State of New Hampshire
Department of Health and Human Services

REQUEST FOR INFORMATION #RFI-2018-DBH-07-DEVEL
FOR
Development and Implementation of an Integrated Data Management System for Acute Psychiatric Patient Transfer and Inpatient Bed Tracking

July 26, 2017
REQUEST FOR INFORMATION

1. Purpose and Overview

This Request for Information (RFI) is issued by the New Hampshire Department of Health and Human Services’ (“DHHS” or “Department”), Division for Behavioral Health (DBH), to solicit information regarding solutions to develop and implement an integrated data management system to manage and track inpatient beds and facilitate the referral, assessment and transfer of patients in need of acute psychiatric inpatient services.

1.1. Purpose

During the 2017 legislative session, the New Hampshire General Court, through HB517, made investments to improve the State’s mental health system. These improvements include but are not limited to:

(1) Establishing up to 20 additional designated receiving facility (DRF) beds for up to two years to serve individuals with severe mental illness who meet the criteria for involuntary emergency admission;

(2) Adding transitional and community residential beds with wrap-around services and supports;

(3) Adding a mobile crisis team and apartments in a geographic location that has high rates of admissions to and discharges from New Hampshire Hospital (NHH);

(4) Developing and implementing an integrated data management system to provide real-time information about the availability of involuntary and voluntary inpatient psychiatric beds in New Hampshire; and

(5) Conducting an independent evaluation of the capacity of the current health system in New Hampshire to respond to inpatient, acute psychiatric needs of patients, including but not limited to those patients who require involuntary emergency admissions.

This Request for Information (RFI) is published to solicit information that may inform the Department’s approach to the development and implementation of the integrated data management system referenced in (4) above.
1.2. Overview

While this RFI focuses on a particular component of the overall statewide system of care for patients receiving psychiatric treatment, approaches to develop and implement an integrated data management system must take into consideration the New Hampshire health care landscape, which is currently in a state of significant transition. Numerous improvements are being sought, developed or are being implemented by various providers, treatment sites, and state agencies. These efforts may be underway due to state or federal mandates or funding sources, or may be voluntarily pursued by providers and treatment sites on an individual or collaborative basis.

In New Hampshire, currently there are two primary methods for patients to receive psychiatric inpatient treatment:

- Voluntary basis.
- Involuntary emergency basis.

For children, the process is largely voluntary because approval of the guardian is generally given and avoids the need for court-ordered intervention. Both of these methods, and the legal framework and processes that support them, are also under review at this time. Changes to this framework and processes may be identified or implemented within the next two to four years.

2. Objectives

2.1. Preliminary Objectives

2.1.1. The Department’s preliminary objectives for an integrated data management system that will greatly reduce the number of patients waiting within an emergency department setting for entry to a psychiatric bed include:

2.1.1.1. **Developing a highly responsive system to provide real time or near real time information sharing.** Initially, the information may be limited to inpatient psychiatric bed inventory and availability, and move in subsequent phases to include the transfer of patient information to support triage and transfer processes, etc. Must be able to receive and transfer information to and from participating treatment providers/sites.

2.1.1.2. **Develop a highly scalable system to achieve right-sized interoperability with treatment sites’ EMRs, networked data transfer tools, and shared care plans in potentially subsequent phases of development.** This may include, but is not limited to:

2.1.1.2.1. The system transferring protected health information to help coordinate services and triage of patient treatment need.
2.1.1.2.2. Elimination of redundancies.
2.1.1.2.3. Improvements in patient outcomes.
2.1.1.2.4. Improvements to the timeliness of patient transfer between treatment sites.

2.1.1.3. **Reduce manual processes.** While HB517 requires that the system addresses the availability and tracking of inpatient psychiatric beds, in practicality this is informed by the flow of patients and by the prompt triage of the patient's treatment needs and decisions to transfer patients between sites. The proposed solution should have the ability to accommodate future add-on functional capacities to reduce manual processes that impact the flow of patients, potentially including the collection of information needed to assess patients, ensure patient and quality of care, the transfer of medication lists, and the transfer of this information between provider and treatment site systems.

2.1.1.4. **Accommodate a variety of users accessing the solution in various settings and with various devices, and through multiple platforms.** The solution developed must be able to accommodate potentially hundreds of users who will have varying degrees of input and access privileges into the system, and who will access the system through devices ranging from stationary computer stations, desktop computers, to smartphones and tablets.

2.2. **RFI Objectives**

2.2.1. Evaluate vendor supplied information to conduct a comparative analysis of the possible solutions to aid in determining the optimal approach to system design.

2.2.2. Identify possible automated solutions for improved management of essential patient triage and treatment site transfer options.

2.2.3. Utilize information collected to facilitate the evaluation of the feasibility and cost/benefit of suggested approaches for the development and implementation of a solution.

2.2.4. Collect information to better understand opportunities for interoperability of the solution with other providers’ and treatment sites’ systems serving psychiatric patients.

2.2.5. Identify new technology, best practices and business initiatives to be considered in the solution planning process.

2.2.6. Evaluate vendor supplied information to conduct a comparative analysis to improve reporting capability.
3. Concept of Operations

3.1. Timeliness

3.1.1. To improve the ability for patients to receive the appropriate level of inpatient psychiatric treatment on a timely basis, the New Hampshire General Court has authorized the Department to develop and implement an integrated data system to better manage these processes. The integrated data management system, once fully implemented, must be of sufficient complexity to effectively support the ability for patient triage and transfer.

3.1.2. Also authorized within HB517 is a dedicated mental health medical supervisor who will be employed by the Department to collect and report information regarding patients in need of high acuity mental health treatment and information regarding treatment options. The mental health medical supervisor will be clinically qualified to assist in the triage for appropriate inpatient, partial hospitalization, and/or community based services, including individuals awaiting inpatient psychiatric treatment within the emergency department setting on an involuntary basis.

3.2. Other Factors to Consider

3.2.1. Under the New Hampshire Building Capacity for Transformation (NHBCT) Demonstration Medicaid section 1115(a) Waiver, seven (7) Integrated Delivery Networks (IDNs) are currently in development. All CMHCs and the majority of hospitals are connected to an IDN. Together, all seven IDNs are pursuing Health Information Technology standards for all IDN partners. The IDNs have selected a system for the shared care plan component of this demonstration.

3.2.2. NHH is in the process of implementing Care Connect, which will provide networked data transfer tool functionality with its EMR to actively exchange permitted information with other treatment providers. NHH will be entering into formal agreements with willing hospitals and emergency departments to securely share electronic medical information of patients, as necessary, in order to streamline and support prompt, quality treatment. As the project progresses, the number of hospitals without an electronic means to share such information will decrease but there is no guarantee all hospitals will participate.

3.2.3. Users of the integrated data management system will have varying levels of access depending on the system’s functional capacity and user roles and responsibilities within the health care delivery system.

3.2.4. The integrated data management system developed must be device independent and able to accommodate users accessing the system from a stationary device to mobile devices, including smartphones.
3.2.5. Because individuals experiencing a medical emergency due to a substance use disorder (SUD) may similarly need access to an inpatient psychiatric or other treatment bed, there is the potential that the scope of the integrated data management system may, at some point in the future, be expanded to include coordinating bed capacity in SUD treatment sites and users of the system may be expanded to include SUD treatment sites and service providers.

3.2.6. The Department encourages and is seeking input into the development of this solution from external stakeholders and likely end-users.

3.2.7. The Department intends to ultimately select an approach that optimizes treatment provider participation, eliminates redundancies, is interoperable and avoids system redesign for the EMR, shared care plans, and networked data transfer tools projects already underway within the treatment site and provider communities.

3.2.8. The integrated data management solution developed and implemented must have the ability to integrate, to the extent practicable, with the evolving health care system. For this reason, a phased in approach that can flexibly accommodate the variety of different users, and varying functional capacities of treatment providers’ own EMRs likely to be encountered in the future two to five years, is most desirable.

3.2.9. The solution will also likely require the following additional supports:

3.2.9.1. User profile management/
3.2.9.2. Training for users.
3.2.9.3. System protocols and associated policy development.
3.2.9.4. Business agreement management between the State and accessing treatment sites and providers.
3.2.9.5. Consulting services to support the implementation of the system.

3.2.10. Funding for system development to meet the baseline requirements is not currently specified. Funding for additional, future capacity is may involve future state budget cycle consideration.

3.2.11. Baseline functionality of the integrated data management system is targeted for January 1, 2018 operational capacity.
3.3. Multiuse System

3.3.1. The Department envisions a multiuse system available at varying degrees by the Department and other resources, providers and stakeholders, as identified in Section 5.2 below.

3.3.2. The illustration below indicates potential users of the integrated data management system.

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4. Solution Approaches

4.1. High Quality Solution

4.1.1. The State seeks to gather information from a variety of vendors to aid it in evaluating approaches to ensure a high quality solution is ultimately developed to support and streamline the patient flow between treatment sites and track available inpatient psychiatric beds.

4.1.2. Information provided should take the following information into
consideration:

4.1.2.1. The manual processes currently in use by a variety of stakeholders.

4.1.2.2. Multiple inputs and inputting entities involved in the management and tracking of patients awaiting entry to an inpatient psychiatric bed.

4.1.2.3. Discharge processes used to ensure transition to a step-down treatment site or community based program is successful.

4.1.3. The State is considering the merits of the following approaches:

4.1.3.1. Integrating the baseline requirements into an existing system operating in New Hampshire or one under development in New Hampshire’s health care delivery system.

4.1.3.2. Fulfilling the baseline requirements with a commercial off-the-shelf (COTS) product.

4.1.3.3. Multi-phased solution development and implementation such as:

4.1.3.3.1. **Phase I:** Fulfillment of the baseline requirement – an integrated data management system that provides real-time or near real-time information about the availability of involuntary and voluntary inpatient psychiatric beds in the state of New Hampshire.

4.1.3.3.2. **Phase II:** Adding patient specific information to support and streamline triage and transfer from one treatment site to another.

4.1.3.3.3. **Phase III:** Adding patient specific information to support and streamline discharge out of an inpatient psychiatric bed.

4.1.3.3.4. **Phase IV:** Transfer of various legal documentation to expedite completion of court-involved processes.

4.1.3.3.5. **Phase V:** Transfer of information to health insurance payer to support care coordination efforts.

4.1.3.3.6. **Phase VI:** Data analytics to support tracking of patient and bed statistics.

4.1.3.3.7. **Phase VII:** SUD bed capacity incorporated.

4.1.3.4. Development and implementation of a comprehensive integrated solution.

4.1.3.5. Fulfilling multiple business requirements to create a more robust interoperable data management system with a COTS
product.

4.1.3.6. A hybrid of any combination of the above.

4.1.4. Concise, conceptual responses are sought which will inform the Department of the options available, estimates of cost and implementation timeframes.

4.1.5. The Department seeks to gain a better understanding of the available approaches. Vendors and stakeholders may submit a response that includes one or more proposed solutions. However, responses should separately address all applicable information sought in Section 4.1.3 of this RFI as it pertains to each solution.

4.2. Business Requirements

4.2.1. The following business requirements have been preliminarily identified for the integrated data management system.

4.2.1.1. Visualizations and dashboards to provide quick, easy access to inpatient bed availability information, patient queue data, etc.

4.2.1.2. Interoperability with treatment sites and providers to accommodate the transfer of patient information for triage and transfer purposes. The solution should accommodate treatment site acceptance or deferral of a patient transfer.

4.2.1.3. Bed inventory management, including but not limited to:

4.2.1.3.1. Treatment site characteristics/restrictions.

4.2.1.3.2. Bed-specific characteristics/restrictions.

4.2.1.3.3. Actual bed availability status – ideally updated automatically upon patient transfer but with the ability to be determined by the treatment site if a bed needs to be taken offline temporarily for staffing shortages, repairs, etc.

4.2.1.4. Patient specific information transfer between treatment sites and providers, such as:

4.2.1.4.1. Name.

4.2.1.4.2. DOB.

4.2.1.4.3. Gender.

4.2.1.4.4. Partial SSN.

4.2.1.4.5. Type of admission and discharge (voluntary, involuntary, conditional discharge, revoked conditional discharge).

4.2.1.5. Patient status updates to track, at a patient level, the
progression through the triage and transfer process. This status is not to track clinical status updates.

4.2.1.6. Event notification to alert applicable users of bed and patient status changes.

4.2.1.7. Data analytics and reporting capacity to support canned and ad-hoc reporting.

4.2.1.8. Secure transfer of supporting documentation needed for admission and discharge, such as:
   4.2.1.8.1. Medication list,
   4.2.1.8.2. Care coordination.
   4.2.1.8.3. Court documents.
   4.2.1.8.4. Guardian documents.

4.2.1.9. Solution complies with all applicable federal and state regulations regarding protected health information, parity.

4.2.1.10. Solution must be device independent.

4.2.1.11. Solution must have ability to quickly onboard new user accounts and cease access to terminated user accounts.

5. Background Information

5.1. Division for Behavioral Health

5.1.1. The Division for Behavioral Health (DBH) oversees and coordinates Department of Health and Human Services programs and policies for mental health services and substance use disorder services. DBH oversees and manages the following New Hampshire service systems, which provide services to both children and adults:

5.1.1.1. Bureau of Mental Health Services (BMHS) - Community based mental health services for adults.

5.1.1.2. Bureau for Children’s Behavioral Health (BCBH) - Children’s behavioral health services.

5.1.1.3. Bureau of Drug and Alcohol Services Substance (BDAS) – drug and alcohol use prevention and disorder treatment and recovery services for adults and children.

5.1.1.4. New Hampshire Hospital (NHH) and Glencliff Home - Inpatient psychiatric treatment facilities for children and adults.

5.2. Other Resources, Providers and Stakeholders

5.2.1. Designated Receiving Facilities (DRF) – five DRF facilities – including New Hampshire Hospital – currently exist to receive and treat patients in need of psychiatric services. Patients admitted to
New Hampshire Hospital are usually on an involuntary emergency admission (IEA) basis. Patients admitted to other DRFs may be admitted on a voluntary or involuntary basis.

5.2.2. **Community Mental Health Centers (CMHCs)** – ten CMHCs are the primary deliverers of community based mental health services for adults and children.

5.2.3. **Hospital Emergency Departments (ED)** – emergency departments receive patients experiencing an emergency need for acute psychiatric treatment.

5.2.4. **Hospitals** – eleven of the state’s community hospitals have voluntary psychiatric beds.

5.2.5. **Substance Use Disorder (SUD) Providers** – a network of SUD community based service providers deliver a variety of SUD services at varying levels of care.

5.2.6. **Health Insurance Payers** – New Hampshire currently has two Medicaid Managed Care Organizations, and three private payers that join efforts with the State to effectuate prompt treatment and transfer of patients. Out of state insurance payers may also be involved.

5.2.7. **New Hampshire Courts** - Courts hear and rule on petitions for involuntary emergency admissions.

5.3. **Concerns with Current Processes**

5.3.1. Patients waiting for entry into an inpatient psychiatric bed are typically monitored in the ED setting within a community hospital. EDs may lack sufficient psychiatric treatment expertise and physical and professional safeguards necessary to best accommodate the needs of a patient experiencing a psychiatric emergency within that setting.

5.3.2. During the last two years, the daily number of individuals waiting for access to an inpatient psychiatric bed averaged between 32-46 individuals. Contributing factors to the high number of patients awaiting entry, include but are not limited to:

5.3.2.1. A limited number of psychiatric beds.
5.3.2.2. A shortage of step-down treatment sites.
5.3.2.3. Complex manual processes.
5.3.2.4. Workforce shortages.
5.3.2.5. Communication barriers.

5.3.3. Within HB517, the Department has been authorized to:

5.3.3.1. Increase step-down treatment sites and beds.
5.3.3.2. Increase the number of designated receiving facility beds.
5.3.3.3. Increase the number of mobile crisis teams.

5.3.3.4. Conduct a capacity assessment and gap analysis to inform the development of additional improvements to the mental health and substance use disorder systems of care.

5.3.4. The integrated data management solution to be developed pursuant to HB517 is intended to greatly reduce the number of patients in the ED setting who are waiting for access to a psychiatric bed.

6. **Current Methods For Accessing Psychiatric Inpatient Beds**

This RFI addresses both voluntary and involuntary methods for accessing a psychiatric inpatient bed, and differentiates system needs between the voluntary and involuntary status. However, approaches to develop and implement an integrated data management system, as referenced in Section 1.1, should take into consideration the New Hampshire health care landscape, which is currently in a state of significant change.

6.1. **Voluntary System**

6.1.1. A variety of providers, insurance payers and treatment sites may interact with each other to appropriately address patient needs for access to a psychiatric inpatient bed. These interactions are not currently managed or facilitated by a centralized system or entity.

6.1.2. Psychiatric inpatient beds for voluntary admissions may be dedicated for that purpose by the treatment site or may be available for involuntary admission at the treatment site’s discretion.

6.1.3. Current reporting of voluntary psychiatric inpatient bed availability is provided on a voluntary basis by several treatment sites to the New Hampshire Hospital Association (NHHA). The NHHA tracks this information through its Knowledge Center application and releases this information to authorized individuals throughout the state.

6.1.4. Although children requiring inpatient psychiatric treatment may be voluntarily referred, their access to New Hampshire Hospital is typically managed in alignment with the involuntary system process due to their clinical needs.

6.2. **Involuntary System**

6.2.1. New Hampshire Hospital (NHH) serves as a central point within the involuntary system. NHH is a State-operated 168 bed acute, inpatient psychiatric hospital that serves children, adults and the elderly who need active treatment.

6.2.2. NHH manages a queue to track those individuals awaiting admission to NHH or another Designated Receiving Facility (DRF); it is the flow of these patients to and from NHH or another DRF that impacts the number of involuntary beds available within New Hampshire at any
point of time each day.

6.2.3. NHH receives referrals for adult patients who have a court order for involuntary emergency admission to NHH or a DRF. Most adult patients awaiting admission to NHH or another DRF may be receiving interim care in one of the state’s 26 EDs.

6.2.4. Other patients receive services in the community through one of the state’s 10 Community Mental Health Centers (CMHC). These patients are referred for admission on an involuntary basis based on a violation of a previously issued Conditional Discharge (CD). For such patients, a Revoked Conditional Discharge (RCD) allows the patient to be held in an ED as they await admission to NHH or another DRF (if applicable).

6.3. Voluntary and Involuntary Basis - Children

6.3.1. In New Hampshire, although there is a legal process for an involuntary emergency admission for children, often parents or guardians authorize voluntary admission.

6.3.2. NHH receives referrals for children from EDs in a fashion similar to that described in Section 3.2.3 and Section 3.2.4, above. There are dedicated NHH beds for children at the Anna Philbrick Center within NHH.

6.4. New Hampshire Hospital Referral Management

6.4.1. NHH has relied on a series of manual processes to manage and track the assessment, transfer and admission of patients from one setting to another as well as their subsequent discharge to a step down treatment site or to community based services. As part of that process, the recording and identification of filled and unfilled inpatient psychiatric beds for involuntary emergency admissions at each facility is tracked and updated two to three times a day.

6.4.2. Tracking of individual patients is managed directly between the applicable providers/sites, including the transfer of key protected health information (PHI) necessary to facilitate the determination of an appropriate treatment site.

6.4.3. NHH, CMHCs, and EDs do not currently operate through a uniform system, nor do they have uniform electronic health records. Transfer of PHI is not uniform across all entities. Due to the constantly changing status of patients and available beds at the statewide level, the tracking and distribution of patient and bed information to the applicable providers and sites may negatively impact provider ability to quickly and efficiently identify the appropriate treatment site for a patient and effectuate a prompt transfer.

7. Treatment Sites and Patients Served
7.1. New Hampshire Hospital

7.1.1. New Hampshire Hospital (NHH) staff work together with treatment providers at other treatment sites to assess the patients for admission into NHH or to consider patient transfer to another treatment site. Annually, over 1,000 patients are admitted to NHH, and over 2,000 are assessed for admission.

7.1.2. Treatment is provided to patients within the acute psychiatric hospital setting, and treatment updates are typically provided to the applicable community based treatment providers.

7.1.3. Discharge of patients is planned and coordinated with applicable community based treatment providers and applicable step-down treatment sites.

7.2. Designated Receiving Facilities

7.2.1. Designated Receiving Facility (DRF) staff work together with New Hampshire Hospital staff and emergency department staff, if applicable to the patient, and community treatment providers to assess patients for admission into the DRF or to consider patient transfer to another treatment site. Annually, over 2,400 patients are admitted to New Hampshire’s DRFs.

7.2.2. Treatment is provided to patients within the DRF setting, and treatment updates are typically provided to the applicable community based treatment providers.

7.2.3. Discharge of patients is planned and coordinated with applicable community based treatment providers, applicable step-down treatment sites, or with NHH for transfer and admission to NHH.

7.3. Emergency Departments (EDs)

7.3.1. ED staff work together with NHH staff, DRF staff, step-down facility staff and community treatment providers to refer patients for admission into the most appropriate treatment site or to conduct discharge planning for patients who stabilize to a level not requiring acute psychiatric inpatient treatment. Annually, over 2,000 patients enter an ED experiencing a psychiatric emergency.

7.3.2. Initial evaluation of patients occurs within the ED setting, and patient assessment updates are typically provided to the applicable treatment site the ED is recommending. In some settings, treatment may be initiated within the ED setting, coordinated with applicable community based treatment providers.

7.3.3. Discharge of patients is planned and coordinated with applicable community based treatment providers, applicable step-down treatment sites, or with DRFs and NHH for transfer and admission to the applicable treatment site.
8. Technical and Manual Environment

8.1. Inpatient Psychiatric Bed Availability

8.1.1. The Knowledge Center application is currently utilized to identify the number of filled and available inpatient psychiatric beds by location. The application primarily uses a spreadsheet format with data entered manually. It is administered through the New Hampshire Hospital Association.

8.1.2. The inventory is updated two to three times per day, and e-mailed to providers throughout the state.

8.1.3. Through community hospitals, access to the inventory is granted. No patient or PHI is included.

8.2. New Hampshire Hospital

8.2.1. NHH’s EMR is Avatar. The Care Connect functionality referenced in Section 1.1.5. is anticipated to be in operation beginning in the fall of 2017; Netsmart Technologies, Inc. is the Department’s contracted vendor.

8.3. Bureau of Mental Health Services

8.3.1. Phoenix is an Oracle database that tracks Community Mental Health Center client services and client demographic data over time. The data is updated monthly. The Phoenix database contains date of birth (DOB), gender, and truncated versions of Social Security Numbers and client names. From these client level features, the Bureau of Mental Health Services can join Phoenix to any other data source so long as it also has the SSN, DOB, client initials and gender. Data can only be loaded in Phoenix by New Hampshire DoIT. Reports can only be retrieved by DHHS employees with permission from the Electronic Data Warehouse (EDW) team.

8.3.2. To support quality assurance efforts to ensure patients within New Hampshire’s mental health system receive quality services and treatment, the integrated data management system would ideally be able to provide data to the Phoenix system.

9. RFI and Requested Responses

9.1. RFI Is Not an RFP

9.1.1. This RFI is for information purposes only, and is not intended to result in a contract or vendor agreement with any respondent. This RFI is not a Request for Proposals, Bids, or Applications. The State is seeking vendor community insight and information prior to finalizing business, functional, operational, and technical requirements prior to considering the publishing of a Request for Proposal (RFP).
9.1.2. This RFI does not commit the State to publish a RFP or award a contract. The issuance of an RFP, as a result of information gathered from these responses, is solely at the discretion of the State. Should an RFP be issued, it will be open to qualified vendors, whether those vendors choose to submit a response to this RFI. This RFI is not a pre-qualification process.

9.1.3. Once information from this RFI is fully evaluated, and depending on funding and other factors, a Request for Proposals (RFP) may be published by the Department to select a vendor for specific work to be performed which could potentially result in a contract after the completion of the RFP scoring process. Nevertheless, the issuance of any RFP in the future does not commit the Department to award a contract.

9.2. RFI Responses

9.2.1. The State is seeking a better understanding in the areas listed below, and requests responding vendors to provide a response to each of the following questions.

9.2.1.1. Vendor Organization/Experience

Q1. Briefly describe the Vendor’s organization, client base, financial stability and history. Please keep generalized marketing material to a minimum.

Q2. With which cyber security national standards does the Vendor’s organization/product comply?

Q3. Describe any experience/expertise specific to the proposed approaches in Section 4.1.3 within the Vendor’s organization.

Q4. Describe the Vendor’s relevant experience, with emphasis in the area of developing and implementing a solution of at least similar size, scope, and complexity as New Hampshire, as well as familiarity with related technologies.

Q5. Provide the Vendor’s experience with adherence to state standards, minimization of impact on state staff, and minimization of impact on providers. Additionally, describe the Vendor’s experience staffing a project of this size with the Vendor’s personnel.

Q6. Provide an overview of the Vendor’s experience with commercial off-the-shelf (COTS) products for similar systems.

9.2.1.2. Proposed Approaches

Q7. Provide an overview of the technology and service offerings that the Vendor currently provides. Provide a breakdown of the number of customers served currently by the Vendor’s various product offerings.

Q8. The State is interested in a comparative analysis of the advantages and disadvantages of the five most probable approaches, which have been identified in Section 4.1.3.
Q9. Describe the Vendor’s recommended approach to converting existing manual and technological processes to a new solution. In doing so, describe the basic strategy and the specific tasks required to execute the conversion.

Q10. Provide the Vendor’s analysis/recommendations for one or all of the proposed approaches.

Q11. Describe how this data system could interact and integrate with current data systems such as Electronic Medical Records.

Q12. Describe what functional capabilities must be in place to ensure the system is efficient and effective for end users outlined in this RFI.

9.2.1.3. Training/Support/Reporting

Q13. Describe the training you believe would be require for all users with varying access to the integrated data management system.

Q14. Describe the levels and frequency of support that should be provided pre and post implementation.

Q15. Define the levels of Department resources that would be needed pre and post implementation.

Q16. Explain the levels and frequency of the support that should be provided by the Department after successful implementation.

Q17. Describe the process involved in obtaining ad-hoc reports.

Q18. Describe the type and variety of canned reports that would be available from the system.

9.2.1.4. Areas of Concern

Q19. Every project has certain inherent risks. Describe the significant risk factors associated with all outlined solutions and how they should be mitigated.

Q20. What other suggestions or recommendations does the Vendor have to ensure the development and implementation of this system is successful?

Q21. Define any areas of concern that are related to hardware requirements.

Q22. Define any areas of concern that are related to hardware or infrastructure capacity.

Q23. Define any areas of concern that are related to software interoperability.

Q24. Are there additional questions or concerns that are important for the Department to consider with regard to developing and implementing an integrated data management system as described in this RFI? What are those questions and/or concerns?
10. Notices

10.1. Contact Information – Sole Point of Contact

The sole point of contact for this RFI relative to the submission of requested information for this RFI, from the RFI issue date until the potential publication of an RFP, if ever, is:

State of New Hampshire
Department of Health and Human Services
Denise Sherburne, Contracts Specialist
Contracts & Procurement
Brown Building
129 Pleasant Street
Concord, NH 03301
Email: Denise.Sherburne@dhhs.nh.gov
Phone: (603) 271-9540

Other state personnel are NOT authorized to discuss this RFI before the submission deadline. The State will not be held responsible for oral responses to vendors regardless of source.

10.2. Request for Information Timetable

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<tr>
<td>1.</td>
<td>Release RFI</td>
<td>07/26/2017</td>
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<td>2.</td>
<td>RFI vendor questions due</td>
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<td>3.</td>
<td>DHHS answers to RFI vendor questions posted</td>
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<td>4.</td>
<td>RFI Submissions due at DHHS</td>
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All times are according to Eastern Time. DHHS reserves the right to modify these dates at its sole discretion.

10.3. Vendor Questions and Answers

10.3.1. Vendor Questions

All questions about this RFI, including but not limited to requests for clarification, additional information or any changes to the RFI must be made in writing, citing the RFI page number and part or subpart, and submitted to the Procurement Coordinator identified in Section 10.1.

DHHS may consolidate or paraphrase questions for efficiency and clarity. Questions that are not understood will not be answered. Statements that are not questions will not receive a response.

DHHS will not acknowledge receipt of questions.
The questions may be submitted by fax or e-mail; however, DHHS assumes no liability for assuring accurate and complete e-mail transmissions. Questions must be received by the deadline given in Section 10.2 Request for Information Timetable.

10.3.2. DHHS Answers

DHHS intends to issue responses to properly submitted questions by the deadline specified in Section 10.2 Request for Information Timetable. Oral answers given are non-binding. Written answers to questions submitted will be posted on online at (http://www.dhhs.nh.gov/business/rfp/index.htm). This date may be subject to change at DHHS’ discretion.

10.4. RFI Amendment

DHHS reserves the right to amend this RFI, as it deems appropriate prior to the submission deadline on its own initiative or in response to issues raised through vendor questions. In the event of an amendment to the RFI, DHHS, at its sole discretion, may extend the submission deadline. The amended language will be posted on the DHHS Internet site.

10.5. RFI Response Submission

10.5.1. RFI responses submitted in response to this RFI must be received no later than the time and date specified in Section 10.2. RFI responses must be addressed for delivery to the Sole Point of Contact listed in Subsection 10.1. Responses must be marked with RFI-2018-DBH-07-DEVEL.

10.5.2. Delivery of the Vendor’s submission shall be at the Vendor’s expense. The time of receipt shall be considered when a Vendor’s submission has been officially documented by DHHS, in accordance with its established policies, as having been received at the location designated in Subsection 10.1. The State accepts no responsibility for mislabeled mail. Any and all damage that may occur due to shipping shall be the Vendor’s responsibility.

10.6. Non-Collusion

The Vendor’s required signature on the Transmittal Cover Letter for a submission in response to this RFI guarantees they have been established without collusion with other Vendors and without effort to preclude DHHS from obtaining the best possible competitive proposal, should the Department publish an RFP.

10.7. Collaborative Submissions

Submissions must be made by one organization

10.8. Property of Department

All material property submitted and received in response to this RFI will become the property of DHHS and will not be returned to the Vendor. The Department
reserves the right to use any information presented in any submission provided that its use does not violate any copyrights or other provisions of law.

10.9. RFI Response Withdrawal

Prior to the Closing Date for receipt of submissions, a submission may be withdrawn by submitting a written request for its withdrawal to Sole Point of Contact identified in Section 10.1.

10.10. Public Disclosure

10.10.1. Any information submitted as part of a response to this RFI may be subject to public disclosure under RSA 91-A. In addition, in accordance with RSA 9-F:1, should an RFP be published by the Department, and a contract awarded, that information will be made accessible to the public online via the website Transparent New Hampshire (www.nh.gov/transparenthnh/). Accordingly, business financial information and proprietary information such as trade secrets, business and financial models and forecasts, and proprietary formulas may be exempt from public disclosure under RSA 91-A:5, IV.

10.10.2. Insofar as a Vendor seeks to maintain the confidentiality of its confidential commercial, financial or personnel information, the Vendor must clearly identify in writing the information it claims to be confidential and explain the reasons such information should be considered confidential. This should be done by separate letter identifying by page number and RFI section number the specific information the Vendor claims to be exempt from public disclosure pursuant to RSA 91-A:5.

10.10.3. Each Vendor acknowledges that DHHS is subject to the Right-to-Know Law New Hampshire RSA Chapter 91-A. DHHS shall maintain the confidentiality of the identified confidential information insofar as it is consistent with applicable laws or regulations, including but not limited to New Hampshire RSA Chapter 91-A. In the event DHHS receives a request for the information identified by a Vendor as confidential, DHHS shall notify the Vendor and specify the date DHHS intends to release the requested information. Any effort to prohibit or enjoin the release of the information shall be the Vendor's responsibility and at the Vendor's sole expense. If the Vendor fails to obtain a court order from a court of competent jurisdiction enjoining the disclosure, DHHS may release the information on the date DHHS specified in its notice to the Vendor without incurring any liability to the Vendor.

10.11. Non-Commitment

Notwithstanding any other provision of this RFI, this RFI does not commit DHHS to publish an RFP or award a Contract. DHHS reserves the right to reject any and all RFI submissions or any portions thereof, at any time and to cancel this RFI and to solicit new or additional information under a new RFI process.
10.12. Liability

Vendors agree that in no event shall the State be either responsible for or held liable for any costs incurred by a Vendor in the preparation or submittal of or otherwise in connection with their submission.

10.13. Request for Additional Information or Materials

During the period from date of RFI Response submission to the date of RFP publication, if that should occur, DHHS may request from any Vendor additional information or materials needed to clarify information presented as part of their submission. Such a request will be issued in writing.


DHHS reserves the right to request some or all Vendors to make oral presentations based upon their submission. Any and all costs associated with an oral presentation shall be borne entirely by the Vendor. Vendors may be requested to provide demonstrations of any proposed solutions. Such a request will be in writing.

10.15. Site Visits

DHHS reserves the right to request a site visit for DHHS staff to review Vendor’s organization structure, subcontractors, policy and procedures, and any other aspect of the RFI submission that directly affects the provisions of the RFI and the delivery of services. Any and all costs associated with the site visits incurred by the Vendor shall be borne by the Vendor.

11. RFI Response Submission Outline and Requirements

11.1. Presentation and Identification

11.1.1. Overview

11.1.1.1. Vendors are expected to examine all documentation and other requirements.

11.1.1.2. Submissions must conform to all instructions, conditions, and requirements included in the RFI.

11.1.1.3. Vendors are requested to address all questions in Section 10, RFI Requested Response, and agree to the conditions specified throughout the RFI.

11.1.1.4. Submissions should be received by the date and time specified in the Request for Information Timetable, Subsection 11.2, and delivered, under sealed cover, to the Procurement Coordinator specified in Subsection 11.1.

11.1.1.5. Fax or email copies will not be accepted.

11.1.2. Presentation

11.1.2.1. Original Submission in a three-ring binder.
11.1.2.2. One (1) electronic copy on CD or Thumb Drive.

11.1.2.3. Major sections of the Submission separated by tabs.

11.1.2.4. Standard eight and one-half by eleven inch (8 ½” x 11”) white paper.

11.1.2.5. Font size of 10 or larger.

11.1.3. Submission of Information

11.1.3.1. Original Submission marked as “Original.”

11.1.3.2. The original Transmittal Letter (described in Section 4.2.1.1) must be the first page of the Submission and marked as “Original.”

11.1.3.3. 1 electronic copy (divided into folders that correspond to and are labeled the same as the hard copies). NOTE: In the event of any discrepancy between the copies, the hard copy marked “Original” will control.

11.1.3.4. Front cover labeled with
   a. Name of company / organization
   b. RFI#
   c. Submission of Information

11.2. Outline and Detail

11.2.1. Submission Contents – Outline

Each Submission shall contain the following, in the order described in this section (Each of these components must be separate from the others and uniquely identified with labeled tabs.):

11.2.1.1. Transmittal Cover Letter
   The Transmittal Cover Letter must be:
   a. On the Vendor organization’s letterhead;
   b. Identify the name, title, telephone number, and e-mail address of the person who will serve as the Vendor’s representative for all matters relating to the RFI;

11.2.1.2. Table of Contents
   The required elements of the Submission shall be numbered sequentially and represented in the Table of Contents.

11.2.1.3. Executive Summary
   The Vendor shall submit an executive summary to:
   a. Provide DHHS with an overview of the Vendor’s organization;
   b. Demonstrate the Vendor's understanding of the potential solutions
described in this RFI and any anticipated problems associated with each;

c. Show the Vendor’s overall design of the potential solution(s); and
d. Specifically demonstrate the vendor’s familiarity with the potential solutions’ elements, and the Vendor’s solutions to the problems presented.

11.2.1.4. RFI Requested Response

The Vendor is asked to answer all questions and include all items requested in Section 10. The Vendor should address every section of Section 10, RFI Requested Response.

Responses must be in the same sequence and format as listed in Section 10 and must, at a minimum, cite the relevant section, subsection, and paragraph number, as appropriate.

11.2.1.5. Description of Organization

Vendors must include in their submission a summary of their company’s organization, management and history and how the organization’s experience demonstrates the ability to meet the needs of requirements in this RFI.

At a minimum, the Vendor must respond to:

a. General Company Overview
b. Ownership and Subsidiaries
c. Company Background and Primary Lines of Business
d. Number of Employees
e. Headquarters and Satellite Locations
f. Current Project commitments
g. Instances of whether proposed solutions were implemented
h. Mission Statement

This section must include information on:
a. The programs and activities of the organization;
b. The number of people served; and
c. Programmatic accomplishments.