Mini Request for Information to Acquire Population Health Software

This tool can help organizations structure requests for vendors to send proposals for population health software. Vendors often will not respond to a formal, detailed request for information (RFI). However, after completing this tool, you should have all the information necessary to contact a vendor to provide a demo of their product and a quote. You could read from this tool when speaking to a vendor on the phone or you could send it in an email to a sales consultant. No matter how you contact vendors, you must provide a clear picture of what you are looking for and give the same information to each vendor, so you can compare responses side-by-side.

# How to Use this Tool

* Revise the table of population health tool capabilities below to summarize your organization and align with the needs identified when you completed the *Population Health Software Capabilities* tool.
* Work with vendors to complete comparable mini RFIs.
* In addition to understanding whether a vendor’s product can support the key capabilities you’ve identified, consider asking vendors these questions:
  + Does your technology integrate with our current EHR?
  + Can our organization change the software rules that generate workflows?
  + Company experience: How long has your company been in existence? Is it in the process of being purchased or merged? How long has it developed and marketed population health management products?
  + Technology enhancements: Describe the product’s major version history, including whether the product was developed internally or acquired from another source. Are there other planned new releases over the next one to two years? How are enhancement and new release priorities determined? How are clients supported during these releases?
  + Ongoing support: Tell us about your services (personnel skills and availability) to customize functionality and ensure a timely flow of reliable data?

Mini RFI tool starts on next page.

# Background of Your Organization for Vendors

**Organization Name:**

**Address:**

**Contact Person/Title:** **Phone: Email:**

**Brief Description of Your Organization:** (include number of patients, number of providers, specialties provided by your organization, encounters, revenue, who you serve, percentage Medicare/Medicaid, other public payers, private insurance, uninsured self-pay, uncompensated, relevant information about your community or patients)

**Current EHR Software:** (vendor, version, modules installed, meaningful use attainment)

**Data Warehouse Capabilities:** (explain any progress on data warehousing capabilities, if relevant)

**ACO Status:** (in an ACO, considering joining an ACO, not going to join an ACO)

**Goals for Population Health Software:** (from Step 3, include a couple of sentences about why you want to acquire population health software)

**Your Organization’s Access to Claims Data:** (Do you have access to your claims data today? If so, from whom and how often?)

**Population Health Software Capabilities**

| Capability | Availability | Additional hardware, software, skills needed |
| --- | --- | --- |
| 1. Patient Subpopulations – registries of who fits criteria |  |  |
| 1. Access to directory services that provide person/patient identification (PID) and record locator services |  |  |
| 1. Aggregate internal clinical data (from EHRs, virtual visits, pharmacy systems, labs)  * Condition/diagnosis * Comorbidities * Conditions requiring follow-up * Problem list * Clinical impression * Lab results * Diagnostic imaging results * Functional status measures * Medications * Procedures * Treatment adherence * Clinical observations (e.g., vital signs) * Specific goals (short, medium, long term) * Gender, race, ethnicity, language * Unstructured notes via natural language processing (NLP) |  |  |
| 1. Aggregate internal administrative and financial data (from billing systems, claims, payers)  * Billing data (e.g. diagnoses from ICD-9 codes, dates of service, utilization/office visits, procedures performed from CPT codes, medication data from NDC codes, cost data) |  |  |
| 1. Create queries to identify subpopulations (save, re-run, share, produce reports) |  |  |
| 1. Identify patient populations based on clinical conditions and health behaviors (e.g., smoking status) |  |  |
| 1. Segment patient populations by provider, intervention, or service type |  |  |
| 2. Integrate External Data |  |  |
| 1. Acquire external data (e.g., HIEs, tele-monitoring from devices such as scales and BP monitors that feed data to a patient portal or EMR) (See also 7.h.) |  |  |
| 1. Integrate external data from payers and others (e.g. claims data from Medicare, Medicaid, commercial payers) |  |  |
| 1. Maintain audit logs and usage reports, as security measure |  |  |
| 3. Risk Stratification |  |  |
| 1. Stratify clinical risk level (i.e., at risk, high risk, very high risk) (includes comorbidities) |  |  |
| 1. Identify highest impact patients (combines clinical risk, utilization, cost) |  |  |
| 1. Identify patients who are at compliance risk by ability to flag potential barriers to adhere to clinical protocols, such as:  * Language barriers * Cognitive inability * Physical inability * Economic inability * Insurance status * Willing and informed refusal to participate in a care protocol (e.g., religious reasons) * Medication contraindications to participating in a care protocol * Geographic barrier * Stress index (i.e., life events, recently deceased spouse) * Mortality * [Medicare risk adjustment information](https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html) |  |  |
| 4. Risk Predictive Analytics |  |  |
| 1. Calculate future risk based on health status and social determinant factors (i.e., readmission management, organization trend data incorporated into prediction) |  |  |
| 1. Predict utilization and cost  * Inpatient visit * Inpatient length of stay * ED visits * Medications * Readmission |  |  |
| 5. Patient-Provider Attribution |  |  |
| 1. Record patient-selected physician during open enrollment |  |  |
| 1. Identify most frequently visited physician over past two years |  |  |
| 1. Record assigned primary care physicians (same geographic area, employer group to primary care physicians in PPO or HMO) |  |  |
| 6. Performance Management |  |  |
| 1. Access a library of common performance metrics (i.e., HEDIS; STAR; Medicare Quality Payment Program; Meaningful Use; NQF measures; ACO measures; state-specific, such as MN Community Measurement) |  |  |
| 1. Produce monitoring reports  * Quality performance (e.g., use of evidence-based guidelines and protocols and progress toward their use, achievement toward common performance metrics) * Regulatory reporting * Others, such as productivity, outcomes, cost savings, disease status, utilization, claims, quality measures, authorizations |  |  |
| 1. Generate dashboards showing quality performance (by facility, region, or practitioner, or other desired metrics) |  |  |
| 1. Generate dashboards showing cost of care for individual patients and populations (by facility, region, or practitioner, or other desired metrics) |  |  |
| 1. Provide drill-down capability in dashboards (from population to individuals, to utilization and financial analytics |  |  |
| 7. Educate and Engage Patients |  |  |
| 1. Integrate with a personal health record (PHR) / patient portals (secure messaging, patient scheduling, refill requests, patient education and health maintenance reminders) |  |  |
| 1. Access and track use of customizable educational material, available at point of care |  |  |
| 1. Document patient-preferred method of contact (i.e., email, text messaging, secure messaging via patient portal, phone call) |  |  |
| 1. Facilitate reminders and campaigns that target populations with gaps in quality measures |  |  |
| 1. Support non-English language notifications |  |  |
| 1. Offer client-specific report cards and diaries |  |  |
| 1. Use templates to build a patient’s self-management plan of care (supports motivational interviewing and shared decision making) |  |  |
| 1. Maintain patient-supplied information (i.e., logs/journals, preferences, biometrics from cloud-based mobile health applications) |  |  |
| 8. Care Team Coordination |  |  |
| 1. Document care team members, including patient’s caregiver/ family support team members |  |  |
| 1. Document social and community supports, including caregiver/family support team members |  |  |
| 1. Produce and maintain care plan (auto-generated from evidence-based assessment, personalized, dynamic) |  |  |
| 1. Access patient dashboards to monitor goals and outcomes |  |  |
| 1. Integrate with EHR for shared access to longitudinal record (e.g., view risk scores, care gaps, plan of care) |  |  |
| 1. Send secure, HIPAA-compliant messages to both internal and external recipients |  |  |
| 1. Export patient data (e.g. spreadsheets, CSV, XML) to share with external partners |  |  |
| 1. Manage referrals (i.e., referral to care manager for assessment) |  |  |
| 1. Generate event-driven workflow (known as Admit, Discharge, Transfer (ADT) events), such as:  * Patient status updates for admissions and discharges, Bluetooth device alerts * Readmissions management (hospital admission, risk of readmission, updates with status changes, discharge planning) |  |  |
| 1. Generate diagnosis-based workflow, such as for patients with diabetes |  |  |
| 1. Generate role-based workflows |  |  |
| 1. Generate care manager dashboard – prioritize tasks |  |  |
| 1. Generate care management analytics – monitor program and tasks |  |  |

### References

* [A Health IT Framework for Accountable Care](https://www.healthit.gov/FACAS/sites/faca/files/a_health_it_framework_for_accountable_care_0.pdf), Certification Commission for Health IT (CCHIT), March 2013.
* [Population Health Management Software: An Opportunity to Advance Primary Care and Public Health Integration](http://phii.org/PHM), Public Health Informatics Institute (PHII), June 2016.
* [Stratis Health Health IT Toolkits](http://www.stratishealth.org/expertise/healthit/index.html): Vendor Selection Due Diligence; EHR Request for Proposal.
* [What It Means to Be a Successful Population Health Management Vendor in 2016,](http://www.klasresearch.com/resources/klas-blog/klas-blog/2016/01/13/what-it-means-to-be-a-successful-population-health-management-vendor-in-2016) KLAS Enterprises, January 2016.
* Vendor websites: [Caradigm](http://www.caradigm.com/en-us/), [HealthCatalyst,](https://www.healthcatalyst.com/population-health/) [Impact Advisors](http://www.impact-advisors.com/population-health/population-health-management-vendor-selection/), [LexisNexis](http://www.lexisnexis.com/risk/products/health-care/population-health-monitor.aspx), [McKesson](http://www.mckesson.com/population-health-management/population-health-management/), and [Zeomega](http://www.zeomega.com/what-we-do/population-health-management-technology-platform/)

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