	varchar	15	



2.2.16 Document Management

The goal of any EHR is to store all treatment data into tables that allow for the retrieval of a multitude of discrete values about each client. However, there is also a requirement to be able to scan the occasional analog document and attach it to the client record. Scans may include items such as paper lab results, paper progress notes, insurance cards, or any non-digital item that may benefit the client treatment by having it attached to the client treatment record inside the EHR.

It is also helpful to be able to create categories of scans in the same way we use folders in computers to help keep our data files organized. A set scan file properties to assist in the search of scanned documents in the client record is also helpful. The interface should be able to interact with either a desktop scanner or a network attached scanner. The document management system should be able to capture directly from a scanner, or upload already digitized scan files.

High Level Requirements

- Each scanned document is associated/linked with a client record
- The document management interface must provide effective search and retrieval of scanned client content functionality.
- Allow non-digital data to be added to the client record via several input sources such as desktop scanner, network attached scanner, direct file upload, mobile device scan applications, web content, etc.
- Allow separate folders to be created for each client to enable document organization.
- Allow different scan file properties to be set to act as a meta data layer for each document.

2.3 Care Coordination Requirements

A large portion of the operations of these organizations extend beyond the actual treatment provided to clients. Functions and data associated with activities that occur prior to a client being admitted for treatment have some unique requirements that will need to be supported by the Enterprise Health Record.

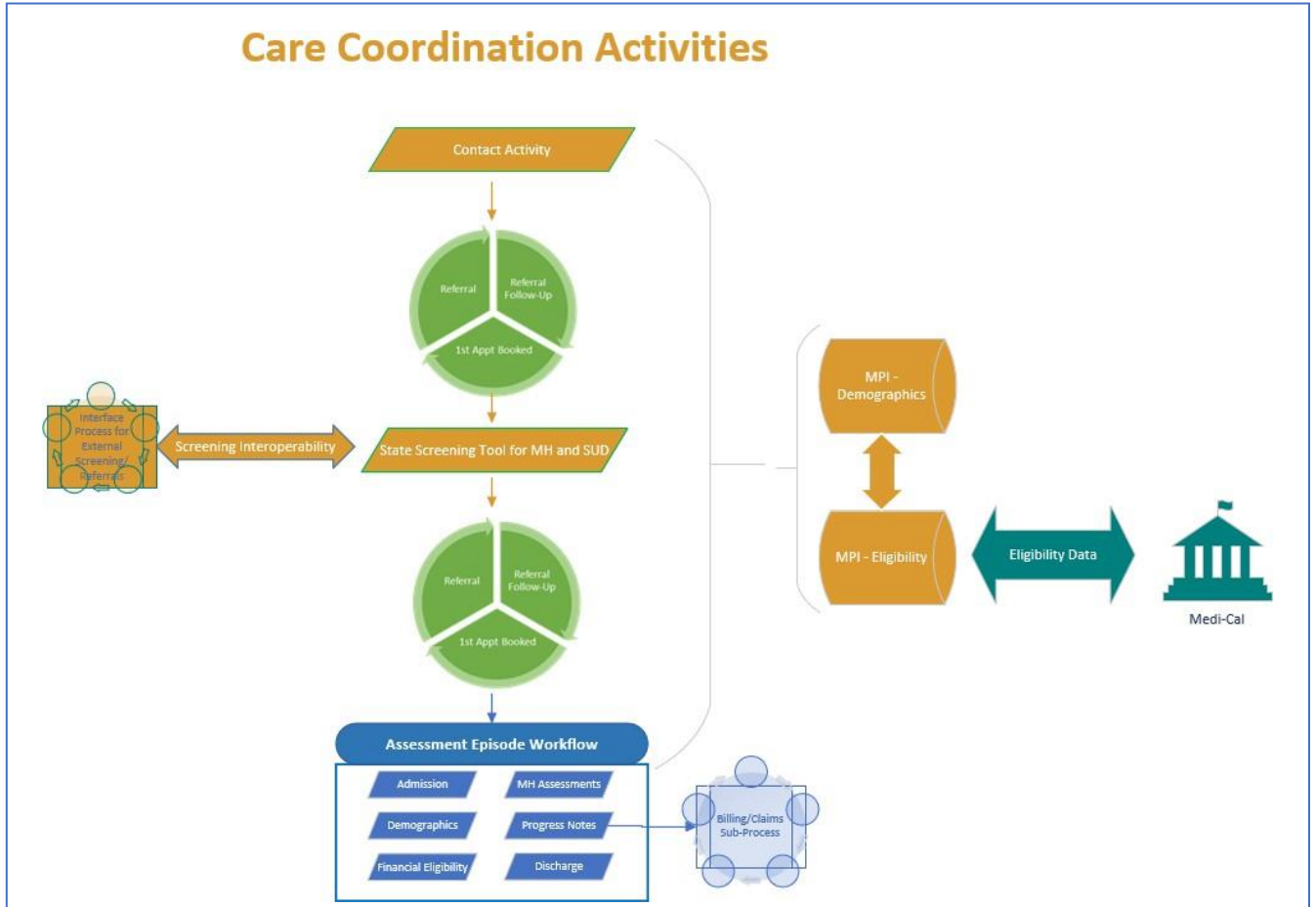
As the basis of these requirements, CalMHSA and its partner Counties have defined a standard workflow associated with the matriculation of potential clients and other activities which fall within the category of “Care Coordination”. The following descriptions of the proposed functional requirements follow the steps/activities in this defined workflow. It is important to note that the workflow is presented in its totality, but it does not mean that all activities will be performed for all potential clients/clients. Instead, as potential clients matriculate through the workflow, there are a variety of circumstances that could lead to them leaving before the “Care Coordination” workflow is completed. In other instances, the first activity performed may differ across different potential clients.

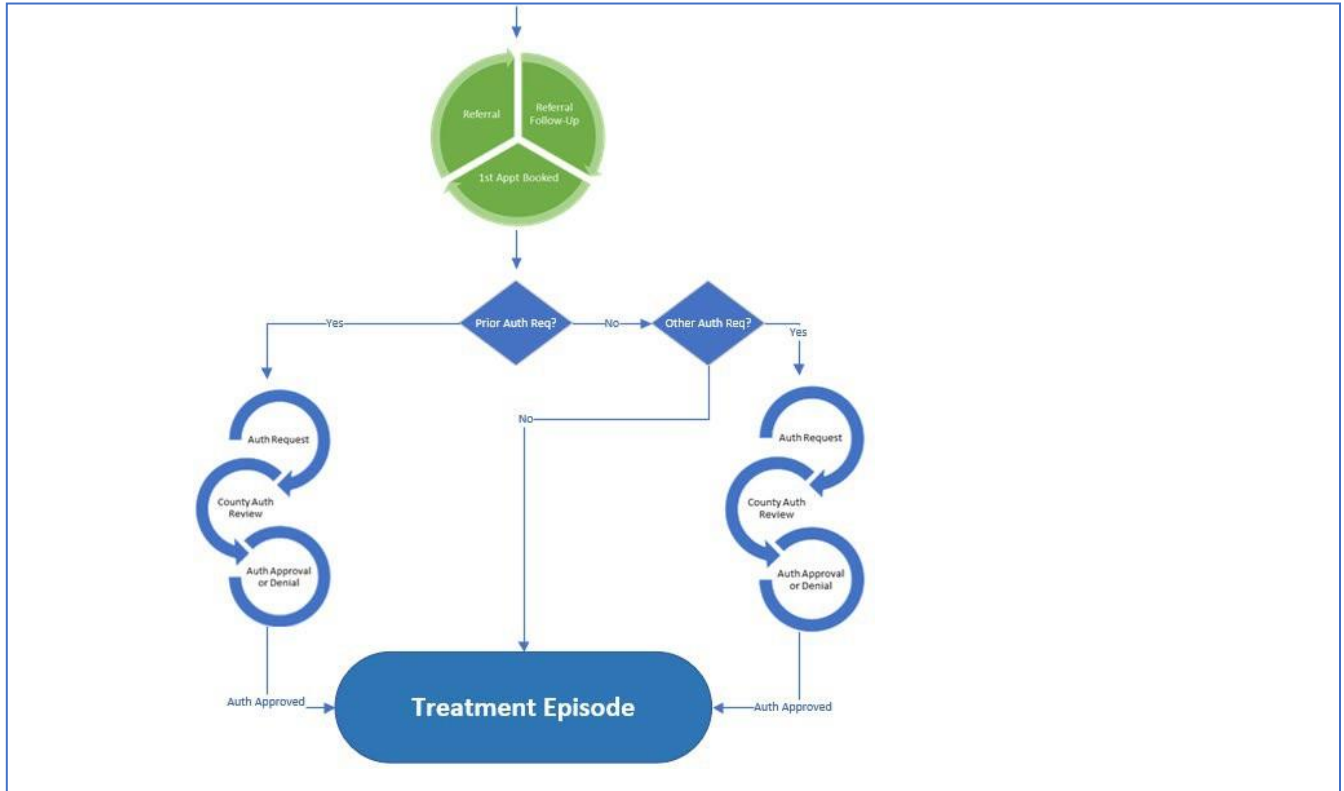


Throughout the “Care Coordination” workflow, there is a **very** high dependence upon and assumption that the concepts of “Workflow Definition and Application Functions” are fully supported within the Enterprise Health Record.

In addition to the establishment and support of the predefined workflow, “Care Coordination” activities will be highly dependent upon the ability of the Enterprise Health Record to accommodate data collection forms for “Potential Clients” and/or “Clients”. It is quite common that during initial interactions (e.g., Screening) with County Behavioral Health organizations potential clients may wish to remain anonymous. In other instances, users of the enterprise system will perform the same activity (e.g., Screening) for a returning client who has a PatientID/MRN assigned by the Master Patient Index (MPI). Each use case is equally common and thus, the Enterprise Health Record will require mechanisms to accommodate.

CalMHSA and its partners will consider vendors whose systems are currently client and/or admission/episode specific, but such respondents will need to explain in their response the design they will employ to retrofit their solution to meet these needs. Additionally, the cost and timeline for development of any work to perform such retrofit will need to be specifically identified in the RFP response.





2.3.1 Support Care Coordination Activities in Non-Client-Specific Manner

For traditional healthcare providers, almost all data collected by the organization pertains to treatment provided to its patients/clients and associated collateral activities (e.g., claims processing and reporting). As such, the functionality of Electronic Health Records employed by such organizations generally focuses on the treatment of **active clients** as the basis of all activities in the system.

It is quite common that during initial interactions (e.g., Screening) with County Behavioral Health organizations potential clients may wish to remain anonymous. In other instances, users of the enterprise system will perform the same activity (e.g., Screening) a returning client who has a PatientID/MRN assigned by the Master Patient Index (MPI). Still in other scenarios, an activity is performed where the person with whom the county is interfacing with is acting on behalf of another, unnamed, third party. Each use case is equally common and thus, the Enterprise Health Record will require mechanisms to support the execution of all activities all-the-while accommodate all potential scenarios.

CalMHSA and its partners will consider vendors whose systems are currently client and/or admission/episode specific, but such respondents will need to explain in their response the design they will employ to retrofit their solution to meet these needs. Additionally, the cost and timeline for development of any work to perform such retrofit will need to be specifically identified in the RFP response.



High Level Requirements

- Core/Base forms/screens that support the identified Care Coordination activities in a non-episodic manner
- Core/Base forms/screens that support the identified Care Coordination activities in a non-client specific manner
- Core/Base forms/screens that support the identified Care Coordination activities where a returning client who has a PatientID/MRN assigned by the Master Patient Index (MPI) is identified and part of the record
- Core/Base forms/screens that support the identified Care Coordination activities where the person is identified as a “Potential Client” and stored as part of the record
- Core/Base forms/screens that support the identified Care Coordination activities where:
 - Only a third party is identified and stored as part of the record
 - A third party and a returning client who has a PatientID/MRN assigned by the Master Patient Index (MPI) is identified and part of the record.
 - A third party and a “Potential Client” is identified and part of the record.
- Core/Base forms/screens that support the identified Care Coordination activities where neither a client, potential client, nor third party is identified. The activity is anonymous
- Forms/screens created using the Application Configuration Tools that support the identified Care Coordination activities where no person (Client/Potential Client/Third Party) is identified and part of the record
- Forms/screens created using the Application Configuration Tools that support the identified Care Coordination activities in a non-episodic manner
- Forms/screens created using the Application Configuration Tools that support the identified Care Coordination activities in a non-client specific manner
- Forms/screens created using the Application Configuration Tools that support the identified Care Coordination activities where a returning client who has a PatientID/MRN assigned by the Master Patient Index (MPI) is identified and part of the record
- Forms/screens created using the Application Configuration Tools that support the identified Care Coordination activities where the person is identified as a “Potential Client” and stored as part of the record
- Forms/screens created using the Application Configuration Tools that support the identified Care Coordination activities where:
 - Only a third party is identified and stored as part of the record
 - A third party and a returning client who has a PatientID/MRN assigned by the Master Patient Index (MPI) is identified and part of the record.
 - A third party and a “Potential Client” is identified and part of the record.



- Forms/screens created using the Application Configuration Tools that support the identified Care Coordination activities where no person (Client/Potential Client/Third Party) is identified and part of the record
- For both Core/Base forms/screens and those created using the Application Configuration Tools, the ability to search for existing records by
 - Client Name
 - PatientID/MRN
 - Potential Client Name
 - Name of Third Party
 - Activity Date
 - Data Entry User
 - Other
- Integration between both Core/Base forms/screens and those created using the Application Configuration Tools Creation with the by the Master Patient Index (MPI) such that when needed, “Potential Clients” can be created as Clients and assigned PatientID/MRN
- Ability to transform “Potential Client” records into “Client” records (MPI – Demographics) and as a by-product have all existing records where the “Potential Client” was identified updated such that they now reference/point to the “Client”

Use Cases

First Use Case: County “A” has a toll-free Access Line to field inquiries from the public. To support the recording of such activities, the Enterprise Health Record has been configured to provide a “Contact Activity” data input form. A call comes into the line. The caller simply wants to know the address for the main facility. This inquiry does not rise to the level where the user feels the need to ask the caller their name. The user answers the caller’s question and logs a record via the “Contact Activity” form. The system allows them to file/save the form without a “Name” being identified for the caller

Second Use Case: Another call is received on the Access Line. The caller identifies herself as the mother of a person who has been struggling with substance use. The staff member asks the caller what the name of their child is, but the caller does not want to potentially get their child in trouble, so they refuse to provide that information. The caller is interested in what treatment options might be available for her child and what the Medi-Cal eligibility and other prerequisites might exist. As the staff member answers all the caller’s questions, records the details of the interaction in the “Contact Activity” form, and files the record

Third Use Case: Two days later, the Access Line receives a call from a young man. He explains that his mother had called previously to ask about potential treatment options. The staff member initiates a new “Call Activity” record. They link this new record to the previous call from the mother. The caller explains that he is skeptical that he has a problem, but he promised his mother he would speak to a professional. He agrees to speak to a clinician and have a “Substance Use Screening” performed. He provides his name and other identifying information. It is still unclear as to whether he will enroll in treatment with the County and so he is still considered a “Potential” client.



Fourth Use Case: Another call is received on the Access Line. This time the caller is in high distress, and they are reporting serious mental health issues. During the conversation with the county staff member, the caller informs the staff member that they have been treated by the County Behavioral Health agency. The user is able to search the Mater Patient Index for the client’s existing profile (PatientID/MRN) and that is associated with the “Contact Activity” record.

2.3.2 Support Multiple Care Coordination Activity Records

Although the workflow associated with “Care Coordination Activities” seems linear, there are in fact many variable paths. One common scenario is that a certain activity is performed multiple times for a given client without any progression to the next activity. In this scenario, it will be important to provide users with the ability to create a correlation/link between the different records.

High Level Requirements

- Core/Base forms/screens that support multiple Care Coordination activities for any Client, Potential Client, Third Party, or Anonymous records
- Forms/screens created using the Application Configuration that support multiple Care Coordination activities for any Client, Potential Client, Third Party, or Anonymous records
- Within both Core/Base forms/screens and those created using the Application Configuration Tools, the ability to search the data table for the activities to find existing records
- Based upon the result of this search, allow the user to select existing records from the table associated with the activity and store the Unique_ID of the selected records to be stored with the current record being entered

Use Cases

First Use Case: A call is received on the Access Line. The caller identifies herself as the mother of a person who has been struggling with substance use. The staff member asks the caller what the name of their child is, but the caller does not want to potentially get their child in trouble, so they refuse to provide that information. The caller is interested in what treatment options might be available for her child and what the Medi-Cal eligibility and other prerequisites might exist. As the staff member answers all the caller’s questions, records the details of the interaction in the “Contact Activity” form, and files the record

Two days later, the Access Line receives a call from a young man. He explains that his mother had called previously to ask about potential treatment options. The staff member initiates a new “Call Activity” record. They use the search function within the “Contact Activity” form to find the previous call from the mother. The caller explains that he is skeptical that he has a problem, but he speaks to the staff member for a while but remains unconvinced and is not at this time ready to move forward to have a Substance Use Screening Performed. When the user files the “Call Activity” record for this interaction, the Unique_ID from the previous call with the mother is stored as an element of the new record.

A few days later, the young man calls back to ask additional questions. The staff member initiates a new “Call Activity” record. They use the search function within the “Contact Activity” form to find the previous call from



the mother and the young man. They link this with the current “Call Activity” record using their respective Unique_IDs.

2.3.3 “Contact Activity” Form

Within behavioral health organizations there is a high volume of activities related to fielding inquiries and communicating with the public. While a large portion of these activities are related, or become related, to treatment of a client, the volume of activities not related to client care require a high level of flexibility to support all possible scenarios. As such, this RFP seeks an Enterprise Health Record that supports a “Contact Activity” function/form that includes the following requirements:

High Level Requirements

- A “Contact Activity” form that accommodates all requirements associated with Supporting Care Coordination Activities in Non-Client-Specific Manner as described within this document
- A “Contact Activity” form that accommodates all requirements associated with [Highly Accessible Data Architecture and Reporting Tools](#) as described within this document
- A “Contact Activity” form that accommodates all requirements associated with [Integration Tools – Standard Healthcare APIs and System Open Architecture](#) as described within this document
- A “Contact Activity” form that accommodates all requirements associated with [Multi-County Installation](#) as described within this document
- A “Contact Activity” form that accommodates all requirements associated with [Application Configuration Tools](#) as described within this document
- A “Contact Activity” form that accommodates all requirements associated with [Dynamic User Interface](#) as described within this document
- A “Contact Activity” form that accommodates all requirements associated with [Workflow Definition and Application Functions](#) as described within this document
- A “Contact Activity” form that accommodates all requirements associated with [Consent Management](#) as described within this document
- A “Contact Activity” form that accommodates all requirements associated with [Master Patient Index](#) as described within this document
- Fields/data collected within a “Contact Activity” record would include but not be limited to:
 - Contact Unique ID
 - Date of contact/activity
 - Time of contact/activity
 - Caller Name
 - Reason for contact/activity
 - Relationship of caller to potential client
 - Client (optional)
 - Contact/Activity Notes



- Disposition of contact/activity
- User completing contact/activity
- Application will support search of “Contact Activity” records based upon
 - Contact Unique ID
 - Date of contact/activity
 - Time of contact/activity
 - Caller Name
 - Client Name (Optional)
 - User completing contact/activity
 - Disposition of contact/activity
- The ability to mark “Contact Activities” records as “Draft” or “Completed”
- Records identified as “Completed” will not be able to be edited/updated

Use Cases

First Use Case: A call is received on the Access Line. The caller identifies herself as the mother of a person who has been struggling with substance use. The staff member asks the caller what the name of their child is, but the caller does not want to potentially get their child in trouble, so they refuse to provide that information. The caller is interested in what treatment options might be available for her child and what the Medi-Cal eligibility and other prerequisites might exist. As the staff member answers all the caller’s questions, records the details of the interaction in the “Contact Activity” form, and files the record.

Second Use Case: Two days later, the Access Line receives a call from a young man. He explains that his mother had called previously to ask about potential treatment options. The staff member initiates a new “Call Activity” record. They link this new record to the previous call from the mother. The caller explains that he is skeptical that he has a problem, but he promised his mother he would speak to a professional. He agrees to speak to a clinician and have a “Substance Use Screening” performed. He provides his name and other identifying information. It is still unclear as to whether he will enroll in treatment with the County and so he is still considered a “Potential” client.

Based upon the information shared by the potential client, the staff member determines that a Substance Use Screening is warranted. This organization happens to have one or more qualified staff available for warm hand-offs for “walk-ins” or people in crisis. Based upon the “Disposition Type” of the “Call Activity” record, the staff member identifies a specific clinician to be assigned a “Referral” to complete the screening. The clinician is informed of a client on the phone awaiting a screening. He/she logs into the Enterprise Health Record and their work queue is presented with this “Referral” as task assigned to them.

Third Use Case: Another call is received on the Access Line. This time the caller is in high distress, and they are reporting serious mental health issues. During the conversation with the county staff member, the caller informs the staff member that they have been treated by the County Behavioral Health agency. The user is able to search the Mater Patient Index for the client’s existing profile (PatientID/MRN) and that is associated with the “Contact Activity” record.



The client is very interested in speaking to their former case manager and asks that they call them. Based upon the “Disposition Type” of the “Call Activity” record, the staff member identifies a specific clinician to be assigned the referral.

2.3.4 Referral Process - Screening

It is generally understood that the periods between active engagement with potential clients present the greatest risk to the potential client’s motivation for change. As such, implementation and adherence to an effective workflow is extremely important to CalMHSA. To support the workflow anticipated by CalMHSA and its partners, the Enterprise Health Record should employ all requirements associated with Workflow Definition and Application Functions as described within this document.

Within the workflow associated with supporting clients in their care coordination phase, there exists a multi-step, sub-process referred to as the “Referral Process”. The “Referral Process” is the sum of the steps necessary to contact a potential client to coordinate the completion of the next care coordination activity. The “Referral Process” is invoked and followed any time that the care coordination activities are handed off/assigned to a different person/group. Reference to the “Referral Process” will appear several times throughout this document but the requirements remain consistent.

It is anticipated that the “Referral Process” will be comprised of two data input forms. The first form will be associated with the creation of a Referral record. In addition to demographic/contact information of the client/potential client, the Referral record will identify the person/group to whom the Referral is being assigned, the next care coordination activity to be completed, indication of whether the Referral is to be considered “urgent”, etc. When the system creates the initial Referral record, it should assign a unique identifier that will be used as the basis to link all subsequent steps in the “Referral Process”.

The second data input form will be associated with the follow-up activities after the initial Referral. It is within this form that the assigned user/group will record their follow-up activities. Such activities will be identified as the “Disposition Type” of the Referral Follow-Up and will include items like; “Attempted Contact”, “Client Declined Services”, “Unable to Contact Client – Close Referral”, “Referral Re-Assigned”, “Care Coordination Activity Performed” or “Care Coordination Activity Booked”. Each Referral Follow-Up record should contain the Unique ID of the initial Referral record, as well as a sequential sequence number.

Requirements associated with the “Referral Process” include:

High Level Requirements

- “Referral” Data Input Form
 - A “Referral” form that accommodates all requirements associated with [Supporting Care Coordination Activities in Non-Client-Specific Manner](#) as described within this document
 - A “Referral” form that accommodates all requirements associated with [Highly Accessible Data Architecture and Reporting Tools](#) as described within this document
 - A “Referral” form that accommodates all requirements associated with [Integration Tools – Standard Healthcare APIs and System Open Architecture](#) as described within this document



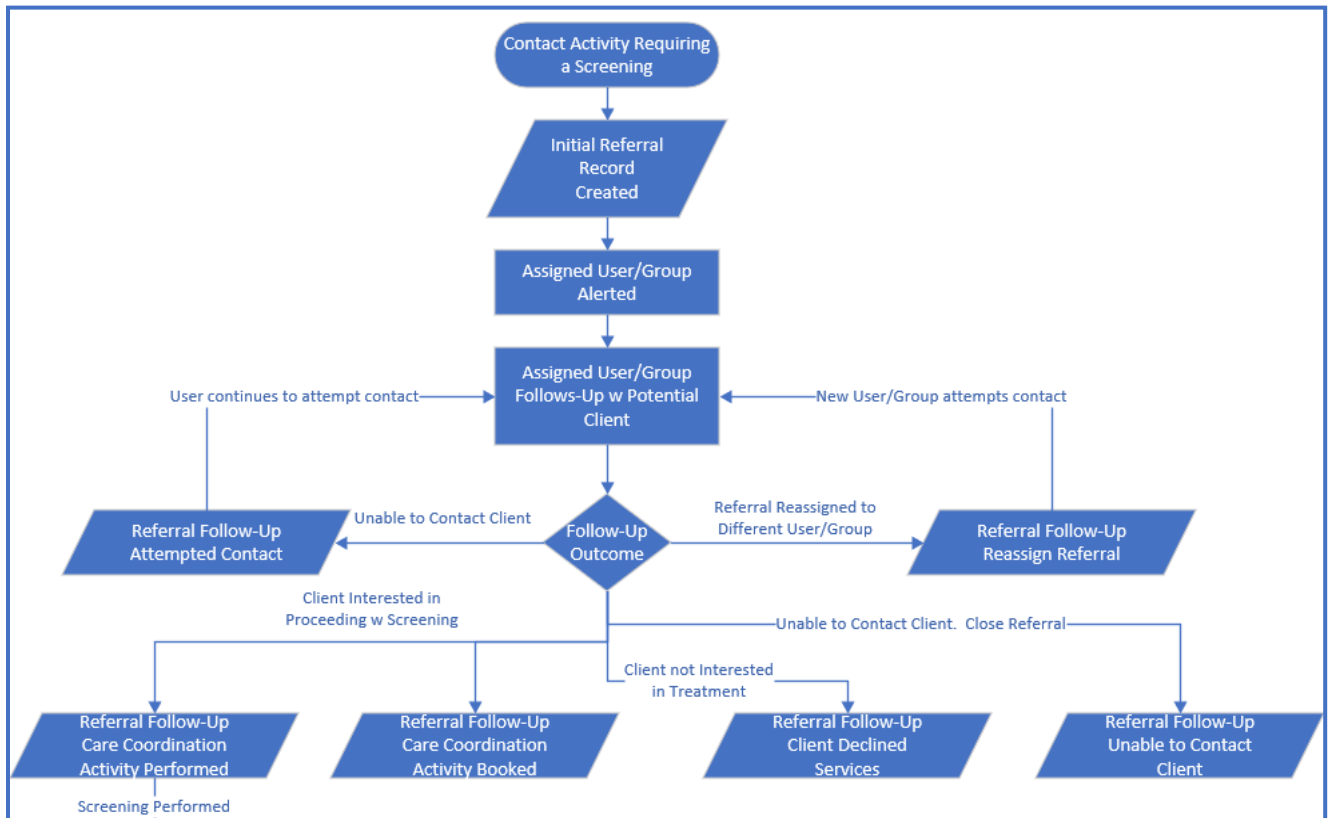
- A “Referral” form that accommodates all requirements associated with [Multi-County Installation](#) as described within this document
- A “Referral” form that accommodates all requirements associated with [Application Configuration Tools](#) as described within this document
- A “Referral” form that accommodates all requirements associated with [Dynamic User Interface](#) as described within this document
- A “Referral” form that accommodates all requirements associated with [Workflow Definition and Application Functions](#) as described within this document
- A “Referral” form that accommodates all requirements associated with [Consent Management](#) as described within this document
- A “Referral” form that accommodates all requirements associated with [Master Patient Index](#) as described within this document
- Fields/data collected within a “Referral” record would include but not be limited to:
 - Referral Date
 - Referral Time
 - Referring Username
 - Referring User Contact Phone
 - Referral Type (SUD vs. Mental Health)
 - Is Referral Urgent
 - Has Medi-Cal been verified?
 - Referral Level of Care
 - Preferred Language (For Contact)
 - Cell Phone (For Contact)
 - Home Phone (For Contact)
 - Group – Assigned To
 - Individual – Assigned To
 - Referral Comments/Details
 - Referral Unique ID
- “Referral Follow-Up” Data Input Form
 - A “Referral Follow-Up” form that accommodates all requirements associated with [Supporting Care Coordination Activities in Non-Client-Specific Manner](#) as described within this document
 - A “Referral Follow-Up” form that accommodates all requirements associated with [Highly Accessible Data Architecture and Reporting Tools](#) as described within this document
 - A “Referral Follow-Up” form that accommodates all requirements associated with [Integration Tools – Standard Healthcare APIs and System Open Architecture](#) as described within this document
 - A “Referral Follow-Up” form that accommodates all requirements associated with [Multi-County Installation](#) as described within this document



- A “Referral Follow-Up” form that accommodates all requirements associated with [Application Configuration Tools](#) as described within this document
- A “Referral Follow-Up” form that accommodates all requirements associated with [Dynamic User Interface](#) as described within this document
- A “Referral Follow-Up” form that accommodates all requirements associated with [Workflow Definition and Application Functions](#) as described within this document
- A “Referral Follow-Up” form that accommodates all requirements associated with [Consent Management](#) as described within this document
- A “Referral Follow-Up” form that accommodates all requirements associated with [Master Patient Index](#) as described within this document
- Fields/data collected within a “Referral Follow-Up” record would include but not be limited to:
 - Referral Follow-Up Date
 - Referral Follow-Up Time
 - Referral Follow-Up Username
 - Follow-Up User Contact Phone
 - Referral Type (SUD vs. Mental Health)
 - Preferred Language (For Contact)
 - Cell Phone (For Contact)
 - Home Phone (For Contact)
 - Referral Follow-up Disposition
 - Contact Attempt Notes/Details
 - Client Declined Services Notes/Details
 - Group – Re-Assigned To
 - Individual – Re-Assigned To
 - Referral Reassigned Notes/Details
 - Referral Unique ID
 - Referral Follow- Up Sequence



Use Cases



First Use Case: It is almost midnight on a Friday and the County Access Line receives a call from a person who is experiencing severe depression and anxiety due to the COVID-19 pandemic. Their family has experienced employment insecurity and now faces the threat of eviction. The caller is skeptical that they can be helped and afraid that their spouse will not approve of them calling the County to inquire about help. The Access Center staff assists the caller with information about food banks and other resources for those struggling economically. Based upon the rapport that is established, the caller agrees to speak to a clinician to have a Mental Health Screening performed. The staff member completes the “Call Activity” form and based upon the “Disposition” identified, through the Dynamic User Interface, the enterprise health system presents the staff member the “Referral” form so that a different staff member might make contact and schedule the Screening. The staff member identifies the potential client’s name, their preferred language, their contact information, and they assign the referral to a local Contract Provider, Hope House.

Second Use Case: It is the following Monday morning and a clinician from Hope House logs into the Enterprise Health Record. In their work queue they see a Referral record that has been assigned to Hope House. The clinician selects the Referral from their work queue and the system launches a form that is a combination of the initial “Referral” and the “Referral Follow-Up” forms. The staff member reviews the Referral and sees that that the potential client’s preferred language is Tagalog. The clinician knows that they do not have any staff that speak Tagalog fluently but another agency in the area does. The clinician completes the “Referral Follow-Up” record and reassigns the Referral to the Health Service Plus agency.



Third Use Case: A staff member from Health Service Plus logs into the Enterprise Health Record and sees a new referral in the work queue for their group. The user selects the Referral from their work queue and the system launches a form that is a combination of information from initial “Referral” and the subsequent “Referral Follow-up”, as well as the “Referral Follow-Up” form. The staff member calls the potential client. Upon this first attempt, they get voicemail and leave a message. They complete the “Referral Follow-Up” record documenting the contact attempt. Based upon that Disposition, the Referral remains in the work queue for the HealthRIGHT 360 group.

Later in the day, a different staff member sees the Referral still in the group’s work queue. They select the Referral from their work queue and the system launches a form that is a combination of the initial “Referral” and information from the two “Referral Follow-Up” records. The user attempts to contact the potential client again. This time they are successful. Initially, the potential client is hesitant but when told that a clinician fluent in Tagalog is on-staff, the potential client agrees to proceed with booking an appointment. The staff member completes the “Referral Follow-Up” record and based upon the “Disposition Type”, the Dynamic User Interface of the system launches the Appointment Scheduling functions and the staff member and potential client identify a date/time that would work for a phone screening.

2.3.5 Appointment Scheduling

To support activities throughout all stages of a potential client and/or client’s care coordination and treatment, the Enterprise Health Record will need to provide highly flexible Appointment Scheduling capabilities. Within Care Coordination activities, such flexibility will focus on the supporting appointments for entities other than existing clients. As previously noted, throughout the Care Coordination process it is possible/common that appointments will need to be booked for people who have not yet been added to the Master Patient Index – Demographics, and therefore, are not yet clients.

Additionally, as with all activities throughout the Care Coordination process, the Enterprise Health Record should employ all requirements associated with Workflow Definition and Application Functions as described within this document. Specifically, when appointments are booked as a result of previous activities (e.g., Referral Follow-Up), mechanisms to link the activities within the system and database need to be applied.

High Level Requirements

- “Appointment Scheduling” capabilities that accommodates all requirements associated with [Supporting Care Coordination Activities in Non-Client-Specific Manner](#) as described within this document
- “Appointment Scheduling” capabilities that accommodates all requirements associated with [Highly Accessible Data Architecture and Reporting Tools](#) as described within this document
- “Appointment Scheduling” capabilities that accommodates all requirements associated with [Integration Tools – Standard Healthcare APIs and System Open Architecture](#) as described within this document
- “Appointment Scheduling” capabilities that accommodates all requirements associated with [Multi-County Installation](#) as described within this document



- “Appointment Scheduling” capabilities that accommodates all requirements associated with [Application Configuration Tools](#) as described within this document
- “Appointment Scheduling” capabilities that accommodates all requirements associated with [Dynamic User Interface](#) as described within this document
- “Appointment Scheduling” capabilities that accommodates all requirements associated with [Workflow Definition and Application Functions](#) as described within this document
- “Appointment Scheduling” capabilities that accommodates all requirements associated with [Consent Management](#) as described within this document
- “Appointment Scheduling” capabilities that accommodates all requirements associated with [Master Patient Index](#) as described within this document
- “Appointment Scheduling” capabilities that support the following:
 - Establishment of calendars/schedules for
 - Clinicians
 - Other Staff
 - Rooms
 - Other Resources
 - Appointment Scheduling for
 - Clients
 - Potential Clients
 - 3rd Party/Guardian
 - Staff Meetings
 - Paid Time Off other Staff Time categories
 - Other Activities
 - Appointment Requests/Scheduling through Patient Portal
 - Appointment Reminders
 - Via SMS Text
 - Via Patient Portal
 - Waitlist Management
 - Integration with Telehealth Platforms
 - Integration with MS Outlook and other Calendars using De-Identified Client Data

Use Cases

First Use Case: A staff member from Health Service Plus logs into the Enterprise Health Record and sees a new referral in the work queue for their group. The user selects the Referral from their work queue and the system launches a form that is a combination of the initial “Referral” information, the subsequent “Referral Follow-up” information, and the “Referral Follow-Up” forms. The staff member completes the “Referral Follow-Up” record and based upon the “Disposition Type”, the system launches the Appointment Scheduling functions and the staff member and potential client identify a date/time that would work for a phone screening. The Enterprise



Health Record allows the appointment to be booked although the has not yet been added to the Mater Patient Index – Demographics. Additionally, there is a link between the scheduled appointment and the preceding “Referral Follow-Up” activity.

A day prior to the scheduled appointment, the person receives an appointment reminder via (short message service) SMS text on their mobile phone.

Second Use Case: An existing client receiving treatment has decompensated and needs an appointment with their care team as soon as possible. The client is in distress and cannot find the telephone number for the clinic/site/clinician from whom they have been receiving treatment. The client looks online and finds the number for a local Mental Health provider in the area. This provider is one of the County’s Contract Providers. A user at this agency answers the phone, logs into the Enterprise Health Record and can search the schedules in the system based upon the name of the clinician the caller provided. The staff from the agency can book an appointment for the client with the clinician without seeing any clinical data about the client’s current or past treatment. In short, the appointment for a known client is able to be booked without being associated with an episode.

Upon check-in with the staff associated with the program that is actually treating the client, the staff at the front desk are able to update the Appointment and associate it with their episode for that client.

Third Use Case: The County is scheduling training for its Licensed Clinical Social Workers (LCSWs). To assure that operations are not interrupted, the training is being performed in 45-minute blocks each morning throughout the week. Using the Enterprise Health Record, an administrative staff is asked to schedule each LCSW for the morning training and use the appointment scheduling module to secure a meeting room. This appointment appears both on each LCSW’s calendar in the Enterprise Health Record, as well as on their MS Outlook Calendar.

2.3.6 “State Screening Tool for MH and SUD” Form

In California, there are multiple initiatives underway to create a consolidated, universal behavioral health screening tool to evaluate for a broad spectrum of mental health disorders ranging from depression to schizophrenia. As part of this RFP, it is anticipated that the screening tool designed by these statewide efforts will be supported as a data input form within the selected Enterprise Health Record either through development performed by the vendor, or through the use of the Application Configuration Tools.

Frequently the completion of this State Screening Tool will be part of the Care Coordination efforts when evaluating and on-boarding potential clients. As with most clinical tools, it is anticipated that the State’s Screening Tool will be both flexible and comprehensive. As such, to assist the staff as they use the tool, it is anticipated that most of the elements described as Dynamic User Interface will be employed. For example, within the form, the application should guide the user through the screening for a potential client (e.g., fields made required, fields added, fields removed). Based upon answers provided during the screening, additional forms/screenings may be required and thus appended to the form. Calculations/scorings may be included within the screening and should be performed immediately without the need to submit/file the record.

As such, solutions proposed should support the following:



High Level Requirements

- “State Screening Tool for MH and SUD” form that accommodates all requirements associated with [Supporting Care Coordination Activities in Non-Client-Specific Manner](#) as described within this document
- “State Screening Tool for MH and SUD” form capabilities that accommodates all requirements associated with [Highly Accessible Data Architecture and Reporting Tools](#) as described within this document
- “State Screening Tool for MH and SUD” form capabilities that accommodates all requirements associated with [Integration Tools – Standard Healthcare APIs and System Open Architecture](#) as described within this document
- “State Screening Tool for MH and SUD” form capabilities that accommodates all requirements associated with [Multi-County Installation](#) as described within this document
- “State Screening Tool for MH and SUD” form capabilities that accommodates all requirements associated with [Application Configuration Tools](#) as described within this document
- “State Screening Tool for MH and SUD” form capabilities that accommodates all requirements associated with [Dynamic User Interface](#) as described within this document
- “State Screening Tool for MH and SUD” form capabilities that accommodates all requirements associated with [Workflow Definition and Application Functions](#) as described within this document
- “State Screening Tool for MH and SUD” form capabilities that accommodates all requirements associated with [Consent Management](#) as described within this document
- “State Screening Tool for MH and SUD” form capabilities that accommodates all requirements associated with [Master Patient Index](#) as described within this document
- In addition to the Screening questions to be identified within the statewide initiative to develop a universal screening tool, the following data elements are expected to be collected in the Enterprise Health Record for each screening:
 - Screening Unique ID (System created/assigned)
 - Date of Screening
 - Time of Screening
 - Screening Participant Name
 - Relationship of participant to potential client
 - Client (optional)
 - Screening Notes
 - Disposition of screening
 - User completing screening



Use Cases

First Use Case: In addition to being required to complete a screening tool to support Care Coordination efforts when evaluating and on-boarding potential clients, counties must be able to easily send the screening tool to the applicable managed care plans. For example, a client is seen by a BHP staff who conducts and completes the screening tool in the Enterprise Health Record. Upon finalization of the screening tool, the system will include functionality that support easily submitting the tool to the appropriate managed care plan.

Given that the Screening Tool will heavily rely upon all the requirements listed within the “[System Wide Requirements](#)” section of this document, the use cases for the “Screening Tool” should be a variation of the previous use cases provided, with a specific focus on:

- [Supporting Care Coordination Activities in Non-Client-Specific Manner](#)
- [Highly Accessible Data Architecture and Reporting Tools](#)
- [Application Configuration Tools](#)
- [Dynamic User Interface](#)
- [Workflow Definition and Application Functions](#)

2.3.7 Care Coordination Activities Interoperability

As previously identified, there are several initiatives in California focused on creating a consolidated, universal behavioral health screening tool to evaluate individuals for a broad spectrum of mental health disorders ranging from depression to schizophrenia and to identify potential substance use disorders. Once this universal screening tool is developed, it is anticipated that it will be deployed via the Internet for use by potential clients.

Additionally, there are requirements in both the ONC, and CMS “Final Rules” associated with event notifications that require hospitals, including psychiatric hospitals, to send electronic event notifications of a patient’s admission/discharge to community providers or practitioners.

Both projects promise to become mechanisms through which County BHPs are informed of potential clients in need of outreach and possibly, treatment. As such, this RFP includes requirements that the proposed solution include interoperability mechanisms that will result in the creation of either/both “Contact Activity” and/or “Screening” records within the Enterprise Health Record based upon interfaces with external systems.

It is understood that without specific technical requirements it is impossible for any vendor to commit to adherence and delivery of a working interoperability solution. Nonetheless the “Care Coordination Activities Interoperability” is provided as a use case for the requirements described in the [Integration Tools – Standard Healthcare APIs and System Open Architecture](#) section of this document. Although it will ultimately be based upon the progress of efforts by outside trading partners, it is anticipated that the “Care Coordination Activities Interoperability” will be part of the initial implementation of the Enterprise Health Record. As such, vendors should use this example as the basis for their response to requirements described in the [Integration Tools – Standard Healthcare APIs and System Open Architecture](#) section of this document. The proposed interoperability should not be based upon custom or proprietary development but rather leverage industry best practices including Fast Healthcare Interoperability Resources (FHIR).



The requirements for the “Care Coordination Activities Interoperability” should be a variation of the earlier requirements provided in the following sections:

High Level Requirements

- “Care Coordination Activities Interoperability” capabilities that accommodates all requirements associated with [Supporting Care Coordination Activities in Non-Client-Specific Manner](#) as described within this document.
- “Care Coordination Activities Interoperability” capabilities that accommodates all requirements associated with [Highly Accessible Data Architecture and Reporting Tools](#) as described within this document.
- “Care Coordination Activities Interoperability” capabilities that accommodates all requirements associated with [Integration Tools – Standard Healthcare APIs and System Open Architecture](#) as described within this document.
- “Care Coordination Activities Interoperability” capabilities that accommodates all requirements associated with [Multi-County Installation](#) as described within this document.
- When records associated with Care Coordination activities are created in the Enterprise Health Record as a by-product of interoperability functions, requirements associated with Workflow Definition and Application Functions as described within this document will be supported:
 - For example, when a “Screening” is created in the Enterprise Health Record via interoperability, the solution will create a corresponding “Referral” record assigned to a pre-defined User or User Group for appropriate follow-up.
 - The record being created, and any corresponding records created in the Enterprise Health Record via interoperability, will be linked based upon the established workflow.

Use Cases

First Use Case: A client is being discharged from a local psychiatric hospital. Based upon ONC and CMS “Final Rule” requirements, the hospital sends out an “event” informing local community providers (including the County BHP) of this client’s discharge. As a by-product of receiving the event notification, CalMHSA’s Enterprise Health Record creates a “Contact Activity” record and a corresponding Referral record to be assigned to a pre-determined group for appropriate follow-up.

Second Use Case: A person in the community has been struggling with depression and anxiety. They find the State’s Universal Screening Tool on-line and after providing some basic demographic information they complete the screening questionnaire. As a by-product of the screening being completed, a record is sent to the appropriate county installation on CalMHSA’s Enterprise Health Record. As a by-product of receiving the data from the state website, CalMHSA’s Enterprise Health Record creates a “Screening” record and a corresponding Referral record to be assigned to a pre-determined group for appropriate follow-up.



2.3.8 Referral Process – Assessment Episode

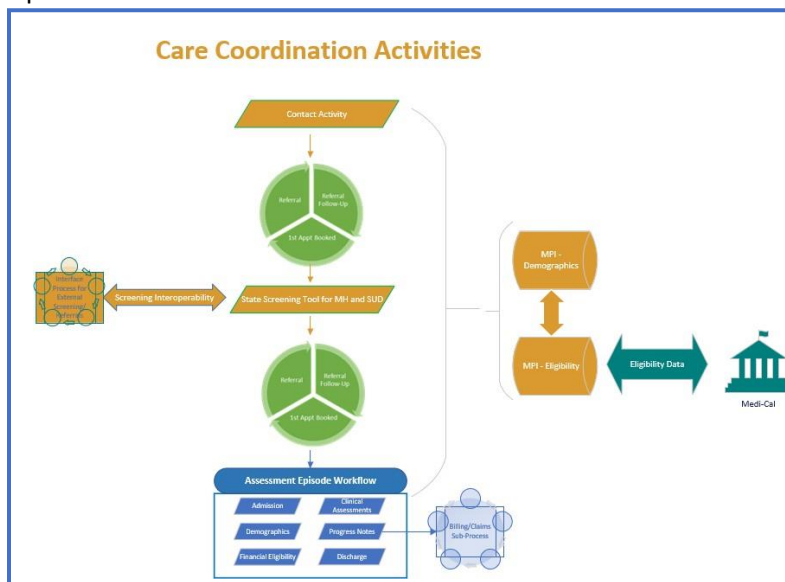
Per the Workflow Definition and Application Functions as described within this document, following the completion of a “Screening” record within the Enterprise Health System, based upon the “Disposition Type” selected by the user, subsequent Care Coordination activities may be warranted. In such instances, to support potential clients between periods of active engagement, the Referral Process previously described will be followed.

2.3.9 Assessment Episode

Within the Care Coordination workflow, when appropriate, potential clients will eventually be admitted/on-boarded so that Medi-Cal eligibility verification and a clinical assessment can be completed.

The “Assessment Episode” is a series of activities occurring over a longer span of time during which several different records are completed. The “Assessment Episode” is the sum of all these individual activities and there are several functions that are required based upon the business rules of the organizations.

First, though the “Assessment Episode” is comprised of several activities, the initiation and conclusion of the episode need to be elements of the Care Coordination workflow. Specifically, the State is interested in



collecting data related to the duration between different activities within the Care Coordination workflow. Recording the suspense time between a client’s first contact, when they initiated treatment, and the steps along this path, is a requirement associated with “Timeliness Reporting” described later in this document. Given these requirements, the Enterprise Health Record needs to include the initiation (i.e., Admission) and conclusion (i.e., Discharge) of the “Assessment Episode” as part of the Care Coordination workflow described in Workflow Definition and Application Functions within this document and assure

that these activities are linked with all preceding/associated Care Coordination activities.

Second, initiation of an “Assessment Episode” is the point at which those seeking treatment **must** officially become “Clients”. Within preceding Care Coordination activities, the person could remain anonymous or be represented by guardians or 3rd parties, but as part of the Admission process, potential clients need to provide all necessary information so that the organization can compare them against the shared Master Patient Index and either be linked with an existing PatientID/MRN or be added as a new client. As part of the function of the Master Patient Index, the system will also perform a real-time eligibility verification against the Medi-Cal Eligibility system.



Third, some of the activities performed during the “Assessment Episode” are billable under Medi-Cal regulations. As such, all functions associated and with the medical billing/practice management process will be employed so that claims (i.e., 837P Claim Forms) can be produced.

The specific requirements, as well as some special considerations, are:

High Level Requirements

- **MPI – Demographics** – The Assessment Episode indicates the point at which the relationship between the behavioral health organization and the potential client graduates to a more formal relationship.
- **MPI – Eligibility** – The MPI-Eligibility functions previously described will be required to be employed at this point in the workflow.
- **Admission** –The activities associated with the assessment of the potential client are such that an “episode” or similar construct should be created.
- **Mental Health and Substance Use Assessments** – The specific forms that will be required within the Enterprise Health Record are covered later within this RFP, but within the workflow, these will need to be available for use. These forms will require that the person has been created as a “Client” (has been added to the MPI and assigned a unique identifier) and has been admitted (open episode).
- **Appointment Scheduling** – It is common that during the Assessment Episode, multiple sessions with the client will be necessary. As such the appointment scheduling tools of the application should be fully available.
 - The initial appointment booked during the Referral Process will have been booked prior to the potential client being admitted. Nonetheless, this appointment, and its eventual outcome (e.g., Kept) need to be associated with the Assessment Episode that is created.
 - Once the client is admitted to the Assessment Episode, all associated appointment scheduling activities can/should be associated with that episode.
- **Payor/Guarantor Assignment** – The mechanisms necessary to align the client to the payor sources/guarantors to support the claiming process will need to be available. Because the Assessment Episode is limited in the level of engagement and duration, it would be favorable if the Payor/Guarantor Assignment functions available at this point were streamlined to expedite the process/requirements.
- **Assessment Progress Note** – Since some of the activities are billable, the ability to enter a Progress Note will be required of the application. Within the Assessment Progress Note the application will need to support a few special circumstances. These can potentially be addressed with the “[Dynamic User Interface](#)” features but ultimately need to be provided:
 - First, because the client has not been fully assessed and therefore a diagnosis has not been identified for the client, the Assessment Progress Note will need to allow the user to enter one or more Diagnosis Codes (ICD10) to the note and associated charge being created. Subsequently, this point-of-service code should be used in all claims created as a by-product of the service/charge created via the Assessment Progress Note.



- Second, because the client has not been fully assessed, their Problem (SNOMED and/or ICD-10) List may not have been defined. As such the Assessment Progress Note will need to allow the user to enter one or more Problems (SNOMED and/or ICD-10) to the note.
- **Discharge** –In addition to facilitating the end of the Assessment activities, the “Discharge” should allow for the disposition/outcome of the Assessment Episode and drive additional workflow logic accordingly. For example, the outcome of an Assessment Episode may be that the client meets medical necessity for treatment. Assuming that the assessing provider is not the treating provider, at this point the disposition type assigned to the discharge should trigger the initiation of another “Referral Process” to support the transition of the client from “Assessment Episode” to “Treatment Episode”. In cases where an Assessment Episode results in a client not meeting medical necessity for BHP services, a “Referral Process” to a community provider could occur.

Use Cases

First Use Case: A potential client previously met with a clinician to complete a “Screening” and based upon the outcome, the client was informed that they potentially have both a Mental Health and Substance Use problem. After the Screening, administrative staff completed a “Referral Process” resulting in an appointment for the client to meet in-person with County Intake staff.

The client arrives for their appointment. As a by-product of the staff checking the person in for their appointment, the system requires the administrative staff to enter an “admission” into the system or otherwise create an “episode”. When this Admission/Episode record is saved within the Enterprise Health Record, the system needs to link it with the preceding Care Coordination activities.

During this admission process, the client meets with administrative staff who collect demographic and other information. Using identifying demographic information, the admin staff search the shared MPI- Demographics and cannot find an existing record for the client. They proceed with admitting the client and as a by-product of this action, a record is created in the shared MPI-Demographic and a unique PatientID/MRN is assigned. Since this is the first episode for the client, the system assigns the Episode a unique identifier of “1”.

As a by-product of the new record in the MPI-Demographic database, the MPI – Eligibility function executes a Real-Time 270 eligibility inquiry to Medi-Cal. The staff continues the intake process by entering into the Enterprise Health Record details provided by the client regarding their Payor/Guarantor information.

The client meets with the clinician who initially focuses on the potential Mental Health issues by completing a series of Assessments within the client’s episode in the Enterprise Health Record. Throughout, the Dynamic User Interface is guiding the clinician through the process.

After an hour, it is obvious that the client is becoming agitated, and the clinician decides that they should set up a separate appointment to focus on the potential substance use issues. The clinician uses the Appointment Scheduling function to book a follow-up appointment and completes an Assessment Progress Note including selecting “Z03.89: Encounter for Observation for Other Suspected Diseases and Conditions Ruled Out” as the Diagnosis Code (ICD-10) for the charge. When the client is leaving, the admin staff inform them that the Medi-



Cal Eligibility inquiry had indicated that their coverage had lapsed. The admin staff provides the client information as to how to re-establish their eligibility and ask that they do so prior to the next appointment.

On the scheduled date, the client arrives and upon check-in, the Enterprise Health Record allows the admin staff to run a new Real-Time 270 eligibility inquiry to Medi-Cal. They receive back a 271 response indicating the client's Medi-Cal Eligibility is effective. The client meets with the clinician who works with the client to complete a series of substance use assessments based upon the American Society of Addiction Medicine (ASAM) criteria. Throughout, the functions in the Enterprise Health Record associated with the Dynamic User Interface and Application Configuration Tools guide the clinician and ultimately, calculate/determine that the client meets the standards for outpatient intensive substance use treatment. The clinician and client discuss the problems indicated through both the mental health and substance use assessments. Based upon these problems the clinician wants to refer the client for treatment to both a mental health program as well as a substance use program. The client agrees. The clinician documents their interaction in the Assessment Progress Note including identifying "Z03.89: Encounter for Observation for Other Suspected Diseases and Conditions Ruled Out" as the Diagnosis Code (ICD10) for the charge. They also enter a Discharge record into the Enterprise Health Record and based upon the "Disposition Type" the system prompts the clinician to enter two referrals: one to a mental health program and a separate one to a substance use program. Each of these Referral records have links to the "Assessment Episode" so that each is associated with the preceding activity in the Care Coordination process.

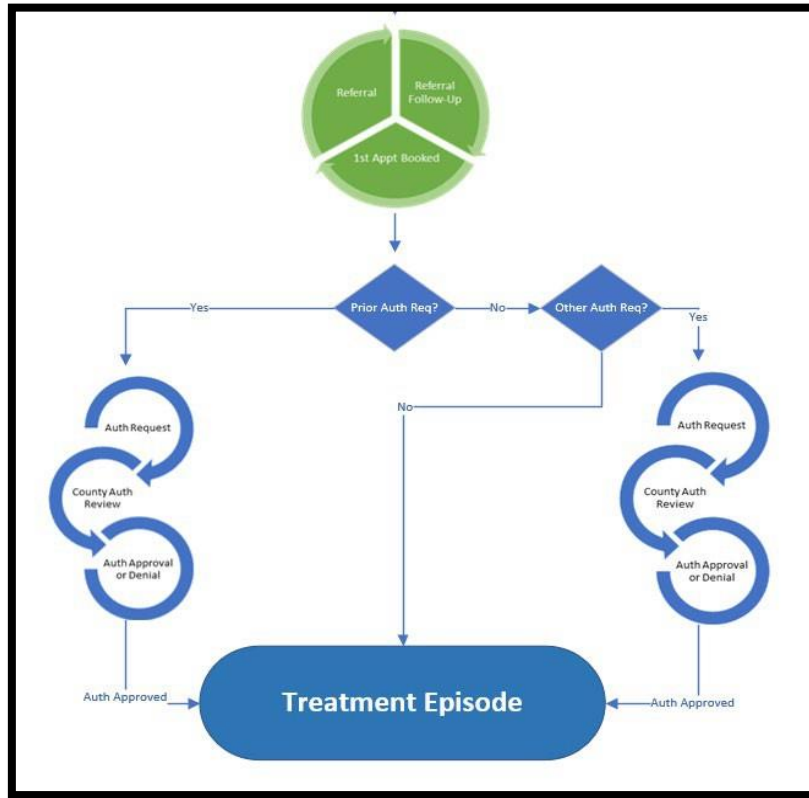
Later, the billing department within the County BHP initiates the process to create claims based upon completed Progress Notes. During this process, the Enterprise Health Record compares the "Date of Service" values from these two Assessment Progress Notes against the historical Medi-Cal eligibility information stored in the MPI- Eligibility database and determines that because the client was not covered by Medi-Cal on the date of their first appointment, it is not billable, but the second visit/charge is. The system creates an 837P claim for Medi-Cal for the second appointment/charge and uses "Note including identifying "Z03.89: Encounter for Observation for Other Suspected Diseases and Conditions Ruled Out" as the Diagnosis Code (ICD-10) in the claim.

2.3.10 Referral Process – Treatment Episode

Per the Workflow Definition and Application Functions as described within this document, following the completion of an "Assessment Episode" within the Enterprise Health Record, based upon the "Disposition Type" selected by the user within the "Discharge" record, subsequent Treatment Episode(s) may be warranted. In such instances, in order to support clients between periods of active engagement the Referral Process previously described will be followed.

2.3.11 Prior Authorization– Treatment Episode

After a client has been confirmed as appropriate for treatment (meets medical necessity/treatment requirements) and Medi-Cal Eligible during their Assessment Episode, for most there are no other impediments to their admission into a Treatment Episode.



However, for some types of service, before a client can receive treatment, further evaluation in terms of limits of coverage and other variables need to be performed. For example, for a client who is determined to require substance use treatment at a 3.1 – Clinically Managed Low-Intensity Residential Services level of care, additional review of a client’s past utilization and available benefits may be necessary (number of treatment episode limitations are being resolved at this writing). It is anticipated that to address these requirements, a series of forms, (Authorization Request and Authorization Response) will be created using the Application Configuration Tools and then these additional steps in the process will be enforced using the mechanisms described in Workflow Definition and Application Functions.

It is anticipated that the potential back-and-forth approval process for requested authorizations will be supported via the Application Configuration Tools and thus, the requirements are:

High Level Requirements

- “Prior Authorization” form that accommodates all requirements associated with [Supporting Care Coordination Activities in Non-Client-Specific Manner](#) as described within this document
- “Prior Authorization” form capabilities that accommodates all requirements associated with [Highly Accessible Data Architecture and Reporting Tools](#) as described within this document



- “Prior Authorization” form capabilities that accommodates all requirements associated with [Integration Tools – Standard Healthcare APIs and System Open Architecture](#) as described within this document
- “Prior Authorization” form capabilities that accommodates all requirements associated with [Multi-County Installation](#) as described within this document
- “Prior Authorization” form capabilities that accommodates all requirements associated with [Application Configuration Tools](#) as described within this document
- “Prior Authorization” form capabilities that accommodates all requirements associated with [Dynamic User Interface](#) as described within this document
- “Prior Authorization” form capabilities that accommodates all requirements associated with [Workflow Definition and Application Functions](#) as described within this document
- “Prior Authorization” form capabilities that accommodates all requirements associated with [Consent Management](#) as described within this document
- “Prior Authorization” form capabilities that accommodates all requirements associated with [Master Patient Index](#) as described within this document

2.4 Treatment Episode Requirements

As stated previously, once clients have been admitted for treatment (e.g., Medi-Cal Eligibility and/or Medical Necessity) the activities and data collected throughout their treatment need to be supported by the Enterprise Health Record. The requirements associated with treatment activities are described in terms of the workflow that is to be established across all partner County BHPs. County BHPs require the ability to effectively manage services provided throughout the length of the client’s treatment episode. This includes having the ability to manage caseloads, enter core & custom forms as well as progress notes. Treatment episode functionality that supports the gathering and reporting of required data elements is crucial.

It is expected that the basis of any vendor’s proposed solution is a standard Electronic Health Record (EHR) incorporated with Practice Management systems or functionality. As such, this RFP presumes that the proposed solution supports the full breadth of common functionality and capabilities anticipated for an electronic health record and associated practice management system focused on the behavioral health market. Such anticipated functions should include but not be limited to:

[High Level Requirements](#)

- Client Demographics - Any fully functioning Electronic Health Record should be coupled with, or have within it, Practice Management functionality to support the management of each client’s profile. As identified the Enterprise Health Record being sought by CaIMHSA will require the integration of an [MPI-Demographics](#). Each Vendor will be expected to explain how their solution integrates the [MPI-Demographics](#) with the Practice Management functions of their Electronic Health Record
- Admissions /Discharge/Transfer (A/D/T) - While the management of client A/D/T transactions should be core to any EHR solution, the proposed solution should support dynamics common to both



Outpatient, Inpatient/Residential, and Day Treatment settings. Of specific note is the establishment of unique treatment Episodes which may extend for long periods of time

- Appointment Scheduling - It is anticipated that the proposed solution will provide robust Appointment Scheduling capabilities
- Next of Kin/Family Member - It is anticipated that the proposed solution will provide tools to collect and manage client Next of Kin/Family information
- Diagnosis
 - Within each episode, the ability to assign one or multiple diagnosis records to each client should be core to any EHR
 - Enterprise health record will include a subscription to and integration with a Diagnosis Code provider that includes and cross references ICD-10, DSM-V, and SNOMED Diagnosis content
 - Enterprise health record should support the look-up and assignment of Diagnosis information using either ICD10 and/or DSM V terminology
 - Enterprise health record should allow for the definition of multiple historic diagnosis records within a client episode
 - Diagnosis records should integrate with all billing/claiming functions so the diagnosis record effective on the data of any service is used for billing/claiming purposes
- Charge Entry – While it is anticipated that most charge activities will be entered via one of the “Progress Note” functions, standard operations require the ability to enter charges independent of Progress Notes. Such functions should include
 - Charge Entry with Charge Override – Allows the entry of a charge/service while allowing the user to define the specific charge
 - Charge Entry with Diagnosis Assignment – Allows the entry of a charge/service while allowing the user the ability to assign a specific diagnosis not currently assigned to the client to the charge. When the claim is created, this diagnosis will be used as the Primary Diagnosis
 - Charge Entry with Charge and Diagnosis Override – A combination of the two items described above
 - Charge Entry for Inpatient/Residential Services – Supports the entry of billable bed days for multiple clients in residence for a span, or specific dates
 - All Charge Entry Forms should include the following data elements
 - Service Code
 - Program of Service
 - Location/Place of Service
 - Clinician/Practitioner
 - Co-Clinician/Practitioner
 - Evidence Based Practices
 - Session Start Time



- Session End Time
- Service Duration Fields
 - Face-to-Face Time (for billing functions)
 - Documentation Time (for reporting)
 - Travel Time (for reporting)
- Medical Billing (Waterfall) – As part of the Practice Management functions of the proposed solution, it is anticipated that the proposed solution will support the full breadth of standard medical billing requirements including
 - Collection of Guarantor/Payor/Benefit Plans – As part of the Practice Management functions of the proposed solution, it is expected that Guarantor/Payor/Benefit Plans profiles can be collected in either an episode-specific or non-episode-specific manner
 - Verification of Guarantor/Payor/Benefit Plans – As identified the Enterprise Health Record being sought by CalMHSA will require the integration of an MPI-Eligibility verification solution for Medi-Cal. Each Vendor will be expected to explain how their solution integrates the MPI-Eligibility with the Practice Management functions of their Electronic Health Record
 - Service Codes – As part of the Practice Management functions of the proposed solution, it is anticipated that each county will be able to define Service Codes to be used by their staff. In the system these Service Codes should be mapped to historical records that can determine each of the following universally, or by specific Guarantor/Payor/:
 - Whether charge calculation should be per unit or based upon service duration
 - Rate/Fee Schedule
 - Procedure Code – CPT and/or HCPCs
 - Coverage Limitation (e.g., Based upon Certification Level of Clinician)
 - Charge Calculation
 - Benefit Coverage Limitation Logic – By service or by types of services, it is common to have coverage limitations based upon elements such as number of units, Maximum dollar amount billed, etc. For example, for Medi-Cal, “Crisis Intervention” cannot be billed for more than 8 hours/day and services with a duration less than 5 minutes are not billed
 - Charge Responsibility/Distribution - Based upon Waterfall Billing logic
 - Claims Creation – Based upon Waterfall Billing logic using one of the following formats
 - HCFA – 1500 (Paper)
 - UB04 (Paper)
 - HIPAA 837P (Electronic)
 - HIPAA 837I (Electronic)
 - Remittance Processing - Based upon Waterfall Billing logic using one of the following formats
 - Manual Entry
 - Proprietary Upload Format
 - HIPAA 835 (Electronic)



- Full Breadth of Billing and Finance Reports including
 - Pre-Billing Error Report
 - Client Ledger
 - Payment/Adjustment Report
 - Active Receivables Report
 - Aged Receivables Report
 - Detailed Aging Report
 - Unbilled Services Report
- Discharge Documentation – Provide tools to consolidate information associated with a client’s treatment into a Discharge Summary or similar documentation created upon a client’s discharge
- System should provide the following voice recognition features
 - Voice recognition using a web-based, learning dictionary that include medical terminology
 - Ability to use voice commands to navigate through the user interface of the enterprise health record

As previously identified, prior to the implementation of the state’s California Advancing and Improving Medi-Cal (CalAIM) initiative, the number and scope of essential items that were unique to the California market due to regulatory requirements was substantially larger. But with the adoption of payment and documentation reforms under CalAIM such requirements are anticipated to be substantially fewer.

Currently, the rules governing the payment and documentation reforms are still being developed and a full representation of these requirements is not available. As such, within the remainder of the “Treatment Episodes” section of this document, in addition to the features and functions that should be commonplace for an electronic health record and practice management system, the requirements that are either currently expected to be required and unique to California BHPs under CalAIM requirements, or are requested based upon anticipated workflows and best practices to be implemented across CalMHSA’s semi-statewide Enterprise health record are presented. (Historic requirements that California BHPs have operated under for years but are anticipated to no longer be applicable under CalAIM are not included).

2.4.1 Progress Notes

The Enterprise Health Record calls for sophisticated functionality that will not only support basic treatment documentation needs, but will employ compliance logic ensuring efficient, accurate entry of services into the Enterprise Health Record.

High Level Requirements:

- CalAIM requires that the following information is in the medical record and “linked” to each service claimed: provider type or qualifications (confirmation of rendering provider scope of practice for code selected), the amount of time directly treating the beneficiary, location of the service, signature/identifier of rendering provider, ICD-10 code(s)
- The Enterprise Health Record supports entering Progress Notes for individual, group, and family sessions, telephone contact notes, and staffing shift notes that include a single narrative field



- Single narrative fields should support customizable role-based “templates”. These templates shall be customizable by the organization to best meet the requirements of individual programs, including the ability to easily IMPORT/COPY & PASTE from other sections of the chart, as well as from previous notes. IMPORT/COPY & PASTE functions should have the capability to time/date stamp the imports to distinguish historical information from the current encounter.
- Staff should not have access to templates and service codes that are not in their scope of service as indicated in their provider set up (see use case scenario below)
- Within the “High Level Requirements” listed under [Treatment Episode Requirements](#), it is anticipated that the billing functions of the electronic health record will support Benefit Coverage Limitation Logic. Because the operations of county BHPs are so aligned with Medi-Cal coverage, it is preferred that the mechanisms are employed to apply the Coverage Limitation Logic at the point of entry through the Progress Notes form(s). As such, as a user is entering a Progress Note, if the service/charge being documented will not be billable due to Min/Max limitation, the system should either alert the user or automatically adjust per Medi-Cal rules
- The Enterprise Health Record shall ensure effective word processing support (grammar, spell check & integration with user-customized MS Word instance dictionaries)
- Functionality will be included that allows for “auto saving” of progress note content so that data can be recovered if not manually saved so impacted documentation does not have to be rewritten
- Functionality will support efficient labeling of encounter type beyond billable activity code (for example “engagement” vs “treatment”) to capture initiation and engagement metrics prior to treatment
- Functionality shall support documentation of “special treatment considerations” (examples: chosen pronouns, trauma triggers, violence potential, etc.)
- Functionality shall support the collection of data within the Progress Note to create a billable service/charge. Supported data should include but not be limited to
 - Service Code
 - Program of Service
 - Location/Place of Service
 - Clinician/Practitioner
 - Co-Clinician/Practitioner
 - Evidence Based Practices
 - Session Start Time
 - Session End Time
 - Service Duration Fields
 - Face-to-Face Time (for use in billing)
 - Documentation Time (for reporting)
 - Travel Time (for reporting)



Use Cases:

First Use Case: Clinical staff will be able to easily access the progress note entry screen (through Appointment Scheduling or other a “caseload” view or additional mechanism) from the main “homepage”. The clinical staff will have the ability to enter all relevant service indicators within each Progress Note. Service indicators include pick list items that must be selected for each Progress Note to document to whom the service was provided, how and where it was provided. These service indicators are typically referred to as: person contacted, contact type, place of service, service intensity, etc. Each County BHP shall be able to identify any service indicators that they wish to “auto populate” based upon the service code selected and arrange these selections in the backend setups of the system. For example, when adding a Psychiatry Progress Note, the “person contacted” indicator would default to “client” versus the practitioner having to select “client” manually from a pick list. Likewise, the contact type would default to “face to face” and the service location would default to “office” to save time selecting the indicators. These setups should be easily managed and customized by each county and able to be easily updated as necessary.

Second Use Case: Clinical staff begin a Progress Note but are not able to complete the document in one sitting. The system shall allow for keeping the note in “draft” status so that the clinician can complete it later. In some instances, a staff person may want to add additional signature lines and/or a co-signature line to a given progress note and that should be a straightforward process which consists of an “add additional signatures” button or right click functionality within the signature section of the Progress Note. The staff should also be able to “route” documents to the co-signer/other staff through an “assign signatory” or “routing” process which allows the additional staff to view the document and sign.

Third Use Case: Staff should not have access to templates and service functions/codes that are not in their scope of service as indicated when they are set up as practitioners in the Enterprise Health Record. This will ensure that staff do not inadvertently bill for a service code outside of their scope (which would lead to a compliance issue). As a result, a staff who does not have access to enter an “Individual Therapy” service code would receive a pop-up message when trying to write an Individual Therapy Progress Note letting them know that Individual Therapy is not a service code available on their menu of service code options. Conversely, service codes outside of a practitioner’s scope could be suppressed based on service code privileging in clinician set up screens.

2.4.2 Problem List

The Problem List names and quantifies the complex needs of the clients served by the County BHP. It is essential that the Problem List stays up-to-date and that it can be edited from the Progress Note, the Assessment, and other relevant clinical documentation. The Problem List shall have a prominent place in the clinical documentation portion of the Enterprise Health Record and shall be easily accessible when entering Progress Notes. Prompts to review and update the Problem List will assist with accuracy. Each Progress Note must be tied to one or more items on the Problem List and the record must clearly demonstrate which specific problems a given staff has selected as the focus of the encounter.



High Level Requirements:

- Within the Progress Note itself, staff must have the ability to view/add (begin date) /close (end date) items from the Problem List as well as the ability to select the order of items/prioritize items on the Problem list
- The software will include customizable pick list functionality to ensure consistency of Problem List data and will allow for the development of progress note templates based on the Problem List items selected (i.e., populating sentence stems generated from the problem list into the notes field). See Use Case
- Enterprise health record will include a subscription to and integration with a Diagnosis Code provider that includes and cross references ICD-10, DSM-V, and SNOMED content
- When identifying/assigning Problems to a client, the cross-reference of ICD-10, DSM-V, and SNOMED content should allow users to search based upon diagnosis code (ICD-10 or DSM), by SNOMED code, or keyword in the description of ICD-10, DSM-V, and SNOMED content
- The Problem List functionality will support reporting on problem list duration/resolution (see Use Case below)

Use Cases:

First Use Case: A clinician begins providing services to a client who is homeless at the beginning of treatment and uses the ICD-10 Code Z59.0 -- Homelessness to search and select a problem. This item will remain on the Problem List for each subsequent service while the clinician and client work together to find permanent housing. Once housing is obtained, the clinician will end date Z59.0 from the Problem List and the Enterprise Health Record will record that data such that a County BHP could aggregate how long it took for that client and clients in general to move from a homeless to housed status.

Second Use Case: While entering a clinical progress note, a clinician selects two Problem List items which then automatically create a “sentence stem” within the progress note narrative that prompt the clinician to enter additional narrative regarding how those Problem List items were addressed during the service. For example, if “homelessness” is selected as a problem list item, a sentence stem that begins with something such as “Homelessness was addressed during this session by_____”.

2.4.3 Caseload Management

Effective Caseload Management is vital to ensuring that clients receive prompt and effective services and that practitioners are deployed in a reasonable and efficient manner. Caseload Management displays the treatment team for an individual client, identifying which practitioner has primary responsibility for the client’s care and the clinical documentation associated with that care, as well as the roles of each of the additional team members (e.g., Psychiatrist/prescribing staff member, Clinician/Therapist, Case or Care Manager, Peer Support Specialist or Recovery Coach). Caseload Management displays metrics of patient engagement across a caseload, ensuring that initiation and engagement goals are met (or if not, prompting Outreach workflows) and that clients are receiving the intended “dose” of treatment for the assigned level of care. Caseload Management should allow staff and teams to view their assigned clients and to track their clinical outcomes based upon the results of embedded behavioral health outcome measures. Caseload Management should support work queue prioritization based upon a set of indicators tied to staff scope of practice – for instance,



Prescribing Staff could easily see clients who need more immediate follow up (titrating on or off medications, lab values outside normal limits, etc.) while prioritization for non-prescribing staff would be dependent on different indicators of urgency.

High Level Requirements:

- Using the tools previously discussed in this document it is anticipated that CalMHSA will create a caseload-weighting tool that will rate client complexity based on clinical indicators, co-morbidities, functional impairments, and Social Determinants of Health (SDOH). This tool will assign a numerical value to each client indicating the complexity of their case
- The enterprise health record should provide a Caseload Management set-up function that will allow the organization to define the different “positions” of which a treatment team should be comprised. During this set-up the organization will be able to define which positions are required for assignment. This function should allow the definition to be based upon program or a group of programs. (e.g., For clients being treated within these programs their treatment team should be comprised of a Psychiatrist and a Clinician/Therapist, and a Case Manager)
- The enterprise health record should provide a form through which the care team for each client is identified. In this form the Caseload Weighted Score assigned to the client will be defaulted from the previously described tool. Also, within this form, users will assign of Clinicians to each of the “Positions” defined for the program under which the client is being treated. Those “positions” identified as required will need to be completed before the Caseload Assignment record can be filed. Optional “Positions” can be left blank
- The Enterprise Health Record shall provide interactive views/widgets that will allow the behavioral health team/practitioners to sort or filter clients to whom they are assigned by specific data variables (date last seen, risk parameters, etc.)
- The Enterprise Health Record shall provide interactive views/widgets to display compliance metrics for clients to whom the clinician is assigned (e.g., number of days elapsed since last treatment encounter will prompt an Outreach Workflow or an Administrative Discharge Review workflow if clients have not been seen within defined parameters)
- The Enterprise Health Record shall support streamlined re-assignment of caseloads. For example, if a practitioner goes on leave or separates from an organization, this functionality will provide a form through which the practitioner’s entire caseload is presented and a user is able to reassign multiple clients to a different practitioner, and then re-assign the remaining clients on a one-by-one basis
- Enterprise Health Record system logic shall support automatically assigning/identifying the primary responsible practitioner (often referred to as the Primary Services Coordinator (PSC) or Single Accountable Individual (SAI)) for each client’s care when simultaneous treatment admissions occur or end. For example, if a client is opened to two programs and one closes, the Enterprise Health Record should automatically assign/identify the relevant practitioner of the remaining program as the PSC/SAI based upon how each program is set up (see Use Case)



Use Cases

First Use Case: A number of clients are assigned to the caseload of a Locum Tenens psychiatrist. That psychiatrist completes her tenure at the BPH, and her caseload must be re-assigned to other practitioners. The administrative staff is assigned to provide notifications to the clients and reassign them to other practitioner(s). The Enterprise Health Record allows the administrative staff person to reassign the departing psychiatrist's caseload without having to discharge and readmit the clients, preserving the original admission date and remaining treatment team.

Second Use Case: A client receiving mental health services is admitted to two separate programs: Psychiatry and Adult Case Management. The Enterprise Health Record is configured to automatically assign a primary responsible practitioner, and therefore assigns the practitioner in Adult Case Management as the PSC/SAI. The Enterprise Health Record makes this assignment based on ranking logic that indicates that a practitioner from the Psychiatry program is only assigned as the PSC/SAI if there is no other practitioner treating the client. If the Adult Case Management program discharged the client, Enterprise Health Record would automatically assign the current practitioner from the Psychiatry program as the new PSC/SAI. In the case of programs where either program could potentially have an PSC/SAI, the BHPs will define the "hierarchy" in the Enterprise Health Record indicating the program order when assigning a PSC/SAI. Additionally, the Enterprise Health Record shall allow staff to override and manually assign a PSC/SAI when desired.

2.4.5 Core Assessments/Forms

There are specific "Core Assessments" (AKA assessments required by all County BHPs) that will need to be available in the Enterprise Health Record. Some of these requirements are currently undefined given that CalAIM Documentation Redesign standards have yet to be finalized. "Assessments" and "Forms" are used in tandem to indicate that the items in this core set may currently be referred to using either term by County BHPs.

High Level Requirements:

- The Enterprise Health Record shall contain Core Assessments/Forms that include but are not limited to the following: Demographic Forms, Screening/Intake Forms, Assessment/Re-Assessment Forms, Psychiatric Assessment Forms, Medication Consent Forms, Diagnosis/Problem List Forms. Additionally, certain Assessment/Form commonly referred to as "symptom inventories", "level of care assessments" and/or state/federal reporting forms are required, currently: Child and Adolescent Needs and Strengths (CANS-50), Pediatric Symptom Checklist (PSC-35), American Society of Addiction Medicine (ASAM); Client and Service Information (CSI) Drug and Alcohol Treatment Access Report (DATAR), Primary Prevention Substance Use Disorder Data Service (PPSDS), Prevention and Early Intervention (PEI), Full-Service Partnership (FSP). (See CA Regulations spreadsheet for additional details)
- Functionality should be present that flags fields on these Core Assessments/Forms as "required" and prevents finalization of the form until required fields are completed
- The Enterprise Health Record shall ensure that only one version of a Core Assessment/Form can be opened for a client at any given time to ensure that multiple versions of the same form are not created and left in draft status (see Use Case)



- The Enterprise Health Record shall support integration with voice recognition software for speech dictation
- The Enterprise Health Record shall limit access to Core Assessments/Forms to ensure that practitioners are only provided access to those they can complete within their scope of practice. (See Use Case)
- The Enterprise Health Record shall allow Core Assessments/Form to be voided or amended according to a pre-defined rule set. (See Use Case)
- The Enterprise Health Record shall maintain the ability to score Core Assessments/Forms – scores on one form, or values of interest in one form field should trigger a related form to further the clinical workflow (e.g., above-threshold score on a depression inventory will trigger a suicide risk assessment form)
- For Core Assessments/Forms that require a client signature, the Enterprise Health Record should support functionality that allows for documenting reasons for the absence of a client signature

Use Cases:

First Use Case: A practitioner begins a Comprehensive Assessment and inadvertently leaves the required trauma fields blank because they had planned to come back to it before finalizing the document but forgot to do so. When the practitioner attempts to electronically sign the document, the system will present an alert that informs the practitioner that required fields are blank and clearly identifies the required fields so that the practitioner can easily find them.

Second Use Case: A practitioner provides a telehealth encounter during which a Core Assessment/Form requiring client signature is completed. The client signature could not be obtained (telehealth encounter). The Core Assessment/Form contains a required field wherein the practitioner can easily document the reason for non-signature prior to finalizing the Core Assessment/Form.

Third Use Case: A practitioner begins a CANS-50 Core Assessment/Form but is interrupted with a client emergency and does not complete the document. The practitioner uses a “save” or “save and close” function that preserves the Core Assessment/Form in “draft” status until they can complete it. Another practitioner treating the same client—not realizing that a CANS-50 is already in process--attempts to start a CANS-50. The Enterprise Health Record notifies the second service practitioner that a draft CANS-50 is already in process and does not allow a second Core Assessment/Form to be created until the first CANS-50 is finalized.

Fourth Use Case: Given that the CANS-50 is one of the Core Assessments/Forms that is required at intervals, or in response to specific conditions, in the use case above, the Enterprise Health Record contains defined fields where a practitioner indicates which CANS-50 is being collected. The practitioner erroneously selects “initial” CANS-50, but since the initial CANS-50 has already been completed, the practitioner is prompted to select another CANS-50 interval (reassessment, urgent, discharge, etc.)

Fifth Use Case: A practitioner finalizes a Core Assessment/Form and discovers that they completed the form in the wrong client’s record. Following a pre-defined policy, the Core Assessment/Form the Enterprise Health Record contains functionality to “void” the Core Assessment/Form and to document the “void reason” including date/time stamp and staff name/credentials. In another use case, a psychiatrist completes a



Psychiatric Assessment, but inadvertently neglects to record a relevant medication on the document. Given that this scenario does not warrant voiding the Core Assessment/Form, the Enterprise Health Record supports the ability to amend or append to the Core Assessment/Form so that the missing information can be added. The append/addendum contains a reason and a date/time stamp. The Enterprise Health Record provides easy access audit logs, voided or modified documents to practitioners who are set up with these permissions (utilization review and technology staff).

2.4.6 Custom Assessments

County BHPs will need to create custom assessments to support local quality improvement and/or performance initiatives. County BHPs with sufficient technical capability should have access to the requisite tools in the Enterprise Health Record to be able to develop and deploy Custom Assessments without vendor intervention. County BHPs that need professional services support should be able to request a custom assessment through a user group or ticketing system and/or will be able to access created custom assessments through a general “library” or repository.

Use Cases:

First Use Case: A County BHP undertakes a Performance Improvement Project (PIP) to study the effectiveness of a new therapeutic intervention. To gather baseline data, the County BHP designs a Custom Assessment for practitioners to complete with their clients at treatment initiation. The Enterprise Health Record supports prompt creation and deployment of the Custom Assessment either by the County BHP or the vendor. The PIP proves effective, and additional County BHPs have easy access to deploy or modify and deploy the Custom Assessment in their instance of the Enterprise Health Record.

Second Use Case: A County BHP is interested in tracking inpatient psychiatric hospitalizations and deploys a Custom Assessment “Hospital Admission Form”. In addition to including standard data (name, date of birth, medical record number), the Hospital Admission Form includes hospital facility, hospital admission date and reason for hospitalization (Danger to Self, Danger to Others, Gravely Disabled, Other). The Custom Assessment tracks additional elements (facilities denying placement and reasons). This Custom Assessment can be routed to relevant practitioners (utilization review/hospital liaison staff) as a communication/planning tool. Data elements from the Custom Assessment can be easily viewed as a report/dashboard through an analytics layer.

2.4.7 ePrescribing, Closed-Loop Medication Administration and eLabs

The adoption of computerized order entry/prescribing solutions can help organizations reduce errors, improve efficiency, and provide better care to clients. Within the treatment workflows across all California BHPs the need exists for an Electronic Prescribing (ePrescribing / eRx) solution, a closed-loop medication solution (CPOE), and an eLab orders/results solution.

The ePrescribing solution is anticipated to be the most highly utilized of these requirements. The ePrescribing solutions should support the following functions:

High Level Requirements:

- Fully integrated with the enterprise health record



- User Interface
- Data replication from the eRx solution back to the enterprise health record for clinical and billing operations
- Certified for the following:
 - Prescriptions (eRx)
 - Prescriptions for Controlled Substances (EPCS)
 - Eligibility
 - Formulary
 - Electronic Prior Authorization
- Performs or Supports:
 - Drug and Allergy Interaction checks
 - Real-time medication history checks
 - Patient-Reported Other Medications
 - Mobile Applications available at no extra cost for both iOS and Android devices
- Integration with local pharmacies through the Surescripts Network

In addition to eRx functions, across the state, there are BHPs that operate either Crisis Stabilization Units or Inpatient Mental Health Treatment centers that will require full, closed-loop medication administration functionality. For these programs the enterprise health solution will require the following:

High Level Requirements:

- Order Entry of Medication Orders
- Integration with Pharmacy System (either on-site or remote)
- Integration of Pharmacy System with
 - On-Site Dispensing Machines (i.e., CareFusion/Pyxis)
 - Electronic Medication Administration Record within the enterprise health record
- Full-Function Electronic Medication Administration Record (eMAR) Functionality in the enterprise health record

Finally, for all BHPs there is a need for electronic Laboratory Order and Results Response capabilities. With the Health Information Technology for Economic and Clinical Health (HITECH) Act, the electronic communication of lab data is a key component of “meaningful use” requirements. While it is understood that full implementation of such functions requires the participation and engagement of regional laboratory testing vendors (e.g., Quest Diagnostics or LabCorp), but as a requirement of this RFP the proposed solution must support:

- Electronic Lab Order Entry
- Ability to print paper Lab Orders
- Ability to eFax Lab Orders to local laboratory testing vendors
- Compliance with Interoperability Standards associated with electronic Lab Order and electronic Lab Results as defined by ONC’s Office of Science & Technology (OST) Standards & Interoperability (S&I) Framework



Use Cases:

First Use Case: A client is admitted to a Crisis Stabilization Unit (CSU) in the evening right before the treating psychiatrist is leaving for the day. The CSU psychiatrist completes a Crisis Psychiatric Evaluation and determines that the client needs two particular medications prescribed; however, before doing so, the CSU psychiatrist consults the list current medications in the Enterprise Health Record to ensure that there are no contraindications. While reviewing the Enterprise Health Record, the CSU psychiatrist notes that the client is already taking one of the medications that they intended to prescribe. This additional information drives more refined clinical decision-making regarding dosage and/or considering other medications. The Enterprise Health Record supports medical coordination via a secure messaging portal with message notification.

Second Use Case: For this same client, CSU nursing staff will have conducted a Nursing Assessment, checked vitals, and are completing 15-minute checks on the client. The Enterprise Health Record will support flow sheets for easy documentation of repeated information like vitals and 15- minute checks.

Third Use Case: A client receiving both substance use and mental health treatment arrives at a Narcotic Treatment Program (NTP) to receive a daily dose of their prescribed Medication Assisted Treatment (MAT) medications. The client has signed consents that allows for information sharing among their treatment providers. Before administering the specific medication, NTP practitioners will be able to reference the eMAR in the Enterprise Health Record to review the client's currently prescribed medications from other county providers and to view/record current vitals and allergies. Later in the day, the client has a psychiatry encounter, and the NTP medications inclusive of the administration of that day's dose are available for viewing in the Enterprise Health Record.

Fourth Use Case: A county psychiatrist sees a client for a monthly medication management appointment. During the appointment, the psychiatrist learns that the client is experiencing an increase in psychiatric symptoms. The psychiatrist uses the Enterprise Health Record to review the client's current medications (dates prescribed, current dosage, method, and frequency of administration) and determines that a dosage increase for one medication and the addition of a new medication is warranted. The psychiatrist accomplishes these tasks using the Enterprise Health Record electronic prescribing capability. The medication changes prompt a workflow to update the required Medication Consent Forms (Core Assessment/Forms) if the new dosage prescribed outside the range documented on the existing signed Medication Consent Form. The pharmacy messages a question about the new prescription, and nursing/support staff access the Enterprise Health Record to handle the inquiry.

Fifth Use Case: Based upon the monthly medication management appointment described above, the increase in medication dosage ordered by the psychiatrist requires additional blood tests to assure no negative impact to the client's kidney functions. Using the eLab capabilities of the enterprise health record, the doctor is able to order the necessary lab tests with the local testing provider, LabCorp. The client is instructed to go to a LabCorp location for their blood draw. The client gets the test and LabCorp enters the test results into their Laboratory Information System (LIS). Subsequently the LIS sends the results back to CalMHSA's enterprise health record. The doctor is alerted that new lab results are available and require their review.



2.4.8 Supplementary Treatment Requirements

County BHPs provide services to individuals who are not current “admitted” and receiving ongoing treatment. These encounters can be variously referred to as “outreach”, “engagement”, “information and referral”, “care coordination” and/or “crisis intervention”. These encounters often include coordination with other county systems (criminal justice, child welfare, social services, medical services) or other levels of care (inpatient psychiatry, detoxification, residential care) etc.

Given that many of the individuals who receive these types of community outreach services are not clients actively receiving services from the county, it can be challenging to document these activities in a way that allows for meaningful encounter documentation that can be shared with external stakeholders in the care environment. The Enterprise Health Record shall allow for documentation of support provided to individuals as they are in transition between levels of care.

High Level Requirements:

- The Enterprise Health Record shall support effective tracking of community outreach/care coordination activities provided to individuals who are not currently admitted to a treatment episode and allow for reporting of the multiple activities (as described above) that have occurred.
- Although many community outreach/care coordination activities are not directly related to a client, they are events which are chargeable to other agencies and organizations. As such these activities need to be supported as charges / receivables within the enterprise health record.
- Payment/Adjustment/Transfer of Charges/receivables associated with community outreach/care coordination activities should be supported within the enterprise health record
- The Enterprise Health Record shall allow for the capture and storing of client photographs to support outreach/engagement activities.

Use Cases:

First Use Case: A mobile crisis response clinician is called out into the community to provide a 5150 evaluation to determine whether an individual meets criterion for involuntary inpatient psychiatric services. The clinician conducts a full assessment and determines that the individual does not meet criteria for an involuntary hold. The clinician notes that the client is not currently receiving services with County BHP. The clinician is able to document that they provided this service in the community even if they do not have extensive demographic information on the individual. Similarly, a clinician may be called into the community to assist local law enforcement with assessing an individual who has been disturbing a particular business for several days by walking around outside and speaking loudly to themselves. The clinician engages with the individual and determines that they are gravely disabled and need to be transferred to the county’s Crisis Stabilization Unit (CSU). Although this individual is not a current client, the clinician must have the ability to document the contact in the Enterprise Health Record.

Second Use Case: A client has become disengaged from treatment and has not responded to outreach attempts to reengage them. Following internal policies and procedures, the County BHP notifies the client and discharges them from treatment. A few days after the discharge, the client walks into the clinic, stating they are



starting services with a new practitioner, but requesting a medication refill to bridge the gap between practitioners. The practitioner needs to document this encounter, regardless of whether the medication refill was provided or not. The Enterprise Health Record will support documenting this encounter without an open admission, utilizing the Community Outreach/Engagement Activities/Level of Care Transitions strategy provided.

Third Use Case: Under DMC-ODS, durations of treatment at any level of care can vary depending on the specific needs of the client receiving treatment. In some instances, treatment may end in one level of care (episode discharge), and the client may not enter directly into a subsequent level of care. During this interval, a client can continue to receive “case management” or “care coordination” services from a Recovery Coach. These services need to be documented in the Enterprise Health Record and claimed regardless of the status of other treatment episodes.

2.4.9 Client/Patient Portal

Incorporating increased interoperability between Enterprise Health Record systems and patients’ mobile technologies and telehealth technologies supports health and wellness and managing behavioral health treatment concerns. The Enterprise Health Record shall support a fully compliant online Client Portal that provides convenient, 24-hour access to personal health information, the medical record, practitioner messaging, appointment scheduling, educational materials, etc. from anywhere with an internet connection.

High Level Requirements:

- Client/Patient Portal will provide a secure online website that gives clients convenient, 24-hour access to personal health information.
- Client/Patient Portal will include integrated phone/mobile apps for Android or Apple devices and available through the Google Play or Apple App stores respectively
- Web portal and phone/mobile apps will provide the following capabilities:
 - 24-hour access to personal health information including
 - Recent visits
 - Discharge summaries
 - Medications
 - Immunizations
 - Allergies
 - Lab results
 - The capability to allow clients to:
 - Securely message treatment team members
 - View prescribed medication lists, medication consents and educational materials and re-order (or request re-ordering of) medications.
 - Schedule/reschedule appointment and receive appointment reminders via secure email, phone call or text.
 - Complete and electronically submit intake, registration, screening & assessment documents. Assessments sent via the Client Portal should be able to be either anonymous or identified depending on the use case.



- Manually update contact information as needed, or periodically in response to a prompt. Contact information changes can be made available in the client’s demographic data fields within the Enterprise Health Record.
- Provide feedback/satisfaction data/service verification responses.
- Read and review downloadable educational materials regarding mental health, substance use treatment, psychotropic medications, etc.
- Launch telehealth sessions within the Client Portal. The telehealth platform integration into the Enterprise Health Record, providing ease of access for both client and clinician.

Use Case:

First Use Case: A client receiving services from the County BHP opens the Client Portal to complete multiple activities. First, the client has a question about medication interactions, so uses the portal to email their psychiatrist. Having sent the email, the client reviews their medications list and determines their anti-depressant is available to be refilled. The client completes the refill activity, specifying the pharmacy where they will pick up the medications. Then the client opens an anonymous client satisfaction survey, which they complete through a weblink in the survey reminder email. Lastly, the client joins their scheduled group therapy telehealth session through the Client Portal.

2.4.10 Medi-Cal Rx

Medi-Cal pharmacy services are transitioning from a Medi-Cal Managed Care delivery system to a Medi-Cal Fee-For-Service (named Medi-Cal RX) delivery system as a result of Executive Order N-01-19. In January 2022, Magellan Medicaid Administration, Inc. (MMA) will assume full administrative responsibility for claims management, prior authorization and utilization management, provider, and beneficiary support services, reporting and other ancillary services. Medi-Cal Health MCPs will receive daily Medi-Cal RX data feeds, and Enterprise Health Record should be prepared to receive such feeds and distribute them to the appropriate County BHP instance should they become available. Additionally, Medi-Cal providers (prescribers and pharmacies) and County BHPs will have real-time access into the Medi-Cal RX contractor’s electronic environment via a secure portal (see State Reporting Requirements & Regulations Spreadsheet for additional information [California Mental Health Services Authority | Multi-County EHR \(calmhhsa.org\)](https://www.calmhhsa.org)).

High Level Requirements:

- The Enterprise Health Record shall be poised to ingest and distribute to the appropriate County BHP instance based upon variables such as Beneficiary County Aid code. The Enterprise Health Record shall store the data such that it is available to the requisite county instance and an analytics layer.
- If warranted, the Enterprise Health Record will support easy access the Medi-Cal Rx portal from the Medical Staff workflows if needed.

2.4.11 Medi-Cal Managed Care Encounter Data Reporting

Managed Care Health Plans (MCPs) are required to submit complete, accurate, and timely encounter data for services provided to enrolled beneficiaries to DHCS to comply with state and federal requirements. Typically, MCP data is not widely available to County BHPs, even though the Plans share responsibility for a common beneficiary pool. With the implementation of CalAIM, data sharing among the Plans will be imperative to

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ensuring successful collaboration and care coordination, while improving outcomes/managing risk. MCPs are required to submit encounter data in the following Health Insurance Portability and Accountability Act (HIPAA) compliant national standard transactions in accordance with the most recent DHCS Companion Guides issued for each transaction type (see State Reporting Requirements & Regulations Spreadsheet for additional information [California Mental Health Services Authority | Multi-County EHR \(calmhhsa.org\)](https://www.calmhhsa.org/))

High Level Requirements:

- The Enterprise Health Record shall support receipt/transmission on MCP/County BHP encounter data as it is made available.
- The Enterprise Health Record shall store the data such that it is available to the relevant county instance and an analytics layer.

2.4.12 Medi-Cal and Other Health Coverage Claims Processing Requirements

As stated previously, California has a complex Medi-Cal billing structure featuring per minute claiming for services covered under the Specialty Mental Health benefit and billing per 15-minute increments for the DMC-ODS benefit). Costs are claimed, Federal Financial Participation (FFP) is paid out proportionally based upon Aid Code, and subsequently settled to interim cost. The cost reporting methodology requires multiple iterations of interim settlement, audit, and final settlement, which typically occurs years after the initial services were rendered. In addition to Medi-Cal, County BHPs claim to other guarantors, including Medicare, Commercial Insurance, Indigent Insurance Programs, Mental Health Services Act (MHSA) Funds, and, in some instances, County General funds and/or beneficiary Share of Cost contributions. Health Common Procedure Coding System (HCPCS), which are used for billing the majority of the County BHPs carved out services, will be replaced by a mixture of Common Procedure Terminology (CPT) codes for qualified staff, and HCPCS codes for paraprofessional staff, and/or for services for which there is no existing CPT code. Post CalAIM implementation, a new (less California-specific) set of requirements must be built into the system to ensure ongoing compliance with all applicable regs/requirements pertaining to documentation/claiming. DHCs guidance is forthcoming.

2.4.13 QI Rules: Pre-Billing Logic/Performance Management

High Level Requirements:

- The Electronic Health Record shall support configuration of warning/hard stops on billing activities that do not meet the minimum requirements/threshold for a billable activity (min/max service times, etc.) according to the available guidance. Additional embedded compliance logic has been discussed previously (e.g., limiting available templates/billing codes to practitioners based upon scope of practice), and further logic will be identified/finalized (e.g., identifying settings with claiming lock out, etc.) when CalAIM Documentation Redesign and Payment Reform initiatives are finalized
- The Electronic Health Record shall support effective tracking of required timeliness metrics. Current requirements provide performance metrics for timeliness to routine and urgent appointments, that are provided by physician or non-physician practitioners and that do/do not require prior authorization. Additionally, timelines tracking includes timeliness to a follow-up appointment post-psychiatric hospitalization as well as tracking of appointment no-show rates. The ability to disaggregate data by age,



aid code, race/ethnicity, language, and other relevant indicators is important when analyzing timeliness data, as it is for other compliance, quality, and performance metrics

- To support the CalAIM “No Wrong Door” principle, Medi-Cal beneficiaries will be able to initiate mental health/substance use treatment with either the County BHP or the MCP, since establishing medical necessity prior to treatment will no longer be required. Services delivered under both benefits are eligible for payment provided there is no duplication of treatment effort. Given this change, the Enterprise Health Record shall support tracking of service initiation/engagement data in a format that can be readily exchanged with the Managed Care Plans to ensure care coordination/non-duplication
- BHPs must have problem resolution processes in place that enable a beneficiary to resolve a problem or concern about any issue related to the BHP’s performance. Each BHP’s beneficiary problem resolution process must include a system to receive and resolve beneficiary grievances, appeals, expedited appeals, and State Fair Hearing. Mental health programs are required to report annually the total number of grievances, appeals, and expedited appeals filed during the previous fiscal year, categorized by type and disposition. This is also known as the Annual Beneficiary Grievance and Appeal Report (ABGAR). SUD programs report grievance and appeals data on a different report, and they do so on a quarterly basis (see State Reporting Requirements & Regulations Spreadsheet for additional details [California Mental Health Services Authority | Multi-County EHR \(calmhsa.org\)](#)). For many BHPs, grievances, appeals and State Fair Hearing requests are tracked outside of the EHR, making for a cumbersome process. To address this challenge, the Enterprise Health Record shall include functionality that will allow grievances, appeals and State Fair Hearing requests to be tracked within the system (including the date the grievance was completed, the date the BHP received the grievance, the method of filing, grievance type, the date the BHP responded and disposition) to ensure complete tracking and accurate reporting

Use Cases:

First Use Case: A practitioner begins to document a brief telephone encounter in the Enterprise Health Record. The call lasted three minutes and was with a client who is incarcerated. When the practitioner attempts to finalize the encounter, the Enterprise Health Record alerts the practitioner of a billing exclusion based on time (encounter less than five minutes) and client location (jail).

Second Use Case: A County BHP data analyst is preparing to submit the annually required Network Adequacy submission to DHCS. As part of this submission, County BHPs currently submit raw and summarized data that demonstrates the timeliness of new treatment initiations during the reporting period comply with the required standards. (It is anticipated that this data will be submitted via a standardized 274 transaction in the future. see State Reporting Requirements & Regulations Spreadsheet for additional information [California Mental Health Services Authority | Multi-County EHR \(calmhsa.org\)](#)). Data variables include times/dates documented as “Activities” that occur prior to treatment admissions (See Care Coordination, “[Contact Activity](#)”). The Enterprise Health Record will allow the analyst to link “Contact Activity” treatment requests with offered, accepted, and completed treatment encounters and calculate timeliness for initial appointments during a date range. For example, if a client requests a routine service with a non-physician on 7/2/21, the Enterprise Health Record shall record those relevant variables as the “request” date. An appointment is offered is on 7/6/21 at 10 am. The client declines that appointment but accepts the next offered appointment on 7/8/21 at 10 am. The



Enterprise Health Record calculates that the offered appointment is within the timeliness requirement, being three business days from the request (subtracting weekend and County holidays).

Third Use Case: The mother of a 16-year-old girl calls the behavioral health line on her insurance card because her daughter suffers from erratic moods affecting her school attendance. She is referred to an MCP psychologist and starts weekly therapy. She gets worse: stops going to school, refuses to leave the house other than for therapy visits, and starts reporting delusions and hallucinations. The therapist refers her to the County BHP, where she receives coordinated specialty care, family support services, and case management, and she is encouraged to continue her established relationship with her MCP psychologist. Over time, it is discovered that the psychotic episode was due to experimental substance use; the teen stops using substances, and the psychosis resolves. She stabilizes, no longer needs County BHP services, and continues to see the MCP psychologist when needed. The Enterprise Health Record is configured to exchange encounter data with the MCP to coordinate care and demonstrate that claiming under both benefits is non-duplicative, and therefore allowed.

Fourth Use Case: The BHP staff that manages grievances, appeals and State Fair Hearing requests receives a grievance on 7/5/21 from a client and the document is dated 7/1/21. As soon as the document is received, the BHP staff enters the grievance information directly into the Enterprise Health Record, being sure to include the date the document was completed, the date the document was received, the method of filing (oral or written), the document type and category, etc.). The system functionality shall allow for the BHP staff to easily determine how much time is left for the grievance, appeal, or State Fair Hearing to be addressed and will provide notifications to the staff if a “due date” is approaching to ensure compliance. When the BHP staff is ready to prepare the grievance and appeals report for submittal (annual or quarterly), they will easily be able to view the data, address any potential errors and submit directly to the proper contact at the DHCS.

2.4.14 Supplementary Claims Processing Requirements

Although under CalAIM payment reform initiatives most of the revenue cycle management activities will align with industry standard medical billing requirements and processes, however there are still a number of reimbursement mechanisms for services or activities that may be unique to California. Several of these mechanisms are noted in this section, including Medi-Cal Administrative Activities (MAA) and Quality Assurance/Utilization Review (QA/UR) Claiming. Additionally, County Mental Health Plans are classified as Pre-Paid Inpatient Health Plans (PIHPs) and as such are responsible for paying for inpatient psychiatric hospitalizations for Medi-Cal beneficiaries and non-Medi-Cal individuals (or settings) that are determined to fall under County responsibility. Although the authorization/payment method for these inpatient episodes is changing from retrospective payment review to concurrent payment review, the current strategy (including Treatment Authorization Requests TARs) is highlighted below.

2.4.15 Medi-Cal Administrative Activities (MAA) & Quality Assurance/Utilization Review (QA/UR) Claiming

The federal government reimburses County BHPs for activities they undertake to administer the Medi-Cal program locally. These activities are referred to as Medi-Cal Administrative Activities (MAA). The activities are grouped into categories, some of which apply to direct service provision to individuals who are otherwise eligible for Medi-Cal, but who are not enrolled in either Medi-Cal, or in Medi-Cal-funded behavioral health



services. Other reimbursable activities are focused on administering Medi-Cal contracts (with BHP subcontractors) or program planning and development activities. MAA claiming requires capturing the staff person's entire workday on a per-minute basis and dividing that time into MAA-claimable and non-claimable activities. A successful Enterprise Health Record would provide a strategy to capture and report on these activities. There are separate claiming mechanisms for Mental Health MAA and Drug Medi-Cal MAA (see State Reporting Requirements & Regulations Spreadsheet for additional information [California Mental Health Services Authority | Multi-County EHR \(calmhhsa.org\)](https://www.calmhhsa.org/)).

2.4.16 Quality Assurance/Utilization Review (QA/UR) Claiming

County BHPs are contractually required to engage in specified QA/UR activities. These activities are claimable based upon the broad activity and the designation of staff completing the activities. Since many of these activities are tied to audits of the Enterprise Health Record, it would be preferable to quantify these activities for claiming within the record (see State Reporting Requirements & Regulations Spreadsheet for additional information [California Mental Health Services Authority | Multi-County EHR \(calmhhsa.org\)](https://www.calmhhsa.org/)).

High Level Requirements:

- MAA and QA/UR time entry will be integrated within the Enterprise Health Record and will support ease of entry via the scheduling solution as well as the ability to compare/validate with other possible data sources such as payroll data, or clinical documentation of direct services
- The Enterprise Health Record shall display MAA code categories and definitions, making categories and revenue-producing codes evident
- MAA codes will be available to both practitioner and administrative staff
- The Enterprise Health Record shall have the ability to present codes based on role/function (ensuring that staff whose positions are funded by sources that would conflict with MAA are not able to erroneously claim MAA)
- The Enterprise Health Record shall provide full MAA/QA/UR reporting functionality with ability to print, add reporting forms to payment and ability access the percent completion by month, longitudinally and by all staff

Use Cases:

First Use Case: A practitioner who works in a County BHP's 24/7 Access Call Center spends 50% of their time providing Medi-Cal billable assessment services, and 50% of their time answering the Toll-Free Call Line. The practitioner provides a mixture of MAA-claimable and Medi-Cal claimable services/activities and can document each in the Enterprise Health Record using a code and brief note for MAA and Medi-Cal compliant documentation for assessment services.

2.4.17 Treatment Authorization Requests (TARs)

TARs are official Medi-Cal forms that are submitted to County BHPs by inpatient psychiatric facilities to request authorization and payment for Medi-Cal inpatient psychiatric hospital stays. Following a client's discharge, the inpatient facility submits a TAR form to the county of responsibility (per the MEDS file), and it is adjudicated by



Utilization Review staff. Hospital stays that are Medi-Cal reimbursable are submitted to the State's identified fiscal intermediary for payment, while county-responsible hospital stays are paid directly by the County. While the State is phasing out retrospective treatment authorization in favor of concurrent authorization activities some retrospective TARs will remain, primarily based upon correct guarantor responsibility information being unavailable until after a treatment episode concludes.

High Level Requirements:

- The Enterprise Health Record shall support electronic submission of TAR documentation, including the state-required TAR form, and any additional medical records/forms from the treating hospital
- The Enterprise Health Record shall support identifying and storing all inpatient hospital information by hospitalized individual, whether they are admitted to County BHP services or not
- The Enterprise Health Record shall alert County BHP treating teams to a client's hospitalization and ensure permissions for review of records for clinical decision making and care coordination
- The Enterprise Health Record shall support secure messaging with hospital staff
- The Enterprise Health Record shall support generation and distribution of Notices of Adverse Beneficiary Determinations (NOABDs) to hospitals and beneficiaries in all relevant languages
- The Enterprise Health Record shall support time and date stamping of documents received and sent to support compliance with timeliness requirements
- The Enterprise Health Record shall support processing of retrospective TARs, if necessary
- The Enterprise Health Record shall support submitting completed TAR forms to the State's designated fiscal intermediary and/or processing the TAR for payment locally based upon provided logic

Use Cases:

First Use Case: Retrospective TAR Scenario: County Utilization Review staff receives a TAR form after a client is discharged from the hospital that identifies the dates of service that a client was psychiatrically hospitalized. County UR staff review the TAR form to ensure accuracy of approved treatment dates and enter the authorization details for the hospitalized client in the Enterprise Health Record. The information entered includes insurance type, admitting facility, dates of service authorized, date of discharge, facility rates (for both contracted/non contracted facilities), etc. County Fiscal staff have access to this information, which allows them to review the authorization, gather data on psychiatric hospitalization and ensure which dates have been approved before paying the facility for any ancillary services (professional fees, etc.) that have been billed to the County BHP by a given facility.

Second Use Case: Concurrent Utilization Review Scenario: The County BHP is informed of a beneficiary hospitalization and provides a physician attestation of medical necessity for the first 48 hours of the inpatient stay. For the subsequent days, the hospital staff submit the required continuing stay documentation, and the stay is approved at three-day intervals until discharge. The medical record information submitted by the hospital is stored in the Enterprise Health Record and is available, not only to the UR staff, but the outpatient treatment team.



2.4.18 State Reporting Requirements

Historically, state reporting has presented challenges for County BHPs for several reasons, many of which CalMHSA seeks to address with the Enterprise Health Record. As Managed Care entities, County BHPs must collect and report data from its entire network of providers, regardless of which EHR (or combination of EHRs) the data was recorded in. As such, it is necessary for the Enterprise Health Record solutions for state reporting to include tight integrations per the requirements identified in the [Integration Tools – Standard Healthcare APIs and System Open Architecture](#) section of this document. In addition to the complexity of data integration, challenges also exist with data completeness. Relatively new reporting requirements (e.g., CSI Timeliness Reporting) pre-supposes data elements that were not collected in a typical EHR but will be captured in [Contact Activity](#). Additionally, new requirements can negatively impact clinical and administrative documentation burden (leading to low field completion) unless strategically woven into existing clinical and administrative workflows. The latter issue can be addressed by employing [Application Configuration Tools](#) and a [Dynamic User Interface](#) to mitigate documentation burden on staff, while the former is addressed above (See Care Coordination, “[Contact Activity](#)”).

Finally, data reporting to the State or other entities inevitably requires resolving error reports. The Enterprise Health Record shall provide a mechanism to consume and resolve error reports. Given the complexity of report submission and error correction across varied state reporting requirements, it is expected that the vendor will provide custom development or initial configuration to support automated submission and error correction tools for all state reporting forms.

It is anticipated that the requirements identified within this document related to both [Application Configuration Tools](#) and [Dynamic User Interface](#) can be used to address most of the rules across all State Reporting formats however, in the vendor’s response to this document, CalMHSA intends that the initial configuration and on-going adherence to the data collection rules will be the responsibility of the Enterprise Health Record vendor. If a data collection requirement extends beyond the capabilities of the proposed solution, then it is expected that the Enterprise Health Record vendor will perform custom development at the guidance of CalMHSA to address the variance.

2.4.19 Specific Required State Reporting Requirements

Below, each state reporting requirement expected to be delivered by the vendor is described along with links to source documentation. The first two state reports are described in detail as they represent some of the more complex examples. It is expected that the following requirements (mostly previously described) will be supported by the Enterprise Health Record:

[High Level Requirements:](#)

- The Enterprise Health Record shall be capable of gathering and reporting on all required data elements and at various frequencies (monthly, biannually, annually, etc.)
- The Enterprise Health Record shall include functionality that supports easily making any necessary edits to submitted data (regardless of treatment episode status) so that it can be quickly corrected and resubmitted to the State
- The Enterprise Health Record shall include capabilities that accommodate all requirements associated with [High Availability Data Architecture and Reporting Tools](#) as described within this document



- The Enterprise Health Record shall include “State Screening Tool for MH and SUD” form capabilities that accommodates all requirements associated with [Integration Tools – Standard Healthcare APIs and System Open Architecture](#) as described within this document
- The Enterprise Health Record shall include capabilities that accommodate all requirements associated with [Multi-County Installation](#) as described within this document
- The Enterprise Health Record shall include capabilities that accommodate all requirements associated with [Application Configuration Tools](#) as described within this document
- The Enterprise Health Record shall include capabilities that accommodate all requirements associated with [Dynamic User Interface](#) as described within this document
- The Enterprise Health Record shall include capabilities that accommodate all requirements associated with [Workflow Definition and Application Functions](#) as described within this document
- The Enterprise Health Record shall include capabilities that accommodate all requirements associated with [Consent Management](#) as described within this document

State Reporting Example 1 – Timeliness Reporting

The DHCS requirement for measuring and reporting the Client Services Information (CSI) for treatment timeliness for a new Mental Health Client is complex. It involves the collection of several date-specific data points for each new client and normally involves multiple users/clinical staff. These include:

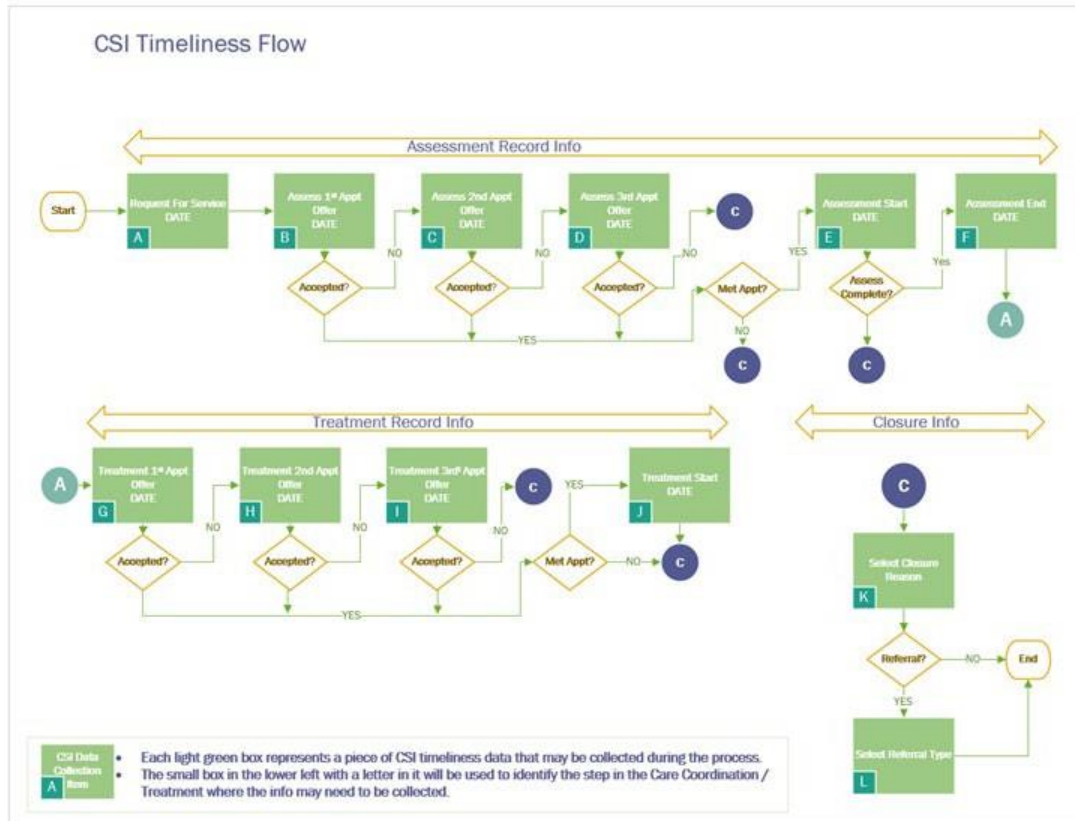
- Initial Date client requested services
- First Assessment Date Offered
- Second Assessment Date Offered
- Third Assessment Date Offered
- Assessment Start Date
- Assessment End Date
- First Treatment Date Offered
- Second Treatment Date Offered
- Third Treatment Date Offered
- Treatment Start Date
- Closure Date and Reason for Closure

The care coordination to treatment workflow and data linking strategies proposed within this RFP will allow for automatic data collection in support of the CSI timeliness requirement. In fact, this design will allow valuable timeliness data to be captured for all client encounters, not just initial encounters, for both mental health and substance use treatment.

Data Collection Workflow:

A basic flow diagram of how CSI timeliness data is collected illustrates some of the challenges with this state reporting requirement. Not only do many dates need to be collected, but the process can potentially be closed (Closure Date) at almost any step if a client discontinues the engagement process.

The flow diagram below illustrates the process: Each light green box represents a CSI timeliness data element that must be collected.



Consider how the collection of this CSI timeliness data overlays the clinical workflow. At each point in the workflow data is being collected and stored. During Call Intake it is likely that the County BHP will have “Contact Activity” information but may not have full demographics (“Client” or “MPI”) information yet. The complexity lies in linking the Call Intake Record with the Screening Record (which might not contain full demographic data) and linking both to the eventual Assessment Record (full demographics collected) and so on until, hopefully, the client receives their initial treatment. Establishing these links between records/clinical events will allow the County BHP to monitor treatment timeliness of the entire provider network, and not just for the subset entering mental health treatment.

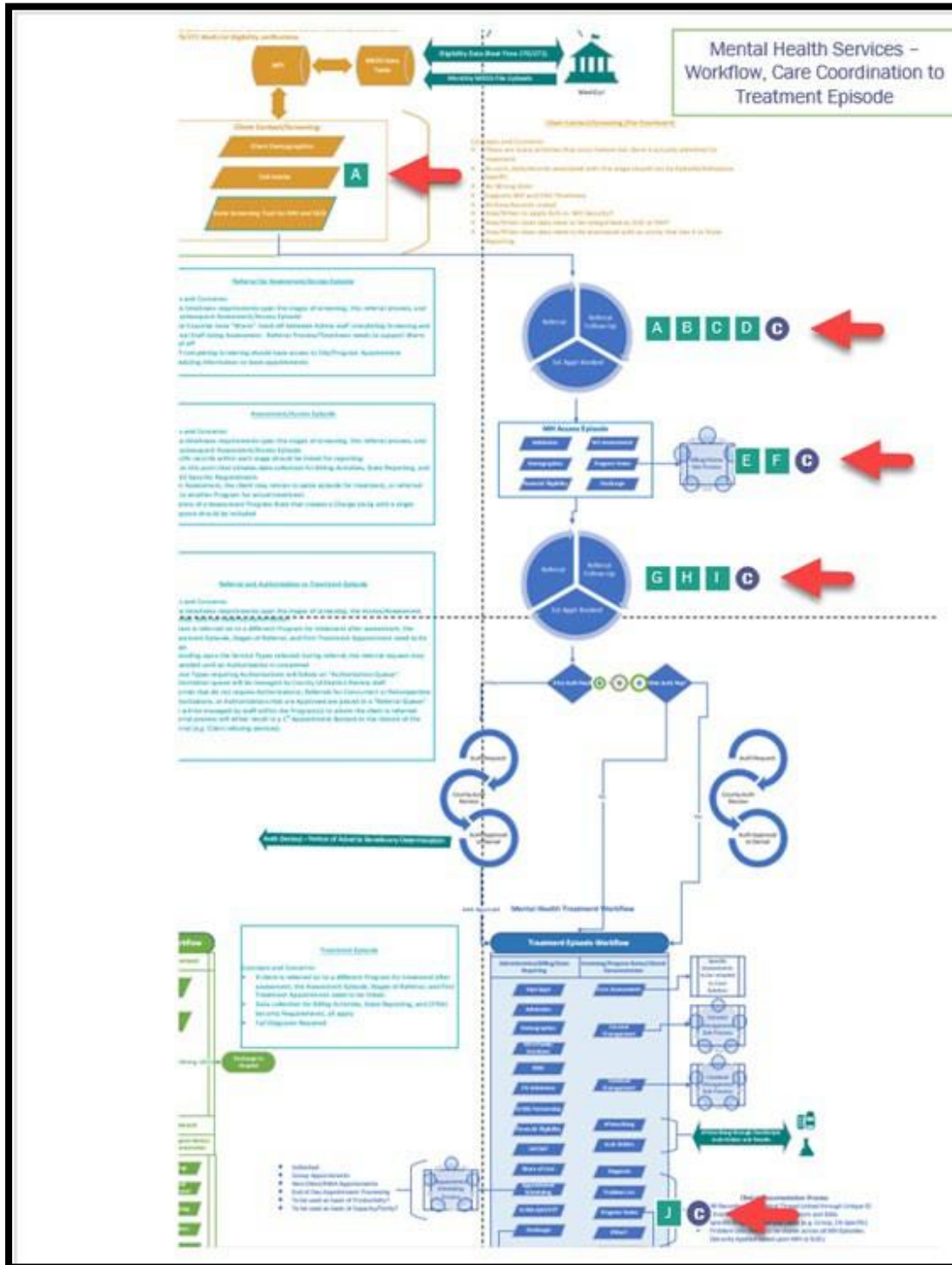
Several users/clinical staff are involved in the care coordination to treatment workflow for each new client. At any point in the process, a single user/clinician communicates with the client. For CSI Timeliness purposes, the immediate users involved in the “current process step” must be presented a work queue of the pending status of their current contacts/clients. At some prescribed timeframe if contact with the client is no longer possible, then the current primary user/clinician must close out the timeliness record.

Using the identifying label within each step in the timeliness workflow:





The diagram below shows the relationship between the CSI Timeliness Flow and the overall Enterprise Health Record workflow defined in this RFP. Timeliness measurement is complicated that it relies on accurate data collection at each point in the workflow across multiple user/clinicians' activities:





Note: the above description is not meant to design the solution to this complex state reporting challenge. Rather it is meant to demonstrate the importance of the care coordination data collection from call intake through treatment.

High Level Requirements:

- The Enterprise Health Record must be able to identify each “Contact”
- For CSI Timeliness reporting any new “Contact” must be identified as the beginning of the workflow measuring timeliness
- Each user/clinician in the workflow must have a work queue showing the status of any pending contacts/clients
- Using the work queue aging, the user/clinician must be able to close out inactive CSI Timeliness records from the pending work queue
- Closure Record must define a valid closure code (CSI Timeliness data dictionary)

Use Cases:

First Use Case: An individual calls the County BHPs Access Call Line requesting treatment. The caller is a potential client and is not in the Enterprise Health Record MPI. (The Enterprise Health Record flags this caller as “new” to begin timeliness tracking.) The caller is screened by clinician Maria and referred to Mental Health for an assessment. During the referral process the potential client is offered a date for an assessment appointment by user Ariel and the caller agrees to the appointment date. (The Enterprise Health Record records this accepted date.) The potential client participates in an assessment appointment with clinician Angel. For the assessment, the potential client is admitted, their demographic information is added to the MPI and becomes a client. If the outcome of the assessment was that the client’s condition “does not meet medical necessity”, then the CSI timeliness record would automatically have closure date applied with the assessment disposition being the closure reason. If the disposition of the assessment is a referral for Mental Health Treatment, then the timeliness record continues through the Treatment referral/appointment process. Offered and accepted treatment appointment dates are tracked, and with the eventual treatment start date recorded, the CSI timeliness record is concluded.

Second Use Case: An individual calls the County BHP Access line, is screened and offered/accepted an assessment appointment. The individual does not keep the assessment appointment, so their contact information remains in assessment referral queue for clinician William for three weeks. In the Enterprise Health Record William has been able to note the dates and results outreach attempts to contact the potential client. After 30 days and six call attempts, William opens the pending work queue item and adds a closure date for the CSI record with closure reason “Client did not attend appointment.” This removes the pending record from William’s work queue.

State Reporting Example 2 – Full-Service Partnership (FSP) Mental Health Services Act (MHSA) Reports

A Full Service Partnership (FSP) is an intensive outpatient mental health program funded by the Mental Health Services Act (MHSA) -- (for more information: [Mental Health Services Act \(MHSA\) \(ca.gov\)](https://www.ca.gov/mental-health-services-act/)). FSP programs are subject to unique reporting requirements, which necessitates structured data collection at program admission,



every three months thereafter, and every time a “Key Event” (e.g., homelessness, hospitalization, employment, incarceration, etc.) occurs. Because FSPs treat clients across the lifespan, and reporting is focused on objective outcomes, some of the data elements are customized to age groups (e.g., data collection for a child in FSP would include school attendance and achievement in lieu of employment metrics).

Several challenges arise from FSP reporting requirements that can be improved by tightly weaving the FSP data collection activities into the routine clinical workflow. For example, it is routine to admit a client to a program and assign a care coordinator. For an FSP client, those activities need to occur, but the client also needs to be “established” as an FSP client at the State and a “Personal Services Coordinator” needs to be identified at the State. Any change that would happen in the EHR -- assigning a new coordinator, transferring to a new FSP, discharge—also needs to happen in the State system. Clients who are enrolled in FSPs are identified as “Partners” for state reporting, and “partnerships” have an “establishment date”. FSP records must be submitted in the correct order, so if a client is only “admitted” to the BHP program, but not also “established” at the State, will not be able to submit subsequent records. Data collection at the required intervals/events also needs to be presented within the core clinical workflow to support timely and complete reporting. Additionally, tools to audit the status of records and help users focus on the pieces of information that are still outstanding would be desirable.

As it relates to data submission format, the FSP/MHSA reporting provides the opportunity to upload data via an .xml upload to the state system. As such, the Enterprise Health Record will need to produce an output per the .xml file specification provided by the State. (For other state reports, other outputs in other formats will need to be designed by the vendor per the proprietary layout defined by the state reporting entity.) The ability to upload error reports and other data from the State to drive error correction activities is desirable. Wherever possible, automated corrective actions and/or interactive tools to guide and expedite record correction and resubmission should be provided.

High Level Requirements:

- Logic will exist within the Enterprise Health Record to assure that state reporting requirements based upon different program types will be enforced and supported
- The Enterprise Health Record will provide clinical compliance tools so that different state reporting requirements can be evaluated to assure that they are initiated, completed, and submitted within required time limit
- The Enterprise Health Record will provide tools to drive a dynamic user interface that will determine the appropriate/required data collection fields based upon a number of criteria including, but not limited to:
 - Age of client at admission
 - Appropriate Record Type Based Upon Suspense Time Since Last Record
- The Enterprise Health Record will provide tools to drive dynamic user interface rules based upon conditional logic established within the relevant state databases for the associated state reports
- The Enterprise Health Record will provide managerial auditing reports to evaluate the current status of all data records that should be in process or submitted based upon the applicable state reporting timeline requirements



- The Enterprise Health Record will support the automatic assignment of unique identifiers to appropriate record types based upon the rules established in the applicable state reporting requirements
- The Enterprise Health Record will support the creation of report data outputs per the specifications established in the applicable state reporting requirements
- The Enterprise Health Record will support the ability to consume available error reports and provide automated corrective actions with the application

Other State Report Requirements

Some of the reporting requirements for County BHPs include but are not limited to the following:

- Client Services Information (CSI) [Assessment Data, Initial, Periodic, Discharge]
- Child and Adolescent Needs and Strengths (CANS)
- Pediatric Symptoms Checklist (PSC-35)
- Network Adequacy Certification Tool (NACT)
- California Outcomes Measurement System Reporting (CalOMS)

[Details of the specific requirements can be found on the State Reporting Requirements & Regulations Spreadsheet [California Mental Health Services Authority | Multi-County EHR \(calmhsa.org\)](#)]

Use Cases:

First Use Case: Counties submit CANS and PSC-35 data monthly to DHCS, which informs counties if the data included any errors (fatal errors and/or non- fatal) that prevent the data from being accepted. These errors could include a missing Client Index Number (CIN), a re-assessment CANS or PSC that was completed outside the allowable timeframe, or an incorrectly identified CANS or PSC assessment “type” (reported as Initial when it should have been Discharge, etc.). The Enterprise Health Record shall supply a simple method to correct these errors (moving the documents from “final” to “draft” status so that the necessary corrections can be made, and the document can be resubmitted) and these corrections should be able to be made regardless of treatment episode status. The corrections should not require reopening a treatment episode.

2.4.20 Sub-Contractor Provider Management Requirements

As identified throughout this document, County Behavioral Health organizations serve as both Med-Cal Plans and Medi-Cal Providers. As a Plan, County BHPs maintain a provider network, which consists of both directly operated county programs, as well as sub-contracted programs. Whether a client is treated by a county directly operated program or one of the county’s Contract Providers, that individual is the responsibility of the County Plan. As such, there are data collection and workflow requirements that are common/consistent regardless of who is treating the client. There are also requirements that are only applicable when clients are being treated by Contract Providers.

Under the requirements of the County BHPs operating as Plans there are essentially four categories.



1. Managing Contract Providers regarding:
 - a. Contract Management
 - b. Network Adequacy
2. Authorizations for Treatment
 - a. Annual Provider Budgets
 - b. Client-Specific Treatment Authorizations
3. Claims Processing/Management
 - a. Submission/Receipt (From Contractor to County)
 - b. Adjudication
 - c. Remittance / Explanation of Benefits (EOB)
 - d. Voucher Creation
4. Data Aggregation
 - a. Claims Data
 - b. State Reporting

On the surface, the dual nature of County Behavioral Health organization might seem simple to address, but historically EHRs have not addressed the needs of the entire BHP enterprise.

First, while the County Behavioral Health Organizations are Plans, they are not the ultimate authority as it relates to the eligibility of the clients, the coverage for claims submitted, or data requirements for state programs. Since DHCS is the ultimate authority for Medi-Cal coverage, the counties in many respects operate as a pass-through entity. This situation has many intrinsic difficulties. For example, although the county is the entity which adjudicates claims related to services provider by their Contract Provider(s), the county is required to subsequently aggregate these services with those provided by county directly operated programs and send an aggregated claim to DHCS. At this point, the state may reject services performed by a Contract Provider despite the same service having been approved and paid by the county.

Second, for several requirements (e.g., Claims and State Reporting) the county is responsible for collecting, aggregating, and submitting data periodically throughout the treatment of all clients. For directly operated programs, this is not a challenge as all these programs and their staff primarily use the County's system/EHR to record all data about client treatment. But as it relates to data associated with treatment provided by Contract Providers, there are fundamental issues. The primary of which is that many Contract Providers have implemented their own electronic health records to manage their operations. As such, the data they provide primarily is entered into their system and governed by their workflow and how these organizations collect data such as State Reporting, submit it to the County, have it uploaded in the County system, maintain data integrity between the different systems and address errors as a result of the county's submission to the state is extremely challenging.

Finally, despite clients being referred to the Contract Providers for treatment, the actual amount of data required to be collected, validated, and ultimately used by the County's enterprise system is extensive. To manage beneficiaries, all data and functions associated with the Mast Patient Index, including Medi-Cal Eligibility verification, need to be managed by the County. Also, all Care Coordination activities need to be managed within the County's enterprise system. Once a client is referred to a Contract Provider the data



requirements of the County are reduced, but not eliminated. While a client is being treated by a Contractor, billing and state reporting requirements still exist. Thus, in the County system the foundational records needed for creating claims to send to the State need to be available. This means even though records such as Admission, Diagnosis, Guarantor/Payor, etc. are being collected, and continually updated, by the Contract Provider for their use, copies of those records need to also be within the County's system for their use when billing the State. The same requirement exists for State Reporting data as the Contractor is responsible for collecting this data as a by-product of their activities with the client(s), but it is ultimately the County that needs this data for their submission(s) to the State.

Historically, different Counties have addressed these requirements in different ways. For some counties, within their contracts with their Contract Providers, they require the Contract Providers to use the county's EHR. The "pros" of this approach are that it supports a consistent workflow across all programs, and it does not require any interoperability/interfaces to support. The "Cons" of this approach are that when a Contract Provider has their own EHR, it requires duplicate data entry by Contract Provider staff and the costs of the county's systems are increased because they must provide user accounts for Contract Prover Staff.

Additionally, having Contract Providers use the county system in the same manner as Directly Operated Programs also means that the fundamental activities between a Health Plan (the County) and its network Health Care Provider such as authorization, claims submission, adjudication, and remittance are removed. In fact, historically despite their role as a "Plan" many of the counties have foregone the implementation of systems specifically designed to support operations of Sub-Contractor Providers and instead have all Contractors using the County electronic health records to support their operations.

But this approach is not universal; it is not in alignment with the industry standard dynamic between "Health Plan" and "Health Care Provider" and as such, it is probable that such an approach may conflict with future requirements from the state and federal government.

All these conflicting requirements and the fact that no county or Health IT vendors has designed and implemented a flexible and scalable solution leads CalMHSA to presume that no off-the-shelf solution exists. CalMHSA views the creation of a viable "Managed Care" solution for the California Behavioral Health organizations as a joint development effort with the selected vendor. As such, CalMHSA is proposing the following design and associated high-level requirements.

In their response, each Vendor should respond by identifying whether they believe that they can successfully augment the Practice Management (PM) software of their proposed solution as described here, how they would envision adding functionality to meet this approach, and the prospective timeline for making such updates.

[Approach and High-Level Requirements:](#)

Based upon the four high-level requirements required of county organizations in their operations as a "Plan", a majority are fulfilled within standard Practice Management (PM) components of electronic health records or, are addressed through such core PM functions coupled with other requirements previously identified in this document (e.g., those identified in the



are intended to address requirements of both Directly Operated Programs as well as Contract Providers in the following categories:

- Managing Contract Providers in Regard To:
 - Contract Management
 - Network Adequacy
- Authorizations for Treatment
 - Client-Specific Treatment Authorizations
- Data Aggregation
 - Claims Data
 - State Reporting
 - Other

Additionally, if the proposed Enterprise Health Record provides the high-level of interoperability anticipated based upon the requirements identified within the [“Integration Tools – Standard Healthcare APIs and System Open Architecture”](#) section of this document, then the mechanisms to support a data-exchange between electronic health records in use by various contractor organizations and the semi-statewide Enterprise Health Record could be established. It is anticipated that such an interoperability mechanism would address the replication of required data records from the Contractor’s electronic health record and the county’s enterprise system: Admission, Diagnosis, Guarantor/Payor, state reporting, encounter/service, etc. As part of the vendor’s response to this proposal, vendors should confirm that their anticipated interoperability solutions as defined within [“Integration Tools – Standard Healthcare APIs and System Open Architecture”](#) would support this specific use-case.

Finally, regardless of whether the data required by the behavioral health organization as a “Plan” is entered directly into the Enterprise Health Record or passed via an integration, functionality would need to be added to support the remaining Managed Care requirements of:

- Authorizations for Treatment
 - Annual Provider Amounts
- Claims
 - Submission/Receipt
 - Adjudication
 - Remittance / EOB
 - Voucher

Based upon these criteria, the anticipated high-level requirements are:

- Within the response provided by the vendor in the [Organizational Data Hierarchy](#) section of this document, will the proposed solution support the historical collection and management of contractor data including:
 - Contract Start/End Dates
 - Network Availability Data



- Office Hours
- Within the response provided by the vendor in the [Personnel Data Hierarchy](#) section of this document, will the proposed solution support the historical collection and management of contractor personnel data including:
 - Employment Start Date
 - Employment End Date
 - Network Availability Data
 - Office Hours
- Within the response provided by the vendor in the [Integration Tools – Standard Healthcare APIs and System Open Architecture](#) section of this document, will the proposed solution support data aggregation requirements through the integration of the semi-statewide Enterprise Health Record with contractor electronic health records including:
 - Master Patient Index – Demographics
 - Admission Records
 - Client Demographics
 - Diagnosis Records
 - Guarantor/Payor Coverage Information
 - State Reporting Records
 - Client Service Information (CSI Admission)
 - CalOMS
 - CalOMS Admission
 - CalOMS Annual Update
 - CalOMS Discharge
 - MHSA
 - Partnership Agreement Form (PAF)
 - Key Event Tracking (KET)
 - Quarterly Assessment Form (QAF)
 - Child and Adolescent Needs and Strengths (CANS)
 - Pediatric Symptoms Checklist (PSC)
 - Network Adequacy Certification Tool (NACT)
 - Billing Details
 - Client Pregnancy Status
 - Uniform Method of Determining Ability to Pay
- Within the response provided by the vendor in the [MH/SUD Authorization Process section](#) of this document, will the proposed solution support the historical creation and management of Client-Specific Treatment Authorizations?
- Will the vendor augment the existing Practice Management components of their proposed solution to add the ability to define Provider Authorization criteria and limitations? (It is anticipated that this would be an additional component of the previously described [Organizational Data Hierarchy](#))



- Will the vendor augment the existing Practice Management components of their proposed solution to add the ability to define upload and process 837P and 837I claims submissions? Through this upload process, the services/charges uploaded will be integrated into the same data tables as services/charges entered by users of the Enterprise Health Record.
- Will the vendor augment the existing Practice Management components of their proposed solution such that it can be configured by county, so that services/charges entered (via either direct data entry, interoperability, or 837 process) against programs identified as “Contract Provider” (per [Organizational Data Hierarchy](#)) will be put into a “Pending” status until a Claims Adjudication Process is completed?
- Will the vendor augment the existing Practice Management components of their proposed solution to add a Claims Adjudication Process that evaluates all services/charges for Contractor Providers in a “Pending” or “Denied” status.? This adjudication process will compare characteristics of the service/charge against both Provider Authorization and Client-Specific Authorization records to determine whether the services/charges entered/provided by the Contract Provider are “Approved” or “Denied” for payment. As a by-product of the adjudication process, the status of each service/charge should be updated from “Pending” to either “Approved” or “Denied”.
- Will the vendor augment the existing Practice Management components of their proposed solution to create remittance outputs via the HIPAA 835 format?
- Will the vendor augment the existing Practice Management components of their proposed solution to add the ability to support the manual correction of information for charges/services associated with a Contract Provider that was denied for payment?
- Will the vendor augment the existing Practice Management components of their proposed solution to add the ability to support the rebilling of charges/services associated from Contract Providers that were denied for payment?
- Will the vendor augment the existing Practice Management components of their proposed solution such that after an adjudication process is completed, vouchers corresponding to the remittance information for each Contract Provider can be produced? These vouchers will be provided to the Fiscal Department of the county organization so that corresponding payments can be processed for the Contractor Provider(s).
- Will the vendor augment the existing Practice Management components of their proposed solution such that when a service/charge is determined “Approved” as the by-product of an adjudication, the service/charge will be aggregated with other service/charge records ready to be billed to Medi-Cal and/or Other Health Plans?

2.5 Legacy System Data Conversion Requirements

County BHPs that are converting to the Semi-Statewide Enterprise Health Record will require data conversion services to archive their legacy data for financial and clinical auditing purposes and to seed the Enterprise Health Record with data relevant to ongoing client care. County BHPs utilize a number of different EHRs, and as such, the legacy data is county-specific and non-normalized. Although the conversion process is outside of the



central scope of the Enterprise Health Record implementation, CalMHSA is requesting a narrative description of your standard conversion process. Please include in your response any additional considerations given the size/scope of the Semi-Statewide Enterprise Health Record project.

Responses should consider the requirements outlined below and include the process to transfer the legacy data for each participating County BHP to:

- Seed the new Enterprise Health Record
- Create an archive database with legacy data
- Build/load the Master Patient Index serving the CalMHSA Semi-Statewide Enterprise Health Record

High Level Requirements:

- Convert minimum necessary data from county legacy EHR to Semi-Statewide Enterprise Health Record:
 - o Data related to current Open Episodes/Clients
 - o Current client demographics
 - o Basic user log in information
 - o Practitioner demographics and credentialing
 - o Diagnosis history for open Clients
 - o Financial eligibility associated with open episodes
 - o Client Service Information (CSI)/California Outcomes Measurement (CaOMS) admission records
 - o Mental Health Services Act Full-Service Partnership data
- Accomplish initial load/implementation of the Semi-Statewide EHR Master Patient Index (MPI):
 - o Master Patient Index must create a Unique Patient Identifier (UPID) for each client across the entire Semi-Statewide Enterprise Health Record
 - o A cross reference between the legacy Client/Patient Number and the UPID must be maintained to allow for linking new Enterprise Health Record data to archived County BHP data
 - o Manage process for identifying and reconciling duplicate and potential duplicate client records across the entire Semi-Statewide Electronic Health Record
 - o Iterative process based on phasing in County BHPs in two cohorts.
- Archive legacy treatment data – archived data must support cost report and other potential audits:
 - o Create cloud based legacy data structure based on each legacy EHR data structure
 - o Extract subset of data from county legacy EHR

2.6 Implementation Requirements

Provide a narrative response to describe your standard EHR implementation process and timeline. Include your:

- Typical Staffing (numbers/types/roles)
- Implementation process and timeline



Based on your standard implementation process describe how you propose implementing across the 20 County BHPs anticipating the two phases defined below.

The CaIMHSA Semi-Statewide Enterprise Health Record project will be implemented in two phases:

Phase 1: 2-3 small counties with 150 – 500 total users. Go Live date: 7/1/2022.

Phase 2: 16-18 counties with 11, 500 – 11,850 total users. Go Live date: 7/1/2023. This planned go live date is tied to the State’s planned go live with payment reform.

Note: Number of counties and end users are approximate. Go Live dates are firm.

What are the resources required/available to perform implementation?

- What existing implementation resources do you have?
 - Please describe staff roles and responsibilities and experience level.
- Number and type of staff resources that you need to hire?
- Define resource plan to support the two deployment phases.

What is the implementation plan and timeframe?

- Assume 95% common processes/forms across the partner counties – standardized user environment across entire Enterprise Health Record.
- Provide timeline to roll out Phase 1 County BHPs.
- Specifically for Phase 2 County BHPs, would you approach this as one large implementation, or several implementations? Define and describe.
- Provide a timeline to roll out to all phase 2 County BHPs.

Estimate Implementation costs:

- Provide Phase 1 implementation cost information in RFP cost matrix.
- Provide Phase 2 implementation cost information in RFP cost matrix.

3. Eligibility

3.1 Minimum Qualifications

To be an eligible vendor for this project the solution proposed by vendors responding to this RFP must have attained certification under the Office of the National Coordinator for Health Information Technology (ONC) Health IT (Information Technology) Certification Program. Furthermore, responding vendors need to commit to continuing certification efforts under the 21st Century Cures Act “Final Rule” as well as future reporting programs implemented by ONC through their Conditions and Maintenance of Certification requirements.



3.2 Evaluation Criteria

Proposals will be scored according to the Evaluation Criteria. CalMHSA intends to select approximately five (5) of the top scoring Proposers to participate in a Vendor Showcase to be held via Zoom. Proposers selected to participate in the Vendor Showcase shall be notified of their selection no later than December 1, 2021, and the Vendor Showcase will be held on the dates identified at Section 9.1. At the Vendor Showcase, Proposers will be expected to introduce key team members (including the proposed Project Manager), discuss and demonstrate the Proposer’s approach and solution, as well as lessons learned from similar projects. CalMHSA intends to select a vendor based upon these Vendor Showcase presentations.

Section #	Description	Max Scoring Value
1	Vendor Experience	200
2	Cloud Based	460
3	Production, Test, and Development Environments	40
4	Highly Accessible Data	460
5	Integration & Interoperability	460
6	Multi-County Installation	200
7	Application Configuration Tools	200
8	Dynamic User Interface	200
9	Workflow Definition and Application Functions	200
10	Integration of External Scripts	200
11	Document Management	100
12	Organizational Data Hierarchy	100
13	Staff and Provider Data Hierarchy	100
14	Consent Management	100
15	Master Patient Index	200
16	Support Multiple Care Coordination Activity Records Link	100
17	Support Care Coordination Activities in Non-Client-Specific Manner	100
18	Contact Activity Form	40
19	Referral Process - Screening	40
20	Appointment Scheduling	40
21	State Screening Tool for MH and SUD Form	40
22	Care Coordination Activities Interoperability	40
23	Assessment Episode	40
24	Prior Authorization	40
25	Treatment Episode Requirements	100
26	Progress Notes	40
27	Problem List	40
28	Caseload Management	100
29	Core Assessments/Forms and Custom Assessments	40



30	ePrescribing, Closed-Loop Medication Administration and eLabs	40
31	Supplementary Treatment Requirements	40
32	Client Portal	100
33	Medi-Cal Rx	40
34	Medi-Cal Managed Care Encounter Data Reporting	40
35	QI Rules: Pre-Billing Logic	40
36	QA-UR Claiming	40
37	Treatment Authorization Requests (TARs)	40
38	State Reporting	100
39	Sub-Contractor Provider Management	100
40	Implementation	100
41	Conversion	100
42	Pricing	200
Point Total		5000



4. Agreement Terms

The Agreement is subject to fund availability. If it is determined funds are no longer available, the Agreement may be terminated without cause or penalties.

The Agreement is intended to commence on January 15, 2022, or upon CalMHSA approval.

The resulting Agreement will not take effect until fully executed by all parties and all insurance requirements set forth in Exhibit B have been met.

The Agreement term may change if CalMHSA makes an award earlier or later than expected, or if CalMHSA cannot execute the Agreement due to unforeseen delays.

5. Proposers

5.1 Proposers Minimum Requirements

Proposer must meet the requirements below otherwise may be considered non-responsive and the proposal may be rejected, at the CalMHSA's sole discretion.

5.1.1 Proposer(s) must have a minimum of five (5) years of experience in developing and launching EHR (or similar) systems. Proposers may demonstrate this experience through the Proposer's own product experience, or through the relevant experience of the principal personnel assigned to the project.

5.1.2 Proposer(s) must submit the required Letter of Intent by the date specified in item 3 below:

5.1.3 Proposer(s) must comply with the RFP format and requirements set forth item 9.10 below.

5.1.4 Proposer(s) must submit three (3) signed letters of support, including references from organizations with whom Proposer has contractual or other business relationships who can substantiate Proposer's capacity to provide such services as described in the Statement of Work (SOW).

5.1.5 By submitting a proposal, Proposer certifies 1) it is not currently subject to any claim or settlement agreement with any CalMHSA member county or DMH for repayment of funds, and 2) it has not been subject to any such claim or entered into any such settlement agreement for the previous five (5) years. If there have been claims against the Proposer in excess of \$50,000 within the last five (5) years, Proposer must disclose and explain such claims in its proposal.

5.1.6 Financial Information: Proposer is required to submit copies of Proposer's most recent audited financial statements.

5.1.7 Suspension or Debarment: By submitting a proposal, Proposer certifies that it agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 2 CFR 180 and 2 CFR 376. Proposer further certifies that to the best of its knowledge and belief, that it and its principals:

5.1.7.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal, State or local department or agency.



5.1.7.2 Have not, within a three-year period preceding this RFP been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) or private transaction or contract; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, obstruction of justice, or the commission of any other offense indicating a lack of business integrity or business honesty that seriously affects is business honesty.

5.1.7.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph 5.1.7.2 herein.

5.1.7.4 Have not within a three-year period preceding this RFP had one or more public transactions (Federal, State or local) terminated for cause or default.

5.1.7.5 Have not, within a three-year period preceding this RFP, engaged in any of the violations listed under 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376.

5.1.7.6 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by CalMHSA.

5.1.7.7 Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

5.1.7.8 The terms and definitions herein have the meanings set out in 2 CFR Part 180 as supplemented by 2 CFR Part 376.

5.1.7.9 If the Proposer is unable to certify to any of the statements in this Section 5.1.7, the Proposer shall submit an explanation to CalMHSA.

5.1.7.10 If the Proposer knowingly violates the certifications set forth in this Section 5.1.7, in addition to other remedies available to the Federal, State or local governments, CalMHSA may terminate the Agreement for cause or default.

5.1.8 California Civil Rights Laws: For contracts over \$100,000, Proposer certifies compliance with the Unruh Civil Rights Act (Section 51 of the Civil Code) and the Fair Employment and Housing Act (Section 12960 of the Government Code). If a Proposer has an internal policy against a sovereign nation or peoples recognized by the United States government, the Proposer certifies that such policies are not used in violation of the Unruh Civil Rights Act (Section 51 of the Civil Code) or the Fair Employment and Housing Act (Section 12960 of the Government Code).

5.1.9 Conflicts of Interest: By submitting a proposal, Proposer acknowledges and understands

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that it must comply with all applicable conflicts of interest laws, including but not limited to those set forth in California Government Code §§ 1090 and 87100. In addition, by submitting a proposal, the Proposer certifies that none of its officers, directors, employees, or the spouses or domestic partners of any of its officers, directors, or employees are an officer, director, or employee of CalMHSA.

5.1.10 Proposer must identify its approach to project organization and staffing of the Enterprise Health Record project. At a minimum, the Proposer must identify the project manager and key staff that will work on the Enterprise Health Record project. For the project manager and each identified key staff proposed to work on the Enterprise Health Record project, the Proposer must provide the following information:

- Education;
- Relevant certifications (if any);
- Descriptions of relevant project experience including the length of time and responsibilities held on such project(s);
- Three (3) references covering similar projects within the previous five (5) years.

6. CalMHSA Rights and Responsibilities

6.1 CalMHSA is not responsible for representations made by any of its officers or employees prior to the execution of the Agreement unless such understanding or representation is included in this RFP or any written addenda to this RFP.

6.2 CalMHSA has the right to amend the RFP by written addendum. CalMHSA is responsible only for that which is expressly stated in the solicitation document and any authorized written addendum thereto. Such addendum shall be made available to each person or organization which CalMHSA records indicate has received this RFP. Should such addendum require additional information not previously requested, failure to address the requirements of such addendum may result in the Proposal Package not being considered, as determined in the sole discretion of CalMHSA. CalMHSA is not responsible for and shall not be bound by any representations otherwise made by any individual acting or purporting to act on its behalf.

7. CalMHSA Option to Reject Proposal Packages

CalMHSA, at its sole discretion, may reject any or all Proposal Packages submitted in response to this solicitation. CalMHSA shall not be liable for any cost incurred by a Proposer in connection with preparation and submittal of any Proposal Package.

8. Truth and Accuracy of Representations

False, misleading, incomplete, or deceptively unresponsive statements in connection with a Proposal Package shall be sufficient cause for rejection of the Proposal Package. The evaluation and determination in this area shall be at CalMHSA's sole judgment and its judgment shall be final.

9. Submission Instructions and Requirements



9.1 Proposal Timeline

EVENT	Key Dates
RFP Issued	September 20, 2021
Intent to Bid Submission	October 1, 2021 by 5:00PM PST
RFP Questions Due	October 1, 2021 by 5:00PM PST
Post Initial Question Responses	October 4, 2021
Bidders Conference	October 4, 2021
Final Posting RFP Questions Answered	October 7, 2021
Deadline for Proposals to be Submitted	November 15, 2021 by 5:00PM PST
Application Review	November 16, 2021
Invited Vendor Showcase	December 13-17, 2021
Final Selection	January 1-15, 2022

9.2 Submittal Address

Vendors should submit intent to bid information in the following from [EMR Intent to Bid Survey \(surveymonkey.com\)](#)

All rating sheet submissions must be submitted electronically using CalMHSA's e-Procurement Portal, Bonfire: <https://calmhsa.bonfirehub.com/>

9.3 RFP Questions and Clarifications

Vendors should submit question in the following form [EMR-RFP Question Submission Survey \(surveymonkey.com\)](#)

The deadline to submit questions for this RFP is October 1, 2021. The final FAQ responding to the questions will be posted on October 7, 2021, on the CalMHSA website.

To ensure all parties have access to the same information at the same time, except as stated below, CalMHSA will NOT respond to questions as they are received and will not accept telephonic questions.

It is the sole responsibility of the proposer to refer to the FAQs, which will be posted on CalMHSA's website.

If a question relates to a proprietary/trade secrets aspect of a proposal and the question would expose proprietary information if disclosed to competitors, the proposer must mark the question as "CONFIDENTIAL." With the question, the proposer must submit a statement explaining why the question is sensitive. If CalMHSA concurs that the disclosure of the question or answer would expose proprietary information, the question will be answered by email reply, and both the question and answer will be kept in

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confidence. If CalMHSA does not concur regarding the proprietary nature of the question, the question will not be answered in this manner and the vendor will be notified and asked whether the vendor would like the question to receive a public response or no response at all.

9.4 Bidders Conference

The Bidders Conference will be held on October 4, 2021, via Zoom. The meeting invite will be posted on the CalMHSA website.

A recording of the Bidders Conference will be posted will be available on CalMHSA's e-Procurement Portal.

9.5 Withdraw

A proposer may withdraw or amend its proposal, but only before the Application Submittal Deadline, directly on CalMHSA's e-Procurement Portal at <https://calmhsa.bonfirehub.com/>.

9.6 Review of Applications

CalMHSA will receive all applications and review for completeness and adherence to the RFP rules stated in this document. Following the initial review, all qualified applications will be reviewed and scored by a review panel. The evaluation panel will conduct a fair and impartial evaluation of proposals received in response to this RFP.

The review panel is comprised of individuals with varied backgrounds, to include professional expertise, lived experience, personal knowledge, etc. Panelists' information will not be disclosed as a matter of confidentiality.

9.7 Negotiations with Potential Proposers

Selection will not be based exclusively on price. CalMHSA reserves the right to negotiate with proposers who, in the opinion of the review panel, have submitted the best proposal in an attempt to reach an agreement. If no agreement is reached, CalMHSA may negotiate with other proposers or may choose to extend the proposal period. CalMHSA also reserves the right to meet with vendors to gather additional information. Additional information may include, but is not limited to, a demonstration of skills described in the proposal.

CalMHSA is interested in exploring ways to secure revenue streams or other financial considerations from the work product to help support its mission and operations. CalMHSA welcomes bidders' proposals, concepts, and recommendations to achieve this end, whether it be through the licensing of the work product to third parties or through some other means.

9.8 Protest Procedures

9.8.1 Right to Protest. Only an entity that has submitted a proposal in response to this RFP shall be entitled to protest the award.

9.8.2 Protest Procedure. An unsuccessful Proposer who intends to protest the awarded contract (Protestant) must submit a Notice of Intent to Protest. The Notice of Intent to Protest must be received by CalMHSA by 5 p.m. PST/PDT not less than three (3) days after the Notice of Intent to Award is posted on the CalMHSA website. Failure to timely provide written notice shall constitute a Proposer's waiver of the right to protest.



Within three (3) business days of receipt of a Notice of Intent to Protest, CalMHSAs shall provide to the Protestant (a) the proposal submitted by the announced awardee (Awardee), as redacted to protect information marked confidential pursuant to Section 9.9 of this RFP, and (b) evaluation materials related to the Awardee's proposal and the Protestant's proposal. CalMHSAs may, in its sole discretion, extend the date to provide this material to the Protestant.

Protests must be received by CalMHSAs by 5 p.m. PST/PDT no later than five (5) business days after the Protestant receives the Awardee's proposal and the evaluation materials.

9.8.3 Protest Contents. The sole basis for protest is that CalMHSAs should have awarded the contract to the Protestant. The protest must (1) state in detail each and every ground supporting the protest, citing to the law, RFP provision, or particular provision of the CalMHSAs procurement policy on which the protest is based; (2) include all supporting evidence; and (3) explain why the grounds asserted in the protest should have resulted in the award of the contract to the Protestant. Material submitted after the bid protest deadline will not be considered.

9.8.4 Protest Submission. The Notice of Intent to Protest and the written protest shall each be submitted via Email to:

info@calmhsa.org

With a copy to:

legal@calmhsa.org

Protestants are advised to submit the Notice of Intent to Protest and the subsequent protest well before 5 p.m. on the due date to ensure timely receipt by CalMHSAs. CalMHSAs shall not be responsible for any delay in CalMHSAs's receipt by email caused by any email, internet or other malfunction.

9.8.5 Copy to Awardee. A copy of the Notice of Intent to Protest must be concurrently provided by email to the Awardee. A copy of the protest and all supporting documents must be concurrently provided by email, by or before the bid protest deadline, to the Awardee.

9.8.6 Response by Awardee. The Awardee may, but is not required to, provide a response to any protest. Any such response shall be submitted within three (3) working days after receipt of the protest, and shall be submitted by email to the CalMHSAs email addresses noted above, and to the Protestant.

9.8.7 Decision on Protest. Within 14 days of receipt of any protest, CalMHSAs's Executive Director will provide a final written decision to the Protestant. CalMHSAs may, in its sole discretion, extend the date to issue the written decision.

9.8.8 Exclusive Remedy. The procedure and time limits set forth in this section are mandatory and are the Proposer's sole and exclusive remedy to contest the award of the contract. A Proposer's failure to comply with these procedures will constitute a waiver of any right to further pursue a bid protest or other claim, including filing a Government Code claim or initiation of legal proceedings. Any appeal of the Executive Director's final decision shall be limited to the grounds stated in the protest.

9.8.9 Right to Award. CalMHSAs reserves the right to award a contract to the Proposer identified in the Notice of Intent to Award, and to issue a notice to proceed with the work, notwithstanding any pending or continuing protest or other challenge to the contract award.

9.9 Notice Regarding Public Records Act Request

Addendum 1, November 10, 2021



CalMHSA is subject to the Ralph M. Brown Act and the California Public Records Act (“CPRA,” Cal. Gov. Code § 6254 et seq.). All documents submitted in connection with this RFP may be subject to public review. Proposals will remain confidential until CalMHSA has concluded negotiations with the successful Proposer but may be released before final approval by CalMHSA during the competitive bid process. Upon notice of intent to award and execution of contract by awardee(s), all proposals and supplemental information may be subject to public review, with the exception of those elements of a proposal that are clearly marked as confidential or trade secrets. Should a Proposer assert that portions of its proposal are exempt from disclosure pursuant to the CPRA, the Proposer must: (1) identify, in writing, all materials that the Proposer claims are exempt from disclosure; and (2) state the precise statutory basis upon which the Proposer claims the material is exempt. General claims of exemption covering entire proposals or without asserting specific statutory authority will not be considered, and such proposals remain subject to disclosure by CalMHSA. The Proposer claiming an exemption under the CPRA must also agree and state in its proposal that, *“The Proposer agrees: (1) to indemnify and hold harmless CalMHSA and its Board, officers, officials, directors, employees, agents, and volunteers (collectively, “Indemnified Parties”) from any claims, liability or damages, including reasonable attorney’s fees and court costs, against the Indemnified Parties; and (2) to defend any actions brought against the Indemnified Parties for its refusal to disclose materials Proposer claims are exempt from production under the California Public Records Acts to any party.”* Notwithstanding the Proposer’s assertion that certain items in its proposal are exempt from the CPRA, CalMHSA reserves the right to disregard such designations if they have been applied indiscriminately to non-protected information, and CalMHSA shall have no liability to the Proposer for such disclosure.

Although the California Public Records Act allows certain confidential or trade secret information to be protected from disclosure, CalMHSA may not be in a position to establish that the information submitted is protected. If CalMHSA receives a request for public disclosure of all or any portion of a proposal that has been designated as exempt from disclosure, CalMHSA will use reasonable efforts to notify the Proposer of the request and give the Proposer an opportunity to assert, at its own expense, a claimed exception under the California Public Records Act or other applicable law within the time period specified in the notice issued by CalMHSA and allowed under the California Public Records Act.

9.10 Format of Proposal

Proposals must be submitted through CalMHSA’s e-Procurement Portal at: <https://CalMHSA.bonfirehub.com/>. Submissions by other methods will not be accepted. Internet Explorer 11, Microsoft Edge, Google Chrome, or Mozilla Firefox. JavaScript must be enabled.

Browser cookies must be enabled. Respondents should contact Bonfire at Support@GoBonfire.com for technical questions related to submissions or visit Bonfire’s help forum at <https://bonfirehub.zendesk.com/hc>.

Submission materials should be prepared in the file formats listed under Requested Information for this opportunity in the Bonfire Portal. All PDFs documents must be formatted in Times New Roman, 12-point font, double spaced, unless otherwise indicated in the Requested Information. The maximum upload file size is 1000 MB. Documents should not be embedded within uploaded files, as the embedded files will not be accessible or evaluated.

9.11 Indemnity and Cost

Addendum 1, November 10, 2021



Each party responding to this RFP shall bear all of its own costs and expenses, direct and indirect, associated with or related to any action taken in response to this RFP, and CalMHSA shall not be responsible in any manner for such costs and expenses. Proposals, including all drawings, plans, photos, and narrative material, shall become the property of the CalMHSA upon receipt. CalMHSA shall have the right to copy, reproduce, publicize, or otherwise dispose of each proposal in any way that CalMHSA selects. CalMHSA shall be free to use as its own, without payment of any kind or liability therefore, any idea, scheme, technique, suggestions, layout, or plan received during its proposal process.



Exhibit B: Insurance Requirements

Contractor shall at all times during the Term of the Agreement maintain, at its sole expense, insurance including but not limited to the following types of insurance, with coverage and terms to be determined by the parties during negotiation of the Agreement. Such insurance policies shall include and insure CaIMHSA, its Board and all its officers, employees, and agents, their successors and assigns, as additional insureds, against the areas of risk associated with the Services as described in the Scope of Work.

B-1. Commercial General Liability.

B-2. Worker's Compensation and Employer's Liability.

B-3. Professional Liability Insurance.

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