Critical Requirements for Creating a Request for Proposal (RFP) for Healthcare IT System Selection

White Paper

Coker GROUP

Business Advisors for the Healthcare Industry

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INTRODUCTION

This paper outlines the critical requirements for creating a request for proposal (RFP) for healthcare IT system selection.

BUSINESS CASE

MAKING A CAREER DEFINING DECISION

A young bride is making her first roast for dinner and cuts off both ends of the meat before cooking. Her husband thinks the meal is delicious, but asks, "Why did you cut off the ends - that's the best part!" She answers, "That's the way my mother always did it." The next week, they go to the mother's house, and she prepares her roast the same way. Convinced he is missing some vital information, the husband asks his new mother-in-law why she cuts off the ends of the meat. She replies, "Why, that's the only way it will fit in the pan!"

Selecting an enterprise IT system for a hospital is often considered a career defining decision by those on the front line of leadership. One small mistake or unforeseen system requirement can lead to a disaster and result in millions of dollars spent in funding on the wrong software. To minimize the risk of purchasing the wrong system, many organizations will develop a request for proposal (RFP), which is a formal/structured document sent to potential vendors under consideration. In theory, to develop an RFP, stakeholders and key users from across the organization would document key requirements by department. These requirements would eventually get compiled into a single document that would become the framework for the RFP. The RFP would then undergo extensive vetting, validation and editing to ensure critical system requirements have been identified and documented. Once finalized, each vendor under consideration would be given a copy of the RFP to formally respond to and would be evaluated on how well they meet the defined requirements of each department. However, when it comes to writing an RFP, many organizations make the same mistake as the bride in the opening statement of this Whitepaper. Instead of defining their own needs, they use a template from a consultant/attorney or other organization that may have different requirements or constraints. Like the bride, these organizations may end up with a "solution" to someone else's problem.

DEFINE THE CRITICAL NEEDS OF THE HEALTH SYSTEM

While it may be tempting to cut and paste from a few "borrowed" RFPs, the needs assessment phase of the RFP should begin with an in-depth survey of the health system's IT requirements. One common mistake is assigning someone from the IT department to gather these requirements. Yes, this is an IT system, but it will NOT be used by the IT department. Engaging

end-users early in the process is not only a critical success factor, but it allows you to blame others if the wrong system is selected. Well, not really, but it is certainly not a Lone Ranger project as the complexity is too great to realistically expect one person to know the requirements for every department. Some organizations form committees, workgroups or will even engage consultants who are non-bias to help with this process.

One highly effective method is to spread out the work. When we help clients develop RFPs, we typically assign one to two people from each department to come up with their system requirements. We also ask them to document the pros and cons of their current IT system. Preserving good processes is just as important as improving what is not working well. Undergoing this process at this critical stage of the selection process helps to ensure the RFP reflects the Hospital's unique priorities and not those of another health system.

As each department starts performing their own needs assessment, it can be likened to a brainstorming session. The assigned project manager (PM) should divide users into teams by application area, including both management and staff level users. A series of small group meetings are then scheduled so each team can discuss what they are looking for in the new system. Again, don't forget to also discuss what is working well as this can be disrupted when migrating to a new system.

We also recommend allowing the end users to see product demonstrations of the system under consideration to become familiar with features and functions. Additionally, by attending professional seminars, reading trade journal articles, and having conversations with colleagues at other organizations using similar systems will help put all of this into perspective. For organizations with older/outdated technology, this process can be like asking them to pick a new car without knowing anything about how a car should perform or function. Creating awareness in advance of trying to define requirements can make this process go much smoother.

As stated previously, the person assigned to this task can also prompt users to think about what they like and dislike about their current system. Important features of the current system should be added to the requirements list because they are not necessarily included with every software package. Conversely, desirable features that are lacking in the current system should also be added to the list.

If available, gaining access to a current and detailed list of functional requirements specific to the existing system in use can also be a tremendous help in identifying your users' needs. If this documentation is inaccessible, using the functional requirements defined under the

meaningful use1 standards can be a good starting point. Coker Group, which specializes in helping organizations create and evaluate RFPs, can also provide guidance on the primary requirements if needed.

While this may seem like an oversimplification, Coker recommends organizing the requirements into three categories:

1. Nice to have
2. Like to have
3. Must have

Knowing the difference between a mission critical requirement, compared to that of something super cool, but not so important, is vital. It will also help the Hospital score the vendor responses as the mission critical requirements should carry more weight. This is discussed in a little more detail in the next section.

Prioritize the System Requirements

Once you are satisfied with your requirements list, every item should be ranked by importance. Some features may be considered mandatory, while less critical items might be ranked as desirable.

Each requirement should then be coded by priority (e.g. "M" for "Mandatory") so that during the evaluation phase, systems that include those features will receive more points. You could also include items that you are just curious about by coding them with an "I" for "Information only." These items would not receive any points in your vendor analysis phase.

Overlooking the Obvious

When defining system needs, it can be difficult to decide which requirements should be included in the RFP. For instance, if you were to develop an RFP for a new car, it might be absurd to include "tires" as a requirement. But what about "a special towing transmission?" if you also own a boat.

Real life examples:

1. Hospital owns and operates a surgery center under a separate tax identification number. The hospital inquires if the vendor can provide system functionality for the

[1] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html

surgery center, but neglects to ask if the vendor can support multiple tax identification numbers in a single database. As a result of this mistake, the hospital now has to support two databases.

2. The Hospital wants to make certain the annual maintenance contract includes unlimited software support. The vendor confirms that it does, however it only applies to the current version. The vendor later releases a new version mid-year and comes back with a new maintenance contract before the first contract has expired.
3. The Hospital agrees to use a "cloud" version of the software, which requires accessing the system over the internet, but forgets to ask the vendor about outages. In most cases, vendors can hold the Hospital financially responsible even when the system is not accessible.

Some key features you might assume would be included may not be available from every vendor. For example, patient portals are mandatory for stage II meaningful use. However, most vendors provide this as an after-the-sale, add-on module. In some cases, the add-on can be significantly higher after the sale as the hospital has lost all leverage ability once the contract is signed. While surprises may be fun on your birthday, no one enjoys the surprise that occurs when users discover their new software cannot perform important functions.

Be Clear and Precise

The RFP should not look like a technical manual for a space shuttle. System functional requirements should be written clearly and concisely so that the vendor does not have to guess your expectations. Choose small words and simple terms (e.g. use vs. utilize)—your goal is to be clear, not to impress the vendor with your stellar HCIT vocabulary. Instead of vague general phrases, use active verbs to describe what you want the system to do.

Case Study:

A large health system in Arizona with an employed physician network used an RFP to select an enterprise patient information system. When creating their RFP, they determined a critical requirement would be multiple users in the same chart at the same time since the hospital and physicians would be sharing one electronic record. In the RFP, they requested general multi-entity capabilities, but were not specific as to what they wanted to accomplish. To their dismay, they learned the software vendor had a much different definitions of "multi-entity." The staff at the hospital was not able to inquire into a patient's records at the physician offices since the system maintained separate patient databases. Patients complained that they had to give the same information at the clinic and hospital on the same campus.

Limit each item to only one concept so the vendors' responses are meaningful. If you bundle a lot of functionality into a single question, a vendor may respond "yes" if their software can do just part of what you're describing. The question should have been:

> *Can two (or more) users from different organizations be in the same patient record at the same time?*

TRUST, BUT VERIFY

As a secondary check and balance, the preferred vendor should be required to demonstrate each of their responses in the RFP. This is a critical step as it will eliminate any misunderstanding that may have been lost on a poorly worded question in the RFP. If possible, run mock scenarios or mock trails of the system requirement as a way to validate and confirm the expectation in real time. For example, an employee and physician role-play a typical scenario of patient/provider interaction while the vendor scribes the visit. This can even be done in the exam room or the ER to give life to the demonstration. Don't forget, most vendor demonstrations are well rehearsed and staged. Creating a mock trail using a real-life scenario[2] is the best strategy for verifying system functionality.

FINAL STEP (SCORING THE RFPS)

Finally, be sure to include features in your requirements list that will show clear distinctions between the different systems under consideration. Going back to the "picking a car" analogy, you can assume most cars will have four tires. What about the gas mileage, the seat warmers, the suspension, does it have four-wheel drive? If any of these amenities are mandatory or desirable for you, you will want to know which automobiles have these features and which do not. Using an RFP score card[3] is a great tool for quickly comparing all the vendors' side-by-side.

Likewise, this is the case with computer systems. Chances are your organization will be living with your decision for the next five to ten years. Be sure to take the time to meet with users and identify all of their needs. Not only will this help you select a better software package, it will also involve your users in the selection process and increase their "buy in" after the new computer system is implemented.

[2] A sample vendor demo scenario provided under Exhibit I
[3] A sample RFP score card provided under Exhibit II.

About Coker Group

For nearly 30 years, Coker has been a trusted advisor to leading healthcare organizations throughout the world on a wide range of financial, transaction and operational solutions.

- Worked with more than 2,500 hospitals, health systems and medical groups throughout the US in the last 3 years in all healthcare sub-sectors and in all 50 states, as well as clients in Europe and the Middle East
- Nearly 100 team members throughout the US, including the headquarters in Atlanta, GA, as well as offices in Dallas, TX, Charlotte, NC and Philadelphia, PA. Opened international office in London, UK in 2012
- Deep domain expertise in hospital and health system operations, strategic and management consulting, financial advisory, practice management and technology solutions
- Published approximately 60 books on healthcare management, including numerous books with the American Medical Association and other prominent publishing houses
- Named to Inc. 500/5,000 list of fastest growing US companies in 2011 and 2012
- Ranked in the Top 25 healthcare consulting firms by Modern Healthcare
- Added to the “Healthcare Informatics 100” (top global health IT firms, published by Modern Healthcare)

About Jeffery Daigrepont

Jeffery Daigrepont, senior vice president of Coker Group, specializes in healthcare automation, system integration, operations, and deployment of enterprise information systems for large integrated delivery networks. A popular national speaker, Jeffery is frequently engaged by highly-respected organizations across the nation, including many non-profit trade associations and state medical societies

Mr. Daigrepont authored a top-selling book, Complete Guide and Toolkit to Successful EHR Adoption, published by HIMSS in 2011 and was a contributing author to Coker's book, The Healthcare Executive's Guide to ACO Strategy, published in March 2012. Mr. Daigrepont is often interviewed by various national media outlets and is frequently quoted in publications.

For FY09, Daigrepont chaired the Ambulatory Information Systems Steering Committee of HIMSS. In addition, as the Ambulatory Committee liaison for FY09 to the ACEC planning Committee, he represented the HIMSS Ambulatory and AISC members. Daigrepont is credentialed by the American Academy of Medical Management (AAMM) with an Executive Fellowship in Practice Management (EFMP).

Mr. Daigrepont also serves as an independent investor advisor to many of the nation's top health care venture capitalist firms such as Kleiner Perkins Caufield & Byers (KPCB) and Silver Lake Partners.

Admit (Delayed Charting note)

4/20/99 0800 16 y.o. white female GII, PO, A1 uncomplicated vaginal, term delivery at 36 weeks on 4/19 0200 developed acute respiratory distress and pulmonary edema 24 hrs postpartum, intubated and transferred to Coronary Care Unit, Cardiology at 0400 today.
PMH: Anemia, UTI, depression
Social hx: recently married
Family hx: noncontributory
Physical Exam:

Cardiovascular (CV)- Tachycardia, regular
Lungs - bilateral crackles in bases
Abdomen - soft, nontender, nondistended, bowel sounds hypoactive
Extremities - 2+ bilateral lower extremity (LE) edema
EENT (ears, eyes, nose, throat) - noncontributory
Skin - warm, dry

Current labs:

NA 135, K+3.2 Cl 105, CO2 26, BUN 38, Creatinine 0.3. WBC 10.5, RBC 4.3, Hgb 9.2, Hct 30.

Plan:

1. mechanical ventilation
2. Diuresis
3. Inotropic support
4. Add ACE inhibitor when stabilizes

Vital signs in ICU 4/21/99

	0600
Temp	98
HR	100
BP	122/80
RR	24
CO	5.7
CI	2.8
CVP	14
PCWP	12
PAS/PAD	36/14
SVR	932
SpO2	98

Resident Progress Note:

4/21/99 0700 Pulmonary artery pressures and cardiac index improved. Enter Vital signs from 6am Afebrile. Enter 0600 AM labs.
Assessment: Pulmonary edema resolving
Plan: 1. Continued diuresis
2. Wean inotropes
3. Wean ventilator to extubate
Resident: John Cherry

ICU/Acute Care Flowsheet 0400

Circulation check: < 2 sec, Left pulse Radial +3, DP+3, Right Pulse: Radial +3, DP +3. Pneumatic stockings Left and Right. Mucous membranes: Dry, Other: pale. Nailbeds: Cyanotic, Skin color: Pale, Skin: Cool, dry. Calf Redness/Tenderness: negative. Pacemaker: NA, IABP: NA

Clinic Visit Note

Cardiology Clinic
5/12/99 Patient states resumed pre-pregnancy activity levels. Breath sounds clear and equal bilaterally. Denies SOB when lying flat. Extremities: no edema, brisk capillary refill. Heart: Regular rate, rhythm. No gallop, no JVD. Creatinine 3.2 today, increased from baseline 2.3.
Medications: Captopril 12.5 mg po tid, Multivitamin I qd.
Assessment: Resolving postpartum cardiomyopathy.
Plan: D/c captopril, return to cardiology clinic in one month.

Register New Patient

Last name:
First name:
Attending:
Service: orthopedics
Admitting Dx:
Referring physician:
Referring physician address:
Patient Mailing address:
Date of Birth:
Age
Sex: e
Patient phone number
SS#:
Contact name:
Relationship:
Phone:
Insurance company:
Race:
Person requesting admission:
Person accepting admission:
Date: Time:

	Clinical Functions						Ancillary			Pt Management								Surgery				Mgt	MR						Other								
Vendor 1																																				
Vendor 2																																				
Vendor 3																																				
Vendor 4																																				
Vendor 5																																				
	Orders & CPOE	Patient Care/Documentation	Care Plans/Protocols/Guidelines	ED	Acuity	ICU / PACU with physiological device connectivity	Pharmacy	Imaging with PACS Link	Lab System	Registration	EMPI	Pt/Bed Management	Patient Scheduling	Outpatient Ancillary Scheduling	Enterprise Eligibility Management	Patient Accounting	Longitudinal Medical Record	Surgery Management	Pre-cards	Big Board Patient Tracking	Anesthesia Record	Pre-Op, Intra-Op, & Post-Op Documentation	Management Reporting	Alerts & Rules Engine	Medical Records Management	Request for Information	Abstracting and Coding	Chart Tracking	Document Imaging	Transcription System	Utilization Review / Case Management	Home Health	Contract Management	Electronic Claims/Remittance Advice	Decision Support	Physician Practice Management	Ambulatory Medical Record	Physician Credentialing	Data Repository for reporting