CRISP Healthcare Provider Directory Vendor Follow-Up Questions

Updated February 3, 2017

1. Is there any need to highlight in our RFP response if anything is out of the box or if requires configuration?
   1. A “Yes” response is adequate but feel free to include notes to provider further clarification.
2. If the expectation is that the system will consume existing inputs from various source systems, will there be a list provided of fields and data elements from the various source systems into the provider directory?
   1. Yes.
3. Are there definitions of the terms used in the pricing table (i.e. What is defined as an organization?) included in the RFP?
   1. Not explicitly listed in the RFP but organizations include any organization which a provider is professionally affiliated. Admins are anyone with elevated privileges and access in the system to conduct routine maintenance.
4. What is the difference between the Phases 1-3 vs. Analytics 1 – 4?
   1. The implementation phases mean we are planning to roll out deliverables which support the initial use case in phases vs. big bang.
   2. For analytics:

* #False Positives (matched when should not have) / #False Negatives (did not match when should have),
* #Successful merges between 2 sources,
* Field data quality, by source, excluding generic values
* #Singletons (records not linked to any other record)

1. In the RFP relationships are discussed. Does this initial phase also include provider to patient relationships?
   1. At this time, no, it just includes provider to organization, provider to hospital, and provider to provider.
2. Is this directory open to general consumers?
   1. No, CRISP services will integrate directly with the healthcare provider directory so the information can be leveraged in downstream systems.
3. Should the pricing include hosting fees?
   1. Yes if you have a hosted solution, feel free to quote that.
4. Can you please provide a brief summary of your technology stack for this product?
   1. We are open to many alternatives but our current in-house stack includes MS SQL servers, MS application servers and .Net
5. Is there an expectation to have the solution responsive and mobile?
   1. We are not currently looking for mobile capabilities.
6. Are the user interfaces listed in the spreadsheet future use cases or current?
   1. The User Interfaces described in the requirements spreadsheet refer to the ability of the Healthcare Provider Directory to enable such capabilities in downstream systems. For example, the Healthcare Provider Directory leverages APIs to push data into a downstream system, which displays that information in the described User Interfaces.
7. Since you have the member patient index IBM Initiate solution already available in house are you looking for alternate solutions for that as well?
   1. For this RFP it is strictly for a provider directory.
8. There is mention of three user interfaces: patient’s ability to search, administrators and providers. Are these all required for the initial release?
   1. Any access to the system from a user perspective is coming from another system.
9. Do the pipes already exist and built to get the data? Does this RFP anticipate any changes to the pipes?
   1. There is current infrastructure in place but to we are unable to respond how it will interact with the solution your organization will propose at this time. If selected, we will learn more during the discovery and planning phase.
10. Given the fact IBM Initiate does provide a provider index and the next phase will require patient relationship to provider, why did you envision going with an RFP when those patient / provider relationships need to be tightly coupled in the next phase?
    1. IBM is a thorough solution but an expensive solution and since we are looking to implement with an assertive schedule, we decided to pursue the RFP route for other solutions.
11. How do you envision taking the next step if you have the provider and member architecture in disparate systems?
    1. We are looking for systems that can integrate and attribute providers to patients downstream in future use cases. We are open to alternatives if presented.
12. Will CRISP be responsible for providing the test environment for unit testing, QA, and user acceptance testing?
    1. Yes.
13. Is the architecture currently service oriented based?
    1. There are pieces of architecture that are SOA and some which are older so a mix.
14. What type of data cleansing would need to be included?
    1. It’s not part of the core RFP but if you have something to perform this for provider data feel free to quote it.
15. How often is new provider data sent to CRISP? Weekly, Monthly?
    1. Provider data is sent in both real-time and batch formats. This could be as frequent as up-to-the-minute or longer than a month.
16. RFP shows approximately 12 data sources. Is layout same across all the data sources? Is the data layout for each of the 12 data files consistent for that particular data file when each new file is refreshed? What is the file format for these data sources?
    1. The layout is not the same across data sources; vendors should expect to integrate with the formats listed in Section B.9. Each new file from the same data source will be consistent.
17. What would be the file frequency for each of these data source? Are they full files all the time?
    1. Data source file frequency varies.
18. How many records (approx.) that each data source contains?
    1. CRISP provides services for every scope / scale of providers in our coverage area. The largest of sources, Insurance providers, will have tens of thousands of providers. At the other extreme are single provider practices.
19. Do these data sources contain Geocoding information?
    1. Typically no.
20. Can CRISP provides us sample file layout for these data sources?
    1. Not at this time.
21. What are the key elements to form the relationship between these data sources?
    1. The most important would be:

Provider – Practice. (*Dr. Kim to Columbia Pediatrics)*

Provider – Location(s) (Dr. Kim is at the Catonsville and Rockville offices)

Practice – “chain” (Columbia Pediatrics is part of Hopkins)

Practice to state – (Columbia Pediatrics is associated with MD)

1. Does this tool need Maps and Directions?
   1. Not required
2. Does this application require any PDF functionality (i.e. Print search results as PDF based on Template)
   1. Desired but not required
3. Does vendor also need to output combined Provider records into a feed in addition to exposing that via Enterprise Services?
   1. Provider records should be consumable by downstream services as both a feed and on-demand.
4. In an effort to help us more accurately estimate implementation hours/costs related to CRISP’s 12 data sources, we thought building a source type cost matrix might be simplest for you and the team. The following are a list of typical data sources we have seen in the past. Please let us know if you think there are others we need to consider.

Data Source Integration Types:

1. Data source requiring a flat file loader (i.e. from a credentialing system)
2. A new data source that uses an existing flat file loader (ie. Adding a credentialing system post go live that is the same as one already built)
3. NPES file loader
4. API Integration via web services
5. Real-time HL7 interface (this is not typical but we always like to ask)

Section B.9 in the Requirements Excel sheet lists the following input data sources, of which only Flat Files are required per this RFP

|  |
| --- |
| **Inputs (Data Sources)** |
| Extract info from FlatFile/CSV |
| Extract info from ADT |
| Extract info from X12 |
| Extract info from ORU |
| Extract info from CCDA |
| Extract info from CarePlan |
| Extract from HL7 MasterFile |
| Extract from CMS CCLF |
| Extract from ENS Panel |
| Extract info from HPD+ |
| Extract info from Other |
| API Query (i.e. pull from SalesForce) |

1. Could you clarify what data or data sources would be accommodated with this Provider Attribute so we may answer it appropriately? B.2.32 : Temporal (attribute history or by visit
   1. This refers to the ability to capture a snapshot of all Provider attributes by visit or track attribute history over time. Note it is marked as Optional (P1) under priority.
2. Could you expand on what is meant by Attribution Algorithms for Relationships so we may answer it appropriately? B.7.18 Attribution Algorithms
   1. Attribution Algorithms, within the Relationships section, refers to the inclusion of logic to satisfy Maryland’s complex attribution requirements. Note it is marked as Optional (P1) under priority. For example, Abraham Lincoln has diabetes and has a care manager. Abraham has an attribution to his care manager.
3. For the CRISP internal users of the provider directory solution would CRISP have available the user licenses for salesforce such that our Provider Directory solution could leverage those salesforce user licenses?  If so, what edition of Salesforce is currently used by CRISP?
   1. CRISP would make available any Salesforce user licenses
4. Are Zip files an acceptable format for the submitted proposal response?
   1. All files should be possible to embed within a single Word Document; this format is easiest for the evaluation team to keep organized and together. If there is a reason why this not materially possible, please let us know.
5. Can the single file for submission containing all RFP response and supporting materials be divided into two files if the single file is too large to be emailed due to vendor Exchange (email) server settings?
   1. Please provide additional explanation as to why such a large file size is required
6. Are the instructions under the “Technical Requirements” heading of Appendix A of the RFP specific to CRISP\_HealthcareProviderDirectory\_Requirements.xlsx or the sub-headings (i.e. questions 1 – 21)?
   1. We are seeking a solution to the first use case identified in the Requirements spreadsheet (Consumer Provider Lookup). For both Appendix A and the Requirements spreadsheet, please tailor your response to this use case. If you would like to provide information for a solution to any of the other identified use cases, please include the information separately.
7. Are the 12 data sources the same health plan data sources used for the CRISP consumer search site today?
   1. No; our consumer search site (<https://providersearch.crisphealth.org/>) is a single source of provider information.
8. The 50 Administration users for use case #1, is that for search only, or do they need read/write privileges?
   1. Read/write privileges as well
9. Are the 4 to 8 analytics listed as part of “Pricing Model Assumptions” in the *Pricing Spreadsheet* analytics reports or users?  Can you provide a use case sample for more definition?
   1. See Section B.14: Reporting in the CRISP\_HealthcareProviderDirectory\_Requirements document
10. Is there integration planned with the Provider Directory and the CRISP portal (<https://crisphealth.force.com/crisp2_login>) as part of use case #1?
    1. No
11. Is there integration planned with the Provider Directory and the consumer search site (<https://providersearch.crisphealth.org/>) as part of use case #1?
    1. Possibly
12. Is the vendor required to provide the appendices listed in the *Directory Requirements* spreadsheet (rows 262 – 267) as part of the vendor RFP response?  If so, what is the recommended approach if the total file size of the appendices is greater than 15 MB?
    1. These are already covered in the RFP and repeated for reference (for example, Technical Diagrams are covered under “General Healthcare Provider Directory Questions” in Appendix A: General and Technical Questions of the RFP).
13. Does all of the provider information reside within Salesforce today?  We have had a couple of integrators contact us and relay how the information is being collected and stored in SF.  Also they said that CRISP preference is to have clients interacting via Salesforce.  That was not in the RFP and wondered if you wanted to have that included as part of a solution today or in a future application.  We are extremely flexible but would like to know.
    1. No, provider information is coming from a variety of sources.
14. For future development phases can you share the number of members  and other domains.  We are focused on provider but wanted to provide some budgets for these other phases as requested in the rfp.
    1. We don’t want to get too specific on the future use cases at this time; a detailed budget is not necessary. We can explore this at a later time if we find it necessary.
15. Relationships/B.7.4: Asks if we support “Patient Consent / Auth to Share (Provider-to-Pt)” as a relationship. What is the “Pt” part of the Provider-to-Pt relationship?
    1. “Pt” stands for Patient
16. Relationships/B.7.18: Asks if we support “Attribution Algorithms” as a relationship. What is meant by “Attribution Algorithms”?
    1. The state of Maryland employs some reasonable complex attributions between patients and a Care Manager. The Healthcare Provider Directory must be able to support these relationships.
17. Data Augmentation Services/B.8.8: Asks if we support “Secure Texting Addresses”. What is meant by that?
    1. As an optional parameter, can you associate a Provider’s Secure Texting Address to their profile.
18. User Interface - Admin/B.12.4: Asks if we support “Licensure UI”. What is meant by that?
    1. As an optional interface available to administrators of the system, can you display the licensure information for providers.
19. We saw that the page limit for the summary section, which includes a proposal summary, company overview and work plan, is 1-2 pages. Is there an overall limit for the entire Technical Proposal?
    1. No there is not a limit to the overall proposal. Please keep in mind that we will have an evaluation team reading each of these and they only have so much time available!
20. Could you help clarify CRISP’s definition of “data sources”.  From what we can see in the requirements and the answers below list 12 “data sources” types.   There are 12 different data formats (flat file, HL7, X12, etc).  There is no indication of the number of actual source systems that would be providing data in these formats. For example, does CRISP get flat file extracts from each of its participating hospitals, which from our perspective would be 50+ sources, but from CRISP’s perspective there is only one “data source” (the flat file/CSV).  Could you please confirm for the Use Case #1 scope how many source systems CRISP is expecting to get data from (in the single flat file/CSV format)?    If it’s 50+ sources that’s makes a big difference in the amount of implementation time vs 12 sources.

Section B.9 in the Requirements Excel sheet lists the following input data sources, of which only Flat Files are required per this RFP

|  |
| --- |
| **Inputs (Data Sources)** |
| Extract info from FlatFile/CSV |
| Extract info from ADT |
| Extract info from X12 |
| Extract info from ORU |
| Extract info from CCDA |
| Extract info from CarePlan |
| Extract from HL7 MasterFile |
| Extract from CMS CCLF |
| Extract from ENS Panel |
| Extract info from HPD+ |
| Extract info from Other |
| API Query (i.e. pull from SalesForce) |

* 1. Using your example, CRISP receives flat file extracts that contain provider data from hundreds of participating ambulatory practices; each of these flat files has the potential for variations in formatting. We also accept ADT feeds from hospitals and larger ambulatory practices, which also may vary in the data they contain.

1. What version of IBM InfoSphere / Initiate is CRISP using?
   1. Version 10.1
2. Is Initiate the Standard or Advanced version?
   1. Standard
3. Is Initiate Physical or Virtual?
   1. Virtual
   2. For reference: Virtual = Golden record is derived in real-time and provided by API or Inspector. Physical = Golden record is derived and persisted in the DB.
4. Are there any MDM UI functionality requests?
   1. No
5. How many community users are in CRISP’s Salesforce instance?
   1. 20,588 users have a Customer Community Login license. Many of these are unnecessary to maintain.
6. Does the Salesforce integration with Jitterbit leverage REST or SOAP?
   1. REST
7. How many custom fields are in the Salesforce environment?
   1. 520
      1. 216 on the Contact
      2. 304 on the Account
      3. Not all are actively used.
8. Is Salesforce the system of record for provider data?
   1. No; provider data comes from a variety of sources, none of which are a system of record
9. Is there an integration layer already built in?
   1. Somewhat – depends on the service
10. Is the directory intended as a Provider Index or a Provider Master?
11. Definitions
    1. Index ~ 10 fields (just enough to identify)
    2. Master ~ 50 fields (all info on a provider)
12. The directory is a Provider Master. As an example, we will be collecting demographic and contact information.
13. Where is organization information and their relationship to a provider stored?
14. Organization information isn’t consolidated; it is on the same data streams as provider information.
15. What integration methods will the system be expected to support?
16. See section B.9 in the Requirements Excel document (required integrations are reproduced below)
17. Inputs
    1. Extract info from FlatFile/CSV
18. Outputs
    1. IHE HPD+
    2. APIs
    3. FlatFile/CSV
19. What are the transaction volumes we expect this system to handle?
20. We do not have an estimate on the number of incoming transactions at this time
21. What is the anticipated traffic to a user Interface?
22. The UI is only for CRISP employees to maintain the system, so low traffic.
23. Earlier, CRISP expressed that it did not want to receive any licensing information. Has that changed?
    1. We do not to stand up a new system, and would not be interested in any license information of this nature. We ARE interested in licensing information related to reconfiguring Initiate or Salesforce.
24. Regardless of what is built on top, is the underlying platform is the same as you have today?
25. Correct
26. How will we receive updated information?
27. The CRISP website (<https://crisphealth.org/healthcare-provider-directory-rfp/>) will be the main source of information. If there are any substantial updates, I will reach out to vendors referencing the website.
28. What is your Data Governance process for providers?
29. We do not have a policy defined
30. Record counts
31. From SFDC, only an estimate, in another doc (answered for Mac)
32. 90,000 Contacts (e.g. 90,000 providers)
33. 9,000 Accounts (e.g. 9,000 organizations)
34. What sort of training practices do you have when you roll out new capabilities in Salesforce?
35. We have no consistent practices. We are open to improvements and suggestions.
36. How many systems is CRISP using to service as its provider master today?
    1. There is no centralized provider master in place today. Any systems that need to take action on a single provider create that record as needed. We have roughly 10 systems with this data.
    2. Is the intent to discontinue using whichever system isn’t chosen moving forward?
       * 1. Existing systems will be updated to reference the provider directory as a source of truth for provider data. This is past MVP.
         2. If so, will a data migration be required?
            1. Data from existing systems will serve as inputs to the provider directory. It is not clear if the data will need to be migrated from its current hosting, or if it will be established as an input stream to the directory.
            2. Yes? Can you provide type of data, estimation of total record count being moved and quality of data

Cannot estimate at this time.

1. How is SF used today? Can you also provide details to the following questions:
   1. What objects?
      1. Contact, Account, Point of Contact
      2. Working to implement Leads and Opportunities
   2. What type of users access the system today?
      1. Internal Users – Operations staff, Outreach staff (i.e. sales)
      2. External Users – Online Registration, Point of Contact page
   3. Custom code?
      1. Online Registration (Standard and Auto-Registration)
      2. Point of Contact page
   4. Apps used?
      1. None
      2. Yes? Please describe apps being used.
   5. Current integrations?
      1. None
   6. What type of users have access to the community today and for what purpose?
      1. Online Registration
2. How many users will be accessing the system?
   1. For the MVP, 10 or fewer. The users will be CRISP staff monitoring and maintaining the system.
   2. Future state – we envision allowing providers to update their information in the directory.
3. The following question was included in the Q&A document:
   * 1. Q: There is mention of three user interfaces: patient’s ability to search, administrators and providers. Are these all required for the initial release?
     2. A: Any access to the system from a user perspective is coming from another system.

To clarify, as part of the initial release, the Master Provider must have outputs to which specific systems for the purpose of user access to the data*?* Also, to clarify, these users will ***not*** be accessing the Master Provider system directly, is that correct?

Yes the provider directory will have outputs to other CRISP systems; users will not interface directly with the provider directory. Examples of systems that will consume provider data are Encounter Notification Service (ENS) and CRISP Reporting Services (CRS).

1. Is the intent that is SF is used as the Master Provider moving forward, will the current community be used to give administrators and providers access to the system?
   1. The current community does not need access to the system. Only Salesforce system administrators will need access
2. How are you ingesting provider information in salesforce today? Are you getting provider data from all the sources today and if so can you give us some detail on how you’re doing it.
   1. Provider data is entered by:
      1. Our online registration process – while providers register for CRISP access, they enter their information into our system
      2. CRISP staff – Also for registration, CRISP staff members will manually update Salesforce information for a provider while they are on the phone or speaking via email
3. How many orgs do you have and how many users per org?
   1. We have 1 org with the following active user types:
      1. Standard = 91
      2. Guest = 2
      3. High Volume Portal = 20,841
4. Is it possible to have bidirectional data sources (both an input and output system)?
   1. Yes
5. In the Requirements spreadsheet, B.13.1 lists a Provider updating information as “required.” My understanding was that only administrators would be accessing the directory.
   1. Your understanding is correct – this was intended to be “optional” for our first use case.
6. Will CRISP sunset the Initiate system as a part of this effort?
   1. No, Initiate will exist regardless of this RFP.
7. Can you provide additional explanation for the items in the “Matching Algorithm” section of the Requirements document (B.6)?
   1. Matching algorithms listed
      1. Golden record
      2. Probablistic
      3. Trusted Source
      4. Evaluate attribute history (i.e. phone, address)
      5. Default matching attributes (and weights)
      6. Provider Search (fuzzy logic)
   2. Additional commentary
      1. The provider directory should be able to create a “golden record” for each provider
      2. Matching should use probabilistic matching techniques.
      3. This record will be the trusted source of a provider across our enterprise.
      4. A particular attribute’s history should be considered in the match (e.g. if a new record wants to overwrite the attribute value in our golden record).
      5. We expect there to be a “core” set of matching attributes and weights associated with each (for example, weighting an NPI match above an address match)
      6. The directory will be searchable using fuzzy logic (for example, John Doe will return a match for Jon Doe)
8. Can you expand on the “required” items in the “Terminology” section of the Requirements document (B.17.1-3)?
   1. CRISP is inquiring into the configurations capable in the solution – can we change terminology to match our branding (e.g. changing a Contact to a Provider)? If not, what aspects of the solution are inflexible to change, and where can we store the crosswalk between terms?
9. Is single sign on required for administrators or is it used today? If so, will SSO method change and where are they coming from?
   1. Single Sign On is not used with Salesforce today, nor will it be required for the provider directory.
10. In phase 1, providers will still have access to the SF Community to update their contact information. The data points that they are updating may change as well now that more information (other than just contact information) is being stored. Is it correct in assuming that the new data fields expected to be accounted for in phase 1 (ex. DOB, specialty, sub-specialty, CDS permit, PDMP registrant, DEA number, etc.) should be exposed to the provider so they can update it in the Community in phase 1?
    1. Providers do provide this information through our Salesforce Community today, and this information is stored on a Contact record for the Provider. We envisioned this data as an input to the provider directory, not to be edited directly in the provider directory.
11. What is the data flow bringing on new providers?
    1. We have provider information in the form of user lists in each of CRISP’s systems. As CRISP provides services to the healthcare community, consumers of those services are healthcare providers. Those providers register to use our services by providing some set of information.
    2. In addition to CRISP systems, our CRM too, Salesforce, is our best-kept source of provider data.
    3. We have no definitive source of truth for provider data; that is why we are interested in creating a provider directory.
12. Are there any integrations in the Salesforce environment?
    1. In addition to out of the box configurations, we have developed custom code on the Force.com platform.
    2. Integrations to external systems to date have been handled through Jitterbit. For now, the only integration in place moves Contact information from Salesforce to our Query Portal system (Mirth Results), through the integration layers of Jitterbit and Mirth Connect.
13. Are files coming from Router or source systems themselves?
    1. We are not sure based on development currently underway. Assume files will come from the source systems directly.
14. In the event we receive information for a provider that does not match our golden record, by what process will we update the golden record?
    1. We have not decided at this time. We are open to suggestions throughout the RFP process as they are appropriate.
15. How many providers are in the system?
    1. Users of the system - Only admins, so very minimal. 5-10.
    2. Have a record in the directory - 50k-100k
16. Where does CRISP data come from?
    1. Multiple hospital systems, ambulatory practices, etc.
17. Are vendors expected to provide extracts or downstream data dumps?
    1. The system needs to be able to support the following outbound integrations: IHE HPD+, APIs, Flat File/CSV. We will not build these integrations in Phase 1, but the ability needs to be there.
18. Is the directory replacing the Business Rules Engine in Router?
    1. No, Router is a separate entity. The requirement for a Business Rules Engine is related to only the provider directory, such as in order to determine which record will update the golden record.
19. Is Initiate is matching providers to then pass into Salesforce?
    1. Provider matching could be Initiate or Salesforce. We can envision a solution leveraging either Initiate or Salesforce or both systems.

## Attachments



