Emergence Health Network
El Paso Center for Mental Health/Intellectual Disabilities

201 E. Main Ave. Suite 600
El Paso, TX 79901
(915) 887-3410
Fax: (915) 351-4703

Request for Application
Open Enrollment

Request for application will be received at Emergence Health Network-9609 Carnegie, El Paso, Texas 79925 on an on-going basis.

Request for application must be received in an envelope and marked:

**"Behavioral Health Telemedicine Services**
**RFA #16-001"**

**Do not contact the requesting department. There will be a pre-application conference on February 2, 2016 at 201 E. Main Suite 600, El Paso, Texas 79901 and by Conference call to 1-866-528-2256 Access Code: 2685928. Any questions or additional information required by interested vendors must be emailed to: bidquestions@ehnelpaso.org before February 2, 2016 at 12:00 p.m. RFA number and title must be on the "Subject Line" of the email. Attempts to circumvent this requirement may result in rejection of the proposal as non-compliant.**

Any changes in the specifications will be posted on the EHN website as an addendum. **It shall be the applicant's responsibility to check the website prior to submitting an application to verify whether any addendums have been posted.** Website: www.emergencehealthnetwork.org; Bids and more.

In order to remain active on the Emergence Health Network Vendor list, each vendor receiving this invitation for application must respond in some form. Vendors submitting application must meet or exceed all requirements herein. Vendors not responding to the request must submit their reason in writing to the Emergence Health Network.

# EHN SIGNATURE PAGE

**Behavioral Health Telemedicine Services**
**RFA #16-001**

Vendor must meet specifications

Please do not include tax, as EHN is tax-exempt. We will sign tax exemption certificates covering these items. **Please submit one (1) original copy** and **two (2) CD copies in Word/PDF Format of your application. CD copies must reflect the original hard copy.**

I or we agree to furnish the following described equipment, supplies, or services for the prices shown in accordance with specifications listed below or attached. By execution of this application, I hereby represent and warrant to Emergence Health Network that I have read and understood the Application Documents and the Contract Documents and this application is made in accordance with the Application Documents.

| | |
|---|---|
| Company | Mailing Address |
| Federal Tax Identification No. | City, State, Zip Code |
| DUNS Number | |
| Representative Name & Title | Telephone Number include area code |
| Signature | Fax Number include area code |
| Date | Email Address |

*****THIS MUST BE THE FIRST PAGE ON ALL APPLICATIONS*****

# Behavioral Health Telemedicine Services
# RFA #16-001

Emergence Health Network

El Paso Center for Mental Health/Intellectual Disabilities

**Date: _____**

**Emergence Health Network**
**as the Local Mental Health Authority**

**Request for Application**
**Open Enrollment**

**Behavioral Health Telemedicine Services**
**RFA# 16-001**

Emergence Health Network (Local Authority) is the Department of State Health Services (DSHS) designated Mental Health Authority established to plan, coordinate, develop policy, develop and allocate resources, supervise, and ensure the provision of community based mental health and intellectual and developmental disability services for the residents of El Paso County, Texas.

**The Local Authority's Mission is:**
Emergence Health Network ensures superior recovery-based services for mental health, developmental disability, and related conditions for the people of El Paso County.

**The Local Authority's Philosophy is:**

- Engage our customers by communicating the benefits of services and recovery
- Celebrate our customers' **strengths** when participating in services
- Foster **hope** in every service delivered
- Demonstrate evidence of our customers' successes toward **recovery**
- Recognize our customers and staff for all achievements made

Pursuant to Texas Administrative Code §412.55 and 412.754, the Local Mental Health Authority has the authority to acquire community services for individuals with mental illness by certain procurement methods. This Request for Applications (RFA) requests proposals from interested persons and organizations (Applicants) for the purpose of entering into one or more contracts (Contracts) to provide effective, evidenced-based behavioral health services to adult clients with mental health illness. The individuals to be served under this arrangement must meet the DSHS definition for the Priority Population for Mental Health, which is included as Attachment A, and must also reside in El Paso County (Clients). This Request for Application is a client choice driven system and there is no warranty or guarantee that successful Applicant will be utilized by a client or any number of clients.

**The goals of any/each Contract awarded under the RFA are**:

1. To provide needed community mental health services as described in Attachment B.
2. To identify, implement and evaluate successful Services based on Client outcomes so that these efforts can be replicated.
3. To create meaningful collaborations between the Local Authority and the health care providers in the community.
4. To provide quality clinical care and achieve the desired outcomes at the most efficient cost possible.
5. To provide smooth transitioning of clients to ensure continuity of care, clinical outcomes, and customer service are not adversely affected.

Successful Applicants will provide Services that build upon and augment existing community resources and that provide for or enhance an existing continuum of care for Clients. The Local Authority will use a pre-defined process to review all proposals at "arms-length", to insure that there is no conflict of interest. Preference will be given to Applicants that are able to provide Services that address the issues of client choice, quality, clinical decision making, and ultimate cost-benefit while assuring adherence to existing standards of care and service definitions.

**Target Population**

The target population for this RFA consists of individuals with mental illness who have been identified by the Local Authority as Priority Population, in accordance with the definitions established by DSHS. (See Attachment A.) Designation of an individual as a member of the Priority Population must be made by the Local Authority and documented in that individual's record.

**Eligible Applicants**

Applicants must be eligible to do business in Texas, and be registered with the Texas Secretary of State to the extent required by Texas law. Professionals must hold valid Texas licenses and/or certifications to the extent required to perform any individual component of the Services. In the situation where a consortium of providers is applying, a single entity responsible for the services delivered must be identified and the financial agent must be an organization with a demonstrated ability to manage funds.

**Local Authority Responsibilities**

The Local Authority 's responsibilities will include, but are not limited to, making appropriate referrals for services, reviewing claims and paying for appropriate, authorizing services rendered by the Successful Applicant. The Local Authority is also responsible for utilization management and quality assurance. The Local Authority ensures that the services address the needs of the Priority Population as required by the State Authority, and that those services comply with the rules and standards adopted under Section 534.052 of the Health and Safety Code. The Local Authority directs its activities based on its mission and values which can be found in on page 1 of this RFA.

The Local Authority will be responsible for determining a client meets the Priority Population definition. The Local Authority must complete a Uniform Assessment on each client and identify the services to be provided. Clients determined to need these services will be offered a choice of providers from the Network.

All services must be authorized by the Utilization Management staff. Quality Management staff will perform regular reviews of clinical services and program standards.

**Rate Schedule**

| | Medicaid | General Revenue | Third Party Payor other than Medicaid |
|---|---|---|---|
| LOCYC | Current Effective Medicaid Rate | Current Effective Medicaid Rate | Current Reimbursement Rate |
| LOC1 | Current Effective Medicaid Rate | Current Effective Medicaid Rate | Current Reimbursement Rate |
| LOC2 | Current Effective Medicaid Rate | Current Effective Medicaid Rate | Current Reimbursement Rate |
| LOC3 | Current Effective Medicaid Rate | Current Effective Medicaid Rate | Current Reimbursement Rate |

**Successful Applicant Responsibilities**

The Successful Applicant(s) shall maintain all records regarding treatment and/or services to Clients under this Contract for a period of seven (7) years, and must allow the Local Authority immediate access during regular business hours to such records upon request. Successful Applicant(s) will be required to comply with all state and federal laws regarding the confidentiality of clients' records and nondiscrimination. Successful Applicant(s) must comply with all applicable requirements of the Local Authority's then-current contract with DSHS. Successful Applicant(s) must also agree that their names may be used, along with descriptions of the

facilities, care, and services in information distributed by the Local Authority in the list of its providers. Successful Applicant(s) will actively assist in the disbursement of Client and advocate satisfaction surveys. Successful Applicant(s) must develop a method to resolve disagreements with clients and stakeholders which will include client involvement. The process for Client appeals and dispute resolution must be approved by the Local Authority. Successful Applicant(s) will be responsible for peer review and quality management. Successful Applicant(s) must agree to mediation if unable to resolve disputes with the Local Authority. Successful Applicant(s) must conform to all guidelines set forth in the Provider Manual which is available for review upon request. Successful Applicant(s) will cooperate and assist with and will not at any time prevent or hinder a client from changing providers. Provider and its employees, as applicable, are responsible, at Provider's sole expense, to comply with all training requirements Local Authority mandates for Successful Applicant.

**Application Instructions**

Applicants must follow the attached outline for submissions to facilitate objective review.

Respondent shall submit original application, identified as the original, and two (2) applications must be received by mail or in person to the address below **:**

EHN
Diana Billingsley
9609 Carnegie
El Paso, Texas 79925

Local Authority reserves the right to reject any and all Proposals, to waive technicalities, and to accept any advantages deemed beneficial to the Local Authority and its clients. It is our intent to evaluate proposals, and negotiate costs and/or services in order to achieve the best value for Local Authority clients. The negotiation process will be done in a confidential manner with no disclosures being made to other Applicants until after the Contract(s) is awarded.

**Timetable:**

| | |
|---|---|
| RFA Issuance | January 25 , 2016 |
| Proposed start date | On-going |

Emergence Health Network reserves the right to modify these dates according to the Emergence Health Network Board of Trustees meeting schedule and at the discretion of the Emergence Health Network Chief Executive Officer. Contract negotiations and Board of Trustees approval may take up to 90 days. Training and credentialing may take an additional 60 days as certain trainings must be provided prior to delivery of service.

**Mental Health-Friendly Workplace:**

A. On September 22, 2005, the Emergence Health Network Board of Trustees approved a Resolution for the Designation of Mental Health Friendly Workplace. This Resolution directs all Emergence Health Network awarded contracts are evaluated for best value, to include the Respondents ability to demonstrate a Mental Health-Friendly Workplace. For the purpose of this Request for Application, Emergence Health Network will review the following elements of a Mental Health-Friendly Workplace:
    1. Respondent welcomes all qualified job applicants and diversity is valued;
    2. Respondent includes health care that treats mental illnesses with the same urgency as physical illness;
    3. Respondent has programs and/or practices that promote and support employee health-wellness and/or work-life balance;
    4. Respondent provides training for managers and front-line supervisors in mental health workplace issues;
    5. Respondent safeguards confidentiality of employee health information;
    6. Respondent provides an Employee Assistance Program (EAP) or other appropriate referral

resources to assist managers and employees;
7. Respondent supports employees who seek treatment or who require hospitalization or disability leave;
8. Respondent ensures "exit with dignity" as a priority, should it become essential for an employee to leave his or her employment;
9. Respondent has reasonable accommodations policy of the Americans with Disabilities Act (ADA); and
10. Respondent provides all-employee communication that promotes an accepting, anti-stigmatizing, anti-discriminating working environment.

B. There is no single "right" picture of a Mental Health-Friendly Workplace. Factors that have a bearing on what will work best for any given business include:
   - The leadership, goals, and values of the business;
   - The culture of the business sector;
   - The culture of the community in which the business operates;
   - The size of the business; and
   - The resources that can be brought to bear from service vendors, the community, and the employees themselves.

C. Whether your business is looking at its mental health friendliness for the first time or taking stock of how well current programs and practices are working, it is important to come back to these questions:
   - What elements of a Mental Health-Friendly Workplace are already in place?
   - How are they working?
   - What are the long- and short-term goals?
   - What are the next priorities and next steps?
   - How will the worth or value of taking these steps be assessed?

D. Specific practices and policies in a workplace that values the health of its employees can be observed, including, of course, practices and policies that promote their mental health and well-being. These practices can positively affect productivity, cost-containment of health care, and employee retention in fact, the entire culture of the business. Some businesses will recognize many of the indicators as descriptors of their own organizations; others will read them as a list of desirable options or components for building a Mental Health-Friendly Workplace. Any business that thinks of itself as being mental health-friendly will have a number of these elements in place.

**Proposal Outline**

Throughout this Proposal Outline, provide detailed information regarding the scope of the Applicant's business. Questions fall under the following sections:

I. Business Demographics
II. Organizational Structure
III. Quality Management/Utilization Management
IV. Services
V. Budget/Financial
VI. Risk Profile
VII. Managed Care Profile
VIII. Information System
IX. Statement
X. Mental Health Friendly Workplace
XI. Assurances Document

Two Attachments are provided as information regarding the Local Authority which may assist in developing the Proposal.

Attachment A -- Priority Population Definitions
Attachment B -- Service Descriptions and Information

Application shall address **one** of the following service options:

| Service Options | Level of Cares |
|---|---|
| Option 1 | YC,1 |
| Option 2 | YC,1,2 |
| Option 3 | YC,1,2,3 |

Please be sure to answer every question. If the question does not apply to the Applicant, simply and clearly document "N/A". Scoring and evaluation is based on completed questions. ALL unanswered questions will be considered omissions. Please limit responses to each question to one double spaced page if possible. Answer all questions in the order of this proposal outline. Use the forms attached or prepare responses in the same format. Clearly designate each item in the document as it appears in this outline (by number, letter, and question). Place tab dividers at the beginning of each section (Roman Numerals) to match those shown above in this Proposal Outline section. The document should be double spaced, type size at least 10 points. The Local Authority reserves the right to review only completed Proposals. The Local Authority reserves the right to hold subsequent face to face or telephone interviews for clarification and/or negotiation purposes. Interviews will not be solicited for the purpose of completing incomplete proposals. Multiple omissions and/or incomplete responses may result in disqualification. All supporting documentation should be attached to the appropriate section of the Proposal and in the order described in this Proposal Outline section.

Questions regarding this proposal should be emailed to bidquestions@ehnelpaso.org . Questions should reference the line number from the RFA. Amendments including questions and answers will be distributed to all those known to have received a copy of the RFA from the Local Authority. Applicants must acknowledge receipt of the amendments and consider these in the final proposal.

False statements by any Applicant may disqualify the Proposal. The Local Authority reserves the right to reject any or all Proposals and reopen the RFA process in total.

Interviews or site visits may be conducted to further evaluate competitive proposals, to negotiate rates, and to select one or more Proposals for award. In this situation, no Applicant will be given information, support, or resources that will give the Applicant a competitive advantage over the other Applicants.

Each Applicant who submits a complete Proposal but is not awarded a Contract will be notified in writing that the proposal is no longer being considered.

**Following Contract award, the contents of all proposals may be made available upon written request. Therefore, any information contained in the proposal that is deemed to be proprietary in nature must clearly be so designated in the proposal. Such information may still be subject to disclosure under the Public Information Act depending on opinions from the Attorney General's office.**

## I. Business Demographics

Name _____
Title of Business _____
SS# _____ and/or Tax ID _____
Address _____
City _____
County _____ Zip Code _____
Business Phone _____ Fax # _____
Website address_____

Contact Person _____
Title _____
Phone # _____ Fax # _____

Billing Address if Different From Above (include Street, City, State, and Zip Code)
_____
_____
Billing Manager _____
Phone # _____ Fax # _____

Other Business Locations in this Market Area: (include Street, City, County, and Zip)
1. _____
2. _____
3. _____
4. _____
Provide a map of locations which specifies the Services provided, capacity and languages spoken (by Service) at each location - Label as **Exhibit IA.**

Other Owners/Partners:

| | Name | % Ownership | If corporate, list organization |
|---|---|---|---|
| 1. | _____ | | |
| 2. | _____ | | |
| 3. | _____ | | |
| 4. | _____ | | |

Type of organization (i.e., non-profit corporation, Limited Liability Company, general partnership, etc.):
_____
_____

Provide a copy of Provider's Articles of Incorporation and 501(c)(3) certificate, or other bylaws/governing documents as appropriate – Label as **Exhibit IB**.

Years in Operation _____
Hours of Operation _____

Certification Number if a Historically Underutilized Business: _____, or qualifications if HUB eligible, but not certified: _____

## II. Organizational Structure

A. Attach a copy of the organizational chart, including names, titles and vacant positions, clearly indicating who will be the main point of contact with respect to any Contract -- Label as **Exhibit IIA**

B. List the names and business affiliations of board members or other governing body:

_____
_____
_____
_____
_____
_____
_____
_____

## III. Quality Management/Utilization Management

A. List all licenses, credentials, certifications, and/or accreditations the Applicant currently holds related to the Services. Provide copies of all licenses, certifications, accreditations -- Label as **Exhibit IIIA**.

B. Provide a copy of the staff roster and their corresponding education and license credentials. Designate if they are full time, part time, or on call. Label as **Exhibit IIIB**.

C. Attach the Applicant's Quality Assurance/Management Plan and Quality Management Program Reports for the last six (6) months -- Label as **Exhibit IIIC**.

D. Describe the Applicant's internal utilization management procedures. Describe methods for ensuring that individuals are receiving services in accordance with internal standards of care. Provide copies of recent reports to payors showing the Applicant's performance relative to its utilization management requirements -- Label as **Exhibit IIID**.

E. Provide a summary of the most recent client satisfaction surveys or other ongoing efforts to obtaining and evaluate client satisfaction -- Label as **Exhibit IIIE**. Describe how this information was obtained.

## IV. Services

A. Describe how Applicant will communicate with the Local Authority regarding the Client referral process, specifically what are the parameters around access.

B. Describe in detail the array of Behavioral Health Services the Applicant would offer under its Proposal. Identify units of Service, where Services are offered, who would provide Services (education and credentials), and the times of day and days of the week the Services would be available. Indicate the capacity of all services. Include a copy of Services schedules and descriptions -- Label as **Exhibit IV**.

C. Describe the frequency and type of in-service training currently offered by the Applicant or provided to employees including, but not limited to, training related to patient rights and standards of services.

D. Describe the Applicant's experience in working with Medicaid and in providing services for persons with severe and persistent mental illness over the last five years. How have services been made accessible for those who are difficult to reach, either due to geography or dissatisfaction with the service delivery system?

E. Describe the Applicant's history of working with this population on an outpatient basis and experience of working with persons who are not compliant with treatment. Describe the ability to treat persons

with disabilities and persons with multiple diagnoses of a developmental disability-mental illness-substance abuse. Detail the specific population the Applicant intends to serve under this Proposal. Include ages and level of severity.

F. Describe the Applicant's ability to work with persons who are hearing impaired, persons who have limited language skills and persons who speak a language other than English. Describe how the Applicant ensures cultural competency on the part of staff with regard to ethnic, racial, religious and sexual orientation differences.

G. Describe or attach policies and procedure which describe any process the Applicant presently has to receive communication from clients, family members and advocates, and to receive and resolve complaints and grievances.

H. Describe any process to transition clients from the Applicant's services as their level of functioning improves.

I. Describe the facility (ies) proximity to public transportation or the Applicant's ability to facilitate access to public transportation.

J. Describe how you will engage and involve clients, legally authorized representatives, and families at the policy and practice levels within your organization.

K. Describe the transition plan between service levels you intend to utilize for Clients.

L. Describe how you will meet the cultural and linguistic needs of the clients in the Local Authority's local service area.

M. Describe where and when you will provide Services within the Local Authority's local service area, and how persons with disabilities will be able to access those Services.

## V. Budget/Financial

A. Attach copies of the Applicant's last three years audited financial reports -- Label as **Exhibit VA2**.

B. Does Applicant own or lease current business properties? If leasing properties, note the upcoming expiration date of the leases.

C. Describe any arrangements to subcontract part or all of these services. All subcontracts must be approved by the Local Authority, in its sole discretion. Name all proposed subcontractors and provide information on their staff credentials, licenses and certifications.

D. If an individual, are any Child Support Payments delinquent? If so, explain in detail.

## VI. Risk Profile

A. Attach a copy of the Risk Management Plan - Label as Exhibit **VIA**.

B. Is Applicant currently under investigation, or had a license or accreditation revoked, by any state/federal/local authority or licensure agency, within the last five (5) years? If yes, explain in detail.

C. Does anyone working for Applicant providing direct care or in management have any felony convictions? If yes, explain. Describe the process, if any, for checking on previous convictions of employees or applicants for employment. Attach any policies and procedures regarding the hiring and

retention of persons with criminal histories -- Label as Exhibit **VIB**. Are criminal history checks done on all Applicant staff annually?

D. Has Applicant had any judgments or settlements entered against it in the last ten (10) years? If so, explain in detail.

E. Has either the Applicant or any of its employees had any validated fraud, client abuse, client neglect, or rights violations claims in the last three (3) years? If so, explain in detail. Describe the process, if any, for checking on previous confirmed fraud, client abuse, client, neglect, or rights violations of employees or applicants for employment, such as through CANRS, the Nurse Aide Registry, and the Employee Misconduct Registry. Describe or attach any current polices and procedures regarding client abuse, client neglect, or rights violations and the training of staff on these issues -- Label as Exhibit **VIC**.

F. Has Applicant been placed on vendor hold within the past five (5) years by any funding agency or company? If yes, explain.

G. Does Applicant have a Letter of Good Standing which verifies that it is not delinquent in payment of Texas State Franchise Tax? Corporations that are non-profit or exempt from Franchise Tax are not required to have this letter, but instead must submit a 501C IRS Exemption form from the Comptroller Office. Attach and label as **Exhibit VID**.

H. Is Applicant currently held in abeyance or barred from the award of a federal or state contract? Has this occurred in the last 5 years? If so, explain.

I. Has Applicant ever filed bankruptcy? If yes, describe in detail.

J. Has Applicant ever defaulted on any business lease arrangement? If so, describe in detail.

K. Provide a Certificate of Insurance showing liability insurance coverage (property and vehicles, including riders) and including directors' and officers' professional liability, errors and omissions, general liability, workers compensation and medical malpractice insurance -- Label as **Exhibit VIE**.

L. Attach any policies and procedures regarding medical records security – Label as Exhibit VIFProvide the name of Workers' Comp carrier if Applicant has Workers' Comp coverage or self funding documents if self funded -- Label as **Exhibit VIF**.

## VII. Managed Care Profile

A. Describe your background and depth of experience with all of the managed care companies with which Applicant currently contracts or has previously contracted. Include the duration of any relationships, numbers of clients served and specific services provided to managed care companies.

B. Provide Applicant's Medicaid Provider number(s). Have these ever been suspended or revoked? If so, explain.

C. Provide Applicant's Medicare Provider number(s). Have these ever been suspended or revoked? If so, explain.

D. Has Applicant ever been dropped from a managed care network? If so, explain.

E. Submit contact information from at least three (3) entities for which Applicant has provided services similar to the Services within the past two years -- Label as **Exhibit VIIA**.

F. Describe any contracts, Memoranda of Understanding, or employment relationships Applicant has with other state, city or county agencies in the El Paso County health care community.

## VIII. Information Systems

Applicant shall be required to utilize LMHA's Cerner system to record behavioral health service delivery.

The applicant's system shall be compatible with the system below:

POYLCOM HDX 7000-720 VIDEO CONFERENCING KIT
Tech Specs

Quick Specs

| | |
|---|---|
| Device Type: | Video conferencing kit |
| Digital Signaling Protocol: | H.323, H.281, SIP, H.225, H.239 |
| Data Compression Protocol: | G.711, G.728, G.722, G.729.A, H.261, H.263, H.264, H.263++, G.722.1, G.722.1C |
| Features: | Auto gain control, echo cancellation |
| Video Input: | Analog video camera - component video output |
| Video Output: | Codec board - 1920 x 1080 |
| Audio Input: | Microphone |
| Input Device: | Remote control ( wireless ) |
| Networking: | Network adapter - Ethernet, Fast Ethernet |
| Power: | AC 120/230 V ( 50/60 Hz ) |

General

| | |
|---|---|
| Device Type: | Video conferencing kit |
| Dimensions & Weight Details: | Main system - Width 5.1 in Depth 11 in Height 13.9 in |

Modem

| | |
|---|---|
| Type: | Wired |
| Digital Signaling Protocol: | H.323, H.281, SIP, H.225, H.239 |
| Data Compression Protocol: | G.711, G.728, G.722, G.729.A, H.261, H.263, H.264, H.263++, G.722.1, G.722.1C |
| Features: | Auto gain control, echo cancellation |

Video Input

| | |
|---|---|
| Type: | Analog video camera ( color ) - external |
| Interface Type: | Component video output |

Digital Video Capture Resolution: 1280 x 720

Video Output

| | |
|---|---|
| Type: | Codec board - external |
| Max External Resolution: | 1920 x 1080 |
| Supported Display Graphics: | XGA (1024x768), SVGA (800x600), HDTV (1920x1080), 1280x720 |
| Analog Video Signal: | S-Video ( NTSC ) |
| Digital Video Standard: | Digital Visual Interface (DVI) |

Audio

| | |
|---|---|
| Audio Input: | Microphone - external |

Input Device

| | |
|---|---|
| Type: | Remote control |

Connectivity Technology: Wireless

Networking
Type: Network adapter
Connectivity Technology: Wired
Data Link Protocol: Ethernet, Fast Ethernet
Features: Manageable
Compliant Standards: UPnP

Expansion / Connectivity
Interfaces
- 1 x video - input
- 1 x video - S-video input - 4 pin mini-DIN
- 1 x video - S-video output - 4 pin mini-DIN
- 1 x video - DVI-Analog/Digital input - 29 pin combined DVI
- 2 x video - DVI-Analog/Digital output - 29 pin combined DVI
- 1 x audio - input - RCA x 2
- 1 x audio - input - mini-phone stereo 3.5 mm
- 1 x audio - line-in - RCA x 2
- 2 x network - Ethernet 10Base-T/100Base-TX - RJ-45
- 1 x serial - RS-232 - 9 pin D-Sub (DB-9)
- 1 x USB - 4 pin USB Type A
- 1 x audio - output - RCA x 2
- 1 x audio - line-out - RCA x 2

Miscellaneous
- 1 x audio cable
- 2 x component video cable
- 1 x network cable

Mounting Kit: Included

Power
Power Device: Power supply - internal
Voltage Required: AC 120/230 V ( 50/60 Hz )

Software / System Requirements
Software Included: People + Content IP, Polycom People On Content

Environmental Parameters
Min Operating Temperature: 32 °F
Max Operating Temperature: 104 °F
Humidity Range Operating: 10 - 80%

## IX. Statement

Provide a statement detailing why Applicant's services best meet the needs of persons with behavioral and primary health concerns. Identify any best practices Applicant is currently utilizing in delivering services similar to the Services sought under this RFA.

List any workload measures or data collected and used that pertains to positive outcomes for this population. Describe training provided to the family members of persons who meet the definition for the Priority Population. Describe how Applicant links services or provides continuity of care with other providers. Describe how Applicant collaborates and shares data with other providers and any limits on this sharing.

State the current organizational mission, values and ethics. Cite any contradictions that may exist between the Applicant's mission and that of the Local Authority. Attach a copy of the mission, values and ethics -- Label as **Exhibit IX.**

## X. Mental Health-Friendly Workplace

The Applicant shall submit narrative demonstrating its commitment as a Mental Health-Friendly Workplace. Please provide in detail all the elements identified in Section entitled Mental Health-Friendly Workplace.

## XI. Assurances Document

Applicant assures the following:

1. That all addenda and attachments to the RFA as distributed by the Local Authority and designated by the checklist have been received.
2. No attempt will be made by the Applicant to induce any person or firm to submit or not to submit a proposal, unless so described in your response document.
3. The Applicant does not discriminate in its services or employment practices on the basis or race color, religion, sex, national origin, disability, veteran status, or age.
4. All cost and pricing information is reflected in the RFA response documents or attachments.
5. Applicant accepts the terms, conditions, criteria, and requirement set forth in the RFA.
6. Applicant accepts the Local Authority's right to cancel the RFA at any time prior to Contract award.
7. Applicant accepts the Local Authority's right to alter the time tables for procurement as set forth in the RFA.
8. The Proposal submitted by the Applicant has been arrived at independently without consultation, communication, or agreement for the purpose of restricting competition.
9. Unless otherwise required by law, the information in the Proposal submitted by the Applicant has not been knowingly disclosed by the Applicant to any other Applicant prior to the notice of intent to award.
10. No claim will be made for payment to cover costs incurred in the preparation of the submission of the Proposal or any other associated costs.
11. Local Authority has the right to complete background checks and verify information.
12. The individual signing this document and the Contract is authorized to legally bind the Applicant.
13. The address submitted by the Applicant to be used for all notices sent by the Local Authority is current and correct.
14. No employee of the Local Authority or DSHS, and no member of the Local Authority's Board will directly or indirectly receive any pecuniary interest from an award of the proposed Contract. If the Applicant is unable to make the affirmation, then the Applicant must disclose any knowledge of such interests.
15. That the Respondent is not currently held in abeyance or barred from the award of a federal or state contract.
16. That the Respondent is not currently delinquent in its payments of any franchise tax or state tax owed to the state of Texas, pursuant to Texas Business Corporation Act, Texas Civil Statutes, Article 2.45.
17. Applicant shall disclose whether any of the directors or personnel of Applicant has either been an employee or a trustee of Local Authority within the past two (2) years preceding the date of submission of the Proposal. This requirement applies to all personnel, whether or not identified as key personnel. If such employment has existed, or at term of office served, the Proposal shall state in an attached writing the nature and time of the affiliations as defined.

18. Applicant shall identify in an attached writing any trustee or employee of Local Authority who has a financial interest in Applicant or who is related within the second degree by consanguinity or affinity to a person having such financial interest. Such disclosure shall include a complete statement of the nature of such financial interest and the relationship, if applicable. Moreover, Applicant shall state in an attached writing whether any of its directors or personnel knowingly has had a personal relationship with employees or officers of Local Authority within the past two (2) years.
19. No former employee or officer of DSHS, DADS, and/or Local Authority directly or indirectly aided or attempted to aid in procurement of Applicant's service.
20. Applicant shall disclose in an attached writing the name of every Local Authority key person with whom Applicant is doing business or has done business during the 365 day period immediately prior to the date on which the Proposal is due; failure to include such a disclosure will be a binding representation by Applicant that the natural person executing the Proposal has no knowledge of any key persons with whom Applicant is doing business or has done business during the 365 day period prior to the immediate date on which the Proposal is due.
21. Under Section 231.006, Family Code, the vendor or applicant certifies that the individual or business entity named in this contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this contract may be terminated and payment may be withheld if this certification is inaccurate. For purposes of the foregoing sentence, "vendor or applicant" shall mean Applicant; contract, bid or application shall mean the Proposal; and "this contract" shall mean any Contract awarded to the Successful Applicant.

_____ _____ _____

Signature Authority for the Provider Title of Organization Date

**Attachment A**

## Mental Health
## Priority Population Definition

The Priority Population for mental health services as defined by DSHS consists of adults who have severe and persistent mental illnesses such schizophrenia, major depression, bipolar disorder, or other severely disabling mental which require crisis resolution or other ongoing and long-term support sand treatment.

The following information must be used to operationalize these definitions to determine if an individual meets this definition. Only the Local Authority may determine an individual is a member of the Priority Population.

### Service Determination

In targeting services to the Priority Population, the choice of and admission to services is determined jointly by the person seeking services and the Local Authority. Criteria used to make these determinations are the diagnosis, the level of functioning of the individual (GAF Score), the needs of the individual, and the availability of resources.

### DSHS Funding

Funds appropriated by the Legislature for mental health services may be spent only to provide services to the Priority Population. Successful Applicants who wish to offer services to people other than those in the Priority Population may do so using non-departmental funds.

**Attachment B**

**TRR Level of Care Definitions And Service Descriptions For Adult Level of Care**

As previously stated, application shall address **one** of the following service options:

| Service Options | Level of Cares |
|---|---|
| **Option 1** | **YC,1** |
| **Option 2** | **YC,1,2** |
| **Option 3** | **YC,1,2,3** |

**Reference to Adult TRR Clinical Guidelines:**
**(See UM Guidelines FY2014 AMH)**

Documentation for services provided as Rehabilitative Services for Persons with Mental Illness must be completed prior to the submission of a claim for payment. Each service unit requires at least minimal documentation of certain key elements:

| Element # | Key Documentation Element |
|---|---|
| 1 | With whom the contact occurred (the consumer or other person). If a person other than the consumer was contacted, the note must identity the consumer on whose behalf the contact was made. |
| 2 | Description of the service that was provided |
| 3 | The date and time of day that the service was delivered (i.e., the start time) |
| 4 | The amount of time that the service was provided. (If the providers want to record both start and stop times, the amount of service will be inferred.) |
| 5 | Who provided the services. This is indicated by the signature of the service provider on the progress note. The signature must include the credentials of professions who deliver a service. In day programs, the person initiating the progress note must sign the note. Day programs must also maintain staff rosters for review. |
| 6 | The setting in which the service was provided (e.g., home, shelter, job site, school, clubhouse, etc.). |
| 7 | The goal or objective of the treatment plan addressed by the service. |
| 8 | Progress or lack of progress in achieving treatment goals/objectives. |

**Attachment C**

**Selection and Notification of Award**

Emergence Health Network Chief Executive Officer shall convene a committee to make the evaluation of applications that result in the recommendation for the selection for award.

The successful Respondent shall receive a written notice of award from Emergence Health Network no later than ten (10) days after selection for award.

Emergence Health Network
El Paso Center for Mental Health/Intellectual Disabilities

# CERTIFICATION REGARDING LOBBYING

## PART A. PREAMBLE

Federal legislation, Section 319 of Public Law 101-121 generally prohibits entities from using federally appropriated funds to lobby the executive or legislative branches of the federal government. Section 319 specifically requires disclosure of certain lobbying activities. A federal government-wide rule, "New Restrictions on Lobbying", published in the Federal Register, February 26, 1990, requires certification and disclosure in specific instances.

## PART B. CERTIFICATION

This certification applies only to the instant federal action for which the certification is being obtained and is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction 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 $100,000 for each such failure.

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No federally appropriated funds have been paid or will be paid, by or on behalf of the undersigned, 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 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, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
2. If any funds other than federally 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 these federally funded contract, subcontract, subgrant, or cooperative agreement, the undersigned shall complete and submit "Disclosure Form to Report Lobbying", in accordance with its instructions.
3. The undersigned shall require that the language of this certification be included in the award documents for all covered subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all covered subrecipients will certify and disclose accordingly.

Do you have or do you anticipate having covered subawards under this transaction?

☐ Yes
☐ No

| **Name of Provider** | **Vendor ID No. or Social Security No.** | **Program No.** |
|---|---|---|
| | | |

| **Name of Authorized Representative** | **Title** |
|---|---|
| | |

_____ _____

Signature – Authorized Representative Date

Emergence Health Network
El Paso Center for Mental Health/Intellectual Disabilities

**201 E. Main Ave.**
**El Paso, TX 79901**
**(915) 887-3410**
**Fax: (915) 351-4703**

RE: Behavioral Health Telemedicine Services RFA# 16-001

Dear Vendor:

All vendors and potential vendors who contract or seek to contract for the sale or purchase of property, goods, or services with any local government entity to complete and submit a Conflicts of Interest Questionnaire. Attached is a copy of the questionnaire.

In filing out the Questionnaire, the following are EHN Officers that will award the application and the employees which will make a recommendation:

| | |
|---|---|
| EHN Officers: | Robert Jacob Cintron, Chair<br>David Stout, Vice-Chair<br>Martin Bartlett, Secretary<br>Michael Escamilla, MD. Trustee<br>Rick Myer, Trustee<br>Pamela Cook-Howard, Trustee<br>Kathleen Peyton, Trustee |
| EHN Employees: | Kristen Daugherty, CEO<br>Pauline Motts, CFO<br>Rene Hurtado, CDO<br>Rene Navarro, CCO<br>Tewiana Norris, CNO<br>Chrystal Davis, COO- Diversion Services<br>Ashley Sandoval, COO-MH Services<br>David Puentes, COO-IDD Services<br>Marcelo Rodriguez-Chevres, MD, CMO<br>Carroll Thornburg, D.O., CMO<br>Juan R. Gonzalez-CIO<br>David Baquera, COO- Addiction Services |
| EHN Employees: | Diana Billingsley, Budget and Operations Accountant |
| Attorney for EHN: | Omar Villa, Assistant El Paso County Attorney |

# CONFLICT OF INTEREST QUESTIONNAIRE — FORM CIQ

**For vendor or other person doing business with local governmental entity**

**This questionnaire reflects changes made to the law by H.B. 1491, 80th Leg., Regular Session.**

This questionnaire is being filed in accordance with Chapter 176, Local Government Code by a person who has a business relationship as defined by Section 176.001(1-a) with a local governmental entity and the person meets requirements under Section 176.006(a).

By law this questionnaire must be filed with the records administrator of the local governmental entity not later than the 7th business day after the date the person becomes aware of facts that require the statement to be filed. *See* Section 176.006, Local Government Code.

A person commits an offense if the person knowingly violates Section 176.006, Local Government Code. An offense under this section is a Class C misdemeanor.

**OFFICE USE ONLY**

Date Received

RFA# 15-023

**1 Name of person who has a business relationship with local governmental entity.**

**2**

☐ **Check this box if you are filing an update to a previously filed questionnaire.**

(The law requires that you file an updated completed questionnaire with the appropriate filing authority not later than the 7th business day after the date the originally filed questionnaire becomes incomplete or inaccurate.)

**3**

**Name of local government officer with whom filer has employment or business relationship.**

_____
Name of Officer

This section (item 3 including subparts A, B, C & D) must be completed for each officer with whom the filer has an employment or other business relationship as defined by Section 176.001(1-a), Local Government Code. Attach additional pages to this Form CIQ as necessary.

A. Is the local government officer named in this section receiving or likely to receive taxable income, other than investment income, from the filer of the questionnaire?

☐ Yes ☐ No

B. Is the filer of the questionnaire receiving or likely to receive taxable income, other than investment income, from or at the direction of the local government officer named in this section AND the taxable income is not received from the local governmental entity?

☐ Yes ☐ No

C. Is the filer of this questionnaire employed by a corporation or other business entity with respect to which the local government officer serves as an officer or director, or holds an ownership of 10 percent or more?

☐ Yes ☐ No

D. Describe each employment or business relationship with the local government officer named in this section.

_____ _____
Signature of person doing business with the governmental entity — Date

Adopted 6/29/2007

# EMERGENCE HEALTH NETWORK

## Solicitation Check List

## Behavioral Health Telemedicine Services RFA# 16-001

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**THIS CHECKLIST IS PROVIDED FOR YOUR CONVENIENCE**

Responses should be delivered to EHN 9609 Carnegie, El Paso, Texas 79925 _____

Did you visit our website (www.emergencehealthnetwork.org) for any addendums? _____

Did you sign the Application? _____

Did you sign the "Certifications Regarding Lobbying" document? _____

Did you provide one original and two (2) CD copies in Word/PDF Format of your response? _____
CD copies must reflect the original hard copy.