Addendum #1

Project #2703

Outpatient Appointment Reminder System

Health & Human Services

September 27, 2024

Request for Proposal

See original specification packet for addresses

THIS ADDENDUM IS ISSUED TO MODIFY, EXPLAIN OR CORRECT THE ORIGINAL DRAWINGS AND SPECIFICATIONS AND IS HEREBY MADE PART OF THE CONTRACT DOCUMENTS. THIS ADDENDUM MUST BE ACKNOWLEDGED ON THE ADDENDUM RECEIPT SCHEDULE, WHICH WAS INCLUDED IN THE ORIGINAL DOCUMENT PACKAGE.

Vendors are required to read entire addendum to determine requirements affecting their contract.

Addendum #1

This addendum is to answer questions received for the project.

Questions:

See attached document

PROPOSAL DUE DATE

10/18/24 BY 3:00 P.M. CST

Questions	Answers
Can you further explain/provide additional details the project objective "ask consumers to confirm financial/insurance information and/or complete a variety of forms prior to appointment date, such as: Is the desire to pull the financial information entered in financial eigibilbility and/or cross financial eligibility in Avatar and display/send to the client to confirm?	We could go one of two ways: 1) extract existing info and solicit a confirmation, or 2) ask a simplified yes/no "has your insurance information changed?" and only further ask for details if they answer yes. We're open to best practices in this area.
What are you expecting to occur if the client does not have financial eligibility and/or cross financial eligibility in Avatar? For example, is the desire for the client to enter insurance information into a form and have it interface into Avatar?	Yes, ideally we would get insurance info but at this time, no desire to directly interface to Avatar financial/cross - we'd rather have a billing person scrub and validate.
If yes, will the information be stored to a custom form?	Could be, or would be open to something more temporary
How many forms are you wanting the client to complete prior to the appointment?	This will vary based on new client/existing client, and the last time certain renewable forms were renewed (example: consent to treat needs to be re-signed annually ... most are annual).
Will the forms completed prior to the appointment save to Avatar as final? Or do they need to save as draft for someone to review?	Open to best practices, but would want to strive for FINAL,
Do you need the ability to send the client an ad-hoc form? Or do have "packets" of forms that are sent at specific intervals?	Yes, it would be an advantage to control ad-hoc what forms are solicited. There are standard groupings (packets) of forms related to new client interactions. We're mostly concerned with those that must be renewed regularly.
Is it acceptable for the appointment reschedule process to write to a custom form in Avatar and display appointments that need to be rescheduled in a widget for the schedulers or send a to-do to the schedulers?	Yes - however remember we're not particularly interested at this time in offering cancel/confirm/request reschedule. We very much drive requests to cancel/reschedule to phone calls.
How are you planning on identifying appointment reminder with no option to respond? (i.e. by client, service code, etc.)	By client and service code.
Are you looking to host the solution or for a vendor hosted solution?	A vendor hosted solution.
Is there a defined retention period for data collected via the application after it is transferred to the EHR (Avatar)?	There is not, but would estimate minimum 90 days to ensure we have all necessary data successfully transferred to our EHR.
Emergency Cancelation of appts - What is the workflow that is being envisioned?Ex: Do you plan to update the appointments in Avatar and want that transmitted to the app and messages sent to the client? Do you want functionality in the app to mark cancelations and have that send out messages and update the status in Avatar? or something else?	We're accustomed to handling the trigger to send emergency cancelations within the appointment reminder platform, then working our EHR to accomodate some inefficiencies with the scheduling calendar. We're open to suggestions/best practices.
Does your instance of Netsmart Avatar support anything other than a file export of the appointments? FHIR API? What data is available about the patient and appointment on the file export?	We prefer the control level of staff utilizing a file export at this time. There are options to support APIs but we're hoping to avoid that expense at this time.
Do you wish to notify the patient when they are ready to be seen once they arrive for their appointment via text?	No
Should patient queue displays be used to show patients that they are in the waiting room and when they are called for service?	No
What languages are needed in both forms and in the app screens?	English, Hmong, Spanish at a minimum - more options would be happily accepted.
Does staff use the application to navigate the patient through their visit steps?	No
What is the plan for the patient to indicate their “arrival’ for the appointment?	That is handled by our reception staff and EHR.

Questions	Answers
How complex are your forms? Can you provide some examples?	Most are a simple signature and signature date on an attestation statement. Some will ask an additional 1-5 dictionary or free text questions. The forms include Consent to Treat, Authorization to Release PHI, etc. **We have attached an example release form.**
Does the County require/prefer a particular pricing format or can each vendor choose to put their pricing in any format they choose (so long as it meets the requirements outlined in the RFP Attachment B)?	Pricing in any format as long as it meets the RFP requirements.
Would the County like to see any value add items?	No
Please expand on what is meant by “secure email”	That the data stored in the email system is protected from unauthorized access and that the vendor makes all necessary efforts to protect it following best practices and reputable frameworks. It would be helpful to see information on your security measures and policies.
Please expand on what is meant by “Confirmation and or changes to …” if more then just a Y / N response.	A Yes/No response would suffice.
What digital signatures are acceptable – typically, confirmation is in the form of “respond Y to confirm or N to cancel” What, beyond this option is your intention?	This section was related to consents and authorization forms, not the appointment itself.
Would this be a desired future enhancement? Meaning, providing access to “MyChart” or a “quality of service survey” for examples on the appointment reminder?	No
Would this be a desired future enhancement? Meaning, providing the ability to CHAT with staff via voice and or digital exchange – or with an AI enhanced virtual agent?	No
Would this be a desired future enhancement? • Consumer ability to reschedule appointments on their own (a cancel response with or without request to reschedule is sufficient, we do not wish to make provider schedules available real-time for consumers to select their own new appointment).	No
Would this be a desired future enhancement? The ability to maintain overall appointment data within your product (our EHR, Avatar, will continue to be our “source of truth” for appointments and appointment history).	No
Is this solution to be a cloud environment or something other like a hybrid solution.	Cloud
Regarding "Ensure system provides for 128-bit data encryption where applicable." Is the encryption to be for both email and voice? Is it your expectation that SMS text also be encrypted?	It would be our expectation that any HIPPA data digitally communicated meets the HIPPA encryption requirements. This would absolutely include voice.
Regarding "Ensure system can operate in a virtualized environment (an interface to BCHHS’s current EHR, myAvatar NX from Netsmart, is preferred)." Will the APIs for the above be made available to responders?	Potentially, but will be pricing dependent.

BROWN COUNTY HEALTH & HUMAN SERVICES/COMMUNITY TREATMENT CENTER
3150 GERSHWIN DRIVE, GREEN BAY, WI 54311 (920) 391-4700; FAX (920) 391-4731

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION - REIMBURSEMENT PURPOSES

______________________________ _______________ ____________________
CLIENT NAME *MEDICAL RECORD #* *DATE OF BIRTH*

I authorize to disclose protected health information to my treating providers, health plans, third-party payers, and people helping to operate this program.

I authorize Brown County Health & Human Services/Community Treatment Center to release information to my insurance company/ies and any of its' review agencies for the purpose of obtaining insurance benefits to pay for my treatment, collecting/authorizing insurance benefits, or for authorization of additional sessions to include all such future uses or disclosures for those purposes.

If I do not authorize billing my insurance, I acknowledge that I will be responsible for payment of services.

Assignment of Benefits

For services performed, I allow Brown County Health & Human Services/Community Treatment Center to receive any insurance benefits meant for covering expenses. I agree that these benefits will be paid directly to Brown County Health & Human Services/Community Treatment Center and that this agreement cannot be changed without Brown County Human Services/Community Treatment Center's permission.

Dates of Information to be disclosed: From: __________________ To: __________________

The type and amount of information to be used or disclosed may include: client name, date and type of services, diagnosis, and records related to mental health, substance abuse, and/or HIV/AIDS related tests or reports.
☐ Check here if you do not want HIV test results (if they exist) to be released.

Expiration: Unless otherwise revoked, this authorization will remain in force for 1 year, or until the purpose for which it is given is fulfilled, or it will expire on the following date, event, or condition:________________________

I am authorizing the release of information that may not have yet been collected. I understand that authorizing the disclosure of this health information is voluntary and I am under no obligation to sign this form and that the covered entity may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I also understand that if I fail to sign or revoke this release and payments for services are denied, I may be responsible for the balance. I understand that I may inspect or receive a copy of this form and information to be used or disclosed (a reasonable fee may apply). I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy standards. For 42 CFR Part 2 Substance use patient treatment records (or information contained in the record) may be redisclosed in accordance with the permissions contained in the HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient. Upon request, a list of disclosures can be provided. I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request. I understand that I have a right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to the authorization. The consent is subject to revocation at any time except to the extent that the part 2 program or other lawful holder of patient identifying information that is permitted to make the disclosure has already acted in reliance on it. This included the provision of treatment services in reliance on a valid consent to disclose information to a third-party payer. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Billing Department. I understand that revocation of consent may result in my being responsible for the payment of any balance for my treatment.

I understand that if I have questions about disclosure of my health information for reimbursement purposes, I can contact the Billing Department at (920) 391-4740.

____ ____________________
Client Signature Date

____ ____________________
Personal Representative (State Relationship) Date

____ ____________________
Witness Signature Date

Revised: 3/2003; 9/2009; 2/2010; 8/2012; 6/2014; 12/2015; 2/2019; 7/2023; 9/2024