

MASSACHUSETTS eHEALTH COLLABORATIVE
EHR RFP FAQs – April 13th -26th 2005

This is the second and final FAQ for the EHR RFP.

Q30: In light of the fact that certain questions require the disclosure of confidential information which may pertain to public companies, will the Collaborative treat the RFP response on a confidential basis? Will the communities be reviewing the responses, and if so will they also treat the responses on a confidential basis?

A30: All RFP responses will be considered confidential information to be used by the Collaborative, its members and the participating communities.

Q31: In the answer to question 29 of the FAQ, you outlined the initial selection process. Can we have more details on the complete process, including how the communities and individual providers will select a vendor? Are you seeking one system to satisfy all requirements, or several (i.e., different systems for different size practices). Please also indicate the timing with respect to the first implementations?

A31: The intent of the EHR RFP process is to select a small number of vendors that would have a preferred relationship with MAeHC. A slate of up to three vendors will be offered to each community, with the slate tailored to meet community preferences and needs. Each community model might vary. Some communities might select to implement a single system. It is likely, however, that some communities will choose different vendors to implement into different practices. We expect that there could be demonstrations or vendor fairs to assist each practice with selecting a vendor. MAeHC will be working with each community to design the appropriate process for vendor selection. The first implementations are expected in the fall of 2005.

Q32: Pg. 14, Integration Checklist: The vocabulary for allergies is recommended as "text". However, the requirement elsewhere for Drug-Allergy contraindication checking must rely on coded allergies using SNOMED or another vendor-specific allergy coding. Can we assume that all participating EHRs will use either the same nomenclature, or ones which can be unambiguously mapped to each other (ie not text)?

Pg 16 - DICOM In other sections, hyperlinks to PACS are suggested for image viewing. Here however, it mentions DICOM. If only one or two key reference images are needed from a full study, without the need to re-window and level, etc., can simpler, non-DICOM image formats be used?

A32: All participating EHRs will need to map to the required nomenclature including DICOM.

Q33: Regarding several references to "Guidelines and Measurement of Variance" (e.g., DC.2.2.1.4) The "granularity" of the variances can vary widely. Which if any of these are examples of the level of variances you are looking to track? Whether a patient in a particular clinical circumstance was:

- prescribed a specific drug or not? (i.e. simple presence or absence of an event)...and was it actually administered or just prescribed?

- prescribed a specific drug 30 mg QID vs. 40 mg TID? (specificity of the event, even if the net dose was the same)
- supposed to get a drug on day 1 and day 8 of a cycle, but got the second dose 1 or 2 or 4 days late? (i.e. was the event within "allowable" time variance)
- supposed to get a 25% dose reduction based on white count, but got the full dose (i.e.. override of dose modification rules)
- supposed to have a chest x-ray according to the guideline, but it was not ordered because it was taken recently for unrelated reasons.

Can you give examples of the type of guidelines you feel is required to track such variance? For example:

- Simplest: text guidelines containing narrative descriptions of eligibility, tests, drugs, imaging etc. which providers must interpret and self report variance;
- Moderate: text guidelines with several executable order sets for different patient parameters from which providers can select and execute;
- Complex: the guidelines are executable medical logic modules or "macros" which include what to do, when and how to automatically modify care based on patient response, etc.

What is the preferred source of guidelines (vendors, provider groups, individual providers, national bodies)?

Is there any preferred method for how guidelines content be input to the system, tailored to groups of providers and individual providers and maintained over time? What is the approximate number of guidelines a typical implementation would be expected to manage?

Is there a standard being considered to represent and share guidelines across EHR platforms?

S.3.6 Acuity and Severity: What scales are driven by what data are assumed here?

I.2.1 Data Retention, Availability and Destruction: Select legacy paper files will be scanned in during the implementation cycle. However, it is unlikely the effort will be made to assign historical dates to each document...therefore most will have a current date. If data is to be retained for 7-10 years, this destruction feature will not be required for approximately that time. Can you confirm this?

Medical Device Communication: Can we assume that medical device data will be interpreted on the medical device, and uploaded for reference only to the EHR? (to avoid the EHR becoming part of a regulated medical device). Will the data to be uploaded be summary data vs. raw data which then requires analytical processing?

DC.1.4.6 Other Blood Products or Biologics: This is identified as Optional in priority level, but the body of the text says "Blood bank or other functionality...is not required; functional communication with such a system is required." Can you please clarify?

In the 2 page description requested on Page 13 of 58 you request details on – Ability/plan to offer service-oriented data exchange architecture..... Could you provide an example of one type?

A33: Each vendor should respond as appropriate for their product and document any assumptions that are made.

Q34: Other Clinical Rules: In several places rules triggering alerts, treatment alternatives or additional actions are mentioned. (e.g.. if a female has abdominal pain, rule out ectopic pregnancy; if Zyban is prescribed, then make a referral to the Smoking Cessation Clinic). Can you comment on the source, input, maintenance and data interchange format of such clinical rule sets?

A34: MAeHC is interested in understanding where the application obtains the rules, the frequency and method for updates and options for customization.

Q35: S1.3.1 Provider Demographics: Will there be a central provider registry that can be accessed?

A35: There is no central provider registry planned at this time.

Q36: 8.S.2.1.2 Performance and Accountability: Can you define the performance and accountability measures you wish to be supported?

A36: These measures are still being defined.

Q37: Regarding erroneous data, common practice has such data marked as deleted, but not actually removed from the database in order that the change to the record is preserved and explicit. Is there an expectation that erroneous values are actually deleted from the database?

A37: MAeHC is interested in support of the common practices.

Q38: You have not specified a budget for each of the different sized institutions. Do you have one in mind?

A38: MAeHC has limited funding and is trying to spend the minimum amount necessary to achieve the maximum capabilities.

Q39: For clinical data exchange capabilities is it intended to use the MA-Share and Medsinfo-ED Project? If so what type of bandwidth do they require?

A39: MA-Share is still defining the requirements to attach to the state grid however it will likely be different than how MedsInfo is defined today.

Q40: There has been no mention of an e-mail solution would this type of solution be provided at a later date?

A40: An e-mail solution could be part of future requirement but is not expected at this time.

Q41: Appendix C 3 (a) Is asking the vendor to agree to service standards that haven't been presented yet - When do you expect to publish these standards?

Appendix C 5 (last paragraph) Termination for any reason - what if the termination was for non-payment? Does the vendor still have to provide service for 24 months?

Appendix C 6 (last paragraph) Vendor shall "maintain certification under the applicable standards set forth from time to time by appropriate organizations reasonably identified by the Collaborative" - When will the Collaborative designate or publish the organizations and/or standards? There are MANY organizations working on standards and these standards may conflict with one another, be too costly to implement or impose usability issues for customers. As such, we are extremely leery of agreeing to such vague terms. Any recommendations?

Appendix C 12 (Acceptance testing portion) Can you define "acceptance testing satisfactory to the collaborative"? Does this mean the vendor's existing testing methodology or is the collaborative requesting additional testing? If additional testing, what are the requirements?

A41: The Additional Terms in Appendix C will be discussed in detail with the selected vendors.

Q42: Can you convert under pricing estimated # of patient visits per model, our pricing metrics are based on visits not Physicians?

A42: Please calculate the pricing based on an assumed number of visits per physician and document all assumptions. We are looking for pricing based on a number of physician model.

Q43: Could you elaborate on the preferred definition of EMR Users in corporate background? Does that mean licensed providers, administrative users, scheduling users, billing users, or the total of all types of users?

A43: EMR Users are considered total users of the system.

Q44: Does the 11 pt font size instruction for our response apply to Appendix "B" responses in the "Comment" column? Regarding Appendix "B" there are no page limits described for this section, could you provide some guidance with respect to the total area available for comments?

A44: All responses including all comments should be in 11pt font size. All comments in Appendix B should be limited to the size of the comments box or less if possible.

Q45: I am working on a proposal with several vendors. I am not sure how to respond to section IV with collaborative approach??

A45: The information in Section IV should be for the primary vendor. The primary vendor will sign all agreements with MAeHC and will need subcontracting agreements with any other vendors.