STATE OF TENNESSEE
TENNESSEE DEPARTMENT OF HEALTH

REQUEST FOR INFORMATION # RFI 34301-20318 AMENDMENT # 1 FOR Electronic Public-Health Information (EPI) System

DATE: June 9, 2017

RFI # 34301-20318 IS AMENDED AS FOLLOWS:

1. **This RFI Schedule of Events updates and confirms scheduled RFI dates.** Any event, time, or date containing revised or new text is highlighted.

	EVENT	TIME (Central Time Zone)	DATE (all dates are State business days)
1.	RFI Issued		May 22, 2017
2.	Question and Comment Deadline	2:00 PM	June 1, 20117
3.	State Response to Written "Questions & Comments"		June 9, 2017
4.	Response Due Date		June 16, 2017

2. **State responses to questions and comments in the table below amend and clarify this RFP.**

   Any restatement of RFP text in the Question/Comment column shall NOT be construed as a change in the actual wording of the RFP document.

	QUESTION / COMMENT	STATE RESPONSE
1	When would the Department like Phase II to be implemented?	No implementation date has been identified.
2	Will DSS be able to bid on any future RFPs for Phase II?	Yes
3	It is my understanding that Phase I was funded through a grant. Are you able to provide the contract amount for Phase I? Will phase II be funded through a grant? What is the anticipated cost for Phase II?	1. The project is state funded. 2. TDH does not have an estimated cost for phase II, this RFI was released to gather information critical to generating a project budget.
4	Will the Department contract for any additional services as part of this effort, but not within the scope of Phase II, such as: staff augmentation, systems integration, data migration, QA, PMO, IV&V, etc. If so, please provide the procurement method and time frame for each subsequent procurement. Also, please indicate if any of the services will be combined or if each will be acquired individually.	1. No decisions have been made regarding additional contracts. This RFI was created to gather information to support planning for phase II. 2. All procurements will follow the standard State procurement policies and processes and no timelines have been identified. 3. An integrated solution is required, so acquiring system components or services individually is not desirable.

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5	When would the Department like to see an RFP hit the street for Phase II?	Within the next 12 months
6	Will there be any other subsequent phases for this project; and if so, are you able to indicate what may be included in each phase and whether or not a procurement will take place for it.	TDH anticipates phase II will be the final phase for the EPI project.
7	Can you please provide more information about the Department's size including your annual number of ambulatory visits based on the definition below? **Definition** Any completed ambulatory patient appointment with a decision-making medical provider. Decision-making providers are providers whose role typically requires a minimum of a 4-yr degree. Excluded are medical students, RNs and LPNs. Doctors, PAs, nurses with advanced training (NPs, CRNA, etc.) are included. Other examples include audiologists, dieticians, optometrists, physical therapists and surgical technicians. Note that some of these visits may also be counted as specialty visits (e.g. a face to face visit with a cardiologist would count as one Ambulatory Visit Equivalent and as one Cardiology Visit). **Examples to Include:** Office visits with decision-making providers, Urgent care visits to facilities that primarily treat patients with lower acuity problems, Telemedicine and video visits, Physical Therapy, Occupational Therapy **Examples to Exclude:** Telephone encounters, Letters, Diagnostic-only visits (lab, rad, etc.) where the patient does not see a decision-making provider, ED Visits and urgent care visits to facilities that primarily treat patients with medium to high acuity problems.	TDH and many public health clinics operate differently than private practices and define our own specifications and providers. We focus on total of medical encounters and non-medical encounters. We do not count ambulatory visits. Our encounters are limited to public health visits and therefore do not include urgent care, physical therapy, occupational therapy, radiology, etc.
8	Can you provide a number of clinical providers per the definition below who deliver patient care? "Providers" mean those Physicians, Nurse Practitioners, Physician Assistants, Audiologists, Optometrists, Therapists, Occupational Therapists, Physical Therapists, Music Therapist, Speech Therapists, Massage Therapists, Chiropractors, Anesthesiologists, Psychologists, Dentists, Hygienists, Licensed Social Workers, Midwife,	TDH employs and contracts with medical doctors, dentists, advanced practice nurses. The total number of staff at the clinics is approximately 400.

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	Nutritionists, Dietitians, Counselors, Mental Health Practitioners, Neurophysiologists, Nurses that provide patient care, and Podiatrists employed by or under contract with Customer to provide services within the medical field. The term Provider shall not include Customer personnel employed by or under contract with Customer as office managers, secretaries, or other administrative staff, and (hereinafter referred to as "Customer Personnel"). For any category of Customer staff not identified above, Vendor and Customer shall agree in writing as to who is a Provider. "Full Time Provider" means any provider that works more than 2 days a week is equal to 1.0 Full Time Equivalent Provider (FTE). "Part Time Provider" means any provider who works 2 days a week or less and is equal to 0.5 Time Equivalent Provider (FTE).	
9	Can you provide the number of Nurses (Excluding Nurse Practitioners as they are considered Providers)?	Approximately 250
10	Can you please clarify the role of the nurses (not including Nurse Practitioners)? 1. Will the nurses be writing prescriptions? 2. Will the nurses be issuing medications? 3. Will the nurses require a schedule? 4. Do the nurses bill for any services performed by them, if so what services?	1. No 2. Yes 3. Yes 4. No
11	Please specify your current hosting method – client server or is your system hosted in a cloud environment that is hosted by your EMR vendor? What is your preference moving forward?	The current system is housed in the State of Tennessee Data Center. The EHR is hosted in a client server environment and the PTBMIS system is hosted on 13 regionally located AS/400s. The preference would be to host future applications in the state's data center.
12	With 13 regions and over 120 service locations, do you currently link your EMR and PTBMIS in a single database linking all facilities or multiple databases, one for each facility?	The two systems do not share a common database. They communicate via HL7 messages through an EDI engine.
13	Section C.1 – Patient Scheduling please explain your requirements for the following: • Schedule by time, provider, program: Q: What programs and how many? • Schedule immediate, past and future appointments: Q: Do you schedule past appointments?	1. The public health clinics operate differently than most private practices. Certain program codes reference services that are funded from multiple funding sources. Federal programs such as Title X or WIC are independently from state funded programs such as TennCare and other state funding sources. 2. If the system is unavailable or data is lost, we

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		continue to see patients. This may create the need to schedule appointments in the past.
14	Section C.2 – Patient Registration • Register patients by registration type; Q: please explain type.	The short registration is used to make an appointment, but cannot be used for services. Community registration requires less information and certain services can be provided within the community (i.e. school registration for flu vaccine). Certain other services can be provided with a long registration.
15	Section C.3 – Billing • Show discounts and/or adjustments on bills; Q: Please explain in more detail. • Track receipts by specific programs; Q: Please explain in more detail. • Bill non-insurance (contracted party) payers; Q: Please explain • Record encounter or service as "confidential"; Q: Please explain • Maintain multiple funding sources for programs; Q: Please explain what type of funding sources and programs	1. The sliding scale discount is a huge component. Program codes are required for encounters and are important for sliding scale discounts. 2. TDH has local contracts that need to be managed when billing non-insurance. 3. There are times when encounters need to be confidential where no correspondence or billing is allowed. Examples include; patient who seek services at a local health department or regional office clinic and don't want anyone to know they are seeking services at the health department, they may have a regular doctor but decide not to receive services/treatment at their doctor's office for confidential reasons or the patient is a minor or has spouse/partner/parent that is unaware of the service/treatment.
16	Section C.4 – Case Management • Q: Please explain what you mean by manage these services; is this strictly billing/claims related?	Case Management is for purposes of patient care coordination as opposed to billing.
17	Section C.5 – Pharmacy • This is usually a product of the medical record solution; Q: please explain your requirement for this – and how it works for your today?	TDH requires the ability to bill a patient or a third party payer. The current EMR solution provides the capability to order, issue, and administer medications.
18	Section C.7 – Interoperability – interface with multiple HL7 message formats: • TennIIS – Q: please explain the need for a Practice Management (PM) system to connect to this service • TNWIC program – Q: please explain the need for a PM system to connect to this service • Health Enterprise Warehouse – Q: please explain how this is connected to a PM system. • Laboratory Vendors – Q: please explain how this is connected to a PM system. • Please provide more information on your requirement to connect to the State of Tennessee Financial System for payments.	1. Whenever an immunization is given at a clinic, that record is sent the state system of record for immunizations, TennIIS via HL7 message. 2. The health department clinics provide federally funded services to WIC patients. This information must be sent to the TNWIC system as it is the system of record and used to provide reporting for compliance with the WIC program. 3. The Health Enterprise Warehouse (HEW) requests data from multiple systems to achieve reporting requirements. The data is extracted from each system and ingested into the HEW. 4. Laboratory Vendors are connected to the PM System via HL7 messages (LOI, LRI).
19	Section C.9 – Patient Portal • View encounter summary/lab results – Q:	The patient portal will need to combine medical

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	This is usually a product of the medical record solution; • Q: please explain the need to connect to a PM system for this functionality	record information along with scheduling, registration and billing information. Some components are housed in the medical record and some in the practice management system.
20	Section C.10 – Program Management – multiple programs • Q: Please explain what you want a PM system to provide for these programs	Public health clinics operate differently than most private practices. Certain program codes reference different services that are funded from multiple funding sources. Federal programs such as Title X or WIC are different from state funded programs such as TennCare and other state funding sources.
21	Section C.11 – Claims Payer • Please explain what it meant by manage vendor/payer/payment files Q: do you post to these, ERA's? Q: What vendor systems Q: What clearinghouse(s) do you use?	TDH pays claims for those services not provided at the clinics. Claims are entered and paid to the vendor. Examples include BCS, hemophilia, Ryan White, renal, and retinal screening.
22	Do you have any interest in replacing the legacy vxVisTA EMR with a fully unified EMR/PM and Population health management solution?	The cost of a complete replacement may be cost prohibitive, however, we will not rule out the possibility.
23	What is the desired method for submission of our response? Can we e-mail it directly to Jennifer Garrison at Jennifer.B.Garrison@tn.gov?	You should email directly to Jennifer.B.Garrison@tn.gov.
24	C.6 Pharmacy – is the state looking for a CPOE system or a system that will be used by the pharmacists to fulfill orders/prescriptions?	Our current system provides this functionality.
25	C.3 Billing – Enter and maintain multiple custom procedure codes. Apply charges to multiple funding sources. Can you provide some additional detail around the custom procedure codes?	TDH utilizes many standard codes as well as codes specific to public health and other services provided to the public.
26	As stated on Page 1, "In EPI v1.0 (already implemented), TDH provides interoperability and application integrations between the vxVistA EHR solution and certain PTBMIS modules including patient registration, appointment scheduling, and insurance information. Interoperability for sending vxVistA encounter information to PTBMIS will be implemented in the coming months." *What system is current in use for the EPI v1.0? And is it intended that EDI v2.0 integrate with this system?*	The current system for EPI is the Veterans Administration System VistA/CPRS. The new systems must integrate with this system via HL7 messages.
27	On Page 2, regarding the "Current System", it is stated that "Currently, each regional installation of PTBMIS may have slight variances in program codes, data elements, and hardware configurations, and is supported by one or more local PTBMIS systems administrators. This will be centralized in the new system."	Most program codes are standard across the state. TDH's vision is to allow each region to maintain a limited amount of location specific codes. We expect that all codes will be migrated and maintained in the new system. A final decision has not been made on how much data to migrate from the current system to the new system.

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	Within the new planned centralized system is it preferred that the program codes and data elements be standardized across all regions/organizations or that the regions/organizations continue to be able to use their respective codes and data elements? If there will be a standardized set of program codes and data elements, is there any requirement for the system to still map to external systems that use the old program codes and data sets? Is it expected that all existing data from these systems be migrated to the central system?	
28	On Page 2, under "Proposed Solution", it is stated that "The solution must contain the features listed below, and accommodate thirteen (13) regionalized divisions crossing multiple time zones and TDH's central office in Nashville." *Is there any need for secure data partitioning/distinct data views between the regions/organizations?*	The ability must exist for all providers to view the patient information at organization level. All access to records must be maintained for audit and compliance purposes.
29	On Page 2, C.1, "Patient Scheduling", the requirements are noted for the ability to (among others): "- List appointments per patient or provider - Cancel appointments (patient or clinic cancellation) - Generate missed appointment and reminder letters" *Are there any calendaring options, reporting requirements, notifications/alerts/reminders required by the provider? Is there any requirement for patients to receive automated notifications and reminders regarding scheduled appointments? Is there any requirement for patients to receive calendar invites for their appointments?*	The detailed requirements for scheduling have not been completely defined. The purpose of this RFI is to see what functionality is available in the market and use that information to clearly define our needs
30	On Page 3, C.7, "Interoperability", in terms of integration/interoperability points listed: *Are some or all integrations required to be bi-directional? Is their a preferred push/pull interval: real-time, every hour, scheduled nightly dropoffs, other? Do users need to be able to seamlessly move between the system interfaces (e.g., single sign-on, etc.)? Can examples of the data that needs to be synced to/from the systems please be provided for timeline/effort scoping?*	1. All integrations must be bidirectional. We utilize real-time messaging within the state network and push/pull SFTP with trading partners outside the state network. 2. TDH is currently evaluating single sign-on options and this is not required for this RFI. 3. Currently data is exchanged between systems for patient care and not synced. Data is maintained on the system of record and is shared for patient care. Updates to the system of record are not synced to other systems unless there is a need for current data.

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31	On Page 3, C.3, "Billing", in terms of the capabilities listed: *Is there a requirement for managed rate forms and rules-based discount management? Is there a requirement for the system to do financial calculations? Is there any requirement for special ad-hoc, weekly, monthly, quarterly, annual rollups or reports such as for current sessions allocations, actuals, reallocations, government recovery, etc.? Is there a need for tracking and reconcilation of cashflow? Is there a requirement for an audit-ready compliance history?*	1. Yes 2. Financial calculations will be a requirement (example – sliding scale discount methodology for patient charges). Loading of insurance plan contract rates may be required. Ad hoc reporting will be a requirement for financials. 3. Yes 4. Yes
32	On Page 3, C.6, "Case Management": *Is there any requirement for special ad-hoc or scheduled rollups or reports by program/service/protocol type, for example reports specific to programs such as residential care, assisted living, clinical services, on-call availability programs, provider/physician sessionals, etc.?*	Ad hoc reporting will be required within the Patient Care Coordination module.
33	Page 4, C.8, "Reporting": *Is there any requirement for reports to be automatically emailed, displayed as dashboards, displayed in user-specific to-do lists, etc.? When users query the database for custom reports, is the requirement for every field to be reportable? Should all users be able to generate custom reports or just a specific category of user? What categories of users are anticipated (e.g., Admin, Full Access, Approvers, Read Only, Internal, External, etc.) and how many of each?*	Any and all reporting must be available in many formats including email, pdf, csv, and other industry standard formats. Not all users will be able to create reports. In addition to standard or canned reports, we will require authorized users to create custom reports. The number and type of users have not been defined.
34	On Page 4, C.9, "Patient Portal", it is indicated that patients should be able to: "- Schedule appointments - Interact with providers through a messaging system - View encounter summary - View lab results - View patient liability and make payments through outside vendor" *Should patients also be able to cancel appointments? Is there any requirement for patients to be able to self-register and/or modify their own profile information?*	The detailed requirements for a patient portal have not been completely defined. The purpose of this RFI is to see what functionality is available in the market and use that information to clearly define our needs.
35	Page 4, "Claims Payer", requirements are stated for the ability to:	No final decision has been made on Claims Payer requirements. Managing provider services, invoicing and claims via a centralized system is

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"- Pay claims - Maintain vendor files - Maintain payer files - Manage payments" *Is any requirement foreseen to also manage provider and physician services, contracts and agreements, compensation, clinical services, invoicing and claims via the one central system?*	desired.

3. **RFP Amendment Effective Date.** The revisions set forth herein shall be effective upon release. All other terms and conditions of this RFP not expressly amended herein shall remain in full force and effect.