

MASSACHUSETTS eHEALTH COLLABORATIVE
HIE RFP FAQs – March 8th 2006

A. General:

Q1: MAeHC has said the RFP went to "selected national" vendors. How many and what firms received the RFP?

A1: The RFP is publicly available on our website and is open to any organization that wishes to respond.

Q2: Which vendor has Northern Berkshire selected?

A2: The North Adams community has chosen to deploy eClinicalWorks EHRs throughout the entire community in a centrally-hosted model. For this reason, eClinicalWorks will be providing HIE functions in that community as well.

Q3: We have a major subcontractor. Should we add them to our letter of intent?

A3: The subcontractor should be identified in the proposal, but not the LOI.

Q4: On Page 12, up to Detailed Requirements, are we supposed to answer those questions and address those needs and answer the detailed requirements, or is the verbiage before Detailed Requirements guiding information for the Detailed requirements section and not meant to be answered.

A4: The responses to the questions in the Detailed Requirements should directly apply to the base functionality and technology description requirements outlined in the introduction of section VII. You are free to respond directly to each bullet of the introduction if you feel that would strengthen your proposal.

B. Budget:

Q5: What is MAeHC's budget for the 24 month term?

A5: We envision funding the creation of a basic HIE architecture in each community, and supporting that infrastructure through the pilot period, which ends on June 30, 2008. The proposal should itemize costs for each component, including prototype development, implementation, and ongoing operations.

C. Roles and Responsibilities:

Q6: Why are there community steering committees rather than one MAeHC central steering committee? Isn't this redundant or is this our misunderstanding and there is intended to be one vendor liaison to the communities?

A6: Each Community Pilot Project is a collaboration between MAeHC and the community. As such, each project is guided in partnership with a local Community Steering Committee. MAeHC will have project management responsibility during the pilot period. Each community will assume responsibility for all aspects of the HIE after the pilot period. Thus, it is essential that the project addresses community needs and goals to enable the creation of a sustainable business model after the pilot period.

Q7: The RFP indicates that the proposal must include, "privacy and security technology and ESSENTIAL WRITTEN POLICIES." We would expect the MAeHC and the community steering committees would establish and articulate privacy and security policies to be implemented. Please clarify.

A7: Privacy and security guidelines that have been developed to date are outlined on Pages 7-9 of the RFP. We expect responses to describe how the vendor's solution will facilitate the implementation of these policies. We will also look favorably on suggestions made by vendors regarding relevant additional policies and associated implementation procedures.

Q8: What will be the make-up of the workgroup that is going to review the RFP proposals?

A8: The MAeHC review committee will comprise industry and technical experts, community representatives and MAeHC staff.

Q9: Who will be responsible for developing and testing the interfaces of these systems with the proposed exchange?

A9: It will be the responsibility of the vendor to develop a specification for interfaces based on open standards identified in the RFP. The MAeHC EHR vendors are contractually committed to developing a "community interface" to the network based on this same set of standards. We expect the vendor to test the interfaces.

D. Scope:

Q10: Will the Collaborative entertain a proposal that proposes a clinical data exchange for either Greater Brockton or Greater Newburyport but not both?

A10: Vendors may apply for either or both communities.

Q11: Is the scope of the project implementation to support the exchange of data just **within** each community or does the scope also include the exchange of data **between** the communities?

A11: The proposal should focus primarily on intra-community (ie, within community) exchange of data. As described on page 6 of the RFP, each approach will be required to have the capability to connect to the planned MA-SHARE state-wide (“inter-community”) “grid”. This “grid” is currently under development. The specifications and implementation guides for the MA-SHARE Record Locator Service are available on the MAeHC website, as described in the RFP.

Q12: Are there any transaction volume estimates or assumptions (for clinical and non-clinical transactions)?

A12: Not at this time.

Q13: In this proposal, it indicates 5 EMR vendors that have been selected. On the web site it identifies 7. Please explain the discrepancy. Similarly, can you list the expected PMS systems to which integration must occur once fully implemented?

A13: The HIE will connect EHRs from the five vendors identified in the RFP. This list of vendors reflects the new installations that MAeHC will deploy plus the installed base of EHRs that already exist in the communities. While MAeHC qualified seven EHR vendors for the pilot project, only a subset of those vendors will be deployed in the first three communities. In addition, the HIE will also connect EHRs that already existed in the communities before the MAeHC project.

The PMS systems will be integrated directly with the EHR and therefore there is no separate effort required for integration of outside PMS systems. The focus of this project is to integrate the EHR systems.

Q14: Would the “outload” of clinical information be sent from a repository, or from each source system or from EMR’s?

A14: There is no pre-existing repository, so the vendor proposal should articulate it’s approach for exchanging information from ambulatory EHRs and hospital-based Meditech systems.

Q15: You mentioned that you wanted EMR – EMR communication? What if the EMR’s you have chosen are not capable of bidirectional communication?

A15: Secure messaging should be addressed in the HIE solution. It is not required that this solution be integrated within the deployed EHR applications.

Q16: It's our assumptions that physicians with EMRs would use the EMRs to view comprehensive patient data. How many users will be using portals?

A16: It is not required that patient data from disparate sources be viewable within each EHR application. The number of users for the physician portal will match the number of physicians participating in our pilot in a given community. The number of users using the patient portal will match the patient population of the community. The vendor should specifically articulate its assumptions about the number of simultaneous users expected from these base user populations.

Q17: Can you provide a list of the organizations, sites, and supporting systems that are expected to be sending or receiving data via the proposed exchange by June 2007?

A17: We will provide this list once the contract is awarded. The types of participants are described in the RFP.

Q18: If our solution enables physicians to view comprehensive data using their EHR system, should we include this in our proposal?

A18: Absolutely.

Q19: Would you like to include hospital in-patient EMRs as a part of this network?

A19: No. We are not looking to integrate inpatient EMR systems. Our focus is to network only ambulatory EHR systems within our communities. In so far as inpatient clinical data is available in a hospital information system (e.g. Meditech) from which we can extract relevant data, then that system would be a source for the network.

E. Requirements: (Technical, Timeline, etc.)

Q20: Please clarify what is defined as the 'Pilot Period' (on page 7)?

A20: As noted on page 4 of the RFP, MAeHC will pay for HIE costs through the Pilot Period, which ends on June 30, 2008. After that date, each community will bear full responsibility for managing and funding the HIE.

Q21: Is the goal of the project to deliver a **production** quality system by June 2007 ... that will continue to operate on a production basis (e.g. exchanging real live patient data on a 24x7x365 basis) or is the goal to develop a "pilot/prototype" system by June 2007 which might or might not then continue to operate or proceed forward to a production basis?

A21: We will use a phased approach to build a functional system by July 2007. Appropriate phases will be determined jointly by MAeHC and the vendor. The HIE system will operate on a production basis from July 1, 2007 going forward. MAeHC will support this system through June 2008, after which time each community will take ownership of their respective systems.

Q22: Please clarify the major milestones and the associated expected timeframes for the project.

A22: The RFP will be awarded in June 2006. All components should be prototyped, developed and tested by June 2007. The winning vendor(s) will be expected to produce a detailed project plan to deliver their solution on time.

Q23: The timeline indicates that this must be implemented by June 2007 and that the pilot ends June 2008 and that evaluation will continue until 2010. What specifically will be occurring between June 2007 and June 2008 that is different from just general evaluation that will be continued until 2010?

A23: The period June 2007-June 2008 will be the most intensive period of data collection during the MAeHC Pilot Period. During this period, all MAeHC participants will be required to participate in the HIE and the evaluation. The period from June 2008-June 2010 will be the extended evaluation period, which will be optional for program participants.

Q24: Please confirm that this (initial) 24 month term begins upon the award of the contract, not when the system actually goes into operation.

A24: Yes.

Q25: Will all physicians eventually have MAeHC-provided EMRs? If so, by what date? If not, what percentage will and by when?

A25: 100% of participating physician practices in all three communities will have an EHR system by June 2007.

Q26: It is our experience that training and support of physicians and office staff is mission-critical to a successful initiative. We're assuming that consulting-based best practices that we can bring to the table on MAeHC's behalf would be viewed as a positive, even though they are not mentioned as "required." Are we correct?

A26: Yes. All proposals should include training and support solutions and separately break out the associated costs.

Q27: If we can bring up the HIE requirements and roll-out to users more quickly than the targeted dates, and achieve high levels of user adoption and satisfaction, would MAeHC consider some form of bonus?

A27: No. Each vendor will be required to achieve high user adoption and satisfaction within the timeframe of the project.

Q28: Would MAeHC provide additional information on evaluation or decision criteria and their weights?

A28: The decision criteria are laid out in the RFP.

Q29: Please clarify the concept of support to be provided by the clinical data exchange for the foundational functionality listed in Items 1 through 5. Should we assume that the proposed exchange is required to provide: (1) secure or encrypted communication as listed in Item 3, and (2) the ability to transport the data described in Items 1, 2, 4, and 5 among the types of systems described in Items 1, 2, 4, and 5?

A29: Each of the components of the foundational functionality should be addressed. Security “at rest” and “in transit” must be addressed for all components.

Q30: Can you define the method of communication the Collaborative envisions for physician-to-physician communication and physician-to-patient communication? Is providing this capability a requirement of the proposed exchange?

A30: Secure messaging is a required component of the proposal.

Q31: You define the four components required for clinical data exchange. Could you expand upon number 4 regarding your requirements for Emergency Department connectivity? For example, should we assume this to be integration with the hospital ED systems, access to the patient record while in the ED, a user interface specific for the ED and/or all of the above?

A31: The solution should allow access to patient information while in the ED.

Q32: Can you clarify what the expected functions of a community portal are?

A32: The community portal is simply a mechanism or platform thru or from which patients and physicians will access their respective portals.

Q33: Use of the term **eventually**; is a patient portal within or outside of the current scope of the project?

A33: Each vendor should provide a patient portal solution. Whether it is implemented during the pilot period depends on the cost, complexity, and the priorities of each community.

Q34: Is it true to say that the **preference** is for the vendor to provide a **hosted solution**, or is this in fact even a **requirement**?

A34: It is neither a requirement nor a preference. We are interested in exploring and evaluating all technically viable solutions.

Q35: Are there any limitations on the geographical location of any proposed hosted solution?

A35: Within the Continental United States.

Q36: Does MAeHC have a preference for a federated data exchange or a more centralized/hybrid model?

A36: We will explore and evaluate all technically viable solutions.

Q37: What components of the base or foundational functionality will be deployed in the pilot period? Should pricing be separated for components not deployed in the pilot?

A37: The phasing of the components will depend on price, complexity, and community priorities. The pricing should be separate.

Q38: The RFP indicates that an up-to-date integrated clinical summary with elements similar to the CCR will be implemented. While the sharing of this data can be facilitated by the vendor winning this RFP, the actual clinical summary functionality will be completely dependent on the EHR vendors and their ability to produce this utilizing some type of standards. Please confirm.

A38: Yes. Each of the MAeHC EHR vendors has contractually committed to producing a “community interface” based on the exchange and vocabulary standards outlined in the RFP.

Q39: For the patient portal functionality, please articulate the PHR application. In some instances this references the rendering of clinical information from the EMRs, in other instances it references the ability for a patient to capture their own perspective of their medical information and history to supplement the providers view. Please clarify.

A39: Both are of interest, however, the priority is for a system allowing patients to view summarized clinical information.

Q40: The RFP references the sharing of an integrated, up-to-date clinical summary. Is it the vision that the problems, meds, allergies, directives, etc. for each patient would all be centralized into a single clinical summary, rather than this clinical information living at the actual practices and then each of those being made available to a requesting provider?

A40: We are looking for any viable solution.

Q41: Is there a required components list that must be deployed as part of the pilot? Typically, we propose to our clients solutions that take into account your current needs (required components) but also lays the framework for additional components and requirements. Should the architecture and infrastructure we recommend for MAeHC take into account the future deployment when determining scope and scale of systems or focus only what needs to be deployed now? In other words when developing our systems specifications should we build them based on all components that are part of the pilot and some future implementation or just what may be "required" components should that list be supplied?

A41: The requirements are clearly listed in the RFP. All vendors are invited to respond in whole or in part. Pricing should be structured accordingly.

Q42: Do you want data aggregated for the community analysis? Disease surveillance?

A42: Functionality for population-level analysis will enhance the application.

Q43: Can you clarify the requirement for a single sign-on solution? Are you looking to have a unique user ID across the entire network? Perhaps a Federated model?

A43: We would like the ability to deploy a solution for this network that would allow a user to have a single username and password which they could use to authenticate and then get into those applications or components of applications for which they have the authority to access on the network. Any technically viable solution will be considered and evaluated.

Q44: Could you please provide more definition around what you mean by, "...service-oriented data exchange architecture..."

A44: The answer to this question can be found in the detailed documentation for the MA-SHARE Clinical Data Exchange and Record Locator Service:

“Web services’ are the industry standard for platform-neutral, distributed application interoperation over the internet. Web services should be used to effect data sharing across the health information network.”

F. Terms and Legal:

Q45: Are the terms of ownership of intellectual property negotiable?

A45: Yes.

Q46: Would the Collaborative be agreeable to making the project’s software and associated artifacts publicly available?

A46: Yes.

Q47: Are there any circumstances where the Collaborative would not give consent to allow a third party to host or otherwise support the services proposed?

A47: We will evaluate circumstances on a case by case basis. We reserve the right of approval.

Q48: We see the statement that provisions of this contract will include, without limitation, terms set forth in Attachment B. Will MAeHC be willing to negotiate additional terms or revisions such as a mutually acceptable limitation on liability?

A48: In general, MAeHC is willing to discuss additional terms or revisions. Vendor proposals should identify those terms that they would like to discuss further.