

**MASSACHUSETTS eHEALTH COLLABORATIVE  
RFA FAQ #1**

Please submit RFA questions to [RFAquestions@MAeHC.org](mailto:RFAquestions@MAeHC.org)  
Please direct all other inquiries to [Contact@MAeHC.org](mailto:Contact@MAeHC.org)

**APPLICATION PROCESS**

- 1) Can we participate in both of the conference calls?

Yes, both are open to all. We will also post FAQs after each call and every Friday so that all applicants are able to benefit from questions that arise.

- 2) Is it necessary to hire a consultant to help with the response in order to gain acceptance?

No, it is not necessary, though it is not precluded either. Please be aware, however, that the Collaborative will not cover expenses related to the application.

- 3) Is a survey of local physicians necessary? If so, what are we asking of them?

We do not require a survey of local physicians. Each community is free to make its own decisions regarding how they gather the information necessary to respond to the RFA. Please be aware, however, that the Collaborative will not cover expenses related to the application.

- 4) Please define “10 reference letters i.e. publications” Are these “letters of recommendation” or “publications about our institution”? Are these “letters of recommendation” or “publications about our institution”? Is it appropriate for us to solicit references from: Organizations that are members of the Mass eHealth Collaborative; A hospital where we hold an affiliation.

The references referred to here are citations from published literature. You may cite up to ten such sources of published literature in your application.

- 5) Can the 10 references include relevant community plans, community organization descriptions, and materials such as minutes and time lines that demonstrate community organization and commitment ?

See above.

- 6) Under Preparing an Application in the RFA, are the documents in 2c counted in the 10 references?

No, they are not. See above.

- 7) Regarding RFA questions 1d and 1e: what exactly are you looking for? Percent of visits / encounters or percent of revenue?

Please provide percent of visits/ encounters.

- 8) Obviously, involvement of all of the physicians in the PHO in this project is optimal, but is there a minimal or maximal percentage of physician involvement deemed either acceptable or below which the group would not be considered a suitable participant?

We do not have a minimum threshold for physician participation. However, applicants that encompass a larger portion of patient encounters will be looked upon more favorably (all other factors being equal) in the review process, and we are hoping to have communities covering at least 50% of patient encounters.

- 9) In terms of "community support" (i.e. the Mayor, the Chamber of Commerce etc.) is the collaborative expecting financial support, professional support, significant contributions of time, or simply their approval and/or their endorsement?

There is no specific expectation or requirement regarding "community support". However, as this is an ambitious community endeavor, we do believe that communities exhibiting broad support (financial or otherwise) will have a much higher chance of being successful in the pilot.

- 10) What is the expected time commitment for the "project leader" during and after the implementation phase? Is this likely to be a full time job, half time, several hours/week?

It is difficult to project at this point and likely that the demands would be higher at the beginning and then ramp down as implementation begins. This role might require a half-time commitment for the first six months of the pilot and then decrease to several hours per week thereafter, but we expect a wide variety of arrangements depending on the specifics of each community. The main point is that there will be a need for a dedicated point person for a significant amount of time.

- 11) Please clarify and provide examples of factors in the community that would sustain on-going use of the EHR?

Examples include pay-for-performance initiatives, quality/safety initiatives, and data exchange activities.

- 12) Will any additional information be released prior to the second informational conference call?

We will post FAQs on our website after each call and on each Friday. Please continue to forward questions to [RFAquestions@MAeHC.org](mailto:RFAquestions@MAeHC.org).

- 13) Do you plan to provide an on-site presentation of the program in more detail with all initial applicants? With finalists? If yes, what is the expected time frame?

We do not have a formal schedule of on-site presentations, and any more detailed information we share regarding the RFA will be available to all via the informational calls and FAQs.

- 14) Please provide examples of "embedded decision support" ?

Embedded decision support describes a system that can deliver to physicians and other care givers at the point of care a variety of information, such as: up-to-date information (or advice) regarding the safety and efficacy of potential treatments and diagnostic studies; information and appropriate reminders regarding recommended therapies; preventive screenings and disease management guidelines. More sophisticated systems take information from the electronic health record so that this information can be tailored to the needs of the specific patient being treated.

- 15) Can we have some more examples of data exchange activity to meet the criteria?

Some other examples include electronic results delivery, transfer of prescriptions electronically to pharmacies, high use of physician portals, and patient-physician email.

- 16) Will the application process include site visits?

The first phase of the application process is a written application. Phase 2 will include another written application as well as half-day site visits.

- 17) How much weight will be given to the written responses vs. the site visits?

Phase 1 is strictly a written application, so 100% weight will be given during this phase. The weight of the site visit, as part of Phase 2, has yet to be determined.

- 18) Would an application across several communities be welcomed?

Yes, as long as the community has at least one hospital. However, with limited funds, the MAeHC will have to look at the potential cost of a multi-hospital submission and weigh that into the selection process.

- 19) Is it beneficial to have outside funding as part of a communities proposal?

Yes, additional sources of funds will be looked upon favorably. The lack of such funding is not disqualifying, however.

- 20) Is the given timeline of January 21 for RFA submissions still valid?

Yes, the 1/21/05 date is still the deadline to submit applications

- 21) What happens if one of the members of the Board of Directors has a conflict of interest with respect to the pilot selection process?

Anyone who has a conflict of interest will be recused from the selection process.

- 22) Who should submit the application?

Each application should be led by an identified “community advocate”, who will be the main point person for the application process. There will also be a need for a dedicated individual for project coordination once the pilot is underway, and it is up to the community to decide whether that individual is the same person.

### COMMUNITY DEFINITION

- 23) Is there a minimum size that constitutes a "community?" Is a bigger community more likely to win a grant?

There is no minimum community size. When we talk about a “community” we are describing a population that receives the majority (more is better) of their care from a community hospital, its affiliated primary care and specialty physicians and supporting ancillary providers.

All eligible applications must include at least one of the acute care hospitals listed in appendix B plus surrounding health care entities as listed in the RFA.

- 24) Is this initiative only for community hospitals or are IDN's included?

Eligible applicants must include at least one acute care hospital, as listed in Appendix B of the RFA.

- 25) Please define what entities define a “community” other than hospital affiliated PHO/IPAs? For example: would nursing, dialysis, and rehab centers, which do not have a direct affiliation, be considered part of the “community”?

The primary focus is on hospitals, physician offices, laboratories, pharmacies, and imaging centers. Other entities such as long-term care facilities can be included in the community, however, there is no guarantee that there will be sufficient funds to incorporate all of them during the pilot period.

- 26) Will the funding and support be provided for other stakeholders in our patients care such as the community VNS and mental health organizations ?

See above.

- 27) In defining the community, should an applicant consider only their major PHO/IPA or all practices in the service area?

Applicants should include the largest number of practices in the service area to the extent that this increases the percentage of encounters delivered in the “community”.

- 28) Are all physicians in the community required to participate in the pilot project?

No. However, applicants that cover a larger portion of patient encounters in a service area and include more physicians are more likely to be successful. In general, evidence of broad physician commitment to the goals of the pilot project will strengthen the application.

- 29) How many physician practices would have to commit to the initial project?

There is no specific number but again we are looking for “communities” that capture the majority of their care locally.

- 30) Should we consider hospital-based physicians (pathology, ED, anesthesiology, radiology, hospitalists) in the “number of practicing specialists” (question 1a)?

Yes. Please specify how you arrived at your estimates and separate ambulatory vs hospital-based.

- 31) As a community acute care hospital, our services are limited. However, we have a tertiary network that we utilize for tertiary care. In response to questions 1e) and 1f), should we include tertiary referrals within our designated tertiary network?

Yes. The primary focus is on the community acute facility and direct care associated with it. Secondary and tertiary care will be considered on a per community basis later on.

- 32) What is the ideal infrastructure for a pilot community? Is it expected that there will be a legal entity that will facilitate the project management and disperse the funds? (i.e. a new joint venture between the hospital and the IPA)

There is no expectation for a new legal entity at any pilot site. The Collaborative will provide support to each pilot site to facilitate project management and dispersal of funds.

- 33) Is funding only available to a community that has an acute hospital (listed in Appendix B) as part of their submission?

Yes, each application must include at least one of the acute hospitals listed in Appendix B.

- 34) Can an application only have specialists without any PCP participation?

No.

- 35) Can some providers be part of multiple applications?

Yes, it is acceptable for providers to be part of multiple submissions; however, there should not be multiple submissions for the same acute hospital. As per the RFA, the hospital administration will provide only one support letter to be included in the sole application that it is affiliated with.

- 36) Should an IPA that admits to more than one hospital only include their encounters with the hospital on the submission or their total encounters?

The total number should include all encounters, not just those associated with the acute hospital that is listed on the application.

- 37) If a facility is not listed in Appendix B, how can they participate?

If a facility is not listed in Appendix B, they should contact one that does, and attempt to be included in their application.

- 38) Will the selection process favor community hospitals over tertiary ones?

Yes.

## EVALUATION

- 39) What metrics will be used to evaluate a successful pilot? Will pilots be measured "against" each other?

Fulfillment of goals, as outlined in the RFA, will determine the success of pilots. The goal is state-wide implementation, but pilots will help us to learn the steps to get there, barriers/facilitators, and the costs/consequences. Pilots will likely be compared and contrasted in terms of what worked and didn't work, recognizing that pilot communities will likely be very different on a variety of parameters (e.g., size, geography, degree of IT implementation at baseline).

- 40) Should applicants be building and developing the systems for data collection, such as cost benefit analysis, or will the funding be assumed by consumption by collaborative staff?

Each applicant community will bring to bear different resources and capabilities regarding data collection and evaluation. If these resources are available and in place or planned, the community should describe them as they will be seen as favorable. Again, however, communities without these resources will be considered similarly competitive, as our goal is to have a spectrum of communities in the pilot.

- 41) Describe the process(es) for gathering data from the pilots regarding cost/benefit, the impact on the quality and safety of health care, adoption barriers. Will "tools" be used to capture the information ?

Data about quality and utilization will be collected from the underlying information systems. Pilot participants will also be expected to participate in surveys on IT.

## FUNDING

- 42) What will be the share of costs for which doctors and other clinicians will pay?

There is no threshold share requirement for the pilot program. However, communities that can offer resources to leverage the Collaborative's funding will have a higher chance of success.

- 43) What are we expecting from our "communities" in the way of financial support? Do we have to find that support in advance of the response to the RFA?

See above. Regarding commitment of funds, we do ask that a letter of support from the entity offering funding be submitted for any funds that are being represented in the application. This letter will not be legally binding but will represent a good faith representation that the funding will be made available should the pilot proceed in that community.

- 44) It is implied in the press release that a robust hospital-based EMR including CPOE is expected. Will the funds for the pilot community include funding for the roll out of CPOE in the hospital?

The funding for each community will be tailored to the individual needs of the community and will focus on areas that will give the greatest progress toward the overall project goals. In principle, some funding will be available to help to support hospital CPOE, but the availability will depend on the overall needs of the community.

- 45) If, indeed, a group's application is approved, can all of the groups' physicians expect to receive similar financial support or is that determined later by the PHO or the collaborative?

The Collaborative will determine the level and distribution of support.

- 46) Is there an anticipated commitment of either time or money by individual participating physicians after the term of the project is complete?

The expectation is that this will be an ongoing effort that will enable physicians to adopt IT long-term through sustainable reimbursement and/or incentives.

- 47) Will the allotted funds be subject to Federal and State income taxes at the practice level? If yes, what services (hardware, software, consultant services) will it apply to?

To the extent that funds are provided to for-profit entities or organizations it is expected that these recipients will receive an IRS 1099 form to describe this income. Since these funds will be used for business expenses (purchase of hardware, software and implementation support), they may not be subject to income tax, however, each participant will need to determine the tax implications of their participation individually.

48) Who will manage the grant money for each pilot project?

The Collaborative will manage the grant money.

49) How will funding flow to selected pilot communities (ex: as grants to a "lead" agency?)

Funding will be as grants, not contracts. Each grantee community will reach agreement with the Collaborative on level and uses of such funds. In some cases, funds will flow directly from Collaborative to vendors; in other cases, funds will flow to "lead" agencies in community; in other cases, funds may flow to individual providers. We are open to a variety of models and anticipate working with the pilot communities to set up mutually satisfactory structures and processes.

50) Is it the responsibility of the physicians to pay for their own EMR software?

No, the MAeHC will provide funding to purchase EHR software in the pilot communities.

51) What will be paid for by the MAeHC?

Examples of what might be paid for by the MAeHC are: hardware, software, training, implementation costs, etc..

## **HARDWARE/SOFTWARE/SUPPORT**

52) What about the two EMR softwares offered by the Massachusetts Medical Society to its members?

We will do our best to work with existing vendors. Details regarding vendor selection are currently being developed.

53) During Phase 2, will the EHR software be determined by the Massachusetts eHealth Collaborative? That is, will the Collaborative be defining the EHR product(s) that the pilots must purchase or require the pilots to choose only one product or no more than a specified number of products? If yes: What about practices that already have an EHR? This is a question for both interoperability and funds flow to those particular practices. The physicians are concerned about integration with their billing systems and medical office equipment. Comments? If no: What is your long-term technical strategy for determining a Massachusetts-wide solution?

We expect to work with participants in each community to identify options that meet their needs and also meet our project standards. We expect to be able to offer participants a choice of systems from a pre-selected set of options. For those practices that already have an EHR, we anticipate providing support to integrate those systems with the broader community health exchange infrastructure, however, the extent of this support will depend on funding availability and individual community circumstances.

- 54) What types of expert technical assistance will the Collaborative bring to the grantees vs. technical assistance the grantees will be expected to secure from in-house and outside experts?

As specified in the RFA, the Collaborative anticipates providing implementation support. We will have dedicated staff to provide ongoing assistance to participants and will likely offer to participants technical support as part of the vendor packages that we negotiate. Details are still being worked out and will in part be determined by funding constraints and the specific needs of the pilot communities.

- 55) Will funding and support will be offered to physicians who wish to integrate their existing electronic medical record into the system? Will this include money already spent?

We anticipate providing support to integrate existing EHRs into the system. We will not compensate for investments already made, however.

- 56) Will the Collaborative control the E.H.R. selection ? Is there a list of approved software vendors ? Is it available ?

The current plan is for the Collaborative to work with vendors to provide a set of options from which participants may choose. These options will be chosen to meet participants needs to the greatest extent feasible while at the same time meeting our project requirements. Vendors have not yet been selected.

- 57) Will the eHealth Collaborative provide their own staff or fund staff within the selected communities?

In all likelihood, MAeHC will have its own staff and may also fund staff within the selected communities. We will work with each pilot community to determine the optimal model.

- 58) What happens to those who are early adopters of this technology and whose systems are not compatible with what ever gets distributed?

We will make every attempt to choose a set of vendors that encompasses as many currently installed systems as possible. We anticipate providing support to integrate certain existing systems into the community network, however, we cannot guarantee support to integrate all existing systems.

- 59) What is the timeline for the vendor selection?

We expect that approved vendors will be selected by MAeHC during 2Q05 and the pilots will choose their specific vendors some time during 3Q05. This timeline will be revisited once the pilot communities are chosen and we understand more about their needs.

- 60) Should a community delay their independent EMR vendor evaluation until the MAeHC develops its list of approved vendors?

No, communities should continue their independent work. The vendor options that ultimately become available will be driven in part by the installed base in each community. Further, we anticipate providing some support to integrate certain existing systems into the community pilot network. Finally, self-initiated pursuit of IT solutions is a demonstration of alignment with our project objectives and thus will be viewed favorably in the selection process.

- 61) Who will be responsible for converting old files (paper or electronic) that providers need to input into a new system?

The practices will be responsible for this conversion. Depending on community need, we may try to facilitate this process where we can, but we cannot commit to any specific support at this time.

- 62) Who will negotiate with the vendors?

The MAeHC will be responsible for all vendor negotiations.

- 63) Will the vendors be selected before the Jan. 21 application deadline?

No, vendor selection will not be complete until the 2Q05, at the earliest.

## **TIMELINES**

- 64) Will all three pilots have the same start date and end date?

All sites will have the same approximate start date, now envisioned for late in the 2nd quarter of 2005. The end dates are more flexible as communities are likely to have different profiles and requirements. We anticipate that the duration of the pilot programs will be 18-24 months, though these estimates will be refined depending on individual pilot project plans.

- 65) How long is the project likely to go on, including data collection, review of results, etc.?

We envision the pilot phase extending 18-24 months, meaning that direct Collaborative support will be available for roughly that time period. Our aim is to transition each of the pilot communities to sustainable models where reimbursement and incentives fund the effort going forward. The exact timing of that transition, and whether additional funding might be available after the pilot period, are unknown at this time.

- 66) Once selected, will structures be put in place to facilitate shared learning between communities during the pilot?

Yes, both among communities and, ultimately, statewide.

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