The Massachusetts eHealth Collaborative
Expanding the Use of Electronic Health Records and Establishing a Regional Health Information Infrastructure in Massachusetts

Request for Applications (RFA)

RFA Release Date: December 6, 2004
First Informational Conference Call: December 13, 2004; 12:00 Noon, E.S.T.
Application Receipt Date: January 21, 2005; 5:00 P.M. E.S.T.

Summary:

The Massachusetts eHealth Collaborative ("the Collaborative," www.maehc.org) is accepting applications from Massachusetts communities interested in hosting pilot projects in community-wide implementation of electronic health records (EHRs) and clinical data exchange capabilities. The Collaborative is a newly launched, non-profit entity, which brings together more than three dozen Massachusetts organizations representing the State's key stakeholders in health care. The mission of the Collaborative is to improve the quality, safety, and efficiency of health care delivery in Massachusetts by promoting widespread and sustained use of electronic health records (EHRs) across the State.

The Collaborative will select up to three communities for pilot projects. These projects will provide funding and support to healthcare providers for implementation and adoption of electronic health records with embedded decision support. The Collaborative will also support the development of clinical data exchange capabilities for patient care purposes among physician offices, hospitals, and other healthcare service providers, such as laboratories and imaging centers. The total funding available for all of the pilots is expected to range from $30 million to $50 million; the allocation across individual pilot projects will vary depending on the level of investment and support required by each community.

The goal of the pilot projects is to assess the costs and benefits of community-wide EHR adoption from a number of perspectives: quality and safety of patient care, user satisfaction of physicians, nurses, and other health care professionals and support staff, protection of privacy and confidentiality, and barriers to adoption both within and across institutions and office practices. Ultimately, the pilot projects will serve to develop operational and financing models that will foster and sustain statewide adoption and continued use and improvement of such technologies and capabilities.

Candidate communities will be evaluated along three key dimensions: 1) breadth and depth of participating provider network, 2) organization and commitment of stakeholders, including physicians, health care institutions, and community leaders, and 3) participation in other relevant activities, such as clinical data exchange (e.g.,

MedsInfo) or computerized provider order entry (CPOE - e.g., main hospital implementing or planning CPOE system). In addition, the Collaborative will balance other factors – such as community size, geography, and level of IT adoption – to ensure that the projects represent the diversity of communities in the state. The Board of Directors of the Massachusetts eHealth Collaborative will make final decisions on community selection.

Background:

The mission of the Massachusetts eHealth Collaborative (the "Collaborative") is to improve the safety, efficiency, and quality of health care delivery in Massachusetts through promotion of widespread implementation and sustained use of electronic health records (EHR) with embedded medical decision support, and health information exchange (HIE) capabilities. To fulfill this mission, the Collaborative will develop and promote such technology and supporting infrastructure to achieve, demonstrate, and evaluate successful large-scale implementation and sustained use in community settings.

The Collaborative comprises more than three dozen organizations in the Commonwealth, including many leading health care institutions (see Appendix A). Their collective vision is that using this technology as a tool will lead to systems changes that will reduce medical error rates and deliver better information to physicians, at the point of care, which will in turn improve the quality of care. In addition, substantial cost savings are expected to be generated – for example, by targeting the estimated billions of dollars wasted annually in Massachusetts on health care that does not improve patient outcomes, and by reducing the costs associated with medical errors – which will free up resources to both improve access to care and ease its financial burdens.

Purpose of the RFA:

In early 2005, the Massachusetts eHealth Collaborative will launch a pilot project in up to three (3) separate communities in the Commonwealth, with the overall goal of gaining knowledge and experience that will enable the statewide implementation of EHRs and the establishment of a statewide health information infrastructure. The specific objectives of this pilot include: (1) measuring the costs and benefits of community-wide EHR implementation; (2) assessing the effects of such implementation on the quality and safety of health care, as well as the effects on patient and health care professional satisfaction and patient privacy and confidentiality; and (3) identifying key adoption barriers (e.g., concerns about data sharing, reimbursement for purchase of hardware and software) and the strategic/tactical approaches to overcoming them. The data generated from the pilots will also be used to help develop a sound infrastructure and durable system of financing to support statewide implementation and continued use and improvement of electronic health records.

The scope of each community pilot project will be the near-universal adoption of office-based electronic health records and the establishment of functional exchange of health information (e.g., laboratory results) for patient care among health care professionals within that community. This pilot program will include robust electronic data exchange between physicians' office practices and hospitals, laboratories, imaging centers, pharmacies and other health care facilities. Implementation will begin in the first half of 2005, with an ongoing period of evaluation both during and after the implementation period.

The Collaborative will attempt to provide all the necessary funding and support to implement an electronic health record system in every physician's office in the selected communities. Support will also be provided to hospitals for implementing or completing implementation of computerized provider order entry (CPOE) systems, with the level of support determined by the individual circumstances of each participating hospital. Additional support provided to the communities will include implementation support, including guidance in vendor selection, establishment of minimum functional requirements and interoperability standards, assistance in contract negotiation (e.g. with laboratory vendors, electronic health record vendors), assistance in addressing privacy and security issues, and provision for productivity decreases (i.e., financial compensation).

Ultimately, the program will establish and demonstrate a measurable degree of health information exchange among physicians' offices and their local community hospital(s), and other local providers of healthcare services, such as community health centers, laboratories, and imaging centers. This RFA seeks to identify candidate communities who can best use the available funding and support to successfully meet these objectives.

Eligibility:

Any community in Massachusetts is eligible to apply for participation. For the purpose of this RFA, a community is defined as a group of physician practices (primary care and specialty) that are closely affiliated with an acute-care hospital (see Appendix B) or several closely integrated acute-care hospitals in the community. "Closely affiliated" is defined to mean that the acute-care hospital(s) perform(s) a majority of the hospitalizations for patients seeing physicians in this community.

A community may be geographically defined (e.g., the physician practices in a certain town or city) or it may cross geographic boundaries; the key criterion for defining a community is the affiliation with the acute-care hospital(s) and the existence of, and potential for, ongoing communication among the physician practices. Evidence of prior collaboration across and among physicians and practice groups will be desirable. The physician practices in this community should have an existing mechanism for, and history of, communication and collaboration, which may be in the form of a Physician Hospital Organization (PHO), Independent Practice Association (IPA), or other

established linkage. Evidence of community support (e.g., mayor, chamber of commerce, etc.) would also be desirable.

Communities may vary in size, with respect to both the number of physician practices and the overall population of the individuals residing therein. For example, the Collaborative expects that many communities will include on the order of 50-100 physicians, with perhaps 10 to 40 practice groups. However, these figures are rough estimates only, and the Collaborative welcomes applications from communities of all sizes.

Each applicant community should identify a *community advocate*, who will serve as the liaison to the Massachusetts eHealth Collaborative Board during the application and review process. This individual may be a leading physician within the community, a PHO or hospital executive, or any other individual with a similar leadership role in the health care community. The community advocate will submit the application on behalf of the community and may serve as local leader and coordinator of the community pilot project. *The importance to the success of the project of identifying and establishing community-based leadership cannot be overemphasized and will be a key criterion for selection of pilot communities.*

Funds Available:

Implementation costs for each community are expected to range widely, e.g. from $2 million to $20 million. It is anticipated that each of the three communities will require differing types and degrees of support for their EHR expansion and health information exchange (HIE) development efforts, which will determine both the level of investment required and the time required for implementation. As such, the funds may not be equally distributed across the communities.

Allocation of funds will be determined by the Massachusetts eHealth Collaborative Board of Directors. Communities should <u>not</u> submit a budget with their response to this RFA. Instead, selected communities will develop budgets in conjunction with the Collaborative.

Application Process:

This RFA is an open process, and the Collaborative welcomes applications from any community in the Commonwealth of Massachusetts. The Collaborative has no established plans with, or commitments to, any communities and will identify the communities for this pilot program solely through this application process.

Competition for participation in the pilot project will proceed via a two-stage application process. In Stage 1, communities must submit a 5-page application providing background information describing the community and its resources (see Preparing an

Application, below). A committee appointed by the Massachusetts eHealth Collaborative will review the submitted applications and will identify 5-6 finalist communities to participate in the Stage 2 application process. The Stage 2 application will involve an additional written application, as well as a half-day site visit including community interviews. Any costs associated with developing a community and an application for such community shall be borne solely by the community and its participants. No funding shall be provided by the Collaborative for the development of community applications for either Stage of the application process.

Submitting an Application:

Stage 1 applications must be submitted via e-mail attachment to RFA@MAEHC.ORG no later than **January 21, 2005, 5 p.m. E.S.T**. Applications received after this date and time will not be considered. In the body of the e-mail, please include the name and contact information of the community advocate.

Preparing an Application:

The application should be no more than 5 single-spaced 8.5" x 11" pages in length. Applicants must use Arial 12-point font and 1-inch margins. Letters of support (described later) are not included in the 5-page count. Any deviations from these guidelines may disqualify the application. Up to 10 references (i.e., publications) may be cited and attached on an additional page if necessary. In the header of the application, please include the name of the community.

The application comprises questions covering three areas: 1) breadth and depth of the provider network, 2) organization and commitment of community and stakeholders, and 3) ongoing participation in other relevant activities.

1) <u>Breadth and depth of provider network</u>

1a) How many primary care physicians and specialty physicians practice within the community?

1b) How are physicians and practices in the community affiliated with the acute-care hospital? Specifically, is there a PHO, IPA or other similar entity?

1c) Is there one or more than one hospital in the community to which a majority of the primary care patients are referred for hospitalization when necessary? If more than one hospital, describe how they are integrated.

1d) Approximately how many patients (individuals) are covered by the provider "network" participating in this project? Approximately how many patient visits annually?

1e) Among patients receiving care from practices in this community, what proportion is referred to the community acute-care hospital(s) (as opposed to a hospital(s) outside the community) when hospitalization is necessary?

1f) Among patients receiving primary care from practices within this community, what proportion is referred to specialists within the community (as opposed to specialists outside the community) when specialty care is necessary?

1g) Besides physician offices and the acute care hospital(s), what other providers play a major role in delivering health care to the community? Examples include but are not limited to community health centers, laboratories, and imaging centers.

2) Organization and commitment of community and stakeholders

2a) What financial and organizational resources, if any, are available within the community to launch and sustain this project?

2b) What other factors within the community will help sustain the ongoing use of electronic health records and health information exchange?

2c) Among physicians and other health care professionals in the community, what is the level of interest and leadership in embarking on this collaborative effort? Provide evidence (e.g., examples of work in progress, planning meetings or forums, informal discussions, anecdotes).

2d) What financial incentives, if any, exist in the community to sustain the use of electronic health records and related health information infrastructure? (e.g., incentives from payers, provider groups, or employers)?

3) Ongoing participation in other associated activities

3a) What is the current state of electronic health record use among physicians in the community?

3b) Which vendor(s) have provided electronic health records in the community, both in offices and in hospitals?

3c) What is the current state of the community hospital's use of electronic health records, computerized provider order entry, electronic clinical decision support, and/or health information exchange within and outside the hospital(s)?

Additional Requirements:

Applicants should submit a letter of support from the chief executive officer of the acute-care hospital in their community indicating the hospital's support of the application and willingness to be a major partner in this pilot project. If a community's application represents more than one acute-care hospital, then each participating hospital's CEO should co-sign the letter. This letter of support should be submitted as a separate e-mail attachment along with the application. Letters from key community leaders (e.g., mayor, chamber of commerce, etc) in support of the application are also welcome as indications of community commitment and leadership. These additional letters should also be submitted as attachments along with the application.

Selection Criteria:

Communities will be selected based on the three general areas covered in the application process. The key selection criteria will include:

1) A high percentage of each patient's care being done within the applicant community. The advantages of health information exchange are most beneficial to patients when shared for treatment purposes by the various providers of that care.
2) Demonstration of support, commitment, and leadership by health care professionals, health care institutions, and the community at large. This endeavor cannot succeed without the commitment of physicians, nurses, other health care professionals, medical support staff, administrators, and community leaders. While a primary aim of the project is to demonstrate ways of achieving high user satisfaction, applicants that already have high interest and clear commitment at the outset will be more likely to succeed in the long run.
3) Existing or planned engagement in EHR and/or other technologies supportive of the Collaborative's objectives. Examples include the degree to which the hospital(s) is/are actively engaged in, or strongly considering, the adoption of computerized provider order entry (CPOE), or participation in or the desire to participate in clinical data exchange activities between public or private entities, such as MedsInfo (http://www.mahealthdata.org/ma-share/projects/medsinfo.html). These are not the only examples, however, and applicants are encouraged to highlight such existing activities or plans in their submissions.

The Collaborative will attempt to achieve balance across the 3 communities it selects to demonstrate the applicability of such projects in the wide variety of communities that make up the Commonwealth. For example, communities vary widely in their adoption of health information technology, and the Collaborative will seek to achieve a mix of communities that covers that range. The Collaborative welcomes applications from communities with current health information technology systems ranging from nascent to mature. The mix of small and large institutions, including mix of small and large physician practices, is another factor that varies widely across communities, and which the Collaborative will seek to balance in its selections.

Timeline:

Release of RFA	December 6, 2004
First Informational Conference Call	December 13, 2004, 12:00 Noon, E.S.T.
Second Information Conference Call	January 4, 2005, 12:00 Noon, E.S.T
Phase 1 Application Receipt Deadline	January 21, 2005, 5:00 P.M., E.S.T.
Notification of Finalist Communities	January 31, 2005
Phase 2 Written Application Receipt Deadline	March 1, 2005
Phase 2 Site Visits Completed	March 1, 2005
Notification of Selected Communities	March, 2005

Where to Send Inquiries:

The Collaborative encourages your inquiries concerning this RFA and welcome the opportunity to answer questions from potential applicants. Please direct your questions to:

Before December 20, 2004: RFAQUESTIONS@MAEHC.ORG

After December 20, 2004:

Mr. Micky Tripathi
Chief Executive Officer
Massachusetts eHealth Collaborative
860 Winter Street
Waltham, MA 02451

Phone: (781) 434-7905
Email: RFAQUESTIONS@MAEHC.ORG

Informational Conference Call:

The Massachusetts eHealth Collaborative will conduct two1-hour informational conference calls to answer questions from potential applicants about this RFA. The first call is scheduled for December 13, 2004, 12:00 Noon, E.S.T. To participate in this conference call, please submit an e-mail message to RFA@MAEHC.ORG by December 9, 2004, 5:00 P.M. E.S.T., and you will receive dial-in information by return e-mail. During the conference call, Massachusetts eHealth Collaborative representatives will answer questions submitted by e-mail prior to the conference call. Please submit questions to RFAQUESTIONS@MAEHC.ORG by December 10, 2004, 5:00 P.M. E.S.T. The second call will take place on January 4, 2005, 12:00 Noon, E.S.T. Procedures for obtaining dial-in information will be made available on the Collaborative's website, www.maehc.org, no later than December 27, 2004.

Appendix A

Members of The Massachusetts eHealth Collaborative

Associated Industries of Massachusetts
Alliance for Health Care Improvement
Baystate Health System
Beth Israel Deaconess Medical Center
Blue Cross Blue Shield of Massachusetts
Boston Medical Center
Caritas Christi
Executive Office of Health and Human Services
Fallon Clinic, Inc.
Fallon Community Health Plan
Harvard Pilgrim Health Care
Health Care for All
Lahey Clinic Medical Center
Massachusetts Business Roundtable
Massachusetts Coalition for the Prevention of Medical Errors
Massachusetts Health Quality Partners
Massachusetts Medical Society
Massachusetts League of Community Health Centers
Massachusetts Nurses Association
Massachusetts Council of Community Hospitals
Massachusetts Association of Health Plans
Massachusetts Chapter American College of Physicians
Massachusetts Health Data Consortium
Massachusetts Group Insurance Commission
Massachusetts Hospital Association
Massachusetts Technology Collaborative
Massachusetts Taxpayers Foundation
MassPRO, Inc.
New England Healthcare Institute
Partners Healthcare
Tufts Associated Health Maintenance Organization, Inc
Tufts-New England Medical Center
University of Massachusetts Memorial Medical Center

Appendix B
Acute Care Hospitals in Massachusetts

Anna Jaques Hospital
Athol Memorial Hospital
BayState Health Systems
    BayState Medical Center
    Franklin Medical Center
Berkshire Health Systems
    Berkshire Medical Center
    Fairview Hospital
Boston Medical Center
Brockton Hospital
Cambridge Public Health Commission
    Cambridge Hospital
        Cambridge Campus
        Somerville Campus
        Whidden Memorial Campus
Cape Cod Healthcare
    Cape Cod Hospital
    Falmouth Hospital
CareGroup, Inc
    BIDMC East
    BIDMC West
    BIDMC Needham
    Mt. Auburn Hospital
    New England Baptist Hospital
Caritas Christi Health Care System
    Caritas Carney Hospital
    Caritas Good Samaritan Hospital
    Caritas Norwood Hospital
    Caritas St Elizabeth's Medical Center
    Holy Family Hospital
    St. Anne's Hospital
Children's Hospital
Cooley Dickinson Hospital
Dana Farber Cancer Institute
Emerson Hospital
Hallmark Health System
    Lawrence Memorial Hospital
    Melrose-Wakefield Hospital
Harrington Memorial Hospital
Henry Heywood Memorial Hospital
Holyoke Hospital
Hubbard Regional Hospital
Jordan Hospital

Lahey Clinic
Lawrence General Hospital
Lowell General Hospital
Martha's Vineyard Hospital
Mass Eye & Ear Infirmary
Merrimack Valley Hospital
MetroWest Medical Center
    Framingham Campus
    Leonard Morse Campus
Milford-Whitinsville Regional Hospital
Milton Hospital
Morton Hospital
Nantucket Cottage Hospital
Nashoba Valley Medical Center
New England Medical Center
Noble Hospital
North Adams Regional Hospital
Northeast Health Systems
    Addison Gilbert Hospital
    Beverly Hospital
Partners Healthcare System
    Brigham & Women's Hospital
    Mass General Hospital
    Faulkner Hospital
    Newton-Wellesley Hospital
    North Shore Medical Center
        Salem Campus
        Union Campus
Quincy Medical Center
Saint Vincent Hospital
Saints Memorial Hospital
Sisters of Providence Health System
    Mercy Hospital
South Shore Hospital
Southcoast Hospitals Group
    Charlton Memorial Hospital
    St. Luke's Hospital
    Tobey Hospital
Sturdy Memorial Hospital
U Mass Memorial Health Care
    U Mass Memorial Medical Center
        Memorial Campus
        University Campus
    Marlborough Hospital
    Clinton Hospital
    Health Alliance Hospitals

Burbank Campus
Leominster Campus
Wing Memorial Hospital
Winchester Hospital