AHC RFP Questions and Answers

Last Update: 7/19/2017

Item	Question	Answer
1	Could you provide the names and EMR system for the screening partners	Tentative list (pending finalization of contracts): Health Systems: 1. TriHealth (Epic) 2. Cincinnati Children's (Epic) 3. The Christ Hospital (Epic) 4. UC Health (Epic) 5. Mercy Health (Epic) Other: 6. Talbert House (Athena) 7. Greater Cincinnati Behavioral Health Services
2	Could you provide the breakdown of the number of primary care, ER and inpatient locations for the Health System partners	The finalized list has yet to be confirmed. Each organization is currently evaluating locations (facilities) and settings where AHC-based screenings will take place.
3	Could you provide the names and EMR systems for the FQHC partners	1. Crossroad Health Center (NextGen) 2. City of Cincinnati Health Clinics (Epic) 3. CenterPoint Health 4. Warren County Combined Health District (e-MDs) 5. Primary Health Solutions (NextGen) 6. WinMed Health Services (NextGen) 7. The HealthCare Connection (NextGen) 8. HealthSource of Ohio (NextGen)
4	How many social service providers are participating in the AHC Model?	THC intends to take full advantage of the UW Cincinnati 2-1-1 Community Resource Inventory. We do not have any exclusive relationships with specific social service agencies as part of this project.
5	Can you provide background on the HealthBridge HIE including which partners are on the HealthBridge platform, what kind of connectivity exists	All Health System Partners have bi-directional connectivity in place to exchange HL7 v2 messages. All Health System partners have DIRECT access either though HealthBridge's hb/direct (HISP) service or through another HISP that is connected to HealthBridge via our DirectTrust engagement. We have one-direction interfaces in place with about half of the FQHCs. These organizations receive data from HealthBridge only.
6	Can you confirm if the HealthBridge MPI can be used for patient matching for new patients not currently in the HIE	Yes, the HealthBridge MPI can provide matching logic for new and existing patients.
7	Can you confirm that health systems will have the first right of refusal for navigation; 4 or 5 independent navigation agencies would be ready to provide navigation if needed?	Screening partners will have first right of refusal.
8	Can you identify the names of the navigation partners	Tentative list (pending finalization of contracts): 1. All screening partners (first right of refusal) 2. Council on Aging 3. Talbert House 4. HealthCare Access Now (HCAN) 5. Community Action Agency
9	Is it possible to interface with the 2-1-1 database to enable real-time query (i.e. we would send a list of patient demographic and social needs to 2-1-1 and they would return a list of social service providers that can serve this patient)	This type of integration does not currently exist, but could be explored. More analysis would be needed.
10	If a real-time interface to 2-1-1 is not possible, could a monthly extract be possible.	A monthly extract is feasible.
11	Can you provide a ballpark budget?	We expect the proposed budget to match the level of effort and functionality provided within the proposal. The AHC model restricts the total cost of IT infrastructure to 15% of the total award. However, there will be additional IT costs beyond the cost to license, implement and support this new tool.
12	Should we assume that each partner would require one integration (i.e., for a system with multiple clinical delivery sites such as primary care sites, ER, inpatient, all of these sites would use the same workflow and share the same interface between the system and our platform)?	This is a reasonable assumption. As scope is finalized, this assumption may or may not hold true and as such, we would want to understand the implications to your proposed scope/budget
13	Should we assume that the costs of these healthcare partners (their IT personnel time, hardware/software purchases, etc.) would be paid for using another source (such as the AHC budget), and as such we do not need to include these costs in our budget?	This is a reasonable assumption. As scope is finalized, this assumption may or may not hold true and as such, we would want to understand the implications to your proposed scope/budget
14	Please describe the extent to which THC expects consumers/public/patients to have the ability to originate self or other referrals (e.g. from a public web portal)	We do not anticipate this occurring
15	Please describe the extent to which THC expects consumers/public/patients to have access to and ability to interact with individualized health plans online or via mobile application	We do not anticipate this occurring
16	Please describe the extent to which THC expects consumers/public/patients to have any other consumer-centric access	We do not anticipate this occurring
17	Does THC has a timeframe for entering into a vendor contract (and kicking off prelaunch planning and implementation)?	See question #31.
18	Does THC have any guidance around its budget for the project or vendor pricing considerations (beyond the scope of the program and functionality requested)	See question #11

19	Does THC's desired program model call for any central coordinating staff to serve as a 'hub' for direct client/patient traffic?	Ideally, the solution would have logic/rules that would evaluate completed screenings to risk stratify beneficiaries, generate referrals and route those referrals to an appropriate navigator based on the following criteria: 1. First right to refusal for Health-System performed screenings 2. navigator's prior relationship to beneficiary 3. Beneficiary's demographics and/or social needs
20	Can you please provide additional information on the RFP evaluation process? In particular, which personnel will review and what guidelines will support their review process.	The Health Collaborative has a governance structure for the AHC project, which includes a technical committee made up of technical resources across our various partners. A subset of members from the technical committee, representing a mix of screening, navigation and United Way partners will be responsible for evaluating the RFPs. Each RFP will be evaluated on Technical Solution (60 pts), Implementation and support plan (15 pts) and pricing (25 pts) for a total of 100 points. Specific evaluation criteria will be uploaded to our website.
21	How are organizations currently providing screenings in the community?	Our screening partners are already providing screenings at varying efforts across the community. The AHC Model provides our community with the opportunity to standardize and centralize these activities, and also provides a framework to provide closed-loop referrals back to screening partners. Screenings are occuring for beneficiaries beyond the scope of the AHC model program (high-risk dual-eligible Medicare/Medicaid beneficiaries), and our desire is to provide a tool that can satisfy both AHC model requirements as well as provide screening opoprtunity to the general population as well.
22	Do you have a sample care plan?	At this time, we have not established a community-based care plan. Each organization generates their own careplan and has various methods to distribute/share with beneficiaries
23	What are your reporting requirements	To comply with CMS requirements, we must be able to report metrics to CMS on a monthly basis (subject to change). An initial list of data elements can be found in Appendix B of the RFP. This list is subject to change, based on CMS requirements. Additionally, as the Bridge organization, THC desires reports - or access to the data - that would allow us to perform gap analysis and other functions.
24	Does THC only want professionals to screen patients, or will beneficiaries be allowed to screen patients	We would like to have the option for both. Our initial analysis with screening partners indicates that there is higher engagement when beneficiaries are able to self-screen.
25	Does THC intend to use the tool after the AHC model concludes	It is THC's intent to continue using the tool after the AHC model is concluded.
26	Does THC prefer an on-premise of hosted solution	THC does not have a strong preference either way. Either solution must comply with requirements outlined in section 2.15 and 2.16 of the RFP.
27	Will the Navigation partners use this new tool exclusively (will they migrate to the new tool or continue using their existng tools)	This is yet to be determined. Navigators already have systems in place. While possible that they may determine it best to migrate to new platform, it would be outside of the intended scope of the project. Integration opportunitues are the more likely scenario.
28	What is THC's footprint of the AHC Model?	THC, as the bridge organization, is operating the AHC model in 8 counties in Southwest Ohio: Butler, Warren, Clinton, Hamilton, Clermont, Brown, Highland, Adams
29	Would different screening organizations have different workflows?	Potentially. As the bridge organization, our goal is to provide standard SOPs to all screening organizations to standardize workflows as much as possible. However, we recognize we will need to be cognizant of existing workflows and policies.
30	Would some systems use their EMR for screening and some use the proposed platform?	We fully expect the large health systems to want to use their EMR software to provide screening. FQHCs, we expect, to want to integrate with their existing software and want to use the new tool.
31	What is the anticipated project timeline?	Year 1 of the AHC model (May 2017 - May 2018) is a planning year whereby we have to finalize SOP and workflows and implement the new platform and all necessary integration. Screenings will not take place until May 1, 2018. We would like to perform a small scale pilot of the platform with limited screeners and navigators in February-March of 2018.
32	Would THC be willing to take on some of the development work for the project	Through THC's HealthBridge service line, THC can facilitate some of the integration aspects of the project, including network connectivity, data exchange via DIRECT or HL7, and MPI patient matching work. THC is not suited to developing core functionality within the platform.
33	The RFP limits section 3 to a maximum of 10 pages. Can this be expanded.	No. The limit will remain at 10 pages. However, we will accept appendices to allow for screenshots, sample reports, etc.
34	Section 2 of the RFP cannot be edited in the PDF.	THC will release an Excel version of Section 2.