T.7.C.3

AGENDA COVER MEMO

AGENDA DATE: January 12, 2011

TO: Board of County Commissioners

DEPARTMENT: Health & Human Services

PRESENTED BY: Rob Rockstroh

AGENDA TITLE: ORDER _____ / IN THE MATTER OF APPROVING AWARD OF A PROFESSIONAL SERVICES CONTRACT WITH NEXTGEN IN THE AMOUNT OF $422,938 FOR THE PERIOD SEPTEMBER 1, 2011 THROUGH AUGUST 31, 2014 FOR THE PROVISION OF A HOSTED ELECTRONIC HEALTH RECORD FOR THE COMMUNITY HEALTH CENTERS OF LANE COUNTY

I. MOTION

In the Matter of Approving Award of a Professional Services Contract with NextGen in the Amount of $422,938 for the Period September 1, 2011 through August 31, 2014 for the Provision of a Hosted Electronic Health Record for the Community Health Centers of Lane County

II. AGENDA ITEM SUMMARY

The Board is being asked to award a professional services contract for an electronic health record for the Community Health Centers of Lane County (CHCLC). The CHCLC seeks to implement an EHR to improve services to its clients and it seeks to implement at this time in order to qualify for the funding offered via the American Recovery and Reinvestment Act of 2009.

Health & Human Services (H&HS) released a Request for Proposals (RFP) and conducted a competitive selection process that attracted nine responses. A committee of seven CHCLC representatives and one from County IS reviewed the submissions and

III. BACKGROUND/IMPLICATIONS OF ACTION

A. Board Action and Other History

i. Administrative Procedures Manual revision:
Effective April 27, 2011, the County Administrator put in place the procedures governing the reassignment of EHR incentive payments from the federal government to the County (APM Chapter 3, Section 11, Issue 1).

ii. Request for Proposals:
H&HS RFP 20458 was posted to the Lane County website, announced in the Register-Guard and the Oregonian on July 23, 2010, with one addendum posted and published on September 1, 2010. There were nine respondents, but two failed the basic qualifying

criteria (one failed to submit a budget and one submitted a budget far in excess of the other respondents).

iii. Selection Committee:
H&HS convened a seven plus one-person selection committee composed of:

- Division Manager - Community Health Centers of Lane County (CHCLC) (Jeri Weeks)
- Division Manager – Clinical Financial Services (CFS) (Ron Hjelm)
- Two Primary Care Medical Providers – RiverStone Clinic (Karen Woodson & Cynthia Voegeli)
- The CFS Supervisor (Peggy Lewis)
- The CHCLC Clerical Support Supervisor (Carla Stout)
- The CHCLC Nursing Supervisor (Larry Garcia)
- IS Technician* (John Careccia)

*IS participated only in the first round of the selection process, assessing the technical specifications. As the selection process was for a "hosted" (not housed on County servers), cloud-based suite of applications, IS remained only peripherally-involved in subsequent deliberations, responding to questions from H&HS support staff.

iv. Selection Process:
The seven-person CHCLC selection committee rated the seven proposals that H&HS referred to them for consideration in accordance with the applicable tables designed to assess the responses with respect to "functional requirements" (100 points, maximum) and "practice management requirements" (100 points, maximum). The County IS participant rated the proposals with respect to the "technical criteria" (50 points, maximum). The CFS Manager calculated the relative costs of the offered systems and costs (rated at a maximum of 50 points) were then factored into the scoring, as provided for in the RFP. The four highest-scoring respondents were invited to Lane County to give interactive presentations. Upon completion of those presentation, the three highest-scoring presenters were then subjected to further consideration, consisting of comprehensive reference checks (corporate reference checks preceded the interactive presentations), supplemental questions, remote interactive presentations for key CHCLC staff and committee members and, when possible, an opportunity for CHCLC providers and staff to have limited access to an on-line mock-up of the system. The three remaining proposals were then again rank ordered. NextGen scored 380.1 out of a possible 450 points, the second-ranked proposal scored 365 points. At that point the committee authorized site visits for the CFS Supervisor, the two primary care medical providers and two CHCLC support staff. A final request for supplemental information was also sent to the top-ranked proposer. Upon completion of the site visits, which returned only positive comments, and receipt of the final supplemental responses, which were again affirmative, confirmation of selection of the top ranked proposal was made on May 10, 2011.

B. Policy Issues

Lane County Behavioral Health utilizes a specialized electronic health record that will not be compatible with NextGen.

The NextGen product is in use by both FQHCs and private clinics throughout Oregon and

it has some interactivity with State of Oregon electronic healthcare databases.

The implementation of EHRs is a costly best-practice which would be out of reach for the CHCLC, without federal assistance. H&HS has advanced this selection process and the APM implementation referenced it Item A.i in order to be able to take full advantage of the federal funding which is expected to be released later this year and to end in 2013 or 2014.

C. Board Goals

Not applicable.

D. Financial and/or Resource Considerations

CHCLC provider staff and, therefore, Lane County may be eligible for more than one type of incentive payment to adopt healthcare information technology to be issued by the federal government in 2011 through 2014. The funding for which the CHCLC, through its providers, will be eligible cannot be accurately predicted at this time, but is anticipated to be equivalent to approximately $63,750 per provider (under Medicaid, both physicians, of which the CHCLC has 5 fulltime and 6 part-time, and nurse practitioner, with 7 being currently employed at the CHCLC, are eligible) over the life of the program. Some of the proposed incentive payments are based on percentages of Medicare or Medicaid billings for the eligible incentive years. Some providers may assign initial incentive payments to Lane County, but then depart County employ during subsequent years; some part-time employees may assign the incentive payments to Lane County and some may not. Still a conservative estimate of the value of the incentive payments, based only on current permanent, direct-hire staffing, would yield approximately $350,000 over the next two years and an additional $415,000 over the following four years.

E. Analysis

H&HS, in conjunction with the CHCLC and IS, has conducted a comprehensive selection process that has resulted in the identification of an EHR industry leader, with experience supporting FQHCs in Oregon. Federal funding presents an opportunity that supports being proactive in the acquisition of an HER at this time and the implementation of electronic healthcare information has demonstrated benefits and is recognized as a best practice.

F. Alternatives / Options

1. Approve the award a contract in the amount of $422,938 to NextGen.
2. Approve no contract award at this time.

IV. TIMING/IMPLEMENTATION

Health & Human Services will negotiate the agreement, but must await federal funding disbursement later in 2011, in order to execute the contract being awarded via this action.

Estimated contract dates are September 1, 2011 through August 31, 2014.

V. RECOMMENDATION

H&HS recommends Option 1, above.

VI. FOLLOW-UP

Health & Human Services will enter into direct contract negotiations with NextGen.

VII. ATTACHMENTS

Board Order
RFP
RFP Recap score sheet

BOARD OF COUNTY COMMISSIONERS, LANE COUNTY, OREGON

ORDER:) IN THE MATTER OF APPROVING AWARD OF A PROFESSIONAL
) SERVICES CONTRACT WITH NEXTGEN IN THE AMOUNT OF
) $422,938 FOR THE PERIOD SEPTEMBER 1, 2011 THROUGH
) AUGUST 31, 2014 FOR THE PROVISION OF A HOSTED
) ELECTRONIC HEALTH RECORD FOR THE COMMUNITY HEALTH
) CENTERS OF LANE COUNTY

WHEREAS, The Board of County Commissioners recognizes the benefits associated with implementing health information technology systems in order to better serve clients of the Community Health Centers of Lane County; and

WHEREAS, The American Recovery and Reinvestment Act of 2009 authorizes incentive payments for the purchase of electronic health record technology which Lane County may use to invest in health information technology systems; and

WHEREAS, The Health & Human Services Department (H&HS) has conducted a competitive selection process via Request for Proposals Number 20458, issued on July 23, 2010; and

WHEREAS, The H&HS selection committee has selected NextGen from a field of seven respondents; and

WHEREAS, H&HS has referred the NextGen proposal to the Board of County Commissioners for contract award;

NOW, THEREFORE, IT IS HEREBY ORDERED that the Board of County Commissioners award a contract in the amount of $422,938 to NextGen for the period September 1, 2011 through August 31, 2014, for the provision of a hosted electronic health record for the Community Health Centers of Lane County, and it is

FURTHER ORDERED that the County Administrator be delegated authority to execute the resulting contract.

Adopted this_____ day of _____, 2011.

APPROVED AS TO FORM
5-17-11
LANE COUNTY
OFFICE OF LEGAL COUNSEL

Faye Stewart, Chair
Lane County Board of Commissioners

ELECTRONIC HEALTH RECORD

PRIMARY CARE

REQUEST FOR PROPOSALS – PROFESSIONAL SERVICES

December 1, 2010 through November 30, 2011 (renewable)

Solicitation on behalf of:
LANE COUNTY
The Community Health Centers of Lane County
a Division of the
Department of Health & Human Services

Submit Proposals to:
Lane County Health & Human Services
125 East 8th Avenue
Eugene, OR 97401
Attn: Collette M. Christian
Program Services Coordinator

Solicitation issued: July 23, 2010

Deadline: Program Qualification Packet Due September 7, 2010 at 12:00 Noon

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You are hereby requested to respond to the following Request for Proposals. The Program Qualifications packet is due Monday, September 7, 2010 at 12:00 Noon. Proposals received after this deadline will not be accepted.

PART I - GENERAL INFORMATION

Introduction

Lane County is an Equal Opportunity Employer and the Lane County process of contracting is built on the principles of equity, consistency and understandability. When competition over services may exist, a full Request for Proposals (RFP) process is initiated. Appropriate accommodations can be made, upon notice, for individuals with disabilities who wish to respond.

The Lane County Department of Health & Human Services, on behalf of the Community Health Centers of Lane County (CHCLC), seeks proposals to provide an CCHIT-compliant, Electronic Health Record (hereinafter, EHR) for the CHCLC clinics.

Lane County has prepared a detailed analysis of the functional attributes required for this EHR, please refer to pages 11 through 46. However, Lane County takes this opportunity to note that, the CHCLC and Lane County's Behavioral Health Services work in tandem to provide integrated care. The County is interested in responses that indicate the possibility of either subsequently adding a behavioral health charting component or interfacing the current behavioral health record system, ProFiler, with the CHCLC-selected primary care EHR.

The contract arising from this RFP will commence on or about November 1, 2010 and shall be renewed on an annual basis, as long as the EHR remains in use by the Lane County; subject to revenue availability and contractor performance.

Please note: only the Lane County Board of Commissioners can approve contract renewals in excess of three years. Therefore, the resulting agreement will be subject to periodic review and approval for renewal by the Board of County Commissioners.

Submission of Proposal

Respondent may submit only one proposal.

Contract Requirements

A. The contractor must operate the program independently and not as an agent of Lane County. Applications will be accepted from a consortium of agencies. One joint application from each consortium will be required with the lead agency identified in the application.

B. The contractor shall be held to the highest standards prevalent in the industry, including ongoing CCHIT-compliance and shall sign a contract requiring the completion of a scope of work and the achievement of performance standards based on this RFP. Contractor's failure to meet the performance standards established in the contract may result in consequences including the reduction or withholding of payment; a requirement that the contractor perform, at contractor's expense, additional work to meet the performance standards identified in the scope of work; the declaration of "default" by the County, resulting in the termination of the public contract and the seeking of damages or other relief available to the County.

C. The contractor must comply with all applicable federal, state, local statutes, and rules governing the operations of the program, including, but not limited to the following:

1. The Americans with Disabilities Act of 1990, 42 USC 12101 et seq. as well as ORS 30.670 through 30.685, ORS 659.425 and ORS 659.430, and all rules and regulations implementing those laws.

2. Federal Code, Title 5 USCA 7201 et seq.: Anti-discrimination in Employment

3. ORS 659.010, 659.015, 659.020 and, 659.030: Enforcement of Civil Rights

4. OAR 309-013-0200: Basic Accounting Records (11/87) (309-013-0020 [Renumbered to 309-013-0120, 309-013-0130, 309-013-0140, 309-013-0150, 309-013-0160, 309-013-0170, 309-013-0180, 309-013-0190, 309-013-0200, 309-013-0210, 309-013-0220]

5. OAR 309-013-0075 through 309-013-0105: Fraud & Embezzlement

6. The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Upon request, information will be provided to assist in locating copies of these rules.

D. Contractors should include their boilerplate contract as an attachment to the RFP response. Contractors preferring to utilize the standard Lane County contract for services may request a copy for prior review. Regardless of which standard agreement is utilized the contractor's or County's provision shall be made to ensure that:

1. Lane County shall be named as an additional insured for any proof of insurance required by County. Types of insurance that may be required are: professional liability, fidelity bonding and workers' compensation coverage.

2. Automobile insurance is required if clients are transported or a vehicle is used in conducting agency business under the contract. Professional liability insurance is required if services are provided by licensed staff. See the insurance required checklist, Exhibit H of the contract (Attachment A).

Evaluation of Proposals and Selection of Contractors

A. Applications must include all required documentation to be considered. Any application not including all required documentation will be rejected.

Applications with all required documentation will be initially reviewed by an evaluation committee appointed by the Department of Health & Human Services (H&HS). This initial review committee composed of the Program Services Coordinator for the Community Health Centers of Lane County and the Health & Human Services Management Analyst will rate the full criteria, to ensure the response application merits referral to the full evaluation committee, per the threshold criteria established below in paragraph B.

B. There are three rated sections comprising the full criteria for further consideration: Functional Requirements, Practice Management Requirements and Technical Criteria. The vendor shall reply in the space/column provided in the criteria tables (pages 11 to 46 of this package), either "yes"/"no" or "partial", as appropriate. "Yes" responses shall be counted as affirmative responses with respect to the required percentage thresholds, as detailed below. "Partial" responses shall count as half credit only. "No" responses will receive no credit, In order to "pass" the threshold for full consideration and rank ordering, an application must demonstrate the following affirmative response percentages:

1. a minimum of 70% of the "Required" Functional Requirements, and
2. a minimum of 70% of the "Required" Practice Management Requirements, and
3. a minimum of 70% of the "Required" Technical Criteria.

Lane County reserves the right to reject any applications that are found to have misrepresented the capabilities of proposed EHR software.

C. All vendor applications that reach the thresholds stated above shall receive subsequent consideration by the full program evaluation committee. The full program evaluation committee, which shall review and score the application packets in accordance with the criteria established in the RFP, shall be comprised of:

- Representative(s) of Management of the Community Health Centers of Lane County
- Representative(s) of Management of the Clinical Financial Services Division of the Department of Health & Human Services of Lane County
- Representative(s) of clinical provider services, Community Health Centers of Lane County
- Representative(s) of Information Services of Lane County
- Representative(s) of Administration of the Department of Health & Human Services of Lane County

D. The full evaluation committee shall consider each of the application packets and weigh:

- the importance of the "required" items in each portion of this package (Functional Requirements/Practice Management/Technical Criteria) not met in each vendor submission
- both the one-time and recurring/annual costs associated with each product or system
- the results of a quantitative analysis of the "required" and 'desired" line items and the line items listed under item seven of the Technical Criteria. This last step must be adapted to consider the impact of unmet "required" elements that may be, to some extent, compensated for by alternate "desired" elements.

The committee shall then determine which products/systems merit further consideration via an in-house "hands-on" demonstration of a live production system. Selected vendor finalists will be asked to arrange for representatives of Lane County to visit a current user of the vendor's product for (1) an on-site demonstration of a live production system and (2) in order to conduct interviews with current users. The audience for demonstrations and the site visit teams may include Lane County staff who are not members of the evaluation committee.

E. Award of services will be made to the top scoring proposal only, except:
   - in a case where the difference in total scores between two or more high-scoring proposals is ten (10) percent or less. In this case, the evaluation committee shall consider these top-scoring proposals, using the established criteria for all elements defined in this RFP, including the on-site demonstration referenced in Item D, above and shall conduct a final review pursuant to rank ordering the responses and recommending contract award to the Director, Health & Human Services, for submission to the County Administrator and/or the Board of County Commissioners.
   - in the instance of tied scores, the evaluation committee will determine which of the tied scores shall receive the award.

F. All applicants will be notified, in writing, of the evaluation committee's recommendation within three working days of the committee's decision. The Lane County **Board of Commissioners** will make the final decision on the contract award.

G. The department retains the right to reject any proposal not in compliance with the Request for Proposals or all prescribed Request for Proposal's procedures and requirements and may, for good cause, reject any or all proposals when it is in the public interest to do so. The department further retains the right to request additional information from any applicant during the evaluation process to clarify the applicant's response to any requirement.

Protest Process

An applicant who is not recommended by the evaluation committee for contract award may protest the committee's recommendation and intent to award per LM21.107(14). The protest must be made in writing and received by the department no later than 12:00 noon, seven (7) calendar days after notice of the committee's recommendation is mailed to the applicants.

The protest must clearly state the grounds for protest and describe the conditions which, in the applicant's view, resulted in their proposal not being recommended for award. The grounds for protest include any one or more of the following:

- The evaluation committee has failed to conduct the evaluation of proposals in accordance with the criteria or processes described in the solicitation materials.

- Differing criteria were used to evaluate different proposals.

- The evaluation committee unfairly applied evaluation criteria to a proposal.

- A member or members of the evaluation committee had a relationship with a proposer which represented a conflict of interest.

- The criteria used to evaluate proposals did not pertain to the services requested.

- A member or members of the evaluation committee demonstrated bias toward a proposal or responder.

- The County abused its discretion in rejecting the protestor's proposal as non-responsive.

- The evaluation of the proposals is otherwise in violation of any application provisions of ORS 279A or ORS 279B.

Upon receiving a protest, the department will notify the applicant who was recommended for contract award and the evaluation committee that made the recommendation. Both the applicant and the evaluation committee may respond to the protest in writing up to 5:00 p.m. on the third (3) calendar day after the department received the protest.

When a protest is filed, the department will prepare a written analysis of the protest. If the decision maker is the Board, the department will present the issues orally and/or in writing to the Board of County Commissioners in a public meeting.

The appellant shall then have 10 minutes to specifically address the protest criteria and the evaluation committee's recommendation.

The recommended proposer(s) shall have a total of 10 minutes to respond, divided between them as they wish.

If the decision maker is the County Administrator the decision shall be made on the written record.

If a protest is timely filed, the Board or County Administrator, as appropriate, shall consider the evaluation committee's recommendation and the allegations of the protest before rendering a final decision. The decision maker may grant or deny the protest, reject proposals, or cancel the solicitation pursuant to LM 21.107(12) or remand to the department or evaluation committee for further information or consideration. In the event of remand, the department will report back to the decision maker as soon as reasonably possible if the protest remains pending. The County Administrator's response to the protest will be in writing. If the Board is the decision maker, it shall evaluate any protest before rendering a decision and shall state reasons and conclusions reached either in writing or on the record in a public meeting, with a Board Order referencing reasons for its decision on the protest. Any decision to overturn the recommendation shall be based on a finding that one of the criteria of LM 21.107(14)(d) above occurred to the substantial prejudice of the protestor. The protestor must be eligible and next in line to be awarded the contact if the protest was successful.

Investigation of References

The COUNTY reserves the right to investigate the references and conduct other investigations as necessary, to determine the past performance of any respondent with respect to its successful performance of similar projects, compliance with specifications and contractual obligations, its completion or delivery of a project on schedule, and its lawful payment of suppliers, sub-contractors, and workers. This investigation may occur throughout

the evaluation process, including up to final execution of any contract. The COUNTY may postpone the award or execution of the contract after the announcement of the apparent successful Vendor in order to complete its investigation. The COUNTY reserves its right to reject any proposal, any part of a proposal, to reject all proposals, and to cancel the award of any contract at any time prior to COUNTY'S execution of a contract.

PART II - PROGRAM INFORMATION
Program Description

Lane County seeks to purchase software licenses, training and implementation services to securely automate and integrate the Community Health Centers of Lane County's client health records. The detailed program functional elements sought for this electronic health record are contained in the three tables (Functional Requirements, Practice Management Requirements and Technical Criteria) that comprise the "proposal content" portion of this RFP, pages 13-49.

The Community Health Centers of Lane County (CHCLC) is a federally qualified health center (FQHC) and an "eligible entity" for the 340B pharmaceuticals program. The CHCLC operates two mid-sized clinics (RiverStone in Springfield and Charnelton in Eugene, Oregon) and three smaller satellite clinics (two are co-located with High Schools and one is co-located with Lane County's behavioral health services).

The CHCLC has twenty individually licensed providers and serves more than 10,000 clients per year. The CHCLC's web page can be viewed at:
http://www.lanecounty.org/Departments/HHS/CHC/Pages/default.aspx

Additional Program Information

If applicants need additional information about any aspect of the program, questions and requests for information should be addressed to **Collette Christian, Program Services Coordinator** at **125, E. 8th, Eugene, OR, 97401 or (541) 682-3086 or collette.christian@co.lane.or.us**. Requested information to the extent it is available, will be provided to any applicant.

PART III - CALENDAR OF EVENTS

July 23, 2010 at 9:00 a.m. ..... RFP Packets Available

July 30, 2010 at 12:00 noon ..... Deadline for Commenting on or Protesting Specifications Believed to Limit Competition

September 7, 2010 ..... One Original and 5 Copies of Proposal Due at 12:00 Noon to Health & Human Services (No Postmarked Proposal Accepted After Deadline)

September 24, 2010 ..... Interviews, site visits, and product demonstrations

October 15, 2010 ..... Notification of Committee Recommendations Mailed

October 25, 2010 at 12:00 Noon ..... Protests of Recommendations Due

November 10, 2010 ..... Contract Awarded By Board of County Commissioners

December 1, 2010 ..... Anticipated Services Begin

PART IV - GENERAL INSTRUCTIONS FOR SUBMISSION OF PROPOSALS

A. All proposals must be in the form specified in the RFP and must respond to all items requested. Proposals which are incomplete or fail to include all items may be rejected.

B. Please provide the responses to Item A – Respondent Contacts & Information either within the response cover page, retaining the same order, or as the first attachment. Please respond to Items B - PROGRAM MANAGEMENT, C - FUNCTIONAL REQUIREMENTS and D -TECHNICAL (IT) REQUIREMENTS, by using the included tables, providing your responses by item/category in the corresponding "check boxes". **Submit one original and** 5 **copies of your proposal.** Your proposal is due by **12:00 noon September 7, 2010** at which time it will be publicly opened by **Collette M. Christian, Program Services Coordinator**.

C. All proposals must be submitted using the tables incorporated herein: Functional Requirements/PracticeManagement Requirements /Technical Criteria. In cases where additional comments are submitted, please ndicate by noting "see attached" in the appropriate column. Attach these additional comments, clearly typewritten; single spaced, on 8 ½" x 11" paper, and typed on only one side of the paper, respecting the sequence or order of the table. (Please note that no responses are elicited during this initial phase to Section 7 of the Technical Criteria. These elements will be addressed during subsequent evaluation of proposals. Section 7 (page 49) has been included at this time, only to alert prospective respondents of the need to be prepared to address these elements.)

D. Please submit only one proposal, per vendor.

E. A proposal may be withdrawn by written request, if such request is received prior to the scheduled closing date for applications. Change of a filed proposal may be made by submitting the change in writing prior to the scheduled closing date for filing.

F. Proposers may comment on, or object to any of the specifications of this RFP document which they believe limit competition or any contract term(s) with which they disagree. Comments must be in writing and submitted to the Lane County Department of Health & Human Services, 125 E. 8th Ave., Eugene, OR 97401 no later than **July 30, 2010** at noon. RFP protests should be clearly marked **A Request for Proposal Protest** and include identification of the RFP involved in the protest. Comments will be reviewed by department staff. If the comments are determined to be valid by the department, an addendum to the RFP will be issued to all applicants.

G. All protests of award must be filed within seven (7) calendar days after notice of the evaluation committee's decision was mailed pursuant to LM 21.107(14)(b)

***** Please keep your proposal as brief as possible and use the provided tables, rather than responding in a narrative format.*****

PART V – PROPOSAL CONTENT

Program Qualifications Section (All proposals must utilize the table format for the three core areas: Functional Requirements, Practice Management Requirements and the Technical Criteria. Any additional application materials, including comments shall be clearly typewritten, single spaced, on 8 ½" x 11" paper and typed on only one side of the paper.)

A. **RESPONDENT CONTACTS & INFORMATION (may be part of the response cover letter)**

B. **FUNCTIONAL REQUIREMENTS**

C. **PRACTICE MANAGMENT REQUIREMENTS**

D. **TECHNICAL (IT) CRITERIA**

B. EMR FUNCTIONAL REQUIREMENTS

Functional Element	yes/no partial	Comment
Section 1: System Specifications		
1.1 General Specifications – Required		
▪ Hosted system delivery is available		
▪ The system allows for remote access.		
▪ The system has the capability to meet "meaningful use" criteria as established in the Health Information Technology for Economic and Clinical Health Act and its corresponding regulations. Please explain.		
▪ The system date and time stamps all entries		
▪ The system supports user defined vocabularies as well as mandated vocabularies and allows for updates and enhancements of codes including DSM-IV, CPT 4-5, SNOMED CT (international), APC (Automatic Payment Classifications)		
▪ The system supports HIPAA Standards for Electronic Transactions		
▪ The system supports the integration of third party coding programs		
▪ The system includes extensive error checking of user input data including, but not limited to ICD-9 (check against gender, age, etc), validity, and chronological order of events. (vendor please elaborate)		
▪ The system identifies and maintains a single patient record for each patient. The system identifies duplicate records and alerts users		
▪ The system supports a user verifiable merge function (vendor please elaborate)		
▪ The system supports purging of incomplete or partial records (vendor please elaborate and provide screen shots)		
1.1 General Specifications – Desired		
▪ The system has current CCHIT certification (If not currently certified, vendor please explain)		
1.2 Confidentially and Security - Required		
▪ The system is HIPPA compliant		

▪ The system includes the ability to alert users that there are missing elements prior to closing out charts and the ability to configure settings so that incomplete charts must be completed before being finalized		
▪ The system is able to audit users and groups of users by documenting audit trails showing who has accessed the system and what operations they have performed during a given period of time		
▪ Full access (data entry) to patient chart is limited to one user in real time and closed to data entry after data has been clinically signed		
▪ The system supports industry standard electronic provider and patient signatures		
▪ The system allows administrators to control access to and within the system at multiple levels (e.g. per user, per user role, per area, per section of the chart) through a consistent mechanism of identification and authentication of all users in accordance with the 'Role Based Access Control' (RBAC) standards. These controls can be set and manipulated by functional system administrators (non-programmers with general IT knowledge) who receive system-specific training (vendor please explain)		
▪ The system verifies and enforces control to all EHR components, information, and functions for end users, applications, sites, etc., to prevent unauthorized use of resources		
▪ The system provides for data integrity through the use of non repudiation technologies such as digital signatures, digital certificates, and date/time stamps. Non-repudiation involves limiting a user's ability to deny (repudiate) an electronic data exchange originated, received, or authorized by that user.		
1.2 Confidentiality and Security - Desired		
▪ The system enforces the applicable jurisdiction's patient privacy rules as they apply to various parts of the EHR through the implementation of standard security mechanisms.		
▪ The system has demonstrated successful track record of implementation in the Pacific Northwest (3 or more user recommendations)		
▪ The system has a demonstrated successful track record of implementation at FQHCs and FQHC look-alikes (vendor please explain)		

1.3 Overall Ease of Use and Flexibility - Required		
▪ The system allows individual user specific customization (vendor please explain)		
▪ The system does not require double data entry		
1.3 Overall Ease of Use and Flexibility - Desired		
▪ The system is intuitive and easy to use (minimum # clicks) (vendor please explain)		
▪ It is easy to find information with few clicks (vendor please explain)		
▪ There is adequate technical support and training. Vendor supports on-going two-tiered implementation plan with initial basic program IT-training and subsequent on-site (Lane County) training on a later date (e.g., two months out) for customization and personalization training to promote optimal use of system		
1.4 Standards and Protocols. The system adheres to the following standards and protocols - Required		
▪ HL7 - messages format for interchange between different record systems and practice management systems		
▪ ANSI X12 (EDI) - A set of transaction protocols used in the US for transmitting virtually any aspect of patient data		
▪ CEN - CONTSYS (EN 13940), a system of concepts to support continuity of care		
▪ CEN - EHRcom (EN 13606), a standard for the communication of information from EHR systems		
▪ CEN - HISA (EN 12967), a services standard for inter-system communication in a clinical information environment		
▪ DICOM - a standard for representing and communicating radiology images and reporting		
Section 2: Clinic Management		
2.1 Clinical Practice Guideline and Chronic Disease Management - Required		
▪ The system includes and maintains evidence-based practice guidelines developed by credible sources that incorporate patient education, and actionable alerts including asthma, CHF, depression, diabetes, CAD, hyperlipidemia, COPD, chronic pain and seizure disorders (vendor please explain) (vendor please explain)		

▪ Actionable alerts are easily identifiable and customizable		
▪ The system populates individualized flow sheets for chronic disease management integrated from problem lists, labs, and medication lists, with no additional data entry required		
2.1 Clinical Practice Guideline and Chronic Disease Management - Desired		
▪ The system provides disease specific flow sheets, and ability for users to create custom flow sheets, including diabetes, CHF, anticoagulation, chronic pain management, HTN, mental health, asthma, COPD, Family Planning (add other provider preferences, and family planning specific tasks) (vendor please elaborate and provide screen shots)		
▪ The system has ability to create, review and update performance data to monitor achievement of targets		
▪ The system provides care plans for chronic diseases and ability to import, create, review and amend information about desired long-term and short-term goals		
▪ The system includes access to medical research and literature databases such as UPTODATE, MEDLINE, JAMA, and others without logging out of the system		
2.2 Communication: The system provides the following - Required		
▪ Messaging within clinic (vendor please elaborate and provide screen shots)		
▪ Provider alerts (vendor please elaborate and provide screen shots)		
▪ The system supports options for sending and receiving reports and records including fax and electronic submission (vendor please elaborate and provide screen shots)		
▪ Missed/upcoming appointment reminders		
▪ Triage/Phone call tracking and documentation		
2.2 Communication: The system provides the following - Desired		
▪ Mass mailing lists, with sorting by age or other demographic data		
▪ Sharing Lab/imaging results w/patients by email		
▪ System supports portal that allows internet access to EHR information for patients		
▪ The system generates automatic patient reminders/follow-up		

2.3 Laboratory and Imaging Management - Required		
▪ The system supports ordering labs from within the EHR. Lab ordering is fully integrated into the EHR rather than the EHR containing a link to third party software. The system has the capability to fax orders and alert if unsuccessful. The system is also able to print orders to give to patient for outside labs		
▪ The system allows users to accept, over-ride, or cancel laboratory orders. The system detects and displays duplicate orders		
▪ Lab Tracking: The system has capability to assign and display active and pending orders (vendor please elaborate and provide screen shots)		
▪ The system supports ordering of imaging from within the EHR. The system has the capability to fax orders and alert if unsuccessful. The system is also able to print orders to give to patient		
▪ Tracking imaging. The system has capability to assign and display active and pending orders (vendor please elaborate and provide screen shots)		
▪ The system flags critical results to user-defined groups (vendor please elaborate and provide screen shots)		
▪ The system allows the provider to task support staff with actions		
2.3 Laboratory and Imaging Management - Desired		
▪ The system Imports reports directly in real-time from laboratories		
▪ The system Imports reports directly in real-time from radiology		
▪ The system generates letters to patients describing laboratory and imaging results		
▪ The system generates phone messages to patients describing laboratory and imaging results. Options are available to generate and send text messages to patient's e-mail or phone.		
2.4 Medical Home Model Support - Required		
▪ The system is able to assign patients to specific multidisciplinary care teams and generate separate client population based on team distribution (vendor please elaborate and provide screen shots)		
2.4 Medical Home Model Support - Desired		
▪ The system supports reminders/alerts systems for teams for specific tasks including call backs, lab reviews, referrals, and		

medication management		
▪ The system supports management of medical team assignment and work flow: assign tasks to teams and set priorities		
▪ The system supports task management with a user page or other method of organizing tasks by category (i.e., labs, referrals, progress note) and status of task (unsigned, pending, hold) (vendor please elaborate and provide screen shots)		
2.5 Medication Management - Required		
▪ The system has the ability to order, refill and track prescriptions, and send the electronically to area pharmacies. The system uses the Surescripts network that is widely accepted by pharmacy management systems		
▪ The system has ability to support fax, electronic and printed order formats		
▪ The system has the ability to deny refill requests electronically with commentary (vendor please elaborate and provide screen shots)		
▪ The system is able to receive pharmacy refill information and allows for display and processing via refill and patient file screens		
▪ The system allows storage of prescription data for retrieval by any of the following: drug name, drug code number (NDC) and other user defined selection criteria		
▪ The system has the capability of creating and maintaining a current medication list for each patient and updating progress notes with prescription information as necessary		
▪ The system creates and maintains patient-specific and adverse reaction list and allows on demand or scheduled reporting from such lists		
▪ The system allows the provider the ability to document the effectiveness and ineffectiveness of a medication		
▪ The system maintains separate historical, chronic (long term current), and acute (short term current) medication lists (vendor please elaborate and provide screen shots)		
▪ The system maintains and updates medication history including medications prescribed by external providers and clinics, and OTC medications		
▪ The system links to drug reference libraries (PDR, Hippocrates, etc.) for appropriately timed drug information updates		

▪ The system provides flags or alerts for allergies and adverse reactions to medications		
▪ The system alerts providers to potential administration errors for both adults and children, such as wrong patient or wrong dose		
▪ The system identifies drug interaction warnings (prescription, over the counter) at the point of medication ordering		
▪ The system provides the following drug information: contraindication, active problem interactions, food interactions		
2.5 *Medication Management - Desired*		
▪ The system has compatibility with drug assistance program application tracking (such as RxAssist)		
▪ The system creates prescription and other medication orders including herbals, supplements, and durable goods with detail adequate for correct filling and administration		
▪ The system support tracking for special conditions (chronic pain, anticoagulation, etc.)		
▪ The system presents to appropriate clinicians the list of medications that are to be administered to the patient, under what circumstances they are to be administered, and captures medication administration details		
▪ The system supports access to pertinent formularies including LIPA, Trillium, Well-Partner etc.		
▪ The system supports access to formulary pre-authorization alerts and forms		
▪ The system supports renal dosage adjustment decision support		
▪ The system allows for the ability to save personal prescription favorites and pre-programmed recommended doses with ability to edit		
▪ The system allows staff to leave comments on dosage, patient tolerability, etc. at medication discontinuation		
▪ The system has the capability to capture sample medications including lot number and expiration date		
2.6 Referral Management - Required		
▪ The system supports ordering of referrals (Vendor – please explain.)		
▪ The system has the capability to maintain a database of referral agencies and associated providers, including data fields such as		

agency name, address, multiple phone and fax numbers, names and titles of providers/staff associated with the agency and staff phone/fax numbers, and email addresses.		
▪ The system is able to track referrals and retrieve information by referral type, referral date, expected response date, referring provider, ICD-9 code, or specific specialist		
▪ The system is able to support insurance carrier portals (LT portal for Medicaid, etc) and is capable of printing consultations and referral forms		
▪ The system has the electronic capability to directly fax reports (dictation, lab, radiology) to outside specialists listed in referral provider database. (vendor please elaborate and provide screen shots)		
▪ The system is able to support downloading and scanning of reports		
▪ The system has the capability to verify referral status from within the patient chart		
▪ The system generates standard reports which indicate referrals that are pending response from specialist provider.		
2.6 Referral Management - Desired		
▪ The system allows user to flag referral for follow-up and automatically generates alerts to user/user groups for follow-up. Alert directly links user to applicable location in patient's chart.		
▪ The system has the ability to retrieve prior authorizations for referrals from insurance companies (e.g., Medicaid, Medicare); i.e., the system is capable of interfacing with selected websites to download referral forms and check referral status		
2.7 Reporting - Required		
▪ The system automatically triggers alerts or prompts upon documentation of diagnoses or events required to be reported to outside agencies including the Centers for Disease Control and Prevention (CDC), PQRI for Medicare patients, State primary and mental health departments (vendor please elaborate and provide screen shots)		
▪ The system supports flexible prompts or alerts to notify user of reportable observation terms that are customizable.		
▪ The system produces standard system-generated reports and customizable reporting options for chronic diseases such ad diabetes and hypertension		

▪ The system tracks all required data elements and provides standard reports to meet the Health Resources and Services Administration, Bureau of Primary Health Care Uniform Data Set (UDS) reports. Information on the UDS reporting data elements and report formats may be found at the following web site: http://www.hrsa.gov/data-statistics/health-center-data/reporting/2009udsreportingmanual.pdf . These reports are automatically updated to reflect changes in UDS reporting requirements.		
▪ The system produces standard system-generated and customizable reporting options for special populations such as children and the elderly		
▪ The system generates reports by disease, lab indices, and other parameters without additional data input		
▪ The system allow for productivity reporting by provider, date range, type of encounter etc.		
▪ The system provides utilization review reports that identify specific clients, clinicians, services, and/or programs that are above or below user-designated trigger thresholds.		
▪ Provide listing and brief description of all standard system reports, and a copy of sample page of each.		
2.7 Reporting - Desired		
▪ The system supports the reporting and data analysis of the county's quality management program including: 1. **Quality Assurance:** The development and production of reports based on payor and county identified performance and outcome measures for access, assessment, treatment planning, service delivery, etc. Also aids random chart sampling and review processes. 2. **Quality Improvement:** The development and production of reports that track and trend quality measures over time and can support the identification of variation that is material and statistically significant		
▪ The system has standard management reports that provide a variety of views of county operations such as monthly trend reports, clinician comparison reports, etc. The key aspect of these reports is that they provide summarized management-related data that support tactical and strategic decision-making. The user has the option of outputting reports to the screen, printer, standard ASCII file format and PC application formats such as XLS, CSV, PDF, MDB, TXT, DIF, etc. Standard reports can be copied, edited, and added to the reports menu with a new		

report name. (vendor please elaborate and provide screen shots)		
▪ The system provides for customizable population-based reporting on prevention, screening, and wellness.		
▪ The system allows for custom reports to be built using integrated reporting functionality. The custom reporting functionality can be learned by staff with higher level spreadsheet skills. Programming skills are not required nor are high level skills with sophisticated reporting engines such as Crystal Reports (vendor please elaborate and provide screen shots)		
▪ The system allows end users with appropriate security settings to easily download raw data in CSV and other delimited data formats.		
▪ The system (1) allows for raw data downloads from all data fields in the system and (2) allows end users to select and configure data fields for raw data downloads.		
▪ The system produces mass mailing lists with sorting by age or other demographic parameters		
Section 3: Patient Care		
3.1 *Dental Health - Desired*		
▪ The system allows for interfaces between medical and dental records		
▪ The functions as an integrated Electronic Dental Record, which contains a summary page, with the capability to view and store patient data, photos and x-rays, and annotations.		
▪ The system contains digital radiography which integrates from office x-ray into the chart. Images can be edited and adjusted and stored on chart		
▪ The system allows for easy charting of (3D) teeth, preexisting conditions, treatment plans, treatments performed, and shows periomeasurements		
3.2 *Family Planning/Reproductive Health - Desired*		
▪ The system supports family planning and reproductive health documentation compliant with FPEP and Title X programs. The following link to State of Oregon web site for Title X and FPEP programs provides functional requirements for participating providers: http://www.oregon.gov/DHS/ph/fp/index.shtml		
▪ The system supports follow-up care including alerts for immunizations and procedures		

▪ The system incorporates ACOG guidelines for management of abnormal pap results and further follow-up and treatment including HPV vaccination, colposcopy, and preventive rescreening		
3.3 Immunizations - Required		
▪ The system provides alerts for due and overdue immunizations		
3.3 Immunizations - Desired		
▪ The system can interface with statewide IRIS database tracking with sort feature (age, immunization)		
▪ Vaccine Administration Record and forms easily accessible within the system		
▪ The system incorporates of CDC protocols for children, adults and, specific foreign travel with due dates and past due dates		
▪ The system includes a real time vaccine inventory		
3.4 Behavioral Health - Required		
▪ The system supports reporting and collection of data for demonstrating effectiveness of treatment regimens (e.g., PHQ-9 monitoring, etc.) and for documentation of achievement of outcome measures		
3.4 Behavioral Health - Desired		
▪ The system has an integrated electronic primary care and behavioral health record which contains a summary page, active medication list, psychiatric assessment, and counseling progress notes (vendor please elaborate and provide screen shots)		
▪ The system provides functionality for mental health evaluation and assessment including (1) initial individual evaluation, (2) core screening and assessment, (3) functional evaluation, (4) updates to evaluations and assessments, (5) crisis assessment, and (6) complete DSM Five Axis diagnosis		
▪ The system provides functionality for mental health case management services including (1) case and progress notes, (2) plan of care development and monitoring, (3) individual service plan development, (4) caseload and resource management, (5)discharge planning, (6) legal tracking, and (7)ongoing eligibility determination		
▪ The system provides functionality for scheduling clients for services in 30 minute increments, scheduling of provider activities and meetings, client check-in, and alerts to providers that clients have arrived		

▪ The system provides two-way integration with Microsoft Outlook		
▪ The system should allow for "double-booking" of appointment times		
▪ The system supports user-selected psychiatric assessment tools such as the MOOD questionnaire, PHQ-9, ADHD assessment, and chronic pain management tools		
▪ The system produces management and end-user reports using data generated by psychiatric assessments		
3.5 Organization and Patient Flow - Required		
▪ The system contains a patient summary page that includes patient medical history, medication list, problem list, allergies, immunization, smoking status and record of patient encounters (vendor please elaborate and provide screen shots)		
▪ The system provides a flexible mechanism for retrieval of encounter information that can be organized in variety of ways, including name, MRI number, and date of birth, diagnosis, medication prescribed and, chronological by encounter date.		
▪ The system supports flexible patient-specific alerts that notify designated staff of required and delinquent laboratory and preventive care monitoring that pops up when patient chart opened.		
▪ Vital signs and lab trends are available and populated and/or updated real-time with no extra data input required		
▪ The system allows providers to review notes, note instructions, comment, and forward to another authorized user for action within patient record		
▪ The system captures and maintains demographic data including race, ethnicity, housing status, migrant farm worker status. These data are reportable, traceable over time, and can interface with an existing practice management system		
3.6 Patient Education - Required		
▪ The system has the capability to create, review, update, or delete patient education materials. The materials must originate from a credible source and be maintained by the vendor as frequently as necessary		

▪ The system includes the capability to develop patient instructions and materials in English and patients native language (at minimum Spanish) for a broad range of treatments and services delivered by providers (wound care, exercise regimens, diet guidelines, oral health, behavioral health, next visit date and time, referral contact, laboratories, etc).		
3.6 *Patient Education - Desired*		
▪ The system allows patient instructions to be selected from a pull down menu		
▪ The system enables the linkage of patient instructions to care plans/care maps/ practice guidelines/orders, enabling automatic printing.		
▪ The system allows for printing of patient-specific instructions and keeps a record of these instructions		
▪ The system provides standardized patient education handouts		
3.7 Patient Visit and Progress Notes - Required		
▪ System supports customizable summary sheet for patient view at visit onset that includes current contact information, problem list, current medications, allergies, immunizations, and smoking status.		
▪ The system has the capability to update other portions of the record with captured vital signs data. At a minimum, the system collects: height; weight; pulse; respiratory rate; blood pressure (including multiples); different position blood pressure; orthostatic blood pressure; oximetry (with FiO2 identifier); pain; BMI (calculated); visual acuity (corrected/uncorrected); audiology screening; chief complaint; onset of symptoms; history of present illness; physical examination findings; physiological findings; psychosocial assessment; diagnosis; goals; medications prescribed; non-drug recommendations; patient education; consultations; and referrals		
▪ Structured templates include chief complaint, onset of symptoms, injury mechanism, physical examination findings and psychological, and social assessment findings		
▪ The system supports user-friendly creation of progress notes using a variety of formats (appropriate size of screen, spell check, formatting, and manipulation of templates combining multiple chief complaints etc.) (vendor please elaborate)		
▪ The system supports automatic entry of nursing note into provider encounter note		

3.7 Patient Visit and Progress Notes - Desired		
▪ Encounter note has capability to include patient provider goals and follow-up plan		
▪ The system supports interactive prevention status (patient refusal of recommendations) documentation including date addressed, result, and reason for not performing		
▪ The system supports multiple note creation options (templates, voice recognition) preferably supporting an interface with Dragon voice recognition system		
▪ The system supports use of last visit template for subsequent patient visit (copy and paste ability)		
▪ System includes templates for procedures and informed consent (e.g. I&D, toe nail removal, colposcopy)		
▪ The system provides a template for documenting informed consent		
▪ The system has the capability to order Rxs, imaging, labs, and referrals in real-time with minimal clicks and screens displays		
▪ At each visit, system has the capability of generating a report for the patient that includes summary of visit, patient education materials on lifestyle modification and follow-up plans, next visit date/time, referral contact information/maps and, laboratory/imaging contact information/maps		
3.8 Patient History - Required		
▪ The system allows the capture, review, and management of medical procedural/OB/surgical, oral health, social, and family history, including the capture of pertinent positive and negative histories, and patient-reported or externally available patient clinical history (including birth history, dietary/nutrition history, immunization history, allergy and developmental history for children and behavioral health history for adolescents)		
▪ For each new patient, the system captures and stores risk factors including the following: history of STDs or STIs; TB Status; tobacco use and history including number of years and packs per day (PPD); alcohol use and history; history of drug use, type, and years; and, occupational environments		
▪ The system collects and stores family history, including, but not limited to: History of chronic diseases, including date of diagnosis (age of patient); disease status; age, and cause of death if deceased.		

▪ The system collects and stores pertinent social history elements including domestic and married couple tracking, socioeconomic status, native language, translation requirements, literacy, housing status, and disability		
▪ The system captures and explicitly labels patient-provided clinical data and supports provider authentication for inclusion into patient history		
3.9 *Prenatal Care - Desired*		
▪ The system contains or interfaces with pregnancy care record system including OB/GYN specific templates and progress notes, patient care plans, summaries		
▪ The system accepts coded input for historical items that are asked at each pregnancy visit (could include, but not limited to key symptoms (e.g., loss of fluid, fetal movement etc)		
▪ The system records fetal heart rate, height, weight, urine analysis, and blood pressure at each visit.		
▪ The system displays the estimated date of delivery (EDD) given the patient's last menstrual period (LMP). The system will calculate an EDD given an ultrasound date and the estimated gestational age (EGA) given by the ultrasound. The provider may specify which of the above methods will be used to calculate the patient's final due date. The EGA (based on the method specified by the provider) is visible at each visit		
▪ The system prompts providers about care that is due at each visit based on EGA (calculated by using the method specified above)		
▪ The system creates a printable view of all visits, labs, due date, ultrasound, problem lists, and plans which can be given to a patient for purposes of communicating with providers on a Labor and Delivery Floor		
▪ The system can exchange data about the current pregnancy with a hospital system		
▪ The system forms separate cohorts for prenatal care and alerts users to evidenced based clinical follow-ups and flow sheets for patient encounters including physical exams, FHR, FM, LABS, Ultrasound, Special High Risk groups etc.		
▪ The system formulates patient education based on check dates and contains special comment sections to add personal recommendations and follow-up times		
▪ The system creates separate high risk pregnancy flow sheets and patient's disposition and outcomes		

3.10 Preventive Care - Required		
▪ The system has capability to display health prevention prompts on patient summary displays. Prompts are dynamic and take into account sex, age, and chronic conditions		
▪ The system supports follow up of annual exams (pediatric, adult, geriatric) including prompts when due and appropriate templates		
▪ The system allows for the graphing of pertinent data into flow sheets for presentation and display		

C- PRACTICE MANAGEMENT REQUIREMENTS

Functional Element	yes/no partial	Comment
Section 1: Eligibility Verification		
1.1 Pre-Registration/Screening - Required		
▪ The system provides user-defined online pre-registration forms to gather initial client demographic and financial resources information for individuals requesting service. If the client becomes registered for service this information can be forwarded to registration so that duplicate data entry is not required. If the client is already registered as a client in the system this is flagged.		
1.2 Insurance Eligibility Loading - Required		
▪ The system supports transmission and automatic updating of client eligibility records using the Oregon Health Plan (OHP) Health Care Eligibility Inquiry and Response 270/271 electronic Eligibility Transaction System files from the State of Oregon.		
▪ The system enables the provider to send an electronic 270 file of all clients to the State. The 271 file updates each client's eligibility information. The assures that all eligible enrollees have a new record added to the county system for Oregon Health Plan (OHP) eligibility each month, including all retroactive additions to Medicaid.		
▪ Prior to implementation, the vendor and the State of Oregon will be compliant with the ASC X12N 270/271 - Eligibility for a Health Plan and ASC X12N 834 - Enrollment and Disenrollment formats.		
1.3 Automated Insurance Eligibility Determination - Required		
▪ Each month, or at a frequency to be determined by the county, the eligibility of registered clients is evaluated against the downloaded eligibility files and updated as necessary based on a matching algorithm. When the process identifies clients where no prior eligibility had been determined or where the eligibility status has changed, including retro-active updates for clients previously served, users have the option of updating client insurance records automatically or through computer-assisted manual updates. The process includes assigning or updating the cascade level of insurance plans that have been changed for a client, identifying clients who have lost their insurance coverage, and determining how previous billings are adjusted.		

▪ The system also supports the manual on-line review and update of insurance records for clients with various special handling conditions including: a partial eligibility match requiring investigation, Oregon Health Plan (OHP), Medicare, private insurance, and Oregon Health Plan (OHP) clients with a different responsible county.		
1.4 Real-Time Eligibility Verification and Eligibility Lookup Access - Required		
▪ The system supports electronic HIPAA 270 and 271 transactions (eligibility verification). Please explain.		
▪ Changes made through the automated insurance eligibility determination process are supported with a complete audit trail.		
1.4 Real-Time Eligibility Verification and Eligibility Lookup Access - Desired		
▪ The system allows a user to poll the system and then easily update a client's eligibility and insurance coverage records if the coverage has changed. For Oregon Health Plan (OHP) clients this includes entry of the Oregon Health Plan (OHP) Eligibility Verification Code (EVC) or, in the absence of an EVC, entering the Primary Aid Code and County Code to support the eligibility status.		
▪ The system supports a real-time interface to the Oregon Health Plan (OHP) Management Information System (MMIS) database for viewing a client's current eligibility status for Oregon Health Plan (OHP) and other included payors.		
▪ Can electronic 270/271 eligibility checks for a single individual be launched from the patient record and the record updated in real time? Does the system allow 270/271 transactions to be sent in a batch mode? If so, can the system automatically batch, send and accept responses for scheduled appointments? Can the system support inquires regarding coverage date ranges, limits, deductibles, etc, or are inquires limited to "yes/no" responses? Please explain.		
▪ The process also supports easy identification and clearance of a client's Share of Cost obligation, ensuring that those services are not billed to Medicaid.		
▪ The system supports easy access to a client's eligibility records for eligibility lookup from various components and modules including Call Logging, Appointment Scheduling, Registration, etc.		

1.5 Authorization Management - Required		
▪ The system is compatible with multiple payment methods for services provided under an authorization including fee-for-service, case rate, per diem, etc.		
▪ The system supports several methods of setting, tracking and providing reminders of service limits for each type of authorization including number of visits or days, number of client or clinician service hours, number of days or weeks, specific service codes, service codes clusters, or specific dollar limits.		
▪ The option exists for linking specific authorization types to insurance plans to aid in the utilization management of those authorizations. As service is provided, actual services are compared with authorized amounts and the system has multiple ways of notifying providers and utilization managers of remaining balances and impending authorization expirations, including during data entry, regular reports, and various ticklers.		
▪ The authorization system supports user-defined rules for determining whether provider payment for unauthorized services will be pended or paid and whether these services will be billed to a third party payor.		
▪ If authorizations are denied because medical necessity has not been met, or if a level of care request is reduced, the system generates the appropriate Notice of Action letter to the provider and client, alerting them of the denial/reduction and informing them of their due process rights.		
▪ The system allows for the creation, approval/deferral/denial, issuance, letter generation, tracking, and closing of a variety of authorizations which constitute discrete episodes of care, compliant with the ASC X12N 278 - Referral Certification and Authorization format. This includes Health Plan-Issued External Authorizations to the county from other health plans and managed care companies, which are approving services to be provided by county staff or contractors.		
Section 2: Payor/Provider Relations and Management		
2.1 Provider Registration and Credentialing - Desired		
▪ The system supports the development of user-defined screens to register, track, and report on individual clinicians who are employed by or who contract with the County. The system supports the ability to manage both contracted and/or employed clinicians who staff the county clinics.		

▪ The system supports the collection of several user-defined clinician characteristics such as location, licensure, language, days, and times worked, and specialties. It also supports the credentialing of individual clinicians (internal and external) and the certification of provider facilities. Credentialing and certification data should include effective and expiration dates.		
2.2 Claims Billing - Required		
▪ The system supports the electronic transmission of ASC X12N 837 - Health Claims or Equivalent Encounter Information using industry standard formats.		
▪ The system can electronically transmit claims to AHLERS for FPEP billing, CVR submission, and to the State of Oregon Breast and Cervical Cancer (BCCP) program.		
▪ The system supports the preparation and printing of standard paper (HCFA 1500) claims.		
▪ Claims processes contain editing protocols that include a combination of standard system edits as well as user-defined edits that will pend claims that do not contain required data. The system includes standard reports that enable billing staff to identify and resolve claims problems. (Vendor – please explain and include sample reports)		
2.3 Multiple Contracting Schemes/Fee Schedules - Required		
▪ The system supports multiple contractor agreements that include services funded by multiple payors with differing benefit designs and multiple provider reimbursement systems such as case rate, fee-for-service, capitation, and fixed fee payments.		
▪ Charge schedules have start and end dates and are applied based on applicable date-of-service.		
▪ The system will automatically price services according to user-defined protocols based on the service provided, the provider credentials, and whether or not the service charge is encounter or time-based. If the service charge is time-based, the user can configure the system to automatically assign the correct CPT code and/or units based on the total time of the service (for example, in assigning routine office visit codes).		
▪ The user can configure the system to establish payor-specific payor code rules that will determine claims processing protocols specific to each payor's billing guidelines. These parameters include payor guidelines for coverage based on provider credentials, place of service, whether or not services		

are time or encounter-based, and the minimum amount of time required for the service to be covered. The payor code rules will allow the user to readily configure the system payor code rules to apply CPT codes, modifiers, and units to meet each payor's billing/claims requirements.		
2.4 FQHC Encounter Pricing - Required		
▪ The Oregon Health Plan (OHP) system establishes an encounter rate that pays the County a flat rate per client per date of service for all of the encounter eligible services provided to a client on a single date. The system should have the ability to bundle and price services based on the State's Medicaid Federally Qualified Health Center (FQHC) encounter payment methodology. This includes the ability to identify and differentiate the specific services that are or are not eligible for encounter payments and to identify and track encounters based on variables including client ID, insurance eligibility, date-of-service, place-of-service, service code, and diagnosis. The system should have the ability to process services that are not eligible for PPS payments according to traditional fee-for-service protocols as established by the payor. See the following web-site for further guidance regarding the State's rules regarding FQHC reimbursement: http://www.sos.state.or.us/archives/rules/OARS_400/OAR_410/410_147.html		
2.4 FQHC Encounter Pricing – Desired		
▪ The system enables the County to maintain distinct encounter rates based on medical, dental, or mental health primary diagnoses. The system also enables the rates to be adjusted for annual rate changes (based on date of service). The system provides reports to identify and flag potential duplicate "same day" encounters.		
2.5 FQHC Wrap Payment Reports - Required		
▪ The system produces reports in the format and with the data elements as required by the State Medicaid system to enable the County to submit monthly wrap reports. The FQHC "wrap payment" process is a mechanism where Oregon Health Plan (OHP) pays the County the balance between the established encounter rate and the amount the County receives for those encounter-eligible services from primary Medicaid or Medicare managed care payors.		
▪ The Medicare FQHC supplemental "wrap payment" process is a mechanism where NGS pays the County the balance between the established Medicare encounter rate and the amount the County receives for those encounter-eligible services from primary Medicare Managed Care plans when		

the patient is also OHP. The system produces reports in the format and with the data elements as required by the NGS and the State systems for the OHP-FQHC wrap processes.		
2.6 Client Billing and Statements - Required		
▪ The system properly calculates, bills and tracks: client co-pays and deductibles; and sliding scale requirements that include billing a pre-calculated monthly total, a pre-calculated per episode total, or per visit charges (depending on service type); other user-defined sliding scales; and the ability to support budget payment plans. The system supports the adjustments to outstanding balances. The system can properly track Oregon Health Plan (OHP) clients, who are currently not subject to copayments and deductibles based on eligibility status and date-of-service.		
▪ The system can produce user-defined client statements on demand and on a cycle basis (e.g. every month) and has the capability of disabling the production of statements for any client and the ability to classify clients into categories for which the user will have control over the decision to print statements (e.g. when the cost of billing exceeds the potential revenue to be billed client may not be sent statements, clients whose services are marked as "confidential", and clients who have Oregon Health Plan (OHP) coverage should not receive statements).		
▪ The system supports the identification of which party should receive statements, such as directly to the client/guarantor, the client's conservator, or both. Client statements production supports the entry of user-defined dunning and thank-you messages based on specific payment or non-payment rules. Statements can be printed in detail or summary format based on user-defined rules. Standard statement layouts are configured to enable the use of standard window mailing envelopes.		
▪ The system allows to user to generate accounts receivable aging detail for patient balances (i.e. over 30, 60, 90 days, etc.), to set parameters and print mass mailings to each patient's responsibility party or on-demand individual patient statements.		
2.6 Client Billing and Statements - Desired		
▪ System has the ability to generate and send patient statements to patient or guarantor's designated e-mail.		

2.7 Revenue Recognition General Ledger Posting, and Payment Posting - Required		
▪ The system generates revenue, contractual allowances, and sliding scale adjustments for each service from all sources at the time of entry based on the billing rules entered for insurance companies and for self-pay clients. All charges are recorded at standard fees and any contractual allowances or sliding scale discounts are recorded as adjustments to the standard fees. These entries can be posted to the county's general ledger via hard copy or electronic posting reports, which can be summarized based on user defined criteria including subtotals by payor, payor class, program, location, etc.		
▪ The system supports the entry and proper tracking of multiple adjustment codes including contractual allowances, sliding scale discounts, and bad debt write-offs, including all standard Medicare, and State of Oregon Oregon Health Plan adjustment codes, as well as enables user to add additional adjustment codes.		
▪ The system allows user to establish multiple GL codes for posting revenue. GL codes may be assigned by payor, and are automatically applied when payments are posted.		
▪ The system supports point of service check-out whereby charges are calculated and added to previous accounts receivable balances, payments can be posted, and payment receipts can be issued. This allows the posting of payments to a client account even though there are no corresponding charges and considers these payments as credit balances to be matched with charges at a later date.		
▪ The system also supports easy data entry of hard copy Remittance Advices. The system should have sufficient controls to support reconciliation of payments entered to cash receipts.		
▪ The system supports electronic posting of the ASC X12N 835 - Healthcare Payment and Remittance Advice to client accounts. The system should have sufficient controls to support reconciliation of payments entered to cash receipts.		
2.8 Cascade Billing and Accounts Receivable Management - Required		
▪ The system provides for open item accounting with the default of posting of payments and adjustments to specific charges/invoices. It properly handles the sequential billing of payors (e.g. Medicare 1st, Private Insurance 2nd; Patient 3rd; or Patient 1st and Oregon Health Plan (OHP) 2nd) ensuring		

that the sequence is based on both the coverage that the client has and the services that are covered by the various plans. When Remittance Advices are posted, outstanding charges are automatically calculated and upon user confirmation, transferred to secondary and tertiary payors and/or client responsibility, and the appropriate electronic and paper claim forms are produced, which include the payments received from the previous payors. Outstanding charges not confirmed and transferred to the next sequential payor remain as open receivables.		
▪ Appropriate audit trails are kept of claims that have been sequentially billed to multiple payors and revenue and accounts receivable balances do not overstate outstanding amounts by reporting balances for multiple payors simultaneously.		
▪ This process includes automatically crediting contractual allowance and other adjustment accounts during payment posting based on predetermined carrier-specific criteria.		
▪ This information is tracked and reported via detailed aged accounts receivable reports with user-defined sort and subtotal criteria including payor type, payor, provider, client, program, location, etc		
2.9 Bundled Billing - Required		
▪ The claims billing system enables services which are delivered by the same provider on the same date-of-service to be bundled into a single service. (For example, multiple instances of case management delivered by the same provider to the same client at different times of the day.)		
2.10 Service Coding and Billing - Required		
▪ The claims system enables different billing codes, including modifiers, to be assigned to the same services based on payor requirements. Additionally, the claim system automatically assigns CPT codes to services based on the time length of the recorded service and user-defined payor code rules for assigning billing codes. The claims system also enables the user to establish payor-specific rules for billing services as encounter or time-based units.		
2.10 Service Coding and Billing - Required		
▪ The system prompts alternative ICD9 codes and or CPT codes based on payor code rules for the patient's primary insurer.		

2.11 Capitation, Grant in Aid, and Collections Management - Required		
▪ The system can compute and automatically write off the positive or negative contractual allowance amounts for bills that are covered by capitated or grant-in-aid funding streams.		
▪ The system produces on-line ledger cards for all client accounts that show the transaction history of all charges, payments, and adjustments for all payors for a specified date range. Data can be filtered to show the same information for a single payor (including client responsibility).		
▪ The system has the ability to attach notes to any transaction regarding collection calls and can generate alert reports based on the follow-up dates entered into these notes. Specific "work que" reports can be generated by each billing staff member for his/her tasks, and supervisory reports can be generated and sorted by each billing staff member listing all open tasks.		
Section 3: Administrative Workflows		
3.1 Client Lookup/Immediate Inquiry - Required		
▪ The system supports rapid inquiry to determine if a client is new to the system. Inquiries may be made by name, partial name, alias, birth date, social security number, ethnicity, other query criteria, or any combination of criteria. The system uses sophisticated identifier matching techniques including Soundex or similar algorithms to identify the client. If the client is new to the system, the client can be added using the registration process. The inquiry process includes the identification of the client's status, which is user-defined and can include values such as pre-registered, enrolled, wait-listed, discharged, etc. The client status is automatically updated whenever an event, such as a discharge, occurs.		
▪ An easily accessible, user-configurable summary screen displays key "at-a-glance" information for a client including basic registration and demographic data, urgent Red Flag information, language requirements, Oregon Health Plan (OHP), /insurance eligibility, FPL percentage, pending appointments, and dates of last service. Vendor -- please explain and include applicable screen shots		
3.2 Registration - Required		
▪ System enables user specification of required (i.e. system will allow user to save data without "required" data) and desired (i.e. system prompts user for missing data but will allow data entry screen to be saved without all "desired" data.) fields for		

recording patient demographics. Standard system reports provide identification and listings of patient files that do not contain all desired data. (Explain and provide samples of relevant reports.)		
▪ System collects all demographic data elements as required for FQHC UDS reporting. See the "Reporting" section under "Functional Requirements."		
▪ System collects all demographic data required for standard billing to primary and secondary payors. (Explain and provide screen shots of screens used to collect and display patient, guarantor, and responsible party demographic information.)		
▪ System has data entry fields for patient/responsible party e-mail addresses.		
▪ The system is able to submit Family Planning visit data to AHLERS on a monthly basis. Please see AHLERS website at www.ahlerssoftware.com and on the Oregon State Family Planning website at http://oregon.gov/DHS/ph/fp/materials.shtml		
▪ System has capability to record listing and contact information for individuals and organizations for which the patient has authorized a Release of Information. System can record patient signature on ROI form.		
3.2 Registration - Desired		
▪ ROI continued - System can list effective and expired dates for each ROI contact.		
▪ System has capability to identify patient's preferred method of contact including phone, text via phone, or email.		
3.3 Duplicate Checking, Merge and Alias Names - Required		
▪ When it is determined that a client has erroneously been registered with two identities the system supports a function which will allow a system manager to merge the client data including all services, charges, payments, adjustments and accounts receivable balances. A single ID number will be retained and all data from the incorrect ID number will be merged. A history of past merged records will be retained for system manager inquiry.		
▪ During the registration process, the system will cross check name inquiries to identify alias names. Clients may have multiple alias names as well as other multiple Personal Identifier such as Date of Births (DOB), Social Security Numbers, etc.		

3.4 Financial Information - Required		
▪ A financial assessment process collects all standard eligibility information from clients. Authorized users collect information required for Oregon Health Plan (OHP), Medicare, and Third Party Insurance. During the financial assessment process, the system makes on-line access to Oregon Health Plan (OHP) eligibility data to determine Oregon Health Plan (OHP) eligibility.		
▪ The system collects income, various categories of expense, family size, family member information, and assets to comply with the County's sliding fee assessment, where appropriate. The financial assessment process prompts for and can produce printed forms to be given to clients at the conclusion of the financial assessment.		
3.5 Sliding Scales - Required		
▪ The system can be configured to support multiple sliding scales including annual deductible, percentage discount, fixed dollar discount, etc. Financial Information is used to place the client on the appropriate sliding scale and calculate client and family financial responsibility. Scales can be configured consistent with local requirements and Oregon/Federal regulations. The system provides the flexibility to accommodate a change in financial status and sliding scale liability with an effective date of the change.		
▪ The system supports the development and application of different sliding scales based on program or services. For example, a different sliding scale may be applied to FPEP (family planning services) than is used for primary care services, or for mental health services. Charges for a specific service such as a routine office visit can be subject to the sliding scale discount and charges for other services such as a sports physical would not be adjusted based on the sliding scale.		
▪ Users can set alerts to prompt verification of patient income/sliding scale eligibility at user defined intervals, i.e. every six months.		
▪ The system provides a financial assessment screening process that collects appropriate information regarding indigent clients who may potentially be Oregon Health Plan (OHP) eligible. Potential eligibility criteria may be configured by the system administrator in support of current Oregon eligibility criteria. When clients match the potential criteria, the financial interviewer is advised immediately and a potential eligibility referral letter to the local Social Services Office is		

prepared by the system.		
3.6 Admission, Discharge, and Transfer - Required		
▪ Clients may be admitted to and discharged from organizational providers through a user-defined online admission/discharge form, which can be customized for different types of provider organizations. The system will allow authorized users to transfer an admission from one organizational provider to another or copy the pertinent information from an existing admission to another to reduce required data entry.		
3.6 *Admission, Discharge, and Transfer - Desired*		
▪ System supports the collection of required demographic data and provides an interface for the automatic electronic submission of client enrollment/disenrollment data to the State of Oregon Alcohol and Drug Client Process Monitoring System (CPMS) (See information on the following website: http://www.oregon.gov/DHS/mentalhealth/publications/main.shtml)		
3.7 Episode Tracking - Required		
▪ The system has the ability to define and track episodes of care for clients based on state and local definitions of episodes. This includes: tracking all of the care provided to an individual within a given service area, by a specific provider, during a given time period (e.g. a client could have mental health and an alcohol drug episodes open at the same time and services would be tracked separately). Separate episodes could be tracked for outpatient services and an admission to an inpatient facility during the same time period, or multiple outpatient episodes may exist concurrently; and episodes could be flagged for closing if a predetermined period of no service occurred. It will also allow for post discharge follow-up and surveys; these clients may be completely closed to the System of care, but will require some level of activity in order to track follow-up activities.		
3.8 Intake Assessment - Required		
▪ The system offers various standard intake assessment instruments including optional 3rd party licensed assessment tools. The system also supports the creation of user defined intake assessment forms. The intake forms can be designed to display current data in the system, such as demographic items.		

3.8 *Intake Assessment - Desired*		
▪ Please include sample screen shots of all applicable primary care and behavioral health standard intake assessment screens		
3.9 Diagnosis Management - Required		
▪ The system accepts either DSM IV or ICD-9 diagnoses as determined by the system administrator. The system supports cross-walk tables to translate the diagnoses from one classification scheme to another. The system can also track multiple diagnoses based on user-defined criteria, such as admission diagnosis and discharge diagnosis.		
▪ The system has the ability to capture and rank multiple diagnoses based on relevant clinical axis's (i.e., medical, dental, mental health, etc.) and by effective/expiration dates. Client diagnosis enable diagnosis ranking and allow each specific diagnosis to be assigned to a patient with effective and expiration dates. Claims submissions include the applicable diagnosis for each date of service based on the effective date ranges to accurately reflect changes in a client's diagnosis.		
▪ The basic system database library includes all standard ICD-9-CM diagnosis codes, including code, long and short-form descriptions. Vendor's standard upgrades include all modifications/additions and include the ICD-10-CM codes that will be mandatory in 2013.		
3.10 Appointment Scheduling - Required		
▪ The system offers a full appointment scheduling system which allows for rapid entry and retrieval of client appointments with staff. The system is designed to support a front-desk environment that is common to busy public sector clinic settings. The system supports common inquiries such as "find first available appointment for Dr. X at Y location". Staff profiles of availability can easily be maintained, noting available and non-available hours. Daily rosters of appointments for provider schedules or for reminder calls and "chart pull" lists can be generated on demand. (Please explain, provide relevant screen shots.)		
▪ The system has the ability to support establishment of provider "pods" or groupings for purposes of appointment scheduling. When searching for next available appointments with Dr. X, the user should readily be able to see next available appointments for other providers in Dr. X's pod/group.		

▪ The appointment scheduling system should provide the user with the ability to easily see appointment schedules and next available appointment by location, by provider, and/or by provider "pod" group. Available appointments should also show relevant user-defined appointment-type information from the provider's appointment template, i.e. "new patient appointment", etc.		
▪ The system has the flexibility to allow appointment scheduling several months in advance to accommodate medication management and other services that are scheduled in. The system also has the functionality to allow for entry of recurring appointments. Appointments can be made for clinicians, rooms, other facilities, vehicles, etc.		
▪ Appointment information is reportable and can interface with appointment reminder call-software. Please provide examples of existing call-reminder software with which you have developed electronic data interfaces for this purpose.		
▪ Appointment scheduling includes the ability for the user to establish appointment slot templates which set the length of the appointment, room, and equipment based on the type of visit and/or provider (Please describe appointment template set-up process).		
3.10 *Appointment Scheduling - Required*		
▪ The system has two-way synchronization to synch appointments in the system with appointments in the provider's Microsoft Outlook calendar.		
▪ The system can be configured to automatically send appointment reminders to patient's designated email. Confidential appointments can be suppressed.		
▪ The system can be configured to send appointment reminder text message to patient's designated phone number. Confidential appointments can be suppressed.		
▪ Appointment templates may be set as reoccurring appointment slots. Individual occurrences of reoccurring appointments may be changed without modifying all other reoccurring appointments in that series.		
3.11 Service Validations - Required		
▪ As services are entered in to the system, essential validations are immediately performed. Each service performed by an identified staff person is automatically checked to confirm that credentials are appropriate to the service rendered. Also, services are checked to determine valid time durations and		

locations of service. Duplicate service entry checks are performed. Validation tables are easily maintained by staff responsible to assure compliance with local, State and Federal regulations. Error notification is immediate at time of data entry and "batch" error listings after services have been entered.		
3.12 Group Service Management - Required		
▪ The system supports the efficient management of group services. Groups can be created easily, and clients added and deleted from particular groups. When services are entered for a group, all group members are displayed for rapid data entry. Therapist and co-therapist time may be recorded. In addition, the system must allow for the therapist and co-therapist to have different billing times including different documentation time per client. Participants in a group may be coordinated by several different teams within the same agency.		
3.13 Incident Tracking - Required		
▪ The system administrator can create a variety of critical incident types that can be easily entered and retrieved. Follow-up responsibility and other configurable fields allow local policy for incident reporting to be supported by this system feature. Administrative alerts can be configured in coordination with the incident tracking function.		
▪ The system provides for staff security tracking for breaches of confidentiality and audit trails for all patients and accounts.		
3.14 Personal Task List/Task Assignments - Required		
▪ A user may create and assign a task to either a specific user or to a defined user group.		
▪ Tasks may be attached to a specific location in a patient file. For example, when the recipient opens a task, the system will automatically take the user to the relevant location in the patient's record.		
▪ Standard system reports enable task senders, recipients, and supervisors to generate report listings of completed and uncompleted tasks.		
3.14 Personal Task List/Task Assignments - Desired		
▪ All system users are offered an on-line personal task list that includes items which may come from varied sources including: client appointments for the day; staff meetings; QI reminders on		

3.15 Service Linkage to Progress Notes - Required		
▪ For users that have implemented the system's progress note function, the system can automatically generate a service transaction that is linked to a progress note entered and signed by a clinician.		
▪ Progress notes that have been pended by the clinician or by a clinical reviewer are held and not forwarded to the billing system. This automatic generation feature may be "switched" on or off by the system administrator. The feature may be enabled or disabled for particular organizational providers or particular clinical staff.		
▪ Standard system reports shall list recorded appointments/services with missing and/or draft progress notes. Clinicians are able to easily run reports for their own services. Supervisors are also able to easily run reports that can be sorted by clinician or program.		
3.16 Integration of Voice Recognition Software to Progress Notes - Required		
▪ The system is able to support and accept dictated progress notes using voice recognition software, specifically Dragon Naturally Speaking.		
3.17 Standard Operational Reports - Required		
▪ The system has standard operational reports to support each functional area in this document. The reports allow users to select and filter data by variables such as date range, department, clinician, etc. Users have the option of outputting reports to the screen, printer, standard ASCII file format and PC application formats such as XLS, CSV, PDF, MDB, TXT, DIF, etc. Standard reports can be copied, edited, and added to the reports menu with a new report name.		

D - TECHNICAL CRITERIA

Technical Element	yes/no partial	Comment
1. General Specifications		
1. General Specifications - Required		
▪ Does your system date and time stamps all entries?		
1. General Specifications - Desired		
▪ Do you regularly have independent audits of your IT controls?		
▪ Can you provide copies of independent audit results including the controls audited and the methods used?		
2. Data		
2.1 Backups -Required		
▪ Are full backups performed daily?		
▪ Can yesterday's data be restored from a backup within eight hours?		
▪ Can last month's data be restored from a backup within eight hours?		
▪ Can Lane County obtain complete exports of its data?		
2.1 Backups - Desired		
▪ Are incremental backups performed throughout the day?		
▪ Are the backups stored off-site in a secured location through a professional organization?		
2.2 HIPAA - Required		
▪ Is the application fully HIPAA-compliant?		
2.2 HIPAA- Desired		
▪ Can you provide a description of how compliance is assured?		
2.3 Security – Required		
▪ Can Lane County manage adding/removing users to/from the system?		
▪ Can Lane County manage user permissions?		

▪ Are there different levels of permissions in your organization where some (but not all) levels can see Lane County data?		
▪ Are background checks performed on your staff?		
3. Datacenter Required		
▪ Do you have more than five people staffing the data center at one time?		
▪ Do you own the Data Center?		
▪ Is the Data Center protected by a professionally installed fire suppression system?		
3.1 Security - Required		
▪ Is there some sort of physical security that protects the Data Center? (Biometric scanning, Key cards, Cameras, etc.)		
3.2 Firewalls - Required		
▪ Are there firewalls in place to isolate and protect Lane County data?		
▪ Does each customer have its own firewall?		
▪ By the use of a firewall can you prevent Customer "A" from accessing Customer "B's" data?		
▪ Do you have intrusion detection systems in place?		
▪ Do you have mechanisms in place to provide real-time alerts for intrusion detection?		
▪ Do you have mechanisms in place to protect against denial of service attacks?		
▪ Do you have a protocol for informing Lane County when an intrusion has been detected that may have compromised the security of Lane County data?		
3.3 Disaster Recovery - Required		
▪ Do you have a specific mitigation plan in case of a disaster?		
▪ Is your disaster recovery plan tested at least annually?		
▪ In the event of catastrophic system failure, would you be able to go to a recovery point of eight hours?		

3.3 Disaster Recovery - Desired		
▪ Is the Data Center protected by a redundant power supply?		
▪ Has the Data Center ever experienced a power failure?		
▪ Is the hardware used for the system fully redundant and architected for automatic failover?		
4. Application - Required		
▪ Can Lane County extract data from the application?		
4. Application - Desired		
▪ Would your hosting solution be shared with other customers?		
▪ Would your hosting solution be dedicated for Lane County's use?		
▪ Can you guarantee data security in a shared hosted environment?		
▪ Is the hosting solution operating in a virtualized environment?		
▪ Is there a limit to the number of users who can be simultaneously using the hosted application?		
▪ Is there a limit to the number of users who can be simultaneously using the hosted application before performance is affected?		
▪ Is the hosted system available during Lane County business hours? (Pacific Time: 8 to 5, Monday through Friday)?		
▪ Is the hosted system availability outside of Lane County business hours? (Pacific Time: 8 to 5, Monday through Friday)		
▪ Is notice given prior to planned system downtime?		
▪ Is there at least twenty-four notice is give prior to planned system downtime.		
▪ Is Lane County allowed to approve/deny planned system downtime?		
▪ Are guarantees made for application accessibility?		

▪ Can Lane County integrate other application systems with the vendor system?		
▪ Can Lane County update data outside of the application?		
▪ Does Lane County have direct access to the database (e.g. for our own reporting or integration purposes)?		
▪ Is the application data structure documentation available to Lane County?		
▪ Do you use internal data encryption?		
▪ Do you use external data encryption?		
▪ Do you use digital certificates (PKI Certificates)?		
▪ Do you enforce password rules?		
▪ Do you enforce periodic password changes?		
▪ Is your application browser based?		
▪ Is your application N tiered?		
▪ Is your application deployed using Terminal Services/Citrix?		
▪ Is your application available via a VPN?		
5. Database - Desired		
▪ Is the application database relational?		
▪ Are there views available for reporting?		
▪ Would Lane County have its own separate database?		
▪ Can you provide different levels of database permissions?		
▪ Can Lane County connect to the hosted database using standard database tools?		
6. Support/SLA - Desired		
▪ Is there availability of support during Lane County business hours (8AM to 5PM Pacific time)?		
▪ Is there availability of support outside of Lane County business hours?		
▪ Can you guarantee support response time within one hour if there is a critical issue?		

▪ Can you guarantee support response time within four hours if there is an urgent issue?		
▪ Can you guarantee support response time within twenty-four hours for a non-urgent or non-critical issue?		
▪ Is there a published escalation process available for support issues?		
▪ Can we contact support using email, telephone and the internet?		
▪ Can you provide us with a copy of your standard support agreement?		
▪ Are there times when no support is available during Lane County business hours?		
▪ Can you provide documentation on your support practices/procedures?		
7. Other Items to be considered in Phase II of the Selection Process		
▪ How quickly can yesterday's data be restored from a backup?		
▪ How are user permissions and adding/removing users from the system managed?		
▪ How many people staff your data center at one time?		
▪ If you contract space in a third party data center, how is data security and integrity assured?		
▪ How is physical security protected at your data center?		

PROJECT EXPENSE DETAIL

Please provide information for both the initial contract year (December 1, 2010 through November 30, 2011) and the second year (December 1, 2011 through November 30, 2012)

Please include all expenses related to software acquisition, required hardware, training, travel, web hosting and incidental services and expenses.

PRODUCT/CATEGORY	COST PER UNIT, if applicable. Define unit – per provider per year	NARRATIVE/EXPLANATION	TOTAL COST
application/software			
licenses			
updates			
interfaces			
one-time set-up			
annual maintenance			
training			
materials			
project maintenance			
other, not mentioned above			

Statement of Assurances and Proposal

The undersigned attests that the information provided to determine eligibility is true and accurate to the best of his/her knowledge. The undersigned further attests the he/she has the authority and/or responsibility to represent his/her organization in all phases of this Request for Proposals process. Finally, the undersigned understands that any false or substantially incorrect statement may disqualify this proposal from further consideration or be cause for termination of any further contract.

If this proposal is selected for funding, the undersigned provides assurances on behalf or his/her organization that the organization will comply with the General Conditions and Special Conditions in its subcontract with Lane County. The organization will also comply with all applicable federal, state, county and local statutes, rules and funding criteria governing service, facilities and operations. Finally, the organization will submit all required reports, documents and forms within the allotted time for their submission.

The undersigned, as proposer, declares that he/she has carefully examined the specifications and requirements of the Lane County Request for Proposals packet and that proposer agrees, if the proposal is accepted, that proposer will contract with Lane County to furnish the services as specified, in accordance with the proposal offered here.

The proposer hereby certifies that he/she is a resident bidder as defined in ORS 279A.120(1)(b) of_____.

By initialing this space_____ proposer hereby certifies that he/she has not discriminated against minorities, women, or emerging small business enterprises in obtaining any required subcontracts. By initialing this space _____ proposer hereby certifies that to the best of proposer's knowledge, he/she is in compliance with all the Oregon tax laws described in ORS 305.380(4).

The proposer represents that the proposal is in all respects fair and without collusion.

Signature: _____ Date: _____

_____ _____

Printed or Typed Name and Title Printed or Typed Agency Name

PART VI - CRITERIA FOR EVALUATION OF PROPOSALS

Each proposal will be evaluated according to the procedures set forth in Part 1 – General Information/Evaluation of Proposals and Selection of Contractors.

For each vendor, evaluation committee members will review all evaluation data and individually assign scores (numbers of points) for each of the four criteria listed below. Total scores will be calculated by summing the scores assigned by each committee member and dividing by the total number of committee menbers to arrive at an average total score.

Program Qualifications Section

Criterion	Maximum Points
Cost	100
EHR Functional Requirements	100
Practice Management Requirements	100
Technical (IT) Criteria	50

TOTAL NUMBER OF POINTS: 350

REVIEWER NAME:
AGENCY REVIEWED:

_____

DATE REVIEWED:

_____

Vendor Presentation/Site Visits

If selected as a finalist, Vendors agree to present their proposal and demonstrate their proposed system to the Evaluation Committee. In addition, Vendors agree to provide the Evaluation Committee the opportunity to interview proposed staff members identified by the Evaluation Committee. Vendor's proposed Project Manager is expected to conduct the session. The Evaluation Committee should receive copies of the proposed Project Manager's CV prior to the presentation and Lane County reserves the right to request an alternative project manager be assigned, if the Evaluation Committee so directs.

PART VII - ATTACHMENTS

Please attach the boilerplate contract used by your entity in offering electronic health records services, software acquisition, training and all other costs associated with adoption and implementation of the program over the first two years.

PART VIII- COUNTY REQUIRED CONTRACT LANGUAGE

The attached documents are required to be incorporated into any agreement Lane County enters into for EHR services.

HIPAA PROVISIONS

For purposes of this Exhibit, COUNTY refers to Lane County, on behalf of a county designated covered program or function under HIPAA.

The parties agree that the following terms and conditions shall apply to the performance of their obligations under the Service Agreement into which it is being incorporated. Contractor is providing services to a County program designated as a covered healthcare component and such services will require disclosure and use of Protected Health Information ("PHI"), including electronic PHI, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA Privacy and Security Rules require that covered entities obtain satisfactory assurances that its Business Associates will comply with the Business Associate requirements of the Privacy Rule set forth in 45 CFR 164.502(e) and 164.504(e), and the Security Rule set forth in 45 CFR 164.314, and Contractor desires to provide such business associate assurances with respect to the performance of its obligations.

ARTICLE 1. Terms

1.1 Terms used, but otherwise not defined, in this Agreement shall have the same meaning as those terms in HIPAA and 45 CFR Parts 160 and 164 (Privacy and Security Rules), and as amended.

1.2 "Individual" shall have the same meaning as the term "individual" in 45 CFR 164.501 and generally means the person who is the subject of protected health information. It also includes a person who qualifies as a personal representative pursuant to 45 CFR 164.502(g).

1.3 "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, subparts A and E and as these may be amended from time to time.

1.4 "Protected Health Information (PHI)" as defined in the Privacy Rule in 45 CFR 164.501, shall mean any PHI received, used, created or disclosed by Contractor from or on behalf of the County's covered component. It relates to the past, present, or future physical or mental health or condition of an Individual; the provision of health care to an Individual, or the past, present, or future payment for the provision of health care to an Individual and identifies the Individual or there is a reasonable basis to believe the information can be used to identify the Individual.

1.5 "Required by Law" shall have the same meaning as the term in 45 CFR 164.501.

1.6 "Secretary" shall mean the Secretary of the federal Department of Health and Human Services (HHS) or their designee.

1.7 "Security Rule" shall mean the standards for security of PHI in subpart A and "Subpart C - Security Standards for the Protection of Electronic Protected Health Information", beginning 45 CFR § 164.302, and particularly requirements for business associates in 45 CFR § 164.308(b) and 45 CFR § 164.314(a). The Security Rule is a subpart of the Privacy Rule.

ARTICLE 2. Permitted Uses and Disclosures in Performing Services

2.1 The parties agree that the following terms and conditions shall apply to Contractor's performance of obligations under the Service Contract.

2.2 Contractor is authorized to access, receive, use or disclose PHI for the express purpose of performing the services under the Services Contract. Except as otherwise expressly permitted and as limited in this Agreement/Amendment or as Required by Law, Contractor may use or disclose PHI to perform the functions, activities or services for, or on behalf of, the County, set forth in the Services Contract and provided that such use or disclosure would not violate the Privacy or Security Rules or any more stringent state law provisions if performed by County. Further use or disclosure other than as permitted or required by this Agreement/Amendment or as Required by Law is prohibited.

2.3 Except as otherwise limited in this Agreement, Contractor may use PHI for the proper management and administration of its business or to carry out its legal responsibilities.

2.4 Except as otherwise limited in this Agreement, Contractor may disclose PHI:

2.4.1 For the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Contractor.

2.4.2 For the proper management and administration of its business, provided that disclosures are Required by Law, or Contractor obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies, in writing, the Contractor of any instance of which it is aware in which the confidentiality of the information has been breached.

2.4.3 For Data Aggregation services to County as requested by County and permitted by 45 CFR § 164.504(e)(2)(i)(B).

2.5 Contractor may use PHI to report violations of law to appropriate Federal and State authorities subject to the conditions in 45 CFR §164.502(j)(1).

ARTICLE 3. Obligations and Activities of Contractor

3.1 Contractor shall not create, receive, use or disclose PHI other than as permitted or required by this Agreement or as provided by law. Contractor further agrees to use or disclose PHI only on behalf of, or to provide services to, the County in fulfilling Contractor's obligations under the Service Contract and to not make uses or disclosures that would violate the Privacy Rule or violate the minimum necessary standard of the Privacy Rule. Unless otherwise imposed by law, Contractor will limit its uses and disclosures of, and requests for, PHI (a) when practical, to the information making up a limited data set; and (b) to the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request. .

3.2 Contractor is directly responsible for full compliance with the relevant requirements of the Privacy Rule to the same extent as the County. This includes, but is not

limited to additional security and Privacy Rule requirements in HITECH made applicable to covered entities, and those are incorporated into this Agreement as Contractor's obligations.

3.3 Contractor will safeguard all PHI according to the terms of this Agreement/Amendment and all HIPAA regulations. Contractor shall implement administrative, physical and, technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI, including electronic PHI that it accesses, creates, receives, maintains or transmits on behalf of the County pursuant to Privacy and Security Rules, including 45 CFR Part 164, Subpart C. Contractor acknowledges its statutory duty to provide safeguards as if it were a covered entity in accordance with 45 CFR 164.308 (Administrative Safeguards); 45 CFR 164.310 (Physical Safeguards); 45 CFR 164.312 (Technical Safeguards) and agrees to follow any guidance which may be issued by the Secretary. Contractor agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement/Amendment.

3.4 Contractor agrees to comply with all applicable law and regulations regarding misuse, improper disclosure, and security incidents or breaches, including but not limited to HIPAA, Health Information Technology for Economic and Clinical Health (HITECH) Act, any implementing regulations or more stringent state law. Contractor agrees to report to the County any use or disclosure of PHI or other data not provided for by this Agreement/Amendment and any material attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, interference with system operations in an information system or security incident or breach of which it becomes aware, as soon as possible.

3.4.1 Contractor will notify County of a Breach of unsecured PHI following the first day on which Contractor (or its employee, officer or agent) knows or should have known of such Breach.

3.4.2 Contractor shall provide County with the identity of each Individual whose PHI has been, or is reasonably believed to have been accessed, acquired or disclosed during such Breach and all other information set forth in 45 CFR 164.404(c) or required by law or other regulation or as may be required by County for County to meet its notification obligations. This information shall be provided at the time of providing County with notice of Breach or promptly thereafter as it becomes available;

3.4.3 Contractor shall confer with County as to the preparation and issuance of appropriate notice(s). Time is of the essence in this obligation to confer with County.

3.4.4 Notifications required by this section are required to be made without unreasonable delay and in no case later than 60 calendar days after the Discovery of a Breach (except where a law enforcement official determines a delay due to criminal investigation or national security is warranted). Accordingly, the notification of a Breach to the County shall be made as soon as possible, and every effort made to provide required information no later than 30 days after Discovery of a Breach. Contractor shall confer with County as soon as practicable.

3.5 Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of PHI or breach of unsecured PHI by Contractor that violates the requirements of this Agreement/Amendment. Contractor agrees

to report to the County, the remedial action taken or proposed to be taken with respect to such use or disclosure. In the event Contractor fails to mitigate in accordance with this provision, Contractor shall cooperate with and conduct any mitigation efforts requested by County.

3.6 Contractor agrees to ensure that any agent, including any subcontractor to whom it provides PHI or makes PHI available, executes an agreement with the same terms, conditions, and restrictions that apply through this Agreement/Amendment to Contractor with respect to such information This includes ensuring that any agent, including subcontractor, agrees to implement reasonable and appropriate safeguards to protect electronic PHI.

3.7 The parties do not anticipate that, at any point in time, the County will be unable to access and control PHI that it uses, discloses or creates or that any change to PHI required below would affect Contractor's performance under the Service Contract. However, in the event Contractor does have access and control of PHI in a Designated Record Set of the County:

a. At the request of the County and within five business days, and unless directed otherwise, Contractor shall provide access of their PHI to an Individual to meet the requirements under 45 CFR § 164.524.

b. Contractor shall make any amendment(s) or add a statement of disagreement from the Individual, to PHI that the County directs or agrees to pursuant to 45 CFR § 164.526 at the request of the County or an Individual with 10 working days of the request.

c. Contractor shall document such disclosures of PHI and information related to such disclosures as are required for the County to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. On request of the County, Contractor shall provide the documentation made in accordance with this Agreement to permit County to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528 within 10 working days..

d. As to Contractor's obligations in 3.7. a., b., and c. above, Contractor shall document and retain for six years from the date of creation or date last in effect, whichever is later:

i. The titles of the person or offices responsible for receiving and processing requests for access, for amendments, and for accounting of disclosures; and

ii. The PHI that are subject to access by individuals under 45 CFR 164.524, subject to the County's direction otherwise;

iii. The written accounting that is provided to the individual;

iv. The information required to be included in the accounting in paragraph (c) above.

3.8 Contractor agrees to make internal practices, books, and records, including policies and procedures relating to the use and disclosure of PHI received from, or created or received by, or made available or accessed by Contractor on behalf of the County, available to the County or to the Secretary within five business days or within the time frame designated by the Secretary, for purposes of determining the County's compliance with the Privacy and Security Rules, or for audit purposes.

3.9 Contractor is solely responsible for determining its obligation to use and the provisions of any Notice of Privacy Rights consistent with the HIPAA Privacy Rule and its services to the extent that they may affect Contractor's creation, receipt, use or disclosure of

PHI. Contractor shall rely on its own judgment, and County's Notice of Privacy Rights has been made available as an example only.

ARTICLE 4. Obligations of County's Covered Component

4.1 The County shall notify Contractor of any restrictions, limitations, changes in, or revocation of, permission by Individual to access, receive, use or disclose PHI, to the extent that Contractor's access, receipt, use or disclosure of PHI may be affected.

4.2 The County shall not request Contractor to use or disclose PHI in any manner that would not be permissible under the Privacy or Security Rules if done by the County, unless the Contractor will use or disclose PHI for data aggregation for County or management and administrative activities of Contractor.

ARTICLE 5. Term and Termination

5.1 The term of this Agreement/Amendment shall begin the date the last party signs this Agreement/Amendment, and shall terminate when all of the PHI provided by the County to Contractor, or created or received by Contractor on behalf of the County, is destroyed or returned to the County, and all ability to access such information is terminated, or if it is infeasible to return or destroy PHI, protections are extended to the information in accordance with the termination provisions in this Agreement/Amendment.

5.2 Termination for Cause. In addition to any other rights or remedies provided in this Agreement, upon either the County's or Contractor's knowledge of a material breach by the other party of that party's obligations under this Agreement, the non-breaching party shall:
:

a. Notify the other party of the breach and provide a reasonable opportunity in a notice of breach to cure the breach or end the violation and terminate this Agreement and the Services Agreement(s) if Contractor does not cure the breach or end the violation within the time specified. Contractor shall notify County in writing of the actions taken to cure the breach or end the violation; or

b. Immediately terminate this Agreement/Amendment and the Services Agreement(s) if there has been a breach of a material term of this Agreement/Amendment and cure is not possible in the reasonable judgment of the non-breaching party; or

c. If neither termination nor cure is feasible, the non-breaching party shall report the violation to the Secretary;

d. The County's remedies under this Agreement/Amendment are cumulative and the exercise of any one remedy shall not preclude the exercise of any other.

5.3 This Agreement/Amendment terminates when the Service Contract terminates.

5.4 Except as provided in subsection 5.5 or 5.6, upon termination of this Agreement/Amendment, for any reason, Contractor shall, at the County's option, return or destroy all PHI belonging to the County, or created or received by Contractor on behalf of the County if in Contractor's possession. This provision shall apply to PHI that is in the possession of subcontractors or agents of Contractor. Contractor and subcontractors or

agents shall not retain any copies of the PHI.

5.5 In the event that Contractor determines that returning or destroying PHI is infeasible, Contractor shall provide to County notification of the conditions that make return or destruction infeasible. Upon written agreement by the County that return or destruction of PHI is infeasible, Contractor shall extend the protections of this Agreement/Amendment to such PHI and limit further uses and disclosures of PHI to those purposes that make the return or destruction infeasible, for so long as Contractor maintains such PHI.

5.6 If it is infeasible for the Contractor to obtain any PHI in the possession of a subcontractor or agent, the Contractor shall provide the notification in 5.5 above within five business days upon learning of the infeasibility. The Contractor shall require the subcontractor or agent to agree to extend the protections as in 5.5 above.

ARTICLE 6. Miscellaneous

6.1 Amendment; waiver.

a. The parties agree to take such action as is necessary to amend this Agreement/Amendment from time to time in order for the County to comply with the requirements of the HIPAA Privacy and Security Rules and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.. The parties agree that any modifications to those laws shall modify the obligations of the parties to this Agreement/Amendment without the need for formal amendment of this Agreement/Amendment. Any other modifications, alterations, variations, or waivers of any provisions shall be valid only when then have been executed in writing.

b. As of the effective dates for each applicable section in HITECH, Contractor acknowledges its statutory duties include, among other duties:

i. Complying with HIPAA Security rules regarding administrative, physical and technical safeguards, as well as policies and procedures and maintenance of documentation (45 CFR 164.316).

ii. Using and disclosing PHI only in compliance with the business associate contract provision rule, 45 CFR 164.504(e). which provisions have been incorporated into this Agreement.

iii. Not receiving direct or indirect remuneration in exchange for PHI unless permitted by the Act or regulations issued by the Secretary.

iv. Complying with all other applicable provisions of HITECH, including but not limited those relating to security and breaches of unsecured PHI and those that are made applicable to covered entities, as if Contractor were a covered entity.

c. No provision in this Agreement/Amendment shall be deemed waived unless in writing, and duly executed. A waiver with respect to one event shall not be construed as continuing, or as a bar to or waiver of any other right or remedy under this Agreement/Amendment.

6.2 Survival. The respective rights and obligations of the parties under the following paragraphs shall survive the termination of this Agreement/Amendment:

a. Subsection 3.7d of the section "ADDITIONAL BUSINESS ASSOCIATE OBLIGATIONS OF CONTRACTOR"

b. Subsections 5.4, 5.5, 5.6 of the section "TERM AND TERMINATION"

c. Subsections 6.1, 6.2, 6.3, 6.4, 6.6, 6.7, and 6.8 of the section

"MISCELLANEOUS" shall survive the termination of this Agreement/Amendment.

6.3 Interpretation; order of precedence. Any ambiguity in this Agreement/Amendment shall be resolved to permit the County to comply with HIPAA and the regulations promulgated in support. The terms of this Agreement/Amendment supplement the terms of the Service Contract and, whenever possible, all terms and conditions of this Agreement/Amendment and the Service Contract are to be harmonized. In the event of a conflict between the terms of this Agreement/Amendment and the terms of the Service Contract, the terms of this Agreement/Amendment shall control, provided that this Agreement/Amendment shall not supersede any other federal or state law or regulation governing the legal relationship of the parties, or the confidentiality of records or information, except to the extent that HIPAA preempts those laws or regulations. In the event of any conflict between the provisions of the Service Contract as amended by this Agreement/Amendment and the Privacy or Security Rules, the Privacy and Security Rules shall control.

6.4 Indemnity. In addition to any other indemnification obligations of Contractor in the Services Contract(s), Contractor shall save, hold harmless, and indemnify the County and its Commissioners, officers, employees, and agents from and against all claims, suits, actions, losses, damages, liabilities, monetary penalties imposed, costs, and expenses of any nature whatsoever resulting from or arising out of Contractor's, or its agent's or subcontractor's performance or failure to perform under this Business Associate Agreement/Amendment, including but not limited to, unauthorized use or disclosure of PHI, or breach of security, privacy or integrity of PHI. Without limiting the generality of the preceding indemnity obligation, Contractor shall also be required to indemnify County consistent with the preceding, including for any claim related to its failure to mitigate and to County's request or failure to request mitigation in Section 3.5, Contractor shall be liable to and indemnify County for any and all costs incurred by the County, including but not limited to, costs associated with Breach notification requirements of HITECH or any other applicable law or rule because of a breach by Contractor.

6.5 Insurance. Contractor shall provide a certificate of insurance establishing coverage for Contractor's activities under this Agreement/Amendment.

6.6 Independent Contractor. Contractor will function as an independent contractor and shall not be considered an employee of the County for any purpose. Contractor is responsible for determining the appropriate means and manner of performance. Nothing in this Agreement/Amendment shall be interpreted as authorizing Contractor or its agents, subcontractors and/or employees to act as an agent or representative for or on behalf of the County.

6.7 Successors and Assigns. The provisions of this Agreement/Amendment and the Contract shall be binding upon and shall inure to the benefit of the parties and their respective successors and permitted assigns, if any. Neither the obligations under this Agreement/Amendment, nor the responsibilities for providing services, shall be assigned or delegated by Contractor without the prior written consent of the County.

6.8 No Third-Party Beneficiaries. The County and Contractor are the only parties to this Agreement/Amendment and are the only parties entitled to enforce its terms. Nothing in this Agreement/Amendment gives, is intended to give, or shall be construed to give or

provide any benefit or right, whether directly, indirectly, or otherwise, to any other third parties.

6.9 Notices. Any notices between the parties or notices to be given under this Agreement/Amendment shall be given in writing by personal or overnight courier delivery, or by mailing by certified mail with return receipt requested, to Contractor or to the County, to the addresses given for each below or to the address either party gives to the other. Any notice so addressed and mailed shall be deemed given five days after mailing, or by facsimile. Any notice delivered by personal or overnight courier delivery shall be deemed given upon receipt. Any notice by facsimile shall be deemed given upon confirmation that notice was received.

6.10 Except as Amended. Except as amended by this Agreement/Amendment, all terms and conditions of the Service Contract, including any prior amendments shall remain in full force and effect.

6.11 This Agreement/Amendment may be executed in any number of counterparts, all of which taken together shall constitute one agreement binding on all parties, notwithstanding that all parties are not signatories to the same counterpart. Each copy of this contract so executed shall constitute an original.

Lane County Insurance Requirements

INSURANCE COVERAGES REQUIRED

Contractor shall not commence any work until Contractor obtains, at Contractor's own expense, all required insurance as specified below. Such insurance must have the approval of Lane County as to limits, form and amount. The types of insurance Contractor is required to obtain or maintain for the full period of the contract will be:

_X_ **COMPREHENSIVE COMMERCIAL GENERAL LIABILITY** insurance including personal injury, bodily injury and property damage with limits as specified below. The insurance shall include:

COVERAGES	*LIMITS*
_____ Explosion & Collapse	_____ $2 million per occurrence
_____ Underground Hazard	X____ Oregon Tort Claim limits currently at $1 combined single limit per accident or $2 million all claimants per accident or e (aggregate)
X____ Products/Completed Operations	_____ Other
_____ Contractual Liability	
_____ Broad Form Property Damage	
_____ Owners' & Contractors' Protective	

FORM All policies must be of the occurrence form with combined single limit for bodily injury and property damage. Any deviation from this must be reviewed by the Risk Manager. All claims-made forms must have tail coverage and the prior approval of Risk Manager. Submit a complete copy of claims-made policies and endorsements with the certificate of insurance.

_X_ **AUTOMOBILE LIABILITY** insurance comprehensive form with limits as specified below. The coverage shall include owned, hired and non-owned automobiles and include Lane County and its divisions, its commissioners, officers, agent, and employees as additional insureds.

LIMITS

___ $2 million combined single limit per accident for bodily injury and property damage
_X_ Not less than the Oregon Tort Claims limits
$1 million combined single limit per accident or occurrence
$2 million all claimants per accident or occurrence (aggregate)

___ **PROFESSIONAL LIABILITY** insurance – with limits not less than $1 million per occurrence.

___ **POLLUTION LIABILITY INSURANCE** – with limits not less than $1 million per occurrence.

_X_ **ADDITIONAL INSURED CLAUSE** The general and auto liability insurance coverage's required for performance of this contract shall be endorsed to name Lane County and its divisions, its commissioners, officers, agents and employees as additional insureds on any insurance policies required herein with respect to Provider's activities being performed under the Contract. The additional insureds must be named as an additional insured by endorsement, and the policy must be endorsed to show cancellation notices to the Lane County department who originated the contract. Coverage shall be primary and non-contributory with any other insurance and self-insurance.

_X__ **WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY** as statutorily required for persons performing work under this contract. Any subcontractor hired by Contractor shall also carry Workers' Compensation and Employers' Liability coverage.

EMPLOYER'S LIABILITY _X__ Limits of $500,000.

___ **BUILDER'S RISK** insurance special form. Limits to be the value of the contract or $_____.

___ **FIDELITY BOND** covering the activities of any person, named or unnamed, responsible for collection and expenditures of funds. Limit $_____ per employee.

Any questions concerning insurance and indemnity should be directed to Lane County Risk Management at 541-682-4392.

Lane County Hold Harmless Language

COUNTY LIMITATIONS ON LIABILITY – HOLD HARMLESS

Subject to the limitations of Article XI, Section 10 of the Oregon Constitution and of the Oregon Tort Claims Act, County agrees to defend, indemnify and hold the contractor, its officers, employees and agents harmless from and against all claims, suits, actions, losses, damages and liabilities, costs and expenses, resulting from or arising out of the negligent performance or failure to perform by the County, its officers, employees or agents under this contract.

Lane Manual Required Contract Provisions

STANDARD PROVISIONS

21.130 Standard Contract Provisions.

The following standard public contract clauses shall be included expressly or by reference where appropriate in every contract of the County.

(1) Contractor shall make payment promptly, as due, to all persons supplying to such contractor labor or material for the prosecution of the work provided for in the contract, and shall be responsible for payment to such persons supplying labor or material to any subcontractor.

(2) Contractor shall pay promptly all contributions or amounts due to the State Industrial Accident Fund and the State Unemployment Compensation Fund from contractor or any subcontractor in connection with the performance of the contract.

(3) Contractor shall not permit any lien or claim to be filed or prosecuted against the County on account of any labor or material furnished, shall assume responsibility for satisfaction of any lien so filed or prosecuted and shall defend against, indemnify and hold County harmless from any such lien or claim.

(4) Contractor and any subcontractor shall pay to the Department of Revenue all sums withheld from employees pursuant to ORS 316.167.

(5) For public improvement and construction contracts only, if contractor fails, neglects or refuses to make prompt payment of any claim for labor or services furnished to the contractor or a subcontractor by any person in connection with the public contract as such claim becomes due, the County may pay such claim to the person furnishing the labor or services and charge the amount of the payment against funds due or to become due the contractor by reason of the contract. The payment of a claim in the manner authorized hereby shall not relieve the contractor or its surety from the obligation with respect to any unpaid claim. If the County is unable to determine the validity of any claim for labor or services furnished, the County may withhold from any current payment due contractor an amount equal to said claim until its validity is determined, and the claim, if valid, is paid by the contractor or the County. There shall be no final acceptance of the work under the contract until all such claims have been resolved.

(6) Contractor shall make payment promptly, as due, to any person, co-partnership, association or corporation furnishing medical, surgical, hospital or other needed care and attention, incident to sickness or injury, to the employees of contractor, of all sums which the contractor agreed to pay or collected or deducted from the wages of employees pursuant to any law, contract or agreement for the purpose of providing payment for such service.

(7) With certain exceptions listed below, contractor shall not require or permit any person to work more than 10 hours in any one day, or 40 hours in any one week except in case of necessity, emergency, or where public policy absolutely requires it, and in such cases the person shall be paid at least time and a half for:

(a) All overtime in excess of eight hours a day or 40 hours in any one week when the work week is five consecutive days, Monday through Friday, or

(b) All overtime in excess of 10 hours a day or 40 hours in any one week when the work week is four consecutive days, Monday through Friday, and

(c) All work performed on the days specified in ORS 279B.020(1) for non-public improvement contracts or ORS 279C.540(1) for public improvement contracts.

For personal/professional service contracts as designated under ORS 279A.055, instead of (a) and (b) above, a laborer shall be paid at least time and a half for all overtime worked in excess of 40 hours in any one week, except for individuals under these contracts who are excluded under ORS 653.010 to 653.261 or under 29 U.S.C. Sections 201 to 209, from receiving overtime. Contractor shall follow all other exceptions, pursuant to ORS 279B.235 (for nonpublic improvement contracts) and ORS 279C.540 (for public improvement contracts), including contracts involving a collective bargaining agreement, contracts for services, and contracts for fire prevention or suppression. For contracts other than construction or public improvements, this subsection (7) does not apply to contracts for purchase of goods or personal property. Contractor must give notice to employees who work on a

public contract in writing, either at the time of hire or before commencement of work on the contract, or by posting a notice in a location frequented by employees, of the number of hours per day and days per week that the employees may be required to work.
(8) The hourly rate of wage to be paid by any contractor or subcontractor to employed workers or other persons doing or contracting to do all or part of the work contemplated by the public works contract shall be not less than the applicable prevailing rate of wage for an hour's work in the same trade or occupation in the locality where such labor is performed, in accordance with ORS 279C.838 and ORS 279C.840. For projects also covered by the federal Davis-Bacon Act (40 USC §3141 et seq.), contractors and subcontractors shall pay workers or others performing work contemplated by the contract the higher of the state or federal prevailing rate of wage, as determined by the Commissioner of the Bureau of Labor and Industries in accordance with ORS 279C.830.
(9) The contractor, its subcontractors, if any, and all employers working under the contract are subject employers under the Oregon Workers' Compensation Law and shall comply with ORS 656.017, or otherwise be exempt under ORS 656.126.
(10) As to public improvement and construction contracts, Contractor shall comply with all applicable federal, state, and local laws and regulations, including but not limited to those dealing with the prevention of environmental pollution and the preservation of natural resources that affect the performance of the contract. A list of entities who have enacted such laws or regulations is found in the Oregon Standard Specifications for Construction, Section 00170.01 currently in effect and published through Oregon Department of Transportation. If new or amended statutes, ordinances, or regulations are adopted, or the contractor encounters a condition not referred to in the bid document not caused by the contractor and not discoverable by reasonable site inspection which requires compliance with federal, state, or local laws or regulations dealing with the prevention of environmental pollution or the preservation of natural resources, the contractor shall immediately give notice to the County. The County and the contractor shall have all the rights and obligations specified in ORS 279C.525 to handle the situation.
(11) The contract may be canceled at the election of County for any substantial breach, willful failure or refusal on the part of contractor to faithfully perform the contract according to its terms. The County may terminate the contract by written order or upon request of the contractor, if the work cannot be completed for reasons beyond the control of either the contractor or the County, or for any reason considered to be in the public interest other than a labor dispute, or by reason of any third party judicial proceeding relating to the work other than one filed in regards to a labor dispute, and when circumstances or conditions are such that it is impracticable within a reasonable time to proceed with a substantial portion of the work. In either case, for public improvement contracts, if the work is suspended but the contract not terminated, the contractor is entitled to a reasonable time extension, costs and overhead per ORS 279C.655. Unless otherwise stated in the contract, if the contract is terminated, the contractor shall be paid per ORS 279C.660 for a public improvement contract.
(12) If the County does not appropriate funds for the next succeeding fiscal year to continue payments otherwise required by the contract, the contract will terminate at the end of the last fiscal year for which payments have been appropriated. The County will notify the contractor of such non-appropriation not later than 30 days before the beginning of the year within which funds are not appropriated. Upon termination pursuant to this clause, the County shall have no further obligation to the contractor for payments beyond the termination date. This provision does not permit the County to terminate the contract in order to provide similar services or goods from a different contractor.
(13) By execution of this contract, contractor certifies, under penalty of perjury that:
(a) To the best of contractor's knowledge, contractor is not in violation of any tax laws described in ORS 305.380(4), and
(b) Contractor has not discriminated against minority, women or small business enterprises in obtaining any required subcontracts.
(14) Contractor agrees to prefer goods or services that have been manufactured or produced in this State if price, fitness, availability or quality are otherwise equal.
(15) Contractor agrees to not assign this contract or any payments due hereunder without the proposed assignee being first approved and accepted in writing by County.

(16) Contractor agrees to make all provisions of the contract with the County applicable to any subcontractor performing work under the contract.
(17) The County will not be responsible for any losses or unanticipated costs suffered by contractor as a result of the contractor's failure to obtain full information in advance in regard to all conditions pertaining to the work.
(18) All modifications and amendments to the contract shall be effective only if in writing and executed by both parties.
(19) The contractor certifies he or she has all necessary licenses, permits, or certificates of registration (including Construction Contractors Board registration or Landscape Contractors Board license, if applicable), necessary to perform the contract and further certifies that all subcontractors shall likewise have all necessary licenses, permits or certificates before performing any work. The failure of contractor to have or maintain such licenses, permits, or certificates is grounds for rejection of a bid or immediate termination of the contract.
(20) Unless otherwise provided, data which originates from this contract shall be "works for hire" as defined by the U.S. Copyright Act of 1976 and shall be owned by the County. Data shall include, but not be limited to, reports, documents, pamphlets, advertisements, books, magazines, surveys, studies, computer programs, films, tapes, and/or sound reproductions. Ownership includes the right to copyright, patent, register and the ability to transfer these rights. Data which is delivered under the contract, but which does not originate therefrom shall be transferred to the County with a nonexclusive, royalty-free, irrevocable license to publish, translate, reproduce, deliver, perform, dispose of, and to authorize others to do so; provided that such license shall be limited to the extent which the contractor has a right to grant such a license. The contractor shall exert all reasonable effort to advise the County, at the time of delivery of data furnished under this contract, of all known or potential invasions of privacy contained therein and of any portion of such document which was not produced in the performance of this contract. The County shall receive prompt written notice of each notice or claim of copyright infringement received by the contractor with respect to any data delivered under this contract. The County shall have the right to modify or remove any restrictive markings placed upon the data by the contractor.
(21) If as a result of this contract, the contractor produces a report, paper, publication, brochure, pamphlet or other document on paper which uses more than a total 500 pages of 8 1/2" by 11" paper, the contractor shall conform to the Lane County Recycled Paper Procurement and Use policy, LM 2.440 through 2.448, by using recycled paper with at least 25% post-consumer content which meets printing specifications and availability requirements.
(22) The Oregon Standard Specifications for Construction adopted by the State of Oregon, and the Manual on Uniform Traffic Control Devices, each as is currently in effect, shall be applicable to all road construction projects except as modified by the bid documents.
(23) As to contracts for lawn and landscape maintenance, the contractor shall salvage, recycle, compost or mulch yard waste material in an approved site, if feasible and cost-effective.
(24) As to public improvement contracts for demolition, the contractor shall salvage or recycle construction and demolition debris, if feasible and cost-effective.
(25) When a public contract is awarded to a nonresident bidder and the contract price exceeds $10,000, the contractor shall promptly report to the Department of Revenue on forms to be provided by the department the total contract price, terms of payment, length of contract and such other information as the department may require before the County will make finalpayment on the contract.
(Revised by Order No. 98-12-2-4, Effective 12.2.98; 04-6-30-12, 6.30.04; 05-2-16-8, 2.28.05; 05-12-14-9, 1.1.06; 08-2-13-1; 2.13.08; 09-12-15-2, 12.15.09)
Revised 12.15.09

Special Federal Requirements Required Contract Provisions

REQUIRED FEDERAL TERMS AND CONDITIONS

CONTRACTOR shall comply with the following federal requirements. For purposes of this Agreement, all references to federal and state laws are references to federal and state laws as they may be amended from time to time.

1. **Miscellaneous Federal Provisions.** CONTRACTOR shall comply with all federal laws, regulations, and executive orders applicable to the Agreement or to the delivery of Services. Without limiting the generality of the foregoing, CONTRACTOR expressly agrees to comply with the following laws, regulations and executive orders to the extent they are applicable to the Agreement: (a) Titles VI and VII of the Civil Rights Act of 1964, as amended, (b) Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, (c) the Americans with Disabilities Act of 1990, as amended, (d) Executive Order 11246, as amended, (e) the Health Insurance Portability and Accountability Act of 1996, (f) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended, (g) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, *as* amended, (h) all regulations and administrative rules established pursuant to the foregoing laws, (i) all other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations, (j) all federal law governing operation of Community Mental Health Programs, including without limitation, all federal laws requiring reporting of Client abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to the Agreement and required by law to be so incorporated. No federal funds may be used to provide Services in violation of 42 USC 14402.

2. **Equal Employment Opportunity.** If this Agreement, including amendments, is for more than $10,000, then CONTRACTOR shall comply with Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in Department of Labor regulations (41 CFR Part 60).

3. **Clean Air, Clean Water, EPA Regulations.** If this Agreement, including amendments, exceeds $100,000 then CONTRACTOR shall comply with all applicable standards, orders, or requirements Issued under Section 306 of the Clean Air Act (42 U.S.C. 7606), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act) (33 U.S.C. 1251 to 1387), specifically including, but not limited to Section 508 (33 U.S.C. 1368). Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 32), which prohibit the use under non-exempt Federal contracts, grants or loans of facilities included on the EPA List of Violating Facilities. Violations shall be reported to DHS, IRIS and the appropriate Regional Office of the Environmental Protection Agency.

4. **Energy Efficiency.** CONTRACTOR shall comply with applicable mandatory standards and policies relating to energy efficiency that are contained in the Oregon energy conservation plan issued in compliance with the Energy Policy and Conservation Act (42 USC 6201 et seq) (Pub.

L. 94-163).

5. **Truth in Lobbying.** The CONTRACTOR certifies, to the best of the CONTRACTOR's knowledge and belief that:

   a. No federal appropriated funds have been paid or will be paid, by or on behalf of CONTRACTOR, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.

   b. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the CONTRACTOR shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.

   c. CONTRACTOR shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients and subcontractors shall certify and disclose accordingly.

   This certification is a material representation of fact upon which reliance was placed when this Agreement was made or entered into. Submission of this certification is a prerequisite for making or entering into this Agreement imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

6. **HIPAA Compliance.** If the Services funded in whole or in part with financial assistance provided under this Agreement are covered by the Health Insurance Portability and Accountability Act or the federal regulations implementing the Act (collectively referred to as HIPAA), CONTRACTOR agrees to deliver the Services in compliance with HIPAA. Without limiting the generality of the foregoing, Services funded in whole or in part with financial assistance provided under this Agreement are covered by HIPAA. CONTRACTOR shall comply with the following:

   a. **Privacy and Security Of Individually Identifiable Health Information.** Individually Identifiable Health Information about specific individuals is confidential. Individually Identifiable Health Information relating to specific individuals may be exchanged between CONTRACTOR and COUNTY or CONTRACTOR and DHS for purposes directly related to the provision of services to Clients which are funded in whole or in part under this Agreement. However, CONTRACTOR shall not use or disclose any Individually Identifiable Health Information about specific individuals in a manner that would violate the DHS Privacy Rules, OAR 410-014-0000 *et. seq.,* or the DHS Notice of Privacy Practices, if done by DHS. A copy of the most recent DHS Notice of Privacy Practices is posted on the DHS web site at http://www.dhs.state.or.us/policy/admin/privacylist.htm, or may be obtained from DHS. CONTRACTOR shall adopt and implement reasonable administrative, physical and technical safeguards to protect the security of Client information consistent with DHS Security Policies applicable to Information Users, which policies can be found at http://www..dhs.state.or.us/policy/admin/infosecuritylist.htm.

   b. **Data Transactions Systems.** If CONTRACTOR intends to exchange electronic data

transactions with COUNTY or DHS in connection with claims or encounter data, eligibility or enrollment information, authorizations or other electronic transaction, including the use of direct data entry through eXPRS, shall comply with the DHS EDI Rules.

c. **Consultation and Testing.** If CONTRACTOR reasonably believes that the CONTRACTOR's , COUNTY's or DHS's data transactions system or other application of HIPAA privacy or security compliance policy may result in a violation of HIPAA requirements, CONTRACTOR shall promptly consult COUNTY's or DHS's HIPAA officer. CONTRACTOR, COUNTY or DHS may initiate a request for testing of HIPAA transaction requirements, subject to available resources and the COUNTY's or DHS's testing schedule.

7. **Resource Conservation and Recovery.** CONTRACTOR shall comply with all mandatory standards and policies that relate to resource conservation and recovery pursuant to the Resource Conservation and Recovery Act (codified at 42 USC 6901 et. seq.). Section 6002 of that Act (codified at 42 USC 6962) requires that preference be given in procurement programs to the purchase of specific products containing recycled materials identified in guidelines developed by the Environmental Protection Agency. Current guidelines are set forth in 40 CFR Part 247.

8. **Substance Abuse Prevention and Treatment.** To the extent CONTRACTOR provides any Service whose costs are paid in whole or in part by the Substance Abuse, Prevention, and Treatment Block Grant, CONTRACTOR shall comply with federal rules and statutes pertaining to the Substance Abuse, Prevention, and Treatment Block Grant, including the reporting provisions of the Public Health Services Act (42 USC 300x through 300x-66). Regardless of funding source, to the extent CONTRACTOR provides any substance abuse prevention or treatment services, CONTRACTOR shall comply with the confidentiality requirements of 42 CFR Part 2.

9. **Audits**. CONTRACTOR shall comply with the applicable audit requirements and responsibilities set forth in the Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations."

10. **Debarment and Suspension.** CONTRACTOR assures that they are not listed and that CONTRACTOR shall not permit any person or entity to be a Provider if the person or entity is listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal Procurement or Nonprocurement Programs" in accordance with Executive Orders No. 12,549 and No. 12,689, "Debarment and Suspension". (See 45 CFR part 76). This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and contractors declared ineligible under statutory authority other than Executive Order No. 12549. CONTRACTOR shall require all Providers with awards that exceed the simplified acquisition threshold to provide the required certification regarding their exclusion status and that of their principals prior to award.

11. **Medicaid Compliance.** To the extent CONTRACTOR provides any Service whose costs are paid in whole or in part by Medicaid, CONTRACTOR shall comply with federal and state Medicaid statutes and regulations applicable to the Service, including but not limited to:

a. In accordance with 42 USC 1396(a)(2) and 42 CFR 431.107(b)(1) & (2), keeping such records as may be necessary to disclose the extent of services furnished to Clients and, upon request, furnish such records or other information to DHS, the Medicaid Fraud Control Unit of the Oregon Department of Justice and the Secretary of Health and Human Services;

b. Complying with all applicable disclosure requirements set forth in 42 CFR Part 455, Subpart B and 42 CFR 1002.3(a);

c. Complying with any applicable advance directive requirements specified in 42 CFR section 431.107(b)(4);

d. Complying with the certification requirements of 42 CFR sections 455.18 and 455.19;

e. Each time a Service is denied, terminated, suspended or reduced, a notice of intended action must be issued to the affected Client at least 10 calendar days before the date of the action unless there is documentation that the Client had previously agreed to the changes. CONTRACTOR shall maintain a grievance system that provides for notices of intended action and Client decision notices and informs Clients of their right to a state fair hearing for Services that complies with the requirements for fair hearings concerning "actions" consistent with 42 CFR Part 431 Subpart R CONTRACTOR shall maintain documentation of all Client complaints and hearing requests, the resolution and the date of resolution. CONTRACTOR shall cooperate with DHS's ombudsmen and hearing representatives in all DHS's activities related to Client complaints and hearing requests, and

f. Entities receiving $5 million or more annually (under this contract and any other Medicaid contract) for furnishing Medicaid health care items or services shall, as a condition of receiving such payments, adopt written fraud, waste and abuse policies and procedures and inform employees, contractors and agents about the policies and procedures in compliance with Section 6032 of the Deficit Reduction Act of 2005, 42 LISC § 1396a(a)(68).

12. **ADA.** CONTRACTOR shall comply with Title II of the Americans with Disabilities Act of 1990 (codified at 42 USC 12131 et. seq.) in the construction, remodeling, maintenance and operation of any structures and facilities, and in the conduct of all programs, services and training associated with the delivery of Services.

13. **Pro-Children Act.** CONTRACTOR shall comply with the Pro-Children Act of 1994 (codified at 20 USC section 6081 et. seq.).

HEALTH AND HUMAN SERVICES
RFP Scoring Recap Sheet #20458

Program Area	CHCLC	**Project Title**	Electronic Health Record - Primary Care
Prepared by	Collette Christian	**Evaluation Date**	Final scoring on 5/xx/2011
LOI/RFP Publication Date	7/23/2010	**Publication Name**	Register Guard & Oregonian

PHASE I ELIMINATION

Proposer Name	**Reason**	**COMMENTS**
Allscripts Professional	no budget	failed threshold
Tidgwell Software	high cost	failed threshold

PHASE II maximum 350

Proposer Name	**Score**	**Rank**	
GE Centricity	244.2	6	
CySolutions (Greenway)	250.08	5	
EClinical Works	321.08	1	presented 12/7/10, eliminated*
InteGreat/Med 3000	215.13	7	
NextGen	307.75	2	presented 12/7/2010
OCHIN	265.33	4	presented 11/30/2010
Sage	304.08	3	presented 11/30/2010

*Providers declined to consider system further, too complex

PHASE III maximum 450

Proposer Name	Score	Rank
NextGen	380.1	1
OCHIN	365	3
SAGE	303.7	2

Proposer Recommended for Award:
NextGen