AMENDMENT OF SOLICITATION

1. Solicitation Number	Page of Pages	
DCHT-2011-T-0009	1	8

2.Modification Number	3. Effective Date	4. Requisition/Purchase Request No.	5. Caption
A0001	4/8/2011	Not Applicable	State Medicaid Health Information Technology Plan

6. Issued By: Code
Department of Health Care Finance
Office of the Director - Division of Contracts
825 No. Capitol Street, NE 6th Floor
Washington, D.C. 20002

7. Administered By (If other than line 6)
Department of Health Care Finance
Office of the Director
825 North Capitol Street, NE 6th Floor
Washington, DC 20002

8. Name and Address of Contractor (No. Street, city, country, state and ZIP Code)
Potential Offerors

X	9A. Amendment of Solicitation No. **DCHT-2011-T-0009**
	9B. Dated (See Item 11) **3/29/2011**
	10A. Modification of Contract/Order No.
	10B. Dated (See Item 13)

11. THIS ITEM ONLY APPLIES TO AMENDMENTS OF SOLICITATIONS

X The above numbered solicitation is amended as set forth in Item 14. The hour and date specified for receipt of Offers [ ] is extended. [X] is not extended. Offers must acknowledge receipt of this amendment prior to the hour and date specified in the solicitation or as amended, by one of the following methods: (a) By completing Items 8 and 15, and returning 1 copy of the amendment: (b) By acknowledging receipt of this amendment on each copy of the offer submitted; or (c) By separate letter or fax which includes a reference to the solicitation and amendment number. FAILURE OF YOUR ACKNOWLEDGEMENT TO BE RECEIVED AT THE PLACE DESIGNATED FOR THE RECEIPT OF OFFERS PRIOR TO THE HOUR AND DATE SPECIFIED MAY RESULT IN REJECTION OF YOUR OFFER. If by virtue of this amendment you desire to change an offer already submitted, such change may be made by letter or fax, provided each letter or telegram makes reference to the solicitation and this amendment, and is received prior to the opening hour and date specified.

12. Accounting and Appropriation Data (If Required)

13. THIS ITEM APPLIES ONLY TO MODIFICATIONS OF CONTRACTS/ORDERS, IT MODIFIES THE CONTRACT/ORDER NO. AS DESCRIBED IN ITEM 14

	A. This change order is issued pursuant to: (Specify Authority) 27 DCMR, Chapter 36, Contract Modifications
	The changes set forth in Item 14 are made in the contract/order no. in item 10A.
	B. The above numbered contract/order is modified to reflect the administrative changes (such as changes in paying office, appropriation data, etc.) set forth in item 14, pursuant to the authority of 27 DCMR, Chapter 36, Section 3601.2.
	Title 27 DCMR, Chapter 36, Section 3601.2 **Bilateral Modification**
	D. Other (Specify type of modification and authority)

E. IMPORTANT: Contractor [ ] is not, [X] is required to sign this document and return 1 copy to the issuing office.

14. Description of amendment/modification (Organized by UCF Section headings, including solicitation/contract subject matter where feasible.)

Solicitation DCHT-2011-T-0009 is hereby amended as described on pages 2-8 that follow and Attachments A, B, C, and D

ALL OTHER TERMS AND CONDITIONS REMAIN UNCHANGED

Except as provided herein, all terms and conditions of the document referenced in Item (9A or 10A) remain unchanged and in full force and effect

15A. Name and Title of Signer (Type or print)		16A. Name of Contracting Officer **James H. Marshall**	
15B. Name of Contractor (Signature of person authorized to sign)	15C. Date Signed	16B. District of Columbia (Signature of Contracting Officer)	16C. Date Signed **4/8/2011**

<table>
<tr><th>Item No.</th><th>RFTOP Selection</th><th>Amendment</th><th>Amended Provision</th></tr>
<tr><td>1</td><td>A, page 1 8B</td><td>Delete:
In its entirety

Insert:
8B Submit To:
The attention of Jim Marshall at jim.marshall@dc.gov
See Section L.2</td><td>8B Submit To:
The attention of Jim Marshall at jim.marshall@dc.gov
See Section L.2</td></tr>
<tr><td>2</td><td>C.1.1</td><td>Insert:
<table>
<tr><th>Item No.</th><th>Document Type</th><th>Title</th><th>Date</th></tr>
<tr><td>3</td><td>District Document</td><td>District of Columbia Planning Advance Planning Document (P-APD) Medicaid Heath Information Technology (HIT) and State Medicaid HIT Plan (DC SMHP) (Attachment J.5)</td><td>Most Recent</td></tr>
</table></td><td>Insert:
<table>
<tr><th>Item No.</th><th>Document Type</th><th>Title</th><th>Date</th></tr>
<tr><td>3</td><td>District Document</td><td>District of Columbia Planning Advance Planning Document (P-APD) Medicaid Heath Information Technology (HIT) and State Medicaid HIT Plan (DC SMHP) (Attachment J.5)</td><td>Most Recent</td></tr>
</table>
(Provided as Attachment A to A0001)</td></tr>
</table>

Item No.	RFTOP Selection	Amendment	Amended Provision
3	C.2.1.1 at the end of the second paragraph	**Insert:** REC (Regional Extension Center) coordination refers to coordination with the local REC grantee, the District of Columbia Primary Care Association (or DCPCA) which has the responsibility for facilitating the EHR adoption of 1,000 small physician practices in the District. Some of these providers will be Medicaid providers who may qualify for participation in the EHR Incentive program.	The mission of DHCF is to improve health outcomes by providing access to comprehensive, cost-effective, and quality health care services for residents of DC. As the oversight agency for both Medicaid and the District's HIE programs, DHCF will ensure Health Information Technology (HIT) initiatives and activities are coordinated, including the identification, prioritization, and implementation of HIT services. DHCF has been appointed by the Mayor's Office as the lead agency for HIE Planning. DHCF is working collaboratively with the DC Department of Health (DOH) and Office of Chief Technology Officer (OCTO) as well as with the District's Regional Health Information Organization (RHIO) and the Regional Extension Center (REC) to implement the HIE project. REC (Regional Extension Center) coordination refers to coordination with the local REC grantee, the District of Columbia Primary Care Association (or DCPCA) which has the responsibility for facilitating the EHR adoption of 1,000 small physician practices in the District. Some of these providers will be Medicaid providers who may qualify for participation in the EHR Incentive program.
4	C.3.1.1.1 1	**Delete:** In its entirety **Insert:** 1. **Relationships with other entities in the State**: The Preliminary Environmental Scan conducted by Fox Systems in partnership with DHCF provided as Attachment J.14 shall be incorporated by the Contractor into the comprehensive documentation of relationships between DHCF and other entities within District of Columbia. See Attachment J.10 for a listing of entities.	1. **Relationships with other entities in the State**: The Preliminary Environmental Scan conducted by Fox Systems in partnership with DHCF and provided as Attachment J.14 shall be incorporated by the Contractor into the comprehensive documentation of relationships between DHCF and other entities within District of Columbia. See Attachment J.10 for a listing of entities.

Item No.	RFTOP Selection	Amendment	Amended Provision
5	C.3.1.1.3	**Delete:** In its entirety **Insert:** **C.3.1.1.3 Description of existing and/or duplicative health related legacy systems that may need updating or replacing** The Contractor shall incorporate any other modifications to the MMIS that would be required for the implementation of the HER incentive program by DHCF. (See H.3.2).	**C.3.1.1.3 Description of existing and/or duplicative health related legacy systems that may need updating or replacing** The Contractor shall incorporate any other modifications to the MMIS that would be required for the implementation of the HER incentive program by DHCF. (See H.3.2).
6	H.3.2	**Delete:** In its entirety **Insert:** The District, through the COTR, will provide relevant information concerning the District's MMIS required for the Contractor to complete the required services.	The District, through the COTR, will provide relevant information concerning the District's MMIS required for the Contractor to complete the required services.
7	H.3.3	**Delete:** In its entirety **Insert:** **H.3.3** The District, through the COTR, will provide feedback regarding required Deliverables. The COTR will review and provide approval or disapproval of deliverables in accordance with the due date for deliverables described in F.2.	**H.3.3** The District, through the COTR, will provide feedback regarding required Deliverables. The COTR will review and provide approval or disapproval of deliverables in accordance with the due date for deliverables described in F.2.

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<tr><th>Item No.</th><th>RFTOP Selection</th><th>Amendment</th><th>Amended Provision</th></tr>
<tr><td>8</td><td>H.3</td><td>Insert:
H.3.8 DHCF will provide workstations for up to four (4) of the contractor's staff performing the required services. Each workstation will include at computer, with internet access and e-mail capability, network printer, and a telephone. Wireless access can be provided to the on-site</td><td>H.3.8 DHCF will provide workstations for up to four (4) of the contractor's staff performing the required services. Each workstation will include at computer, with internet access and e-mail capability, network printer, and a telephone. Wireless access can be provided to the on-site</td></tr>
<tr><td>9</td><td>J.5</td><td>Delete:
Reserved

Insert:<table><tr><th>Attachment Number</th><th>Document</th></tr><tr><td>J.5</td><td>District of Columbia HIT P-APD</td></tr></table></td><td><table><tr><th>Attachment Number</th><th>Document</th></tr><tr><td>J.5</td><td>District of Columbia HIT P-APD</td></tr></table></td></tr>
<tr><td>10</td><td>J</td><td>Insert:<table><tr><th>Attachment Number</th><th>Document</th></tr><tr><td>J.14</td><td>Preliminary Environmental Scan</td></tr></table></td><td><table><tr><th>Attachment Number</th><th>Document</th></tr><tr><td>J.14</td><td>Preliminary Environmental Scan</td></tr></table>Provided as Attachment B to A0001</td></tr>
</table>

Item No.	RFTOP Selection	Amendment	Amended Provision
11	L.2	**Delete:** In its entirety **Insert:** **REQUEST FOR TASK ORDER PROPOSAL FORM, ORGANIZATION AND CONTENT** The Offeror shall submit its proposal in response to the RFTOP electronically as described below. a. The Offeror's proposal shall be organized and submitted in the following two (2) separate e-mail transmissions: 1. Volume I - Technical Proposal 2. Volume II - Price Proposal b. The Offeror shall include "Proposal in Response to Solicitation No. DCHT-2011-T-0009 State Medicaid Health Information Technology Plan" in the subject line of each transmission " c. The Offeror shall ensure the electronic version of the Offeror's Technical and Price Proposals are submitted in the order described in Section L.2 and that all required signatures are included with the electronic transmissions. d. Offerors are directed to the specific proposal evaluation criteria found in Section M of this solicitation, **EVALUATION FACTORS FOR AWARD**. The Offeror shall respond to each factor in a way that will allow the District to evaluate the Offeror's response. The offeror	**REQUEST FOR TASK ORDER PROPOSAL FORM, ORGANIZATION AND CONTENT** The Offeror shall submit its proposal in response to the RFTOP electronically as described below. a. The Offeror's proposal shall be organized and submitted in the following two (2) separate e-mail transmissions: 1. Volume I - Technical Proposal 2. Volume II - Price Proposal b. The Offeror shall include "Proposal in Response to Solicitation No. DCHT-2011-T-0009 State Medicaid Health Information Technology Plan" in the subject line of each transmission " c. The Offeror shall ensure the electronic version of the Offeror's Technical and Price Proposals are submitted in the order described in Section L.2 and that all required signatures are included with the electronic transmissions. d. Offerors are directed to the specific proposal evaluation criteria found in Section M of this solicitation, **EVALUATION FACTORS FOR AWARD**. The Offeror shall respond to each factor in a way that will allow the District to evaluate the Offeror's response. The offeror

		shall submit information in a clear, concise, factual and logical manner providing a comprehensive description of program services and service delivery. The information requested below for the technical proposal shall facilitate evaluation and best value source selection for all proposals. The technical proposal must contain sufficient detail to provide a clear and concise representation of the requirements in Section C.	shall submit information in a clear, concise, factual and logical manner providing a comprehensive description of program services and service delivery. The information requested below for the technical proposal shall facilitate evaluation and best value source selection for all proposals. The technical proposal must contain sufficient detail to provide a clear and concise representation of the requirements in Section C.
12	L.2.1.2 e	**Delete:** In its entirety **Insert:** e. The Offeror shall include in the Technical Proposal or have completed performance evaluations submitted electronically to the attention of Jim Marshall at jim.marshall@dc.gov **on or before the due date for proposals described in L.3.1**at a minimum three (3) completed past Performance Evaluation forms (Attachment J.13) for entities identified in b above.	e. The Offeror shall include in the Technical Proposal or have completed performance evaluations submitted electronically to the attention of Jim Marshall at jim.marshall@dc.gov **on or before the due date for proposals described in L.3.1**at a minimum three (3) completed past Performance Evaluation forms (Attachment J.13) for entities identified in b above.
13	L.2.1.3 c 3	**Delete:** In its entirety **Insert:** 3. Education, including school name of institution, degree(s) conferred and date(s);	3. Education, including school name of institution, degree(s) conferred and date(s);
14	L.2.2 b	**Delete:** Attachment J.14 Insert: Attachment J.12	b. Completed Cost/Price Data (Attachment J.12)

Item No.	RFTOP Selection	Amendment	Amended Provision
15	L.19.2	**Renumber L.12.2**	
16	L.12.2, third sentence	**Delete:** October 22, 2010 **Insert:** 4:00pm April 6, 2011 as described in L.5	Impromptu questions will be permitted and spontaneous answers will be provided at the District's discretion. Verbal answers given at the pre-proposal conference are only intended for general discussion and do not represent the District's final position. All oral questions must be submitted in writing following the close of the pre-proposal conference but no later than 4:00pm April 7, 2011 as described in L.5 in order to generate an official answer. Official answers will be provided in writing to all prospective Offerors who are listed on the official Offerors' list as having received a copy of the solicitation. Answers will also be posted on the OCP website at www.ocp.dc.gov .
17	L.20	**Renumber L.13**	

DCHT-2011-T-0009 A0001

Attachment A

Office of the Chief Administrative Officer

March 17, 2011

Ted Gallagher
Associate Regional Administrator
Department of Health and Human Services
Centers for Medicare and Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Leger Building
Philadelphia, PA 19106-3499

Re: Planning Advance Planning Document

Dear Mr. Gallagher:

The District of Columbia Department of Health Care Finance (DHCF) is pleased to submit the enclosed updated Planning Advance Planning Document (P-APD) for Medicaid Health Information Technology (HIT) and State Medicaid HIT Plan (SMHP) development. This updated P-APD is being submitted as a result of your approval of our request for an extension of time to complete the planning by May 31, 2011. The extension was necessary as a result of a delay of the previous administration to begin the planning process. This P-APD has been prepared consistent with the guidance provided in SMD #09-006.

DHCF looks forward to receiving CMS' expeditious approval of our P-APD and proceeding with the development of our SMHP. Should you have any questions or concerns regarding our P-APD, I can be reached at 202-478-5925 or via email at Brenda.Emanuel@dc.gov. Thank you for your continued support of the DHCF and on behalf of the residents of the District of Columbia.

Sincerely,

Brenda L. Emanuel
Chief Administrative Officer
and Health IT Coordinator

cc: Wayne Turnage, Director, DHCF
Jessica Kahn, CMS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

APR 1 2011

Ms. Brenda L. Emanuel
Chief Administrative Officer
and Health IT Coordinator
Office of the Chief Administrative Officer
Department of Health Care Finance
899 North Capitol Street, N. E.
Washington, D.C. 20002

Dear: Ms. Emanuel:

I write in reference to the Request for Proposal (RFP), submitted via your letter dated March 29, 2011, to secure competitive bids for the development of a State Medicaid Health Information Technical Plan.

We are approving the use of this RFP to procure the necessary services. We are requesting that you inform us in advance of the procurement activity, i.e., the dates and times of important planning meetings and the pre-bid conference as well as any problems that arise during the process. Also, remember that we must review the evaluation and selection of the vendor. Therefore, we are requesting that you submit a copy of the Technical Evaluation Report prior to your final selection of a contractor. In addition, the associated contract must be prior approved.

Should you have any questions on this matter, please contact Sally Heeney of the Financial Management Branch. She can be reached at (215) 861-4273.

Sincerely,

Ted Gallagher

Ted Gallagher
Associate Regional Administrator

Received
APR - 8 2011

Office of the Chief Administrative Officer

March 17, 2011

Ted Gallagher
Associate Regional Administrator
Department of Health and Human Services
Centers for Medicare and Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Leger Building
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Sincerely,

Brenda L. Emanuel
Chief Administrative Officer
and Health IT Coordinator

cc: Wayne Turnage, Director, DHCF
Jessica Kahn, CMS

Government of the District of Columbia

Department of Health Care Finance

Planning Advance Planning Document (P-APD)

Medicaid Health Information Technology (HIT)
And
State Medicaid HIT Plan (DC SMHP)

Submitted by:
District of Columbia Department of Health Care Finance
825 North Capitol Street, N.E.
Washington D.C. 20002

- Revised -
March 17, 2011

Wayne Turnage
Director

Revision History

Version	Date	Author	Status
0.1	March 5, 2010	J. Focht	Initial Draft
1.0	March 25, 2010	J. Focht	CMS Submission
1.1	April 20, 2010	J. Focht	Incorporation of CMS comments
2.0	March 17, 2011	B. Emanuel	CMS Submission-Extension

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Executive Summary

This planning advance planning document (P-APD) is submitted by the District of Columbia Department of Health Care Finance (DHCF) to request federal financial participation (FFP) from the Centers for Medicare and Medicaid Services (CMS) for administrative costs to support planning activities authorized by the American Recovery and Reinvestment Act of 2009 (ARRA) Health Information Technology (HIT) program.

The District seeks to create a world-class health information technology environment which is hallmarked by broad-based adoption of electronic health records (EHRs) as a platform for accessing benefits from HIT and associated health information exchange (HIE). A major component of this vision will include adoption of EHRs by Medicaid providers through the administration of the incentive program authorized under ARRA. The District will develop a sound and logical HIT/HIE strategy incorporating the Medicaid EHR incentive program as a major component. This will result in the delivery of better health care for District residents, enhance patient safety, improve coordination of care, and promote the use of health information technologies meeting national standards. In our roles as the HIE State Cooperative Agreement grantee, the State Medicaid agency, and the predominant payor in the District through the Medicaid and Alliance programs, DHCF will be able to leverage its position to promote the District's HIT vision.

The chapters which follow describe a series of planning tasks that will be carried out under enhanced FFP contemplated in Title IV to develop the District of Columbia State Medicaid HIT Plan (DC SMHP). These include:

1. Medicaid HIT project start-up;
2. Planning for participation by the District's Medicaid program in District-wide HIE activities;
3. Provider outreach and engagement in Medicaid HIT planning;
4. Development of the DC SMHP comprised of: 1) an "as-is" landscape assessment of the current status of HIT in the District; 2) a Medicaid HIT "to-be" vision; and, 3) an EHR roadmap plan;
5. Development of one or more HIT Implementation Advance Planning Document(s) (I-APDs) to implement activities identified in the DC SMHP necessary to support the District's "to-be" vision; and,
6. Development of RFP(s) as necessary to support the procurement of qualified contractor staff to provide operational support and program audit services for the HIT incentive program.

DHCF estimates a seven and one-half month planning project commencing on April 23, 2010 (or upon approval of this P-APD) and continuing to December 1, 2010 (including development and submission of associated I-APD(s) and RFP(s)). A key interim milestone will be the submission of our SMHP on September 30th, 2010. DHCF estimates a total planning budget of $907,578, with an estimated Federal share of $816,820 for all currently anticipated District and contractor expenses.

II. Statement of Need and Objectives

2.1 Statement of Need

This planning advance planning document (P-APD) is submitted by the District of Columbia Department of Health Care Finance (DHCF) to request federal financial participation (FFP) from the Centers for Medicare and Medicaid Services (CMS) for administrative costs to support planning activities authorized by the American Reinvestment and Recovery Act of 2009 (ARRA) Health Information Technology (HIT) program.

Title IV of ARRA established a program to promote the use of HIT and electronic health records (EHRs) among Medicaid providers. Consistent with the interim and proposed rules published by the Office of the National Coordinator for Health IT at the US Department of Health and Human Services (DHHS) and CMS, certain Medicaid providers can qualify for federal incentive funding for certified EHR technology and support services. To support efforts of states and jurisdictions to administer this program, Title IV authorizes 90% FFP for reasonable administrative expenditures, including expenditures for planning.

The District of Columbia Government and DHCF are committed to efforts that foster and enhance HIT adoption and clinical practice workflow reengineering to improve health care coordination, foster economies and efficiency in health care delivery, and ultimately improve health care outcomes for District residents in general and Medicaid recipients in particular. A number of initiatives are currently underway in the District to develop health information exchange (HIE) capability and foster adoption of HIT. Given the significant portion of the District's population who participate in its Medicaid program, fostering HIT among Medicaid providers is a high priority. The results of the planning efforts to be carried out under funding provided through this P-APD will significantly advance our agenda in this regard.

2.2 Purpose of P-APD

This P-APD describes a series of planning tasks that will be carried out under enhanced FFP contemplated in Title IV. These include:

1. Medicaid HIT project start-up;
2. Planning for participation by the District's Medicaid program in District-wide HIE activities;
3. Provider outreach and engagement in Medicaid HIT planning;
4. Development of the District of Columbia State Medicaid HIT Plan (DC SMHP) comprised of an "as-is" landscape assessment of the current status of HIT in the District, a Medicaid HIT "to-be" vision, and an EHR roadmap plan;
5. Development of one or more HIT Implementation Advance Planning Document(s) (I-APDs) to implement activities identified in the DC SMHP as necessary to support the District's "to-be" vision; and,
6. Development of RFP(s) as necessary to support the procurement of qualified contractor staff to provide operational support and program audit services for the HIT incentive program.
7. The project schedule has been reduced to less than three months due to the original project plan not being implemented by the previous administration. After January 1, 2011 the District elected a new Mayor and Wayne Turnage was appointed the new Director of the Department of Health Care Finance. Mr. Turnage took office on February 1, 2011. Brenda Emanuel also began with the DHCF on February 1, 2011. The new administration requested from CMS and was granted an extension to develop the SMHP, I-APD and RFP by May 31, 2011. This is a very tight timeline from the original

seven and one-half month planning project period that should have commenced on about April 23, 2010 and continue to December 1, 2010. DHCF estimates a total planning budget of $572,046, with an estimated Federal share of $514,841 for all currently anticipated District and contractor expenses.

2.3 Statement of Objectives

The purpose of this project will be to develop the DC SMHP and one or more I-APDs and any needed RFP(s) to support DHCF's Medicaid HIT vision, thereby enabling the District to move from the current "as-is" Medicaid HIT landscape to the "to-be" vision defined during this planning process. In conjunction with our planning efforts, we will also support Medicaid's role as a key player in the District's overall HIE initiatives.

DHCF will coordinate our effort to initiate a Medicaid Information Technology Architecture (MITA) project as a way of incorporating MITA principles and approaches as a foundation for analysis to complete the DC SMHP.

Within this framework we will accomplish project objectives as outlined in the following paragraphs.

2.3.1 Medicaid HIT Project Start-up

The objective of this task will be to initiate planning and SMHP development activities by finalizing project plans, engaging necessary resources, establishing project governance, and initiating status and reporting mechanisms.

2.3.2 Medicaid Participation in District HIE Activities

This task's objective will be to carry out activities that are designed to support the connection of Medicaid HIT with wider HIE initiatives being undertaken in the District. As the grant recipient agency for the District's HIE Cooperative Agreement grant from the ONC, we will be well positioned to plan and execute tasks that connect Medicaid to these larger HIE initiatives.

2.3.3 Provider Outreach and Engagement

The objective of this task will be to engage our provider community with initial information on HIT, the EHR incentive program, and the District's process for developing our SMHP. We will initiate provider outreach activities that will promote the HIT project and adoption and meaningful use of EHRs, and explain the District's various HIT initiatives. Specific objectives associated with these activities include:

- Provision of provider education relative to the HIT incentive program;
- Identification of opportunities and barriers associated with EHR adoption; and,
- Establishment of mechanisms for stakeholder participation in the DC SMHP development process.

2.3.4 Development of the District's State Medicaid HIT Plan

The objective of the DC SMHP development task will be to: 1) document "as-is" patterns of current EHR adoption and use; 2) determine the field of eligible providers; 3) identify barriers to acceptance of EHRs, 4) determine the interrelationships between Medicaid, Medicare and other populations as they relate the adoption of HIT and EHRs; 5) identify policy issues and areas where additional guidance from CMS may be required: and, 6) identify available resources.

We will also endeavor to develop a "to-be" vision which focuses on a five (5)-year EHR adoption planning horizon, including a roadmap plan with measurable benchmarks and milestones to achieve our "to-be" vision. The roadmap plan will address the administration of incentive payments to providers, including provider eligibility determination, issuance and tracking of incentive payments, and auditing of financials and meaningful use aspects of the incentive program.

2.3.5 Development of a HIT Implementation APD (I-APD)

This task will have as its objective the development of one or more HIT I-APDs that provide a detailed approach to the implementation of the DC SMHP, establish specific implementation activities necessary to support the DC SMHP, and result in obtaining supporting FFP. HIT I-APD(s) submission will occur upon CMS approval of the DC SMHP.

2.3.6 Development of Necessary RFP(s) for Medicaid HIT Operational Support Services Procurement(s)

Objectives associated with this activity are to develop RFP(s) to secure the services of qualified contractor staff to support the provider incentive payment program, including program auditing/QA services. The District will conduct procurement(s) to obtain (a) qualified contractor(s) to provide operational support and program audit/quality assurance (QA) services for the Medicaid HIT program. Program auditing/QA services will commence once all planning activities are completed and operational activities are initiated.

2.4 The District's HIT Vision

The District seeks to create a world-class health information technology environment which is hallmarked by broad-based adoption of EHRs as a platform for accessing benefits from HIT and associated health information exchange (HIE). A major component of this vision will include adoption of EHRs by Medicaid providers through the administration of the incentive program authorized under ARRA. The District will work to develop a sound and logical HIT/HIE strategy incorporating the Medicaid EHR incentive program as a major component. This will result in the delivery of better health care for District residents, enhance patient safety, improve coordination of care, and promote the use of health information technologies meeting national standards. In our roles as the HIE State Cooperative Agreement grantee, the State Medicaid agency, and the predominant payor in the District through the Medicaid and Alliance programs, DHCF will be able to leverage its position to promote the District's HIT vision.

2.5 Current District HIT Initiatives

The District of Columbia has not yet developed a District-wide Health Information Exchange (HIE) Strategic Plan. This will be developed under the HIE Cooperative Agreement funding received from ONC. Several HIT-related efforts are, however, currently underway which will form the context within which the HIE Strategic Plan and our SMHP will be prepared. A discussion of our major HIE efforts is contained in the paragraphs below, followed by a table summarizing a range of related initiatives.

2.5.1 Medicaid Patient Data Hub Project

In 2007, CMS awarded a Medicaid Transformation Grant to the District for the development and deployment of a Medicaid Patient Data Hub (PDH) pilot that would link six clinics and two hospitals to the Medicaid Management Information System (MMIS). This is planned to allow integrated views of both claims-based and community-based health information for DC's Medicaid population. This richer view of clinical information will be a first for the District's Medicaid providers, and will permit more timely and informed clinical decision making for Medicaid patients and program operations. The PDH will link government systems to pull patient information to facilitate better choices and ultimately higher quality care.

After a lengthy competitive procurement process through early 2009, the District awarded a contract to MedPlus, Inc. The design and initial deployment of the PDH pilot is projected to be completed in late April 2010. Discussions are being held with the District of Columbia Primary Care Association (DCPCA) regarding the design of interfaces with the District of Columbia Regional Health Information

Organization (DC RHIO), other health information organizations, and the PDH. The ultimate objective of the PDH is to improve quality in medical decision making through secure exchanges of accurate and comprehensive patient health information, and through patient-centered and outcomes-driven analytical capabilities.

2.5.2 DC Regional Health Information Organization

The DC Regional Health Information Organization (DC RHIO) is one of the earliest HIE efforts in the District of Columbia. It was funded by the District Government on October 1, 2007 through a $6 million, 3-year grant to the DCPCA. The intent of the grant was to develop a RHIO that would include both public and private sector stakeholders, integrate and exchange data with the Medicaid PDH, and ultimately be expanded to enable the exchange of clinical health information within the National Capital Area. The DC RHIO connects six community clinics and two District hospitals, and a links to the District's Immunization Registry. The participating hospitals and health centers in the DC RHIO have unique electronic health records for 93,000 patients -- 41,000 patients at the six health centers and 52,000 at the two hospitals. The RHIO also receives registration information from five other hospitals, for the purpose of family reunification after a natural disaster or other mass casualty event. The DC RHIO uses eClinicalWorks EHR in the six clinics and Microsoft Amalga for data storage. The Dc RHIO was implemented on March 1, 2010 with the initial exchange of data between RHIO participant entities.

Since 2007, the DC RHIO has played a role as a convener of District stakeholders through periodic Advisory Group meetings, and through various working groups that have addressed areas of governance, finance, technical infrastructure, business and technical operations, as well as legal and policy issues. District stakeholders involved to date include public and private sector providers, payers, businesses, and academic institutions.

2.5.3 Children's IQ Network

The Children's National Medical Center (Children's) and its six Goldberg Ambulatory Pediatric Clinics have created a network of institutional and community-based pediatricians who will all use the eClinicalWorks EHR as an HIE activity focused exclusively on children. The IQ Network became operational on July 1, 2009 and its EHR is the primary medical record for the hospital and its clinics. The Children's IQ Network also plans to connect to the District foster care program to provide EHR capability for foster children undergoing emergency placement, and to Children's mobile medical vans to increase access to vulnerable populations. DHCF and Children's are in the analysis phase of exchanging Admissions/Discharge/Transfer (ADT) and other clinical data between the Children's' IQ Network and the Medicaid PDH. Children's and DHCF have also held discussions on capturing computerized Early and Periodic Screening, Diagnosis and Treatment (EPSDT) data to enable the electronic recording and reporting of well child care visits for District children enrolled in Medicaid. When completed, this activity would be one of the first projects of its kind in the US, and would be used for Medicaid and non-Medicaid children.

Additional Medicaid HIT-related initiatives in the District of Columbia include:

	Sponsoring Organization	Description of Health Information Technology Project
1.	District of Columbia Primary Care Association (DCPCA) [*through a grant from DOH*]	The Medical Homes EHR Project is focusing on the placement of an Electronic Health Record (EHR) into six initial primary care clinics The EHR platform being used by clinics is eClinicalWorks (eCW). The eCW build is said to include a special public health enhancement that was initially developed for New York City and

		will provide added public health monitoring and reporting functions over the standard eCW version. Currently, all six clinics are live with the eCW product and shortly will be able to view patient information across those live clinics for a patient under their care.
	Sponsoring Organization	Description of Health Information Technology Project
3.	DC Dept. of Health Care Finance [*SMRF database*]	The Early, Periodic Screening, Diagnosis and Treatment (EPSDT) system, better known as HealthCheck, is a capability within the MMIS used by DHCF's Office on Children and Families (OCF) to ensure Medicaid children are receiving their well child visits. At the completion of a well child visit, the provider completes a Standard Medical Record Forms (SMRFs) and submits it to OCF. The database of SMRFs allow for more granular, non-MMIS queries related to EPSDT recipients to ensure they are, in fact, receiving their respective well visits. The web-based database application is being developed by Scientific Technologies Inc.
4.	DC Dept. of Health /CHA	The Bureau of Cancer and Chronic Disease in the Department of Health's Community Health Administration proposes to use funding set aside by the City Council for chronic disease management to fund a five-year Chronic Care Initiative that will guide the District's service delivery toward high-reliability, high-value care for chronic disease populations. These target populations include persons at risk for or living with any stage or severity of this group of overlapping illnesses: cardiovascular disease (e.g., heart failure, heart attack, angina, and peripheral vascular disease), hypertension, stroke, chronic kidney disease, diabetes, and chronic obstructive lung disease (emphysema and chronic bronchitis). Persons living with these conditions in the District often use various sources of services, and mostly these services are not connected by a coherent plan of care or a medical record. The Initiative will probably have much better opportunity to succeed if at least the more seriously ill residents have a useful clinical record available at all times. This clinical record (EHR) could be provided through a modification of one of the existing HIE projects.
5.	DC Dept. of Health Care Finance [*New MMIS*]	The new Medicaid Management Information System (MMIS) project is an initiative to replace the existing MMIS platform. The MMIS is the claims processing platform used by DHCF to process claims submitted by providers on behalf of recipients for services rendered. CMS requires states to perform a technology refresh of their MMIS approximately every five years. The contract for the new MMIS was awarded to ACS in October 2007 and system go-live occurred in December, 2009.
6.	DC Dept. of Health Care Finance [*MOU*]	An MOU between DHCF and OCTO is in place to support a number of Medicaid data inputs into a shared data environment. Included in this list of Medicaid data inputs are the following: MMIS MCO enrollment data, MMIS eligibility data, MMIS recipient data, and information from the Lead database.
7.	Unity Health, Inc. Federally Qualified Health Centers (FQHC) Network	This network of FQHCs was awarded a Health Resources and Services (HRSA) High Impact - Electronic Health Record Implementation Initiative grant to equip its member clinics with an EHR. Unity has chosen eClinicalWorks as the EHR for its member clinics.

Figure 1: District of Columbia HIT-Related Initiatives

2.6 Linkage of the DC SMHP to Other DHCF Initiatives

This section acknowledges the connection between the development of the DC SMHP and three on-going District Medicaid initiatives.

2.6.1 District-wide HIE

The development of the DC SMHP will be an integral part of the District's overall plan for fostering the adoption of EHRs and facilitating the development of HIE. Mirroring initiatives at the national level such as CMS' Notice of Proposed Rule Making (NPRM) for adoption and meaningful use of EHRs, ONC's Interim Final Rule (IFR) regarding EHR standards and certification, and ONC's grant awards including HIE Cooperative Agreements and Regional Extension Centers, DHCF will carry out the development of our SMHP within the context of the District's larger HIE planning efforts. As mentioned previously, DHCF will be a key participant in this process as both the Medicaid agency and the primary HIE grantee. While each role requires us to focus on separate and distinct work streams, we will ensure coordination between the larger HIE plan and our Medicaid agency plans such that Medicaid's role as the predominant payor in the District is leveraged to support HIT/HIE adoption objectives.

2.6.2 MITA

The District is just initiating our efforts to conduct a MITA assessment. Given this timing, we intend for the framework that will guide our efforts to produce a MITA State Self-Assessment (SS-A) to also be applied to the development of the DC SMHP. Specifically, we will utilize the "to-be" assessment to serve as the foundation upon which a 5-year future vision will be developed along with the designation of intended maturity state(s) for components of Medicaid HIT. These maturity assessments and their resultant road maps will be aligned as both the mainline MITA assessment and the SMPH develop.

2.6.3 MMIS

Although the District has just implemented it new MMIS – Omnicaid, the ties and connections to the MMIS which Medicaid HIT and its desired "to-be" state will require will be addressed in our planning efforts. These connections will be documented in our SMHP (and associated I-APD(s)) as well as being reflected in our MITA SS-A.

III. Project Management Plan

3.1 Scope of Activities

3.1.1 Project Scope

DHCF will create a comprehensive DC SMHP that will be used to direct the work required to administer and oversee payments to Medicaid providers for adoption of meaningful use of certified EHRs. The plan will include:

- An "as-is" assessment of providers potentially eligible to receive incentive payments through Medicaid under the ARRA legislation;
- A vision of where the HIT environment should be in 2015; and,
- The necessary tasks and activities required to implement the provider incentive payment program and foster HIT adoption by Medicaid providers.

The DC SMHP will identify how the District will move from the current "as-is" landscape to the desired "to-be" HIT vision.

In addition, the DC SMHP will address plans and actions for Medicaid's connection to the District's wider HIE initiatives and continuation of our leadership role in that effort.

3.1.2 Project Tasks

Task 1 - Medicaid HIT Project Startup

The Medicaid HIT project will be initiated by a series of start-up tasks that are designed to secure enhanced funding approval for planning, finalize our project plan, put into place required project resources including consultant staff, identify and engage project policy leadership, and track and report on project progress leading to the submission of the DC SMHP. This task will be comprised of the following activities:

- Submit HIT P-APD;
- Obtain approval from CMS;
- Obtain enhanced funding ;
- Assign Project Manager and Project Coordinator(s);
- Finalize project plan with clear goals and objectives, to include timelines and milestones as well as stakeholders and roles;
- Develop project communication, tracking and reporting plans;
- Establish a DC SMHP Steering Committee; and,
- Develop and issue a solicitation for DC SMHP contractor support (see Section 3.3, below).

Task 2 - Medicaid Participation in District HIE Activities

Under this task, we will continue to coordinate Medicaid's role as a key participant in the District's overall HIE efforts. This will include plans for coordination of the PDH developed under a Medicaid

Transformation Grant with other HIE efforts, coordination of Medicaid's role as a participant in HIE strategic planning decisions, and identification of key connections that will be required between various Medicaid operational functions and the District's planning for HIE. This will include plans for ensuring appropriate use of Medicaid HIT funds vs. other HIE funds.

Task 3 - Provider Outreach and Engagement

In carrying out this task we will engage Medicaid providers to further their understanding of HIT/HIE initiatives in the District and solicit their input as participants in processes related to the adoption and meaningful use of EHRs. Activities will include:

- Provision of education relative to the District's HIT program and the EHR incentive program available under ARRA;
- Identification of opportunities and barriers form the Medicaid provider's prospective associated with EHR adoption; and,
- Establishment of mechanisms for stakeholder participation in the DC SMHP development process.

Task 4 - Develop the District's SMHP

Conduct "As-Is" Assessment:

DHCF and contractor staff will conduct a detailed environmental scan to provide a comprehensive picture of the HIT environment among District of Columbia Medicaid providers, including: the levels of EHR usage; receptiveness to connecting to an HIE; familiarity with and understanding of HIT-related legislation, regulations, and policy; perceived incentives and barriers to EHR adoption; and, other factors effecting EHR adoption and meaningful use.

Environmental Scan Plan

The purpose of the District's environmental scan is to ascertain the degree of HIE readiness for healthcare professionals and facilities that are eligible for the Medicaid incentive program. Our environmental scan will encompass the following components, as they relate to HIE participation and achievement of meaningful use criteria:

- An assessment of current HIE capacities that could be expanded or leveraged;
- Identification of state HIT resources;
- Identification of relevant collaborative opportunities that exist;
- Identification of human capital available;
- Inventory of the number of providers and practices eligible for Medicaid and Medicare incentive programs; and,
- Assessment of perceived and actual readiness indicators among healthcare professionals and facilities.

Environmental Scan Methodology:

Interview Key Stakeholders. Qualitative data will be collected to describe environmental scan components including: current HIE capacities, HIT resources, relevant collaborations, and human capital.

Survey Healthcare Providers. A District-wide survey of Medicaid professionals and facilities will be conducted, including a sample of eligible provider (EP) types as well as hospitals and Federally Qualified

Health Centers (FQHCs). A diverse sample of individual and small group primary care practices that are not FQHCs will be surveyed.

The survey will focus on:

- Knowledge of federal initiatives, incentives, and penalties;
- Current EHR adoption and functionality;
- HIE readiness;
- Plans for adoption – financial, staffing, and training needs;
- Anticipated costs and productivity expectations; and,
- Readiness for collection of quality and meaningful use indicators.

Develop "To-Be" Vision:

DHCF intends to connect this step to the initiation of our MITA State Self-Assessment (SS-A). Establishment of agency goals and MITA maturity model levels will assist in planning efforts as they target a significant increase in technology and its functionality and interoperability. The agency is also currently gathering high-level objectives for the future, which will guide the future detailed requirements for which adoption of HIT will serve as a catalyst or platform. Key steps in this activity will include:

- Sharing environmental scan analysis with key leaders and stakeholders to assist in the development of a cohesive vision;
- Continuing dialogue with key leaders and stakeholders, including the HIT Council, to develop a cohesive vision of the Medicaid HIT landscape through 2015;
- Drafting the vision portion of the DC SMHP;
- Circulating the draft to key leaders and stakeholders for input;
- Revising draft as needed;
- Obtaining approval of draft; and,
- Finalizing vision document for inclusion in the DC SMHP.

Develop Medicaid HIT Roadmap Plan

This activity will encompass documenting both graphically and in narrative form the key tasks to be carried out achieve the "to-be" vision. This will include integration of Medicaid HIT with larger District HIE initiatives as well as implementation and management of the Medicaid EHR incentive program and continued monitoring and auditing associated with the eligibility for the EHR incentive and on-going meaningful use. Action steps will include identification of:

- Activities and steps required to implement the "to-be" vision for EHR adoption and HIE in the District;
- Draft timeline and milestones;
- Resources required for attaining EHR adoption and HIE integration for the District's Medicaid program;

- Measures to be used to gauge progress towards 2015 goals for EHR adoption; and,
- Risks and dependencies.

Prepare State Medicaid HIT Plan

This activity will result in the preparation of the DC SMHP. Production of the SMHP will include the following steps:

- Outline contents of the DC SMHP;
- Prepare draft;
- Distribute to key leaders and stakeholders;
- Revise as needed;
- Submit DC SMHP to CMS, and,
- Obtain CMS approval.

Task 5 - Develop HIT Implementation APD

Based on the contents of the approved DC SMHP, DHCF will develop and submit one, and possibly two I-APDs related to Medicaid HIT. The first I-APD will be for enhanced Administrative funds to carry out the plans to implement and manage the EHR incentive program. This would include, but is not limited to management of requests received through the anticipated national level repository (NLR), the follow-up and decision making related to eligibility for payments, the tracking of meaningful use and related subsequent payments, and developing additional administrative processes such as appeals and audits.

The second possible I-APD will relate to any potential MMIS changes that might be required to enhance our coordination with, and use of, benefits available from the adoption of EHRs as well as other requirements that may emanate from Medicaid HIT initiatives.

Task 6 - Develop RFP(s) for Medicaid HIT Operational Support Services Procurements

We will similarly prepare and submit to CMS for approval any required RFPs or other solicitation documents related to Medicaid use of HIT. This would include, but not be limited to, project management support, audit support, and systems changes or support requirements.

3.2 Personnel Resource Statement

The following section provides a summary of project staffing resources that will be utilized in the development of the District's SMHP.

3.2.1 Project Organization

Personnel resources and associated reporting relationships will be organized according to the following project organization chart.

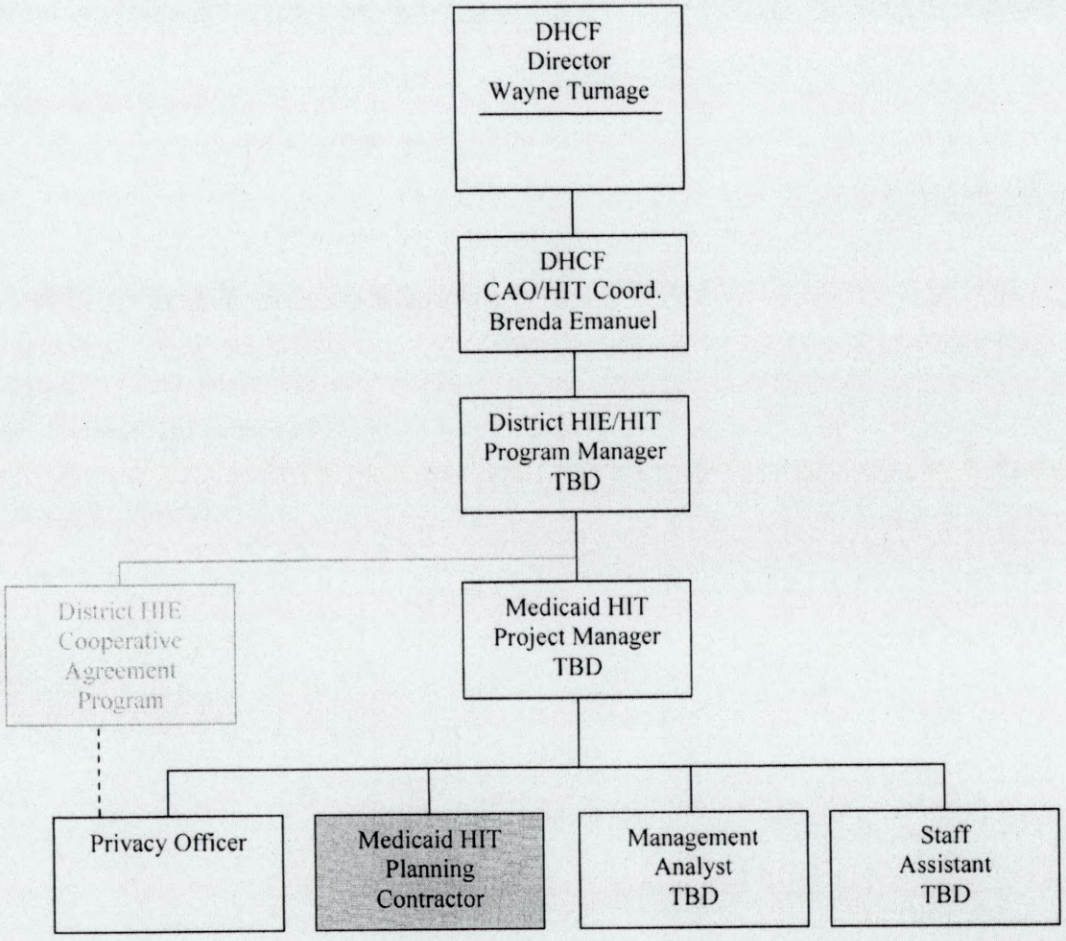


Figure 2: Medicaid HIT Project Organization

3.2.2 Project Staffing

The following table summarizes personnel resources that will staff the DC SMHP development project.

Position	Incumbent	FTE %	Project Role and Responsibilities
DHCF CAO/HIT Coordinator	Brenda Emanuel	25%	Executive responsible for overall conduct of HIT/HIE planning initiatives on behalf of DHCF. Will serve as COTR for Medicaid HIT planning contractual services.
HIE Program Manager	TBD	50%	Responsible for coordination of HIT/HIE efforts including integration of Medicaid processes into overall District HIE initiatives.
Medicaid HIT Project Manager	TBD	100%	Manager with day-to day responsibility for analysis, planning and preparation of DC SMHP. Will be primary point of contact for contractor performance as well as coordination of DHCF resources and subject matter experts necessary for Medicaid HIT planning.
Privacy Officer	LaRah Payne	25%	Senior staff responsible for assuring coordination with existing privacy policies and coordination with other policy areas.
Management Analyst	TBD	100%	Day-to-day project staff responsible for DHCF-assigned tasks, project tracking and progress reporting.
Staff Assistant	TBD	100%	Day-to-day staff responsible for project support tasks including documentation support, preparation of reports and presentations, and maintenance of project management tools.

Figure 3: Medicaid HIT Staffing Plan

3.3 Use of Contractors

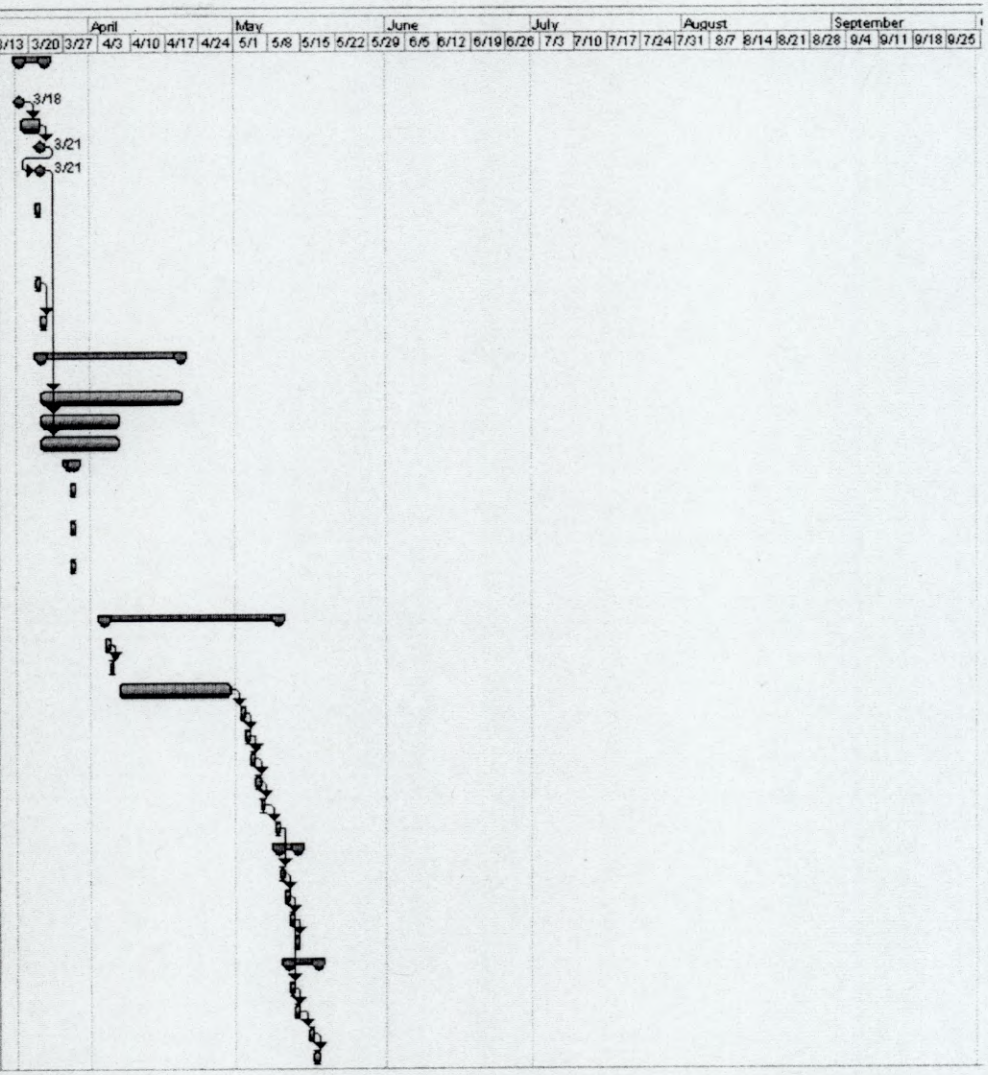
DHCF plans to secure the services of a qualified contractor to carry out Medicaid HIT planning tasks outlined in this P-APD and develop our SMHP. We are currently planning to utilize a task order contract issued under federal GSA schedules for this purpose. The statement of work for the task order contract will be submitted to CMS for prior approval.

3.4 Project Schedule

The project schedule has been reduced to three months due to the original project plan not being implemented by the previous administration. After January 1, 2011 the District elected a new Mayor and Wayne Turnage was appointed the new Director of the Department of Health Care Finance. Mr. Turnage took office on February 1, 2011. Brenda Emanuel also began with the DHCF on February 1, 2011. The new administration requested from CMS and was granted an extension to develop the SMHP, I-APD and RFP by May 31, 2011. This is a very tight timeline from the original seven and one-half month planning project period that should have commenced on about April 23, 2010 and continue to December 1, 2010. The following depicts the new detailed work breakdown structure and associated schedule.

Figure 4: Medicaid HIT Project Plan

ID	Task Name	Duration	Start	Finish
1	1.0 Medicaid HIT Project Start-up	3 days	Fri 3/18/11	Tue 3/22/11
2	Submit HIT P-APD	0 days	Fri 3/18/11	Fri 3/18/11
3	Obtain approval from CMS	2 days	Fri 3/18/11	Mon 3/21/11
4	Obtain enhanced funding	0 days	Mon 3/21/11	Mon 3/21/11
5	Assign Project Manager and Project Coordinator(s)	0 days	Mon 3/21/11	Mon 3/21/11
6	Finalize project plan with clear goals and objectives, to include timelines and milestones as well as stakeholders and role	1 day	Mon 3/21/11	Mon 3/21/11
7	Develop an project communication, trackin and reporting plans	1 day	Mon 3/21/11	Mon 3/21/11
8	Develop and Issue RFP for SMHP contrac support	1 day	Tue 3/22/11	Tue 3/22/11
9	2.0 Medicaid Participation in District HIE Activities	21 days	Tue 3/22/11	Tue 4/19/11
10	Coordination plans for use of Patient Data	21 days	Tue 3/22/11	Tue 4/19/11
11	Coordination of medicaid's role in HIE plan	12 days	Tue 3/22/11	Wed 4/6/11
12	Planning for HIE connections and interfac	12 days	Tue 3/22/11	Wed 4/6/11
13	3.0 Provider Outreach and Engagement	1 day?	Mon 3/28/11	Mon 3/28/11
14	Provision of education relative to the District's HIT program and the HER incenti	1 day?	Mon 3/28/11	Mon 3/28/11
15	Identification of opportunities and barriers from the Medicaid provider's prospective	1 day?	Mon 3/28/11	Mon 3/28/11
16	Establishment of mechanisms for stakeholder participation in the SMHP development process.	1 day?	Mon 3/28/11	Mon 3/28/11
17	4.0 SMHP Development	26 days?	Mon 4/4/11	Mon 5/9/11
18	Contractor management	1 day?	Mon 4/4/11	Mon 4/4/11
19	Stakeholder management	1 day?	Tue 4/5/11	Tue 4/5/11
20	As-Is Assessment	17 days?	Thu 4/7/11	Fri 4/29/11
21	To-Be Assessment	1 day?	Mon 5/2/11	Mon 5/2/11
22	HIT Roadmap Development	1 day?	Tue 5/3/11	Tue 5/3/11
23	SMHP Preparation	1 day?	Wed 5/4/11	Wed 5/4/11
24	SMHP review and signoff	1 day?	Thu 5/5/11	Thu 5/5/11
25	Submit SMHP to CMS	1 day?	Fri 5/6/11	Fri 5/6/11
26	CMS Review	1 day?	Mon 5/9/11	Mon 5/9/11
27	5.0 HIT Implementation APD Development	4 days?	Tue 5/10/11	Fri 5/13/11
28	Prepare I-APD(s)	1 day?	Tue 5/10/11	Tue 5/10/11
29	Review I-APD(s)	1 day?	Wed 5/11/11	Wed 5/11/11
30	Submit I-APD(s) to CMS	1 day?	Thu 5/12/11	Thu 5/12/11
31	CMS Review	1 day?	Fri 5/13/11	Fri 5/13/11
32	6.0 HIT Operational Support Services RFP I	4 days?	Thu 5/12/11	Tue 5/17/11
33	Prepare RFP(s)	1 day?	Thu 5/12/11	Thu 5/12/11
34	Review RFP(s)	1 day?	Fri 5/13/11	Fri 5/13/11
35	Submit RFP(s) to CMS	1 day?	Mon 5/16/11	Mon 5/16/11
36	CMS Review	1 day?	Tue 5/17/11	Tue 5/17/11



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Attachment B

DISTRICT OF COLUMBIA HEALTH INFORMATION EXCHANGE & EHR ADOPTION SURVEY

RESULTS SUMMARY AND ANALYSIS

April 6, 2011

Version 1.1

Prepared by:

FOX
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REVISION HISTORY

Version Number	Date	Reviewer	Comments
Version 1.0	03/30/11	FOX/Cognosante	Initial draft for DHCF review
Version 1.1	04/06/11	FOX/Cognosante	Updates reflecting additional lab survey findings

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LIST OF ACRONYMS

The following acronyms are used throughout this document:

Acronym	Definition
ARRA	American Recovery and Reinvestment Act of 2009
DC	District of Columbia
DC DOH	DC Department of Health
DC RHIO	DC Regional Health Information Organization
DCPCA	District of Columbia Primary Care Association
DHCF	District of Columbia Department of Health Care Finance
DHHS	Department of Health and Human Services
EHR	Electronic Health Record
EP	Eligible Professionals
FQHC	Federally Qualified Health Center
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
IT	Information Technology
MMIS	Medicaid Management Information System
NPPES	National Plan and Provider Enumeration System
ONC	Office of the National Coordinator for Health Information Technology
PIN	Program Information Notice
REC	Regional Extension Center
RHC	Rural Health Clinic
RHIO	Regional Health Information Organization

1 PROJECT OVERVIEW

The District of Columbia Department of Health Care Financing (DHCF) was awarded funding from the U.S. Department of Health and Human Services (DHHS), Office of the National Coordinator for Health Information Technology (ONC) under the State Health Information Exchange Cooperative Agreement (State HIE) Program to plan and implement statewide Health Information Exchange (HIE). On August 31, 2010, the District submitted its initial version of the Strategic and Operational Plans. As a result of ONC feedback, the District has submitted revisions to the initial Plans on November 4, 2010, January 28, 2011 and March 4, 2011. In the March 4, 2011 update, the District reported that an independent survey of District providers, independent pharmacies, and licensed laboratories (non-hospital based) was currently underway. The scope of the current survey was limited to the measures identified in the Program Information Notice (PIN) and several attributes that will provide DHCF and DC HIE a well-formed picture of EHR capacity and use within the District. The survey's data source and methods will provide a foundation or baseline for monitoring HIT adoption in future HIE and Regional Extension Center (REC) activities. A summary of eligible professional capabilities in the areas of e-prescribing, lab results and patient care summaries are in the table below:

Table 1: Eligible Provider Respondent Summary

Survey Areas	Response Results
E-Prescribing	41% of respondents are able to generate and transmit permissible prescriptions electronically. Of those, 75% do so through an EHR. 89% of independent pharmacies have capabilities in place to support e-prescribing.
Electronic Exchange of Lab Results	45% of respondents receive laboratory results electronically, excluding fax transmissions. Of those providers who do receive results electronically, 71% report more than three quarters of their lab results are received in that fashion. 75% of clinical labs have capabilities in place to send lab results electronically (excluding fax transmission), and utilize these capabilities more than 50% of the time.
Patient Care Summary Exchange	32% of the District's providers can transfer patient health information electronically to other providers or hospitals that are not affiliated.

As the summary suggests, there remains significant opportunity to improve the adoption and utilization rate of HIT capabilities for these areas requiring information exchange. The ancillary organizations (independent pharmacies and clinical laboratories) generally have the capacity to support these needs at present. District providers, however, currently have limited capacity to support HIE. When capabilities are available to providers, the use of these capabilities is generally high (used more than 75% of time).

1.1 Project Objective

The objective of the DC HIE survey was to assess the current level of support for key measures of electronic health information exchange within a representative sample of relevant stakeholders within the District. Findings from this survey provide the District a baseline upon which progress in implementing HIE capabilities can be measured. Specific goals of this survey included:

- Collecting information of Electronic Health Record (EHR) adoption and use of information exchange features by District of Columbia (DC) Health Care providers, independent community pharmacies, and clinical laboratories.
- Tabulating results in preparation for comprehensive analysis and reporting.
- Producing a comprehensive database of the DC providers.

1.2 Survey Methodology

FOX utilized the downloadable National Plan and Provider Enumeration System (NPPES) database of 12,998 providers that practice in the District from which to create an initial list of 6,783 Eligible Professionals (EPs). These providers are those eligible for Medicaid or Medicare provider incentives for the meaningful use of HIT. Organizational providers including hospitals, clinics (including Federally Qualified Health Centers and Rural Health Clinics (FQHCs and RHCs)), and military or government healthcare providers were excluded from the survey. The survey was intended to survey individual providers of the following types:

- Primary Care Providers
- Specialists
- Dentists
- Optometrists
- Nurse Practitioners
- Podiatrists
- Certified Nurse Midwives
- Chiropractors
- Physician Assistants
- Behavioral Healthcare Providers

The NPPES data set for each provider includes a self-reported provider type or taxonomy. Surveyors, nonetheless, asked providers to identify the type of primary service provided based on the types available in the survey. Those who responded as specialists were asked to identify their specialty. While specialty data was not available for tabulation, the response data set does include this information as raw data.

FOX conduct outbound survey calls to a sample of 4,447 District providers selected from the initial database of 6,783. The selection process was designed to ensure the survey sample was

representative of the distribution of District's providers. Because many provider phone numbers were disconnected or not accurate, FOX modified the approach somewhat during the survey to include more providers.

This Report's focus is on the current landscape primarily in the areas of e-prescribing, the transmission and receipt of electronic lab results, and the exchange of patient care summary information. Results provide baseline information for EHR capabilities and HIT adoption by EPs. This Summary Report does not stratify by zip code, but the tabulated results do provide pertinent information by zip code for the District.

The following table reports the sample by provider type. All providers reported practice locations in the District.

Table 2: Sample Distribution[1]

Sample by Provider Type		
Provider Type	**Total in Sample**	**Percent of Sample**
Behavioral Healthcare Provider	676	15.2%
Certified Nurse Midwife	31	0.7%
Chiropractor	33	0.7%
Dentist	514	11.6%
Nurse Practitioner	393	8.8%
Optometrist	53	1.2%
Physician Assistant	238	5.4%
Podiatrist	48	1.1%
Primary Care Practice	1,106	24.9%
Specialty	1,355	30.5%
Total	4,447	100.0%

1.2.1 Pharmacies and Clinical Labs

A separate database of independent community pharmacies and clinical labs was created for surveys to be conducted for those provider types. The results are included in this Report in Sections 2.2 and 2.3.

1.3 Survey Limitations

As stated above, the intent of the survey was to develop a foundation or baseline for the future measurement of meaningful use in the District. Individual providers were the focus of the survey, and those were limited to provider types that can take advantage of Medicare or

[1] Appendix D. Q2., Tab 1

Medicaid provider incentive programs for meaningful use of EHRs, assuming their patient populations makes them eligible.

1.3.1 Pharmacy Survey of E-Prescribing Readiness

Outbound survey calls were also made to all 23 of the District's independent community pharmacies. The list of pharmacies originated from the Medicaid Management Information Systems (MMIS) claims payment system for the DHCF. Large chain pharmacies were excluded from the survey as chain pharmacies refer surveys to chain headquarters and chains pharmacies are virtually all e-prescribing enabled. Adding their results would not provide a clear picture of the status of e-prescribing for independent pharmacies where additional work may need to be done to encourage adoption.

1.3.2 Survey of Clinical Laboratories

Eight (8) clinical laboratories were identified as Medicaid payment recipients in the District, and all were contacted for this survey. In order to expand the survey base, an additional eight (8) independent clinical laboratories identified by the CMS CLIA OSCAR database located in the District were added. Laboratories outside the District which service District providers were not included in the survey.

1.4 Conducting the Survey

The DC HIE Survey Project began on February 14th, 2011 with six (6) full time survey specialists. All six went through intensive 1-day training that included an overview on the project methodology and terminology, the survey database and processes, customer service, Health Insurance Portability and Accountability Act (HIPAA) compliance, and practice calls. The survey specialists began making outbound calls and conducting survey interviews to providers, pharmacies, and laboratories on February 15th, 2011.

The survey specialists encountered many providers and office managers that were not available or able to respond to a survey by phone. In order to increase survey completions, the survey specialists gave the provider or office manager the option to obtain the survey by email, fax, or by giving the provider or office manager a callback telephone number. When a provider or office manager was busy, the survey specialist made a callback at the most appropriate time.

The response rate for survey calls was lower than anticipated during the initial weeks for various reasons. To increase the amount of completed surveys, additional survey specialists were hired on February 23, 2011. Calling providers or office managers earlier in the day improved results. Also, the survey was implemented in Survey Monkey on March 2, 2011 in an effort to capture more responses. Survey Monkey is an additional tool that was used to obtain completed DC HIE Surveys from those unable to be surveyed via telephone or fax. Email addresses were taken from the DC Department of Health list of licensed providers (January, 2011). Providers were emailed the link to Survey Monkey and were asked to take the DC HIE Survey by March 11, 2011.

Quality monitoring was conducted for all survey specialists. Every survey specialist has met the requirements for each call monitored.

Appendix A, B, and C include a copy of the survey for providers, pharmacies and clinical laboratories.

2 SUMMARY OF SURVEYS

2.1 Professional Providers Survey

The survey instrument was a 19-question tool designed to aid the District in identifying gaps and establishing a baseline for meaningful use requirements.

The table below provides a breakdown by provider type of respondents, excluding pharmacies and labs, the number of respondents, the distribution of respondents and the survey participation rate[2] by provider type. The survey participation rate was somewhat low for Primary Care Providers at 8.8%. However, with a total of 97 Primary Care providers participating in the survey (the second highest number by provider type), their responses are statistically significant.

Table 3: Respondents by Provider Type[3]

Respondents by Provider Type			
Provider Type	**Total Respondents**	**Percent of All Respondents**	**Survey Participation Rate**
Behavioral Healthcare Provider	30	5.9%	4.4%
Certified Nurse Midwife	2	0.4%	6.5%
Chiropractor	9	1.8%	27.3%
Dentist	75	14.7%	14.6%
Nurse Practitioner	23	4.5%	5.9%
Optometrist	9	1.8%	17.0%
Physician Assistant	14	2.8%	5.9%
Podiatrist	7	1.4%	14.6%
Primary Care Practice	97	19.1%	8.8%
Specialty	233	45.8%	17.2%
Not specified	10	2.0%	n/a
Total	**509**	**100.0%**	11.4%

In addition to confirming their demographic information, providers were asked what payer type represented the majority of their patients (Medicaid/Alliance, Medicare, Commercial, Self-Pay or Uninsured). This information was asked in an attempt to broadly identify the extent that certain types of payers might have on influencing provider behavior with respect to use of HIT and HIE.

[2] Survey Participation Rate is defined as the number or respondents as compared to the number of that specific provider type in the survey sample.
[3] Appendix D Q_02., Tab 2.

Answers were captured on the database and are summarized below. This information has not been correlated with survey results in this study. Results have been correlated primarily with provider type and in some cases, zip code.

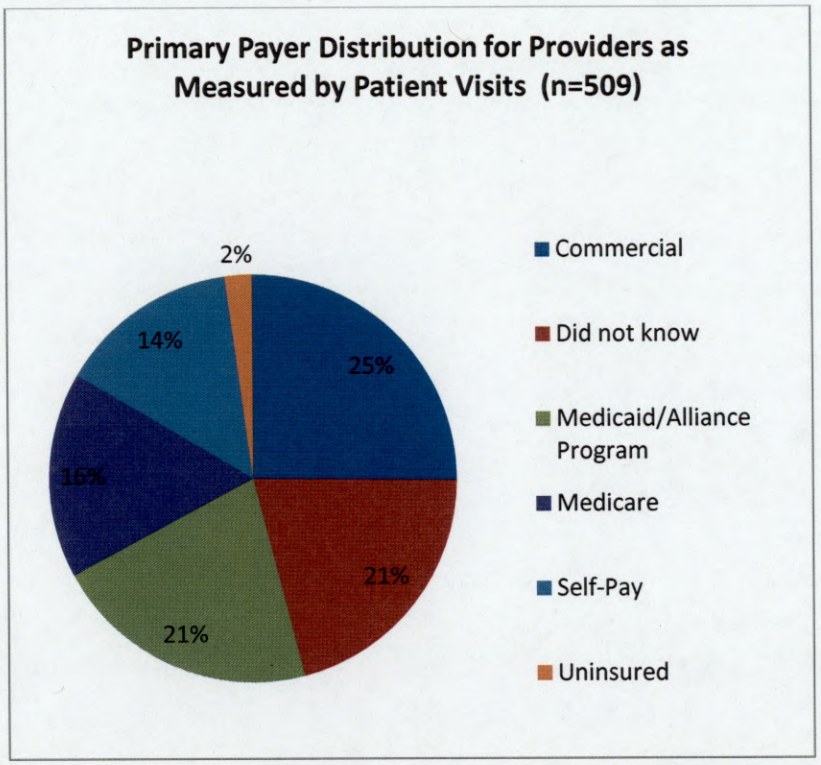


Figure 1: Primary Payer Distribution for Providers

Results and analysis of the survey of Eligible Professionals are in Section 3 below.

2.2 Clinical Laboratory Survey and Analysis

Eight clinical laboratories were identified in the dataset for the District and four responded to the survey. Labs that did not respond are Howard University Hospital, Medstar Georgetown Medical Center, Quest Diagnostic Nichols Institute, Inc., and Parasitology Laboratory of Washington. FOX believes, however, that while this ratio may be statistically significant based on the dataset available for survey, continued reach-out to all the District's clinical laboratories is advisable to validate these results and findings.

2.2.1 Lab Readiness for Electronic Resulting and Ordering

Three of the four clinical laboratories (75%) in the District responding to the survey are currently delivering structured lab results to provider EHRs. The three laboratories that support this functionality transmit the majority of their results (more than 50%) in this fashion. It is not known at this time which exchange standard(s) are utilized.

Four of six respondents (67%) indicate that they currently receive orders electronically from EHR systems. Half of those who receive lab orders electronically do so 25% of the time or less.

Labs responded that they believed the biggest obstacle to the sending of orders and receipt of structured lab results today is the current capabilities of provider HIT systems and the slow adoption of HIT due to cost.

Survey results suggest that the readiness of clinical laboratories is not a barrier to the electronic transmission of lab orders or receipt of lab results electronically by providers.

2.3 Pharmacy Survey and Analysis

DC HIE utilized published data from Surescripts to identify pharmacy and prescriber readiness for e-prescribing in August, 2010. A key element of Surescripts findings, however, is based on payment claims generated by District pharmacies. As patients frequently cross District boundaries to acquire care services and prescriptions, it is unclear if the impact of cross-border prescribing and fulfillment patterns are accurately reflected in the Surescripts findings. Additionally, Surescripts' use of payment claims is generally limited to commercial health plans, and the associated District Medicaid plans are not included in the data. Given the large pool of Medicaid recipients in the District and lack of Medicaid claims history in the Surescripts data, the accuracy of the e-prescribing adoption rate is questionable. The current survey of pharmacy organizations was intended to qualify or dispel the initial findings.

Surescripts data from 2009 indicated that 92% of the District's chain and independent community pharmacies have activated e-prescribing. However, the District was concerned whether independent community pharmacies were adequately represented in the Surescripts data as the number of medium to large chain pharmacies is greater than the number of independent pharmacies or small chains. Therefore, the District requested FOX conduct a survey of independent community pharmacies within the District.

Twenty-three (23) independent pharmacies were requested to take the survey and 9 responded for a 39% response rate.

Of the respondents, all 9 support e-prescribing. Seven (7) indicate they have a system that supports the receipt and filling of prescriptions transmitted electronically (however one pharmacy has not yet installed the capability) and 2 provide e-prescribing capability through a web portal. Therefore, 89% of the pharmacies surveyed have e-prescribing capability in place (in contrast to Surescripts data showing 92% of all pharmacies support e-prescribing). If the pharmacy with system capability not currently enabled were to enable that functionality, 100% of those surveyed would have the capability of receiving electronic prescriptions. This, like the laboratory results, is a small sample. However, because all pharmacies indicated they have e-prescribing capability, the results suggest that a higher number of respondents would not significantly impact the outcome.

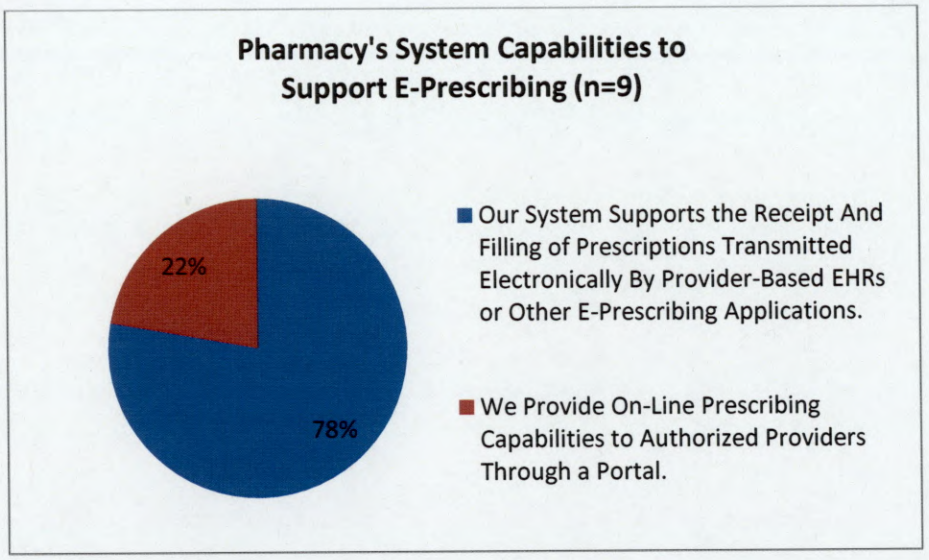


Figure 2: Pharmacy System E-Prescribing Capability[4]

This data, combined with Surescripts data, suggests that barriers to meaningful use of e-prescribing do not include the inability for the District's pharmacies to support the capabilities, but rest primarily with the provider (prescriber) community's lack of utilization of e-prescribing capabilities.

3 ELIGIBLE PROFESSIONAL PROVIDER SURVEY ANALYSIS

Health care providers are at various levels of adoption of electronic health records (EHRs) with specialists, primary care providers and dentists respectively leading the way in most areas surveyed.

Below are the general characteristics related to EHR adoption reported across the different professional provider groups responding to the scans.

Table 4: Eligible Professional Provider Summary

Survey Areas	Response Results
Medicaid Patient Volume	21% of the respondents reported Medicaid as the payer representing the majority of their patient visits[5]
Medicare Patient Volume	16% of the respondents reported Medicare as the payer

[4] Appendix D Pharmacy. Tab 1.
[5] 21% of the respondents did not know or could not answer whether Medicare, Medicaid/Alliance Program, or Commercial/Self-Pay/Uninsured represented their largest patient base by visits. See Question 03 in Appendix D.

Survey Areas	Response Results
	representing the majority of their patient visits[6]
E-Prescribing	41% of respondents are able to generate and transmit permissible prescriptions electronically. Of those, 75% do so through an EHR.
Receipt of Lab Results Electronically	45% of respondents receive laboratory results electronically, excluding fax transmissions. 75% of clinical labs transmit lab results electronically.
Patient Care Summary	32% of the District's providers can transfer patient health information electronically to other providers or hospitals that are not affiliated.

3.1.1 E-Prescribing

The number of respondents who currently have the ability to e-prescribe is 41%. This is in contrast to the Surescripts from 2009 that indicates that 19% of District physicians route prescriptions electronically. Of those that responded that they e-prescribe, about 75% do so through their EHR and others use a stand-alone e-prescribing system. The top provider types who e-prescribe are specialists, primary care providers, nurse practitioners and dentists.

Of those that indicated that they do e-prescribe, 73% of the respondents do so over half of the time and 27% of the respondents indicated they e-prescribe less than half of the time.[7] This suggests that, while the current adoption of e-prescribing capabilities is higher than initially believed, an opportunity exists to (1) increase the number of e-prescribing enabled prescribers through outreach and education, and (2) increase provider utilization of e-prescribing potentially through workflow design support activities.

There also appears to be an opportunity to increase provider access to formulary and benefit information. According to Surescripts 2009 adoption information, 67% of District patients have formulary and medication history information available to providers through Surescripts. However, the current survey results below show that only 42% of respondents receive information on the patient's formulary and/or benefits today[8]. DC HIE may wish to encourage payers - including District Medicaid plans – to make their formularies as well as claims-based medication histories available to e-prescribing networks and/or to providers. Also, the District's REC, District of Columbia Primary Care Association (DCPCA), may wish to place focus on training and awareness of this capability for providers.

Table 5: Capabilities Utilized by Providers Who E-Prescribe[9]

[6] 21% of the respondents did not know or could not answer whether Medicare, Medicaid/Alliance Program, or Commercial/Self-Pay/Uninsured represented their largest patient base by visits. See Question 3 in Appendix D.
[7] Appendix D Q06. Tab Q6_1
[8] Appendix D. Q05. Tab Q5_4
[9] Appendix D Q05.

Response Results	E-Prescribing Capabilities
84%	Generates and transmits permissible prescriptions electronically
76%	Receives Drug-Drug or Drug-Allergy Interactions
87%	Uses claims-based medication history information, if provided by the payer
61%	Receives requests for refills from pharmacies electronically
42%	Receives information on the patient's formulary and/or benefit package including copayments.

3.1.2 Clinical Laboratory Orders and Results

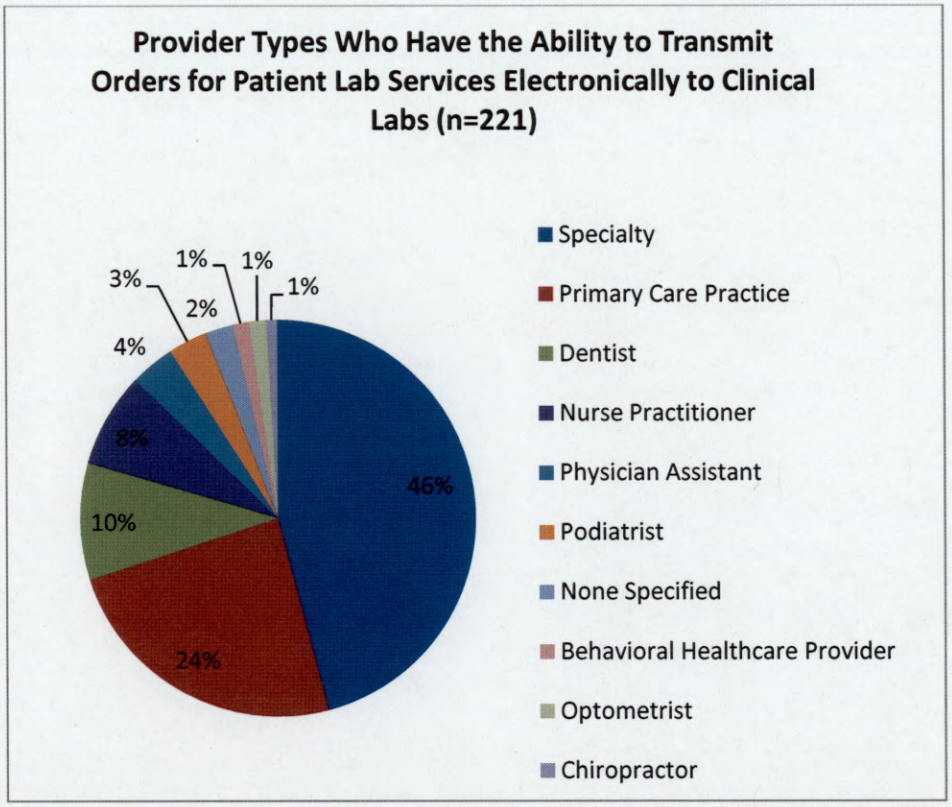
46% of survey respondents indicated that their practice has the ability to submit orders for clinical laboratory services electronically. Of those responding "yes", 65% ordered lab services electronically 76% - 100% of the time[10]. The greatest frequency of "yes" respondents was again specialists, primary care providers, and dentists.

Table 6: Ability to Transmit Orders for Lab Services[11]

Provider Type	Yes	No	Not Sure	Totals
All Provider Types	**221**	**244**	**20**	**485**
Percent	**46%**	**50%**	**4%**	**100%**
Specialty	101	113	10	224
Primary Care Practice	53	39	3	95
Dentist	21	48	3	72
Nurse Practitioner	17	5	-	22
Physician Assistant	8	3	1	12
Podiatrist	7	-	-	7
Not Specified	5	3	-	8
Behavioral Healthcare Provider	3	21	2	26
Optometrist	3	5	-	8
Chiropractor	2	6	1	9
Certified Nurse Midwife	1	1	-	2

Figure 3: Provider Types Submitting Electronic Lab Orders

[10] Appendix D. Q08
[11] Appendix D Q07



45% of providers surveyed receive lab results electronically (excluding fax receipts) and the same provider types comprise those receiving results electronically with the greatest frequency. Most providers responding positively also indicated lab results are received electronically over 75% of the time.

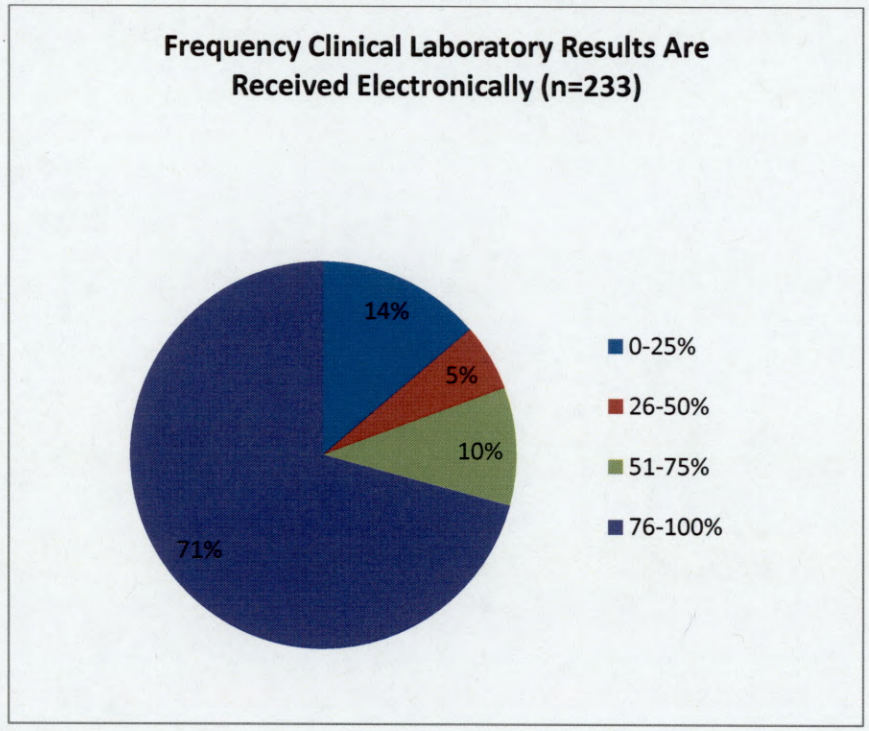
Table 7: Providers Receiving Electronic Lab Results (n=462)[12]

Provider Type	Yes	No	Not Sure	Totals
Totals	**207**	**230**	**25**	**462**
Percent	**45%**	**50%**	**5%**	**100%**
Specialty	99	90	11	200
Primary Care Practice	56	25	2	83
Nurse Practitioner	17	5	1	23
Physician Assistant	10	4	-	14
Dentist	9	61	5	75
Behavioral Healthcare Provider	6	20	4	30
Not specified	6	3	1	10

[12] Appendix D Q_9

Provider Type	Yes	No	Not Sure	Totals
Podiatrist	2	5	-	7
Chiropractor	1	8	-	9
Optometrist	1	7	1	9
Certified Nurse Midwife	-	2	-	2

Table 8: Frequency Electronic Lab Results are received by Providers Electronically[13]



Based on the providers surveyed, slightly less than half have the ability to transmit orders for clinical laboratory services electronically, or to receive laboratory results electronically. When electronic ordering and resulting capabilities are available to providers, these capabilities are utilized to a significant extent (e.g., more than 75% of the time). There are significant opportunities within the District to work with the provider community to encourage the adoption of electronic exchange with clinical laboratory systems.

3.1.3 Patient Health Information

Providers are generally less involved in the exchange of electronic patient health information summaries with other providers. 57% report exchanging information electronically within their

[13] Appendix D. Q10

organization electronically, but only 32% are able to exchange patient health information electronically to other providers or hospitals outside of their organization.

The chart below illustrates the distribution of those providers that can exchange patient health information electronically outside their own organization by provider type.

Table 9: Providers Able to Exchange Patient Information Outside of Own Organization[14]

Provider Type	Yes	No	Not Sure	Total
Totals	**158**	**313**	**18**	**489**
Percent	**32%**	**64%**	**4%**	**100%**
Specialty	67	145	12	224
Dentist	27	45	1	73
Primary Care Practice	27	63	4	94
Behavioral Healthcare Provider	10	17	-	27
Nurse Practitioner	10	12	-	22
Physician Assistant	6	8	-	14
Chiropractor	4	4	1	9
Refused to Answer	4	5	-	9
Optometrist	2	6	-	8
Podiatrist	1	6	-	7
Certified Nurse Midwife	-	2	-	2

3.1.4 Electronic Health Records

Again led by specialists, primary care providers and dentists, 58% of respondents indicated their organization has an EHR system.

Table 10: EHR within Provider Organization (n=492)[15]

Provider Type	Yes	No	Not Sure	Totals
Totals	**284**	**208**	**-**	**492**
Percent	**58%**	**42%**		**100%**
Specialty	137	89	-	226
Primary Care Practice	55	40	-	95
Dentist	36	36	-	72
Nurse Practitioner	19	3	-	22
Behavioral Healthcare Provider	13	15	-	28
Physician Assistant	11	3	-	14
Not specified	6	3	-	9

[14] Appendix D. Q12
[15] Appendix D Q13

Provider Type	Yes	No	Not Sure	Totals
Chiropractor	4	5	-	9
Optometrist	3	5	-	8
Certified Nurse Midwife	-	2	-	2
Podiatrist	-	7	-	7

Of those with an EHR system, 72% responded they use if for more than 90% of its functions. 22.7% partially use their EHR and the remainder have purchased a system or begun installation, but are not yet using the system.[16]

The following table shows the frequency of use of EHR functions by survey respondents. The data show there is opportunity to increase adoption of available functionality. Respondents indicated that certain EHR functions were not used 33% of the time.

Table 11: EHR Capabilities – Frequency of Use[17]

EHR Functions	Used Regularly	Used Occasionally	Not Used	Not Available	Totals
Insurance eligibility checking	140	16	55	13	224
Electronic claims submission	144	16	47	9	216
Electronically transmit prescriptions	148	25	74	11	258
Send electronic lab orders	133	24	89	14	260
Receive electronic lab results	175	24	57	8	264
Receiving imaging results	155	28	61	13	257
Send clinical patient summaries	141	34	73	10	258
Receive clinical patient summaries	133	34	79	12	258
Transmit reports electronically to public health (immunization registries, cancer registries, etc.)	43	20	112	27	202
Send notifiable disease reporting electronically	43	15	102	27	187
Exchange information supporting behavioral or mental health services	62	34	102	26	224

"Other Physicians" topped the list of providers with whom eligible professionals share patient information electronically, followed by hospitals, pharmacies and clinical laboratories. The fewest providers selected HIEs, RHIOS or the IQ Network as organizations with which they

[16] Appendix D Q14
[17] Appendix D Q15

currently share patient information. Specialists, primary care providers, nurse practitioners and dentists again topped the list of provider types sharing patient information with others.

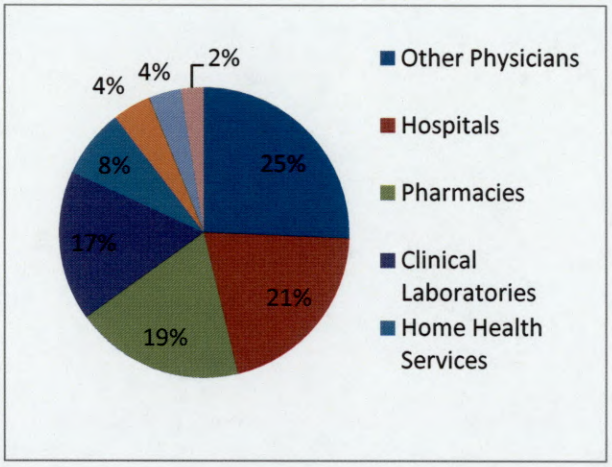


Figure 4: Other Providers or Organizations with Whom Patient Information is Shared (n=582)[18]

4 CONCLUSION

Specialists, Primary Care Providers, Dentists, Nurse Practitioners, and Physician Assistants most commonly send or receive patient information, prescriptions, and lab orders or results electronically.

Significant opportunity remains to improve the adoption and utilization of HIT capabilities to support e-prescribing, electronic exchange of laboratory results, and electronic exchange of patient care summaries. The ancillary organizations (independent pharmacies and clinical laboratories) generally have the capacity to support these needs at present, but require the support of the provider community to realize full potential. District providers currently have limited capacity to support HIE. When capabilities are available to providers, the use of these capabilities is generally high (used more than 75% of time).

Because of the number of responses to District-based clinical laboratories in the survey dataset was small (4 of 8 responded to the survey), FOX recommends continued reach-out to the clinical laboratory community to validate the results of their ability to support transmission of electronic results as well as receipt of electronic orders from care providers.

This Report identifies areas of focus for DC HIE where strategies can be formulated to develop momentum toward increasing adoption. Examples are:

- Identify obstacles for provider adoption of e-prescribing capabilities, and work collaboratively with the District's REC to close those gaps.

[18] Appendix D Q16

- Collaborate with Medicaid to identify opportunities to decrease the gaps for e-prescribing capabilities related to formulary checking and medication histories.
- Continue to engage and collaborate with DCPCA and others to offer patient care summary exchange opportunities.

Importantly, this Report and the accompanying tabulated results establish a baseline for HIT adoption and the exchange of health information in the District. It indicates the areas of focus for DC HIE on the roadmap toward greater adoption. FOX recommends that the same survey be conducted periodically to measure progress in the District.

APPENDIX A – ELIGIBLE PROFESSIONAL PROVIDER SURVEY

The District Survey for Providers is shown on the following pages.

DISTRICT SURVEY FOR PROVIDERS

Survey Results Tracking Template

Hello, my name is (insert name) and I am calling on behalf of the DC Department of Health Care Finance. May I speak to (Provider's Name) or the Office Manager?

The intent of this call is to complete a provider survey to identify the adoption and use of Health Information Technology. Is this a good time for you?

Date:
Surveyor:

Demographic Information

1. Please verify the information or make changes:
   Name
   NPI
   Responder's Title
   Organization
   Practice Zip Code
   Email
   Phone Number

   Comments:

2. Which of the following best describes your practice or profession? (Check one)
   - ☐ Primary Care Practice
   - ☐ Specialty
   - ☐ Dentist
   - ☐ Optometrist
   - ☐ Nurse Practitioner
   - ☐ Podiatrist
   - ☐ Certified Nurse Midwife
   - ☐ Chiropractor
   - ☐ Physician Assistant
   - ☐ Behavioral Healthcare Provider

   a. If response is Specialty, Please describe the area of specialty.

   Comments:

3. Of the following, what payer type accounts is the majority of your patient visits? (based on total visits vs. patient base)

   ☐ Medicaid/Alliance Program
   ☐ Medicare
   ☐ Commercial
   ☐ Self-Pay
   ☐ Uninsured

   Comments:

Use of Technology

4. Which statement best describes your organization's prescribing practices?

   ☐ We order medications by entering prescription information into a stand-alone e-prescribing system.
   ☐ We order medications by entering prescription information into a module of our EHR or practice management system that has e-prescribing capability.
   ☐ We do not use a system to support ordering medications or prescribing. (If answer is yes to this option, proceed to Question 7)
   ☐ Refused to Answer/Did not Know

   Comments:

5. Please indicate whether your organization uses the following e-prescribing functionalities. (Check Yes, No, or Not Sure)

	Yes	No	Not Sure
Generate and transmit permissible prescriptions electronically.	☐	☐	☐
Alerts providers at the point of prescribing for potential drug-drug or drug-allergy interactions.	☐	☐	☐
Receives requests for refills from pharmacies.	☐	☐	☐
Provides information on the patient's formulary and/or benefit package including copays.	☐	☐	☐
Provides information on the patient's medication history	☐	☐	☐

Comments:

6. How frequently do you use your e-prescribing system for permissible prescriptions (excluding prescriptions for controlled substances)?

   ☐ 0-25%
   ☐ 26-50%
   ☐ 51-75%
   ☐ 76-100%
   ☐ Refused to Answer/Did not Know

   Comments:

7. Does your practice have the ability to send orders for patient lab services electronically to clinical laboratories?

   ☐ Yes
   ☐ No (If no, please go to question 9)
   ☐ Not Sure

   Comments:

8. How frequently do you submit orders for clinical laboratory services electronically?
   ☐ 0-25%
   ☐ 26-50%
   ☐ 51-75%
   ☐ 76-100%
   ☐ Refused to Answer/Did not Know

   Comments:

9. Do you currently receive lab results electronically from clinical laboratories, excluding fax transmission?
   ☐ Yes
   ☐ No (If no, go to question 11)
   ☐ Not Sure

   Comments:

10. What percentage of clinical laboratory results are transmitted electronically (not including faxes)?
    - ☐ 0-25%
    - ☐ 26-50%
    - ☐ 51-75%
    - ☐ 76-100%
    - ☐ Refused to Answer/Did not Know

    Comments:

11. Can you transfer patient health information electronically to other providers in your organization?
    - ☐ Yes
    - ☐ No
    - ☐ Not Sure

    Comments:

12. Can you transfer patient health information electronically to other providers or hospitals outside of your office?
    - ☐ Yes
    - ☐ No
    - ☐ Not Sure

    Comments:

Electronic Health Records

13. Does your organization have an Electronic Health Record (EHR) system?

    - ☐ Yes
    - ☐ No (If no, please go to question 18)

    Comments:

14. Which statement best describes your organization's EHR System?

- ☐ We have purchased/begun installation of an EHR, but are not yet using the system.
- ☐ We have an EHR installed, and we use some of the available functions.
- ☐ We have an EHR implemented, and we use it for most (more than 90%) of the functions of our organization.
- ☐ Refused to Answer/Did not Know

Comments:

15. For each of the following EHR or Practice Management capabilities, please describe how often your organization uses the function?

	Used Regularly	**Used Occasionally**	**Not Used**	**Not Available**
Insurance eligibility checking	☐	☐	☐	☐
Electronic claims submission	☐	☐	☐	☐
Electronically transmit prescriptions	☐	☐	☐	☐
Send electronic lab orders	☐	☐	☐	☐
Receive electronic lab results	☐	☐	☐	☐
Receiving imaging results	☐	☐	☐	☐
Send clinical patient summaries	☐	☐	☐	☐
Receive clinical patient summaries	☐	☐	☐	☐
Transmit reports electronically to public health (immunization registries, cancer registries, etc)	☐	☐	☐	☐
Send notifiable disease reporting electronically	☐	☐	☐	☐
Exchange information supporting behavioral or mental health services	☐	☐	☐	☐

Comments:

16. Do you share patient information electronically with other providers or organizations? (Please mark all that apply)

- ☐ Hospital(s)
- ☐ Other physicians
- ☐ Home Health Services

- ☐ Pharmacies
- ☐ Clinical Laboratories
- ☐ Health Information Exchange Organization
  - ☐ Regional Health Information Organization (RHIO)
  - ☐ IQ Network (Children's Hospital)
- ☐ Refused to Answer/Did not Know

Comments:

17. If you do share patient information electronically, please indicate what types of information?
    - ☐ Laboratory Results
    - ☐ Patient Demographics
    - ☐ Disease Management Data
    - ☐ Medications
    - ☐ Pathology Results
    - ☐ Patient Treatment History
    - ☐ Outpatient and Inpatient Episodes
    - ☐ Emergency Departments
    - ☐ Enrollment and Eligibility Information
    - ☐ Refused to Answer/Did not Know

    Comments:

18. What do you consider the biggest obstacle limiting the electronic exchange of patient health information?

19. Thank you for participating. Would you be interested in participating in future DHCF surveys regarding health information technology?
    - ☐ Yes
    - ☐ No

    Comments:

APPENDIX B – QUESTIONS FOR INDEPENDENT COMMUNITY PHARMACIES

The Questions for Independent Community Pharmacies is shown on the following pages.

Questions for Independent Community Pharmacies

1. Which statement best describes your organization's system capabilities to support e-prescribing functions?

   ☐ We provide on-line prescribing capabilities to authorized providers through a portal.
   ☐ Our system supports the receipt and filling of prescriptions transmitted electronically by provider-based EHRs or other provider e-prescribing applications.
   ☐ Our system supports the sending of refill requests to providers electronically.
   ☐ We do not use a system that supports e-prescribing
   ☐ Refused to Answer/Did not Know

   Comments:

2. Please indicate whether your organization ***uses*** the following e-prescribing functions. (Check Yes, No, or Not Sure)

	Yes	No	Not Sure
Can receive permissible prescriptions electronically.	☐	☐	☐
Can generate requests for refills to ordering providers.	☐	☐	☐

Comments:

3. What do you consider the biggest obstacle limiting pharmacies' implementation and use of e-prescribing capabilities?

4. Thank you for participating. Would you be interested in participating in future DHCF surveys regarding health information technology?
   ☐ Yes
   ☐ No

   Comments:

APPENDIX C – QUESTIONS FOR DISTRICT-BASED CLINICAL LABORATORIES

The Questions for District-based Clinical Laboratories is shown on the following pages.

Questions for District-based Clinical Laboratories

1. Does your organization have the ability to receive orders for patient lab services electronically from provider [EHR] systems?

   ☐ Yes
   ☐ No (If no, please go to question 3)
   ☐ Not Sure

   Comments:

2. How frequently do you receive orders for clinical laboratory services electronically?
   ☐ 0-25%
   ☐ 26-50%
   ☐ 51-75%
   ☐ 76-100%
   ☐ Refused to Answer/Did not Know

   Comments:

3. Do you currently send or transmit lab results electronically to provider [EHR] systems, excluding fax transmission?
   ☐ Yes
   ☐ No (If no, go to question 5)
   ☐ Not Sure

   Comments:

4. What percentage of clinical laboratory results are transmitted electronically (not including faxes)?
   ☐ 0-25%
   ☐ 26-50%
   ☐ 51-75%
   ☐ 76-100%
   ☐ Refused to Answer/Did not Know

   Comments:

5. What do you consider the biggest obstacle limiting laboratories' implementation and use of electronic ordering and resulting capabilities with provider-based EHR systems?

6. Thank you for participating. Would you be interested in participating in future DHCF surveys regarding health information technology?
   - ☐ Yes
   - ☐ No

   Comments:

APPENDIX D – SURVEY RESULTS

The Survey Reports and Charts are included in the file below:

Appendix D_Survey Reports and Charts_20110329.zip

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Attachment C

COST / PRICE DISCLOSURE CERTIFICATION

RFP Number: **DCHT-2011-T-0009** Closing Date: **April 14, 2011**

Caption: **State Medicaid Health Information Technology Plan** Total Proposed Amount: _____

The undersigned _____

_____

(please print name and title of Offeror's authorized signatory) hereby certifies that, to the best of my knowledge, the cost and pricing data (i.e. at the time of price agreement this certification represents that all material facts of which prudent buyers and sellers would reasonably expect to affect price negotiations in any significant manner) submitted was accurate, complete, and current as of _____ (date of RFP closing or conclusion of negotiations as appropriate). The undersigned further agrees that it is under a continuing duty to update cost or pricing data through the date that negotiations, if any, with the District are completed. The undersigned further agrees that the price, including profit or fee, will be adjusted to exclude any significant price increases occurring because the cost or pricing data was inaccurate, incomplete or not current. (See D.C. Procurement Regulations, 27 DCMR, Chapter 6, Section 699, Chapter 16, Section 1624; and Section 25 of the Standard Contract Provisions for Use with District of Columbia Government Supply and Services Contracts, March 2007).

Signed: _____ Date:_____

Title: _____

Company: _____

Address: _____

_____

Phone: _____

E-mail: _____

Company Web Site Address: _____

Federal Tax Identification No.: _____

DUNS No.:_____

COST/PRICE DATA REQUIREMENTS

1 GENERAL INFORMATION

1.1 Offerors submitting cost/price proposals, in response to a District Request For Proposal (RFP), sole source procurement, change order, or contract modification exceeding $500,000 in total value, must include a complete cost and pricing data breakdown (i.e., data that is verifiable and factual) for all costs identified in the proposal, and relevant to the performance of the contract. The requirement for submission of cost or pricing data is met when all accurate cost or pricing data reasonably available to the Offeror has been submitted, either actually, or by specific identification, to the District. If not available at the time of submission, as later information comes into the Offeror's possession, it should be promptly submitted to the District in a manner that clearly demonstrates its relationship to, and effect on, the Offeror's cost/price proposal. This requirement continues up to the date of final agreement on price and/or other issues, as agreed upon between the parties.

1.2 There is a clear distinction between submitting cost or pricing data and merely making available books, records and other documents without identification or context. By submitting a cost/price proposal, the Offferor, if selected for negotiation, grants the Contracting Officer, or an authorized representative, the right to examine, at any time before award, those books, records, documents, and other types of factual information, regardless of form or whether such supporting information is specifically referenced or included in the proposal as a basis for pricing, that will permit an adequate evaluation of the proposed cost/price.

1.3 The cost/price proposal will represent the Offeror's understanding of the RFP's requirements and the Offeror's ability to organize and perform those requirements effectively and efficiently. The review and assessment of the Offeror's cost/price proposal will be based on an analysis of the realism and completeness of the cost data, the conformity of the cost to the Offeror's technical proposal and the proposed allocation of labor-hours and skill sets. Pertinent cost information, including but not limited to Defense Contract Auditing Agency (DCAA) and/or the Department of Labor (DOL) recommended rates for direct labor, overhead, general and administrative expense (G&A), etc., as necessary and appropriate, must be used to arrive at the most probable cost to be incurred by the Offeror. If the District considers the proposed costs to be unrealistic, the Offeror should adjust its proposed costs accordingly. Any inconsistency, whether real or apparent, between promised performance and cost or price should be explained in the cost/price proposal. The burden of proof for cost credibility rests with the Offeror.

1.4 The Offeror shall submit its cost/price proposal in hard copy as well as a compact disc (CD), formatted in a program compatible with Microsoft Office. All cost/price proposals shall provide a cost summary containing all cost elements, cross-referenced to supporting documentation. See Table 1.4.

1.5 The Offeror shall provide the following information for the prime contractor and each proposed subcontractor:

a. A properly completed "Cost/Price Disclosure Certification.'

b. Identification of any estimates, along with the rationale and methodology used to develop them, including judgmental factors used in projecting future costs, based on known data, and the timing, nature and extent of any material contingencies.

c. Disclosure of any other activities or likely events which could materially impact specific costs (i.e., existing large material and supply inventories, management/ownership changes, new technologies, collective bargaining agreements, etc.)

d. Disclosure of all awarded and pending contracts with the District of Columbia, including the following for each contract:

1. Contract number
2. Contract amount
3. Contract's Period of Performance (start and end date)
4. Contract type (fixed price, cost reimbursement, etc.)
5. Purchasing agency and
6. Description of services.

Table 1.4
Cost Summary Format

Cost Item	CLIN 0001			CLIN 0002			CLIN 0003			Total
Direct Labor Categories ▪ Employee A ▪ Employee B ▪ Employee C ▪ Employee D	R	H	D	R	H	D	R	H	D	
Total Labor Hours										
Total Labor Dollars										
Total Direct Labor										
Subcontractors ▪ Sub A ▪ Sub B										
Total Price										

H = Hours
R = Rate
D = Dollars (Rate X Hours = Dollars)

2 RESERVED

3 SPECIFIC COST ELEMENTS

3.1 Direct Labor

A task-phased annual breakdown of labor rates and labor hours by category or skill level, including the basis for the rates and hours estimated (i.e., payroll registers, wage determinations, collective bargaining agreements, historical experience, engineering estimates, etc.).

3.1.1 The Offeror shall use the following Table No. 3.1.1 to exhibit its total labor hours by prime contractor and subcontractor(s).

Table 3.1.1
Base Year Labor Summary

Item	CLIN 0001	CLIN 0002	CLIN 0003	Total
Labor Category (Prime) ▪ Employee A ▪ Employee B ▪ Employee C ▪ Employee D Labor Category (Subcontractor A) ▪ Employee A ▪ Employee B ▪ Employee C Labor Category (Subcontractor B) ▪ Employee A ▪ Employee B ▪ Employee C Labor Category (Consultant) ▪ Employee A ▪ Employee B				
Total Labor Hours by Task				

Note: Do not include wage rates in this table

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Attachment D

DCHT-2011-T-0009
Amendment A0001
Attachment D Responses to Questions About the Solicitation

No.	RFTOP Section	Question	Response
1	C.3.1.1.1	The RFP references several activities currently being undertaken by Fox Systems "in partnership with the DHCF". What is the extent of these activities?	Please see Amendment A0001 Items No. 4 and 10.
		Does participation in these activities give Fox Systems a distinct advantage over other potential bidders?	No.
		Is Fox Systems precluded from bidding on this particular procurement?	No.
2	C.3.1.1.1	The scope of work implies that other existing systems beyond the MMIS will need to be reviewed and analyzed for duplicative health related functions. Does the scope of work limit the analysis and recommendations to the MMIS in terms of "legacy" systems that may need to be updated? Please clarify.	The Legacy systems referenced is in terms of the MMIS.
3	C.3.1.1.2/H3.1	Can the District post the Provider Survey Results as a part of the Bid Library for review by potential vendors prior to the bid due date?	Please see Section H.3.1 of the RFTOP.
4	C.3.1.1.3	Please clarify "incorporate any updates to the MMIS System…"	Please see Amendment A0001 Item No. 5.
5	C.3.1.1.3	a. Will District staff and other related stakeholders commit to meeting the timeline required to conduct these meetings such that the overall creation of the SMHP Draft by 05/31/2011 is not delayed?	Please see Amendment A0001 Item No. 6.
6	C.3.1.1.3	b. Given the logistics and coordination required for assembling these types of meetings, would the District consider extending the date due for the Draft SMHP to accommodate scheduling delays or issues?	At present, DHCF must plan according to the deadlines and requirements agreed to between the District and CMS. If there are changes in the CMS requirements then there may be opportunity for accommodating scheduling delays.

No.	RFTOP Section	Question	Response
7	C.3.3.3	On page 26 of the RFP, it states that the Draft IAPD is due no later than May 31, 2011. Section C.3.3.3 references a more reasonable date " not later than 100 days after contract signing" which might be approximately August 2011. Please clarify intent.	CMS has agreed to accept the submission of the SMHP in phases. The May 31, 2011 deliverable will be the first phase deliverable and not the entire final SMHP plan.
8	C.3.3.3	On page 27 of the RFP, it states that the Draft IAPD is due no later than May 31, 2011. Section C.3.3.3 references a more reasonable date of "not later than 100 days after contract signing" which might be approximately August 2011. Please clarify intent.	CMS has agreed to accept the submission of the SMHP in phases. The May 31, 2011 deliverable will be the first phase deliverable and not the entire final SMHP plan. The 100 days reference is to the end date for all the final deliverables.
9	H.3	Will the District provide any office space for the onsite contractor staff? If so, how many contractor staff can the District accommodate? Does the District have wireless access for onsite contractor staff?	Please see Amendment A0001 Item No. 8.
10	C.4.1	Please clarify what is meant by REC Coordination? It is not clearly defined.	Please see Amendment A0001 Item No. 3.
11	F.2	Please clarify if the costs associated with production of the deliverables are the responsibility of the Contractor or the District.	Please see Sections B.2 and B.3 of the RFTOP.
12	L.2	Due to the short turn around time for proposal submission, would the District consider an emailed version of the proposal, followed by (or instead of) hard-copy submission?	Please see Amendment A0001 Items No. 1 and 11.
13	L.2	How many copies of the proposal and media?	Please see Amendment A0001 Item No. 11.
14	L.2.1.2	It will be difficult to gather the required evaluation forms in the limited amount of time for the proposal submission. Would the District consider delaying the due date of the Performance Evaluation Forms by 1 week to accommodate outreach to former and current customers? Can they be submitted electronically?	Please see Amendment A0001 Item No. 12.

No.	RFTOP Section	Question	Response
15	L.2.1.2	Section L.2.1.2: Please clarify how the District differentiates between the information requested in Section L.2.1.2 sub-section a. and Section L.2.1.2 sub-section b. We understand that sub-section a. requires lessons learned while sub-section b. requires contract and contact information. However, is the balance of the information requested to be repeated/copied in sub-section a. and sub-section b.?	Please see Section L.2.1.2 a and b of the RFTOP.
16	L.2.1.2	Section L.2.1.2: Please confirm that the three references do not all have to be for SMHP engagements.	Please see Section L.2.1.2 a and b of the RFTOP.
17	L.2.1.2.b	Please confirm that this is the individual that can verify the contract dates and contract amount.	Please see Section L.2.1.2 b 7 of the RFTOP.
18	L.2.1.2.e	Please outline the process for submission of the Past Performance Evaluation forms.	Please see Amendment A0001 Item No. 12.
19	L.2.1.3	In the limited time available to create the proposal, it will be difficult if not impossible to get this level of information requested regarding each staff persons College Education. Can the District relax or remove this clause?	Please see Amendment A0001 Item No. 13.
20	L.2.2	Pg 61 of the RFP references attachment J.15 as the Performance Evaluation form. There is no attachment J.15. Attachment J.13 provided is titled as the Performance Evaluation form. Is attachment J.13 the correct form to be used?	Please see Amendment A0001 Item No. 14.
21	L.2.2	RFP Attachment J.14/J.12 (Cost/Price Data Disclosure Certification) – Please confirm that the Cost/Price Data Disclosure Certification should be executed by the bidder and included as part of the bid or whether this form is only required as a part of contract award and the contracting process.	Please see Section L.2.2 b of the RFTOP.

No.	RFTOP Section	Question	Response
22	L.2.2	RFP Attachment J.14/J.12 (Cost/Price Data Disclosure Certification) – Would it be possible to have a copy of the schedules in this attachment in Excel?	Attachment J.12 is available in Microsoft Word format and is provided as Attachment C to A0001.
23	L.2.2	A couple of the attachments appear to be mis-referenced in the document – can you please confirm this and provide the correct attachment numbers?	Please see Amendment A0001 Item No. 14.
24	L.2.2.b	Since the contract is only for 6 months, is it necessary to complete attachment J.14 Cost Forms for Option Years 1-4? If so, what is the scope of work to be priced in the balance of the Base Year and all the Option Years?	Please see Amendment A0001 Attachment C.
25	L.2.2	Is a copy of the bidder's full GSA contract on CD acceptable? If so, how many copies on CD would the District require?	Please see Amendment A0001 Item No. 11.
26	L.2.2	The RFP requires a fixed-price based on GSA MOBIs rates, however, the Cost/Price Data Package asks for a cost-plus buildup structure. The RFP appears to contradict the required backup in the Cost/Price Data Package. As such, are we to propose pricing based on discounted GSA rates or should we propose pricing based on a cost build-up. If the GSA MOBIS rates are the preferred pricing structure, then the Cost/Price Data Package would appear to be not applicable.	Please see Section L.2.2 a of the RFTOP.
27	General	What date will answers for submitted questions be completed and posted for vendors to review PRIOR to delivering the proposal?	Please see Amendment A0001 Attachment D.

No.	RFTOP Section	Question	Response
28	L.19.2	Pg 65 of the RFP states that questions shall be submitted after the pre-proposal conference in writing but no later than October 22, 2010 in order to generate an official answer. Can the government provide an expected date of answers to the proposed written questions given the bidders conference was held after the provided questions submission deadline?	Please see Amendment A0001 Item No. 16 and Attachment D.
29	L.19.2	Please provide the correct date.	Please see Amendment A0001 Item No. 16.
30	General	Is there a budget associated with this project?	District procurement regulations prevent the disclosure of the District's independent government estimate.
31	General	will next week's deadline for the above procurement be affected by the potential shutdown?	Not Applicable
32		Does this solicitation adhere to District guidelines and policy, such as the First Source Program or CBE preference points?	The solicitation, as described in Section B.2 is a Request for Task Order Proposal (RFTOP) to be issued against the Contractor's GSA MOBIS Schedule #874-1.
33	General	Are prime and/or subcontractors who are involved with producing I-APDs and/or other planning documents, which cover projects budget for example, restricted from being a prime or sub in the implementation?	Please see solicitation Section B.2 of the RFTOP.
34	General	If there are additionally known links or websites with additional information on the status of the various projects and initiatives cited in the solicitation, please provide if time permits.	All information available has been provided.
35	General	Can the District post the HIT P-APD as a part of the Bid Library for review by potential vendors prior to the bid due date?	Please see Amendment A0001 Item No. 2 and Attachment A.
36	General	Will a cost-allocation deliverable be required in the I-APD, assuming that the implementation with require agencies other than DC DHCF?	The I-APD shall be prepared in accordance with CMS guidelines.