Medical Appointment Scheduling System (MASS) Questions and Answers

Department of Veterans Affairs

July 2, 2014

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Disclaimer: Offerors should be reminded that information provided within the final solicitation takes precedence over any slides, conversations and/or answers to any questions. All information set forth is pre-decisional and subject to change.

1. GENERAL

1) Regarding the one-on-one meetings that will be held starting the afternoon of June 30th through the afternoon of July 2nd, is the TAC open to meeting with System Integrators that are interested in priming the contract or only looking to meet with scheduling providers?
VA is interested in hearing from both, but would recommend coming as a team if integrators are already teamed up with scheduling providers. This will allow additional room for other vendors.

2) Could the TAC please advise if there are any one-on-one time slots still available?
All One-on-One sessions were booked. VA utilized a wait-list in the event of cancellations.

3) Does the Government have an estimated dollar value for this Contract?
The Government does not have this information at this time.

4) What is the Government's anticipated timeline for this Source Selection?
The Government is tentatively projecting release of the Solicitation to occur in the August timeframe.

5) Reference: RFI Vendor Question 3 - Will the VA please clarify what is meant by the sentence "VA desires a COTS application at the presentation layer"?
VA desires an industry proven, robust commercially-available off-the-shelf (COTS) product for outpatient medical appointment scheduling.

6) At the Industry Day presentation, will the VA please provide their thoughts on how they intend to structure the procurement? Does the VA plan to release one, several combined (e.g., System Integration), or individual contracts for scheduling components such as Scheduling Software, Organizational Change, Hardware, VistA Integration, Application Development, IOC, and FOC? Will there be an IV&V contract? Will the VA consider an approach such as Cost Plus Award Fee, Time and Materials, or other approach to reducing risk and increasing speed to solution?
The Government is currently reviewing all of the possible acquisition strategies and will finalize it after the Industry Day and the One-on-Ones are completed and industry responses to the request for information (RFI) are received. The VA anticipates a Hybrid FFP contract with some potential T&M elements.

7) Does the VA anticipate defining near-term and long-term requirements? How is the MASS Blueprint related to the procurement under consideration?
Yes, VA anticipates defining near and long term requirements in the solicitation. The MASS Blueprint defines the business operational needs for both the near and long term solutions.

8) How are the requirements that were published for the VA scheduling competition related to this acquisition?
The Blueprint is a refinement of the requirements supplied for the contest. In the forthcoming solicitation package, there will be additional requirements provided as they are still evolving.

9) Is the VA willing to consider augmenting its current scheduling system with software technology to improve its scheduling efficiency and increase its appointment utilization instead of completely replacing its current system?
VA is engaged in obtaining solutions that improve the current VistA scheduling, referred to as VistA Scheduling Enhancements (VSE). The MASS program is intended to obtain a COTS-based solution that provides resource-centric scheduling practices, which is not possible with VistA scheduling alone. The COTS solution will interface with VistA Scheduling, using VistA Scheduling resources and keeping VistA Scheduling intact while implementing resource-based scheduling.

10) Is the VA considering a system that gives patients real-time access to providers' schedules and the ability to make appointments online 24 hours a day?
Yes.

11) As part of this process, how will the VA evaluate and consider solutions that already exist in the private sector and are widely used by hospitals and health systems?
The purpose of the one-on-ones is to hear about solutions that exist in the private sector which will help the VA formulate the acquisition strategy and solicitation requirements. The VA is also considering directed demonstrations as part of the evaluation criteria for this requirement.

12) Will the new scheduling solution need to have the ability to schedule patients with providers outside of VA facilities?
It is anticipated that the long-term solution needs to possess the functionality required to coordinate with non-VA care.
   a. If so, will this functionality need to be seamlessly integrated with the core scheduling tool?
   Yes, this functionality will need to be seamlessly integrated with the core scheduling tool.

13) Does the VA foresee separate contracts for PMO or testing/IV&V?
Yes.

14) Does the contracting office plan to procure scheduling tools / products with the integration services?
Yes.

15) What is the VA's timeline for completion of requirements and expectation for integration of the MASS solution?
The timeline is still being analyzed and is dependent on the selected vendor's solution. VA anticipates evaluating timelines as part of the evaluation criteria.

16) Does the VA plan on doing a pilot of the solution for specific hospital or clinic locations for integration with VistA? Which locations?
VA is looking into doing pilots after award of the contract; however, the locations are not yet determined.

17) Does the tool need to be able to integrate other non-VA entities or external providers (i.e. DoD MTFs, purchased case system)?

It is anticipated that the long-term solution needs to possess the functionality to coordinate with non-VA care. This functionality will need to be seamlessly integrated with the core scheduling tool.

18) What is the procurement strategy for the contract? Will the VA consider a full and open competition to attract new industry leaders?
The acquisition strategy has not yet been determined. The Government is currently reviewing all of the possible acquisition strategies and will finalize it after the Industry Day and the One-on-Ones are completed and industry responses to the request for information (RFI) are received.

2. TECHNICAL

1) Obviously the availability of assets (people, facilities, etc.) and services required for the appointment is key (VHA Blueprint – 4.6 Coordinate Associated and Occasions of Services). Will the availability (inventory) of the assets and services be managed in the scheduling solution? Will the scheduling solution poll databases within the VA? Or a little of both (in which case can you delineate what components will be managed within the scheduling solution and which will be retrieved from other databases)?
   VA anticipates each solution will have its unique way to handle data retrieval and storage of this information to ensure proper operation of the solution. Synchronizing this information back to VistA data will need to be assessed based on the type of data, which is to be determined.

2) Briefing documents identify several data management pain points including the inability to collect metrics and perform predictive data analysis. However, it is not clear if the VA envisions using existing resources or a new, single data warehouse to get the value out of all the data referenced in Section 4.8.1 of the Business Blueprint.
   VA must continue to supply scheduling data to existing reporting entities. It anticipates using the COTS solution for operational reporting requirements; it is expected that the scheduling system will update VA's existing resources (e.g., Corporate Data Warehouse (CDW), VHA Support Service Center (VSSC)).

3) Please clarify how the VA would like to take advantage of these data assets and how a vendor should address the functional requirements of a proposed COTS solution.
   Any additional technical specifications or requirements for data collection and management to support the VA's Veteran-centric environment will be provided in the solicitation package.

4) Would Veterans Affairs be open to running this system in a FedRAMP cloud environment?
   Yes; however the scheduling solution must comply with all security specifications (e.g., VA Handbook 6500).

5) If VistA instances are tailored at the local level, how does a Veteran 'move' from one instance/location to another? Do all of their records move with them?
   The Veteran is enrolled once, but registers at different facilities for service. Electronic records are transferred during registration.

6) Of the integration points listed, which systems currently support an application programming interface (API)?
   VA is in the process of ascertaining information related to available interfaces and APIs, and will release that information when available.

7) Would future needs also allow this solution to run on additional operating systems such as Mac iOS, Android, and Windows?
   Yes.

8) Reference: MASS Blueprint, Section 3.1, Extensiveness of Scheduling - Could the VA characterize the volume of growth in appointments over the next several years so that bidders can ensure solutions will accommodate anticipated growth?

The rate of Veterans being added to the system is declining. The expected number of services will continue to increase as the average age of the population continues to grow. Specific figures are not available.

9) Reference: MASS Blueprint, Section 3.1, Extensiveness of Scheduling - Different types of appointments have differing levels of activity associated with them. Understanding the appointment volumes by clinical domain better enables us to develop capacity planning and infrastructure scalability. Could the VA breakdown the volume of appointments by clinical domain?
Volumetric data will be published with the RFP if available at that time.

10) Reference: MASS Blueprint, Section 3.1, Extensiveness of Scheduling - Beginning with "Extensiveness of Scheduling", for each area delineated below the pain points, could the VA provide additional detail on the specific issues within that area?
No, there is no additional detail available on the pain points. These pain points were used to develop the framework and are addressed in the unique/high priority business needs.

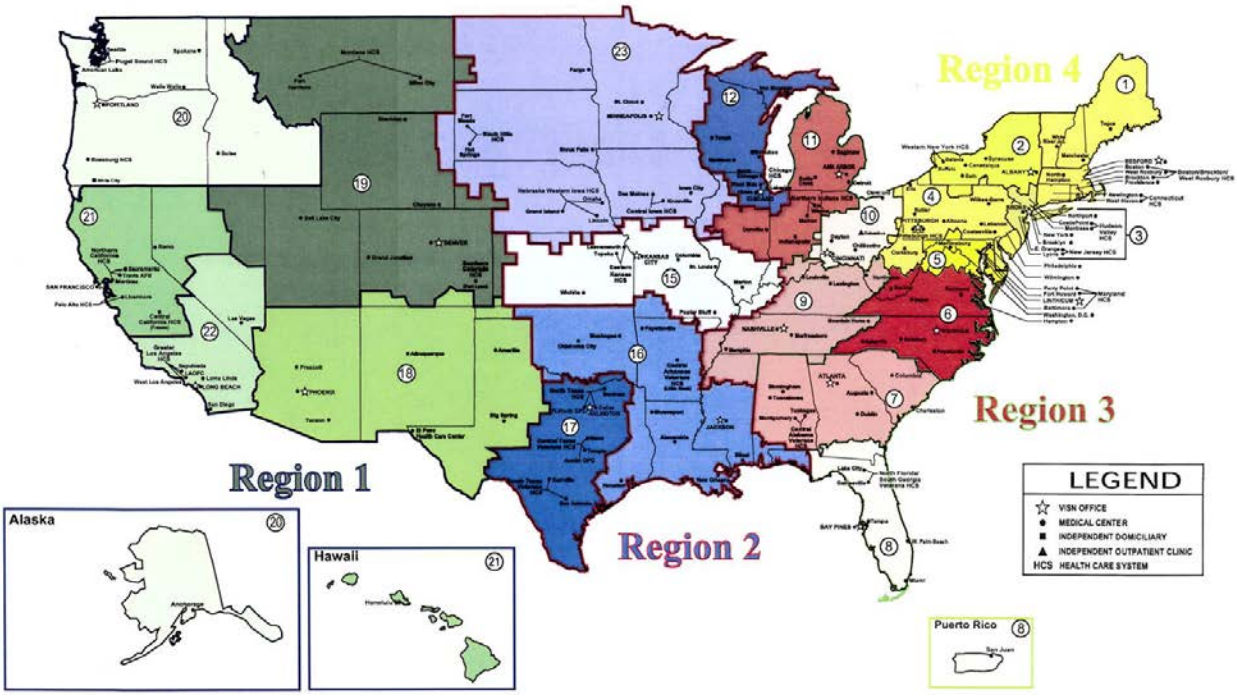
11) Is the solution required to use a service-oriented architecture (as appears to be the case based on page 2 of the Scheduling Capability Architecture PDF file)? Can SOA APIs be used in an incremental development roll-out?
The solution is required by the OneVA Enterprise Architecture to use some service (e.g., Identity Management / Master Veteran Index), and is also required to use authoritative sources, through service interfaces, for much of the Veteran information. The solution must use other enterprise capabilities, as available. The solution is also required to expose service interfaces to allow other systems to request and make appointments, and to support encounter of care management processes.

12) The project manager for the IAM project was assigned in 2008. Is the Identity and Access Management solution known and are details available? Is there a timeline for Identity and Access Management to be implemented?
Identity and Access Management (IAM) is available, as are Single Sign and Provisioning. Provisioning integration between IAM and VistA is planned.

13) Is the CEN (page 17) to be built by the chosen MASS vendor or by the VA?
The core infrastructure is being developed by VA, in support of another project. Integration with Correspondence Engine and Notifications (CEN) and scheduling specific templates and rules would be in scope of MASS.

14) What about Non-OR Procedures?
    a. Will those be scheduled in the surgery package?
    In the future state, VA wants to have the ability to track the data outside of the surgery package.
    b. Will there be a fix to address the existing issue of closing out the non-OR procedure case in the surgery package? Currently many sites schedule them outside of the surgery package due to the issue.
    It is undetermined as to whether non-OR procedures will be scheduled in Surgery Quality Workflow Management (SQWM) or MASS.

15) What is the current status of VA datacenters in terms of location and facilities supported by each? Is there a map that could be provided that shows which VAMCs/VISNs are supported by which datacenter?
That will be described in the RFP, if determined to be germane.



16) Could the VHA please provide a table stating the annual outpatient scheduling volume per VAMC?
Volumetric data will be published with the RFP if available at that time

17) The Business Blueprint states that Veteran information is synchronized with local Vista instances using background processes but that the updates are not real-time. Please describe how the MVI is updated when changes are made to Veteran information within a local Vista.
    a. When are updates synchronized, what communication methodology is used?
    b. Is the MASS solution anticipated to request updated information from the MVI via query and response or will updates be pushed to the MASS solution when received from VistA?
    Synchronization with VistA is supported through HL7 v2.x messaging using a mixture of ADT and MFN messages. Field level triggers in VistA initiate HL7 messages to Master Veteran Index (MVI). MVI updates the enterprise "primary view" of the data based on rules. MVI also offers a SOAP HL7 v3 PIX/PDQ interface. MVI supports multiple integration patterns. The choice of these patterns could depend in part on the COTS scheduling solution, and would not necessarily require the COTS solution to store person data.

18) What communication methodology is anticipated to facilitate the information sharing between the MASS solution and Virtual Lifetime Electronic Record and the NwHIN?
That is being determined, and will be described in the RFP.

19) Is a roadmap available for Enterprise Shared Services illustrating current and planned capabilities?
That is being determined, and will be described in the RFP.

20) What type of coordination is expected from the VistA Evolution project (pages 9, 10)? Is the MASS solution expected to be dependent on services from VE or can the solution leverage existing VistA access technologies to get and update local VistA data?
VA seeks a solution that provides significant capability improvement at the local/VistA instance level. This effort will be in coordination with VistA Evolution.

21) What type of alert mechanism(s) are currently in place for 'facility level alerts' (page 23)? Is the MASS solution expected to provide an interface to enter and resolve any new alerts beyond existing CPRS alerts/reminders/etc?
The Blueprint represents facility-level alerts related to medical scheduling workflows and those activities that require attention in the scheduling domain.

22) What are the current methods for tracking appointment requests outside of VistA, e.g. Telephone, MyHealtheVet (HDR?), Secure Message, NEAR Call List? Is this consistent across VA? Can the MASS solution interface with the existing request source(s) to provide a consolidated Process Request List (page 40)?
Currently, there is no integration between the numerous request lists and VistA Scheduling.

23) Will the ACAP project team (or other business owner) have interface specifications and API descriptions for non-VistA upstream and downstream applications? E.g. Beneficiary Travel, Decision Support, etc.
VA seeks a solution that will not impact non-scheduling processes by leveraging VistA scheduling module as a conduit between the new solution and VistA.

24) Does the CDW accept non-VistA data sources for consolidation for national reporting? Does the ACAP project team know the process to request such an integration (page 84)?
The information schema to support MASS will be determined when the MASS technical requirements are elaborated.

25) How will the ACAP project team mitigate the risks associated with using the ESB for future state VistA (Evolution) architecture? Other VA/DoD initiatives attempting to use the ESB have not been successful due to incomplete development environments and unacceptable throughput.
VA seeks a solution that will not impact non-scheduling processes by leveraging VistA scheduling module as a conduit between the new solution and VistA.

26) Will the MASS solution rollout be dependent on systems engineering, testing, setup and rollout of the VistA Evolution ESB and services?
No, VA seeks a solution that is not reliant on completion of future capabilities.

27) Existing enterprise projects integrating with local VistA Cache databases perform mostly read-only actions or have unsecure authentication methods for data read/write (VPR calls from HMP project, MDWS) that do not appear to establish context with local credentials. What is the VA's plan for how to authenticate users (who have been approved by the local ISO) who access local VistA Cache databases from an enterprise system and constrain them to their defined role(s)?

The VistA Access Enhancements project provides enhancements for system-to-system integration of VistA with remote applications and middleware. This ensures remote users are unambiguously identified and that user identification is properly passed by middleware and processed by VistA.

28) Have any VSA APIs in development been tested through the ESB to simulate capacity and generate performance statistics across the wide variety of VA network capabilities in place today? How will MASS vendors and the VA understand what can be expected for throughput for 50K users and 85 million appointment using this infrastructure?
VA's expectations for capacity and performance will be comparable to the system capacity and user experience of the legacy system. For MASS, the system performance requirements will be elaborated in the solicitation.

29) What risks has the VA identified for deploying a MASS solution within the timeframes required that treats Cache VistA as a NoSQL DB where the solution (and not the database) is responsible for updating all global indexes and updating the known VistA dependent applications (approx. 71)? What about the unknown Class III applications installed in the field?
VA's expectations for the MASS information schema will be elaborated in the solicitation. The Class III applications are known at the sites where they are used and the approach for the incorporation of site-specific configurations must be incorporated in the MASS solution.

30) On page 9 of the Blueprint, it lists Assumptions and Constraints. The last Constraint listed says “No impact to current union agreements”. Can you provide the specifics of those agreements? Those could greatly impact the deployment plan.
The Government does not have this information at this time.

31) Will the VA explain the following constraint stated in the MASS Blueprint "The approach must be able to deliver significant benefit without the need to aggregate VistA instance data at the national level”. This constraint seems to counter some of the desired improvements in reporting, visibility, predictive analytics and even "a single view of the patient" that the VA calls out later in the document.
Scheduling occurs at the local, VistA instance level. Immediate scheduling improvements cannot be reliant on the need to create nationally reconciled data sources that do not currently exist. Improving medical scheduling at the local, VistA instance level is the first priority.

32) The VA's MASS Blueprint includes several areas that on the surface seem to be outside of the scope of a scheduling system and rather part of other ancillary or administrative systems (e.g. Care Coordination Agreements and coordinate medical records). Does the VA expect all aspects of the MASS Blueprint to be fulfilled by a COTS solution as part of the MASS project? If not, will the VA identify only those requirements that are to be fulfilled by a procured COTS Mass solution?
The solution will be required to provide all capability within the blueprint which may require reports, interfaces, customizations, extensions (RICE objects).

33) The VA's MASS Blueprint also describes information exchanges that take place between other systems that are not real-time (e.g. local MVI synchronization) but desires real time display of up-to-date veteran information as part of the MASS project. Does the VA

intend for the MASS project vendor's COTS solution to solve the communication challenges of external systems?
No.

34) The MASS Blueprint discusses viewing and maintaining veteran assignment to PACTs but it is unclear if this assignment should be done by the scheduler during the scheduling process or outside of that process. If within the scheduling process, is it the intent of the VA that the COTS presentation layer should support integration with external packages (such as PCMM-R) and provide the user with the ability to make such selections within the scheduling UI?
Primary care assignments occur in Primary Care Management Module. It is expected that this information will be consumed by MASS.

35) The MASS Blueprint discusses a "horizon" of 3 to 4 months where scheduling does not occur and the veteran goes on a recall waitlist that facilitates scheduling of the appointment when the timeframe falls within the horizon. Would the VA explain the rationale behind the "horizon" timeframe?
Scheduling horizon policy is set nationally and additional local policies may be set. This varies based on specific profile of the care and population. Scheduling horizon is how far out on the calendar an appointment will be made versus adding the request to a queue for later scheduling.

36) Will the MASS vendor(s) be afforded a role (at least a non-voting) voice on the Access and Clinic Administration Program (ACAP) PMO? This will help ensure decisions are made with all relevant information about capability and impact on the MASS COTS and overall solution components on the table.
Program governance is under development. Vendors should propose governance expectations that mitigate risks they have identified.

37) Does the VA intend to go through a business process re-engineering effort as part of the MASS project?
Any BPR and requirements effort will be part of the product configuration effort.

38) What is the role of the MASS product vendor and the VA regarding data standardization?
Provide recommendations and best practices to VA; specific to your solution.

39) In either the Blueprint or the RFP more detailed demographic information would be helpful to define a solution (e.g., number of users by role and location, resource details, transaction volumes, etc.).
Noted.

40) Will the VA clarify the roles and responsibilities that veterans have in regards to managing their own scheduling?
Veteran self-scheduling will be performed in conjunction with current Veteran self-help efforts of mobile appointment scheduling and HealtheVet portal.

41) Will the VA provide more information on the governance process that will be used on this project to facilitate national standardization against local requirements?
This is under development.

42) Some key pieces of the MASS implementation are the rules that will be loaded into the system. What should be expected in the way of existing or new scheduling rules that will be required?
Existing workflows must be accommodated during initial implementation. VA is committed to implementing best in class workflows.

43) Are the flow charts and business processes documented in the Blueprint the final depiction of the "To-Be" or are they representative of a notional end state?
They are representative of a desired end state. They are not representative of all use cases.

44) To what extent are the data structures implied by the taxonomies required in an implementation? As well as to what extent, and over what timescales, is evolution of taxonomies important?
The solution needs to comply with OneVA Enterprise Architecture. It is expected that the physical model for implementation will map to the enterprise logical model. It is also expected that service interfaces and data sent to the corporate data warehouse will be structured and aligned to VA models.

45) Care Coordination Agreements appear to form the legal basis for sourcing arrangements. To what extent are the Coordination Agreements automated, expressed in information record form, and/or expressed as constraints on actions (e.g. scheduling mechanisms, delays).
There are manual agreements between service lines. They are not automated.

46) To what extent have local and regional business rules been deployed? In what form? Please identify the nature and extent of such local or regional rules.
Local business rules are manual and part of clinic specific operations.

47) The Resource Management function seems very broad, including configuration and maintenance. Can the VA elaborate on the expectations from Resource Management?
It is expected to provide visibility into supply of care and demand for care in order to facilitate efficient clinic management and maximum use of provider time.

48) This section suggests that it is a requirement to maintain information to produce specifically mandated reports and classes of reports. Will there be a requirement for the format of the reports to remain the same, or will the historical reports be regenerated in a new format?
The existing VistA reports will remain unchanged. The anticipated solution should be able to provide new reports which display performance and utilization metrics.

49) Would the VA discuss the implied constraints that will be placed on the new MASS product in supporting the existing national and congressional reports? For example, does this reporting constraint impact data standardization and data mapping with the new MASS solution?
This is unknown at this time.

50) What is the VA's tolerance to reduction of feature / functionality of a new MASS solution based on the constraint both stated and implied within the Blueprint?
This depends on the suggested feature reduction.

51) Are there government-defined milestone dates for 1) initial operating capability deployment to a limited number of sites and 2) full operating capability deployment to all sites? If so, please provide.
No, this has not been specified.

52) What system is expected to generate the unique encounter or visit code, MASS or VistA? If VistA is responsible for generating the unique encounter or visit code, should that data be recorded in MASS?
This feature is being determined; vendors should propose this as part of their COTS scheduling solution.

53) If MASS was provided as a hosted solution, would VA allow operation at a FISMA Moderate security level? Allowing MASS to operate at the FISMA Moderate security level would provide more hosting vendor options with reduced development and operational costs while still providing the security controls to protect PII and the subset of PHI.
The security level is being determined.

54) Is it expected that MASS will generate email, letter, text, and postcard notifications? Or will MASS interface to an existing VA system or systems that have that notification capability?
It is anticipated that the solution will provide all notification capability related to appointments.

55) Overarching: Based on the MASS Blueprint, a series of requirements and process flows have been captured. Is it VA's intent for the contracted team to confirm the business requirements and documented process flows that have been compiled to date, and create a plan to analyze all aspects of scheduling, including time to design the detailed business rules required and assessing downstream impacts prior to developing a project approach?
No.

56) Overarching: A number of oversight departments, decision making groups, and operational teams are referenced in the MASS Blueprint (VHA, VA, VACO, DUSHOM, ACAP, CMIO, Primary Care Team, etc.). Has a table been outlined to define the governance structure and how ACAP will integrate into the existing accountability structure? Has the ACAP been formed? What level of accountability and oversight will the ACAP have over clinics once a system is implemented? What role if any, will the contracted team have on designing the MASS project governance structure? What role, if any, will the contracted team have on designing the long-term, national Scheduling governance structure?
Program governance is dictated by PMAS. Additional governance mechanisms are under development. ACAP is in existence, and is responsible for access to care. The role of contractor team in the governance is to be determined.

57) Overarching: The MASS Blueprint addresses technical changes that need to be made to modernize the VHA Medical Scheduling System, as well as, functional changes that need to be addressed to facilitate efficient use of the system and timely access to care. Is it the VA's intent for the contracted team to address both the technical and functional aspects of the project or will separate vendors be considered for each?
Yes, the team is expected to address both functional and technical aspects.

a. Additionally, in the Pain Points table on page 6, can the pain points be categorized to display whether they are technical, functional or both?
Pain points are from the business operations perspective.

58) Section 3 – Background, Page 2: The VHA mission to "provide exceptional healthcare" includes enabling "timely access to care where and when needed." Does the VA define "access to care" differently than scheduling an appointment? If so, can you explain the difference? Is securing the appointment in 14 days the metric that VA will be measuring as success for the project? What other measures of success, if any, have been identified for the MASS project?
From the Industry Day slides: Access means providing the right **services**, in the right **place**, at the right **time**, by the right **providers**, in the right **way**. The 14 day measure is not the project measure of success. Business Operations success will be determined based on meeting the functional business requirements.

59) Section 3 – Background; Page 6: Requirements for MASS are provided at a high-level and the following statement is provided in the final paragraph of this section: "Modernization of the system across the enterprise is required in order to meet ambulatory and patient appointment needs of VHA today." Knowing that well developed business processes are critical to support any system, should this statement also take into account the detailed functional processes around scheduling and the training requirements to ensure staff is accurately completing scheduling, as well as the modernization of the system itself?
Yes.

60) Section 3.1 – Finding from Current Environment; Page 6: Pain Points are outlined and a description of each is provided. Wait list management is not listed as one of the overarching current pain points. Should wait list management be considered one of the current Pain Points and evaluated by the contracted team as a "Request Management: Unique / High Priority Business Need" (Section 4.4, Page 40)?
Yes.

61) Section 3.1 – Finding from Current Environment; Page 6 – The Pain Points table highlights a "lack of visibility into provider availability" (PP6) and that "scheduling is inflexible due to clinic profile construct, resulting in multiple, manual work-arounds" (PP8). Current scheduling and provider template management practices are not documented in the MASS Blueprint but will need to be a focus of the contracted team, both technically and functionally, in order to enable efficient, flexible scheduling and reliable capacity management and provider utilization reporting. Have current template management processes been reviewed and flows been developed? If so, could they be added to the MASS Blueprint?
They have not been developed.

62) Section 3.1 – Findings from Current Environment; Page 8; Indicates Customer Satisfaction is one of the many drivers for a new system. Does VA expect the contracted team to incorporate customer satisfaction metrics, surveys, and reporting into the rollout process? Or will that be incorporated separately through existing mechanisms?
It will be incorporated through a separate, existing mechanism.

63) Section 3.2 – Assumption and Constraints; Page 8-9: The constraints section states that "the solution cannot force extensive changes to other business processes dependent on scheduling data." Is it VA's intent to ensure a comprehensive analysis of downstream impacts to scheduling changes be completed by the contracted team? Such an assessment will ensure all potential downstream changes are documented and understood prior to implementation of the solution.
The architected solution should consider a model that uses the VistA schedule module as the conduit for pushing scheduling data into VistA. The selected solution must ensure the integrity of downstream systems.

64) Section 3.2 – Assumption and Constraints; Page 8-9: The constraints section states that "no impact to current union agreements." With the level of change that will occur as part of this program, is it appropriate to provide additional details around this statement? Based on interactions with union environments and changes that take place as part of large programs such as this, creating a partnering relationship with the union and appropriately changing agreements as part of the project results in better outcomes, especially when productivity and quality measures are to be implemented.
Yes.

65) Section 3.2 – Assumptions and Constraints; Page 9: This section states "Funding for this effort will be phased over 3-5 years". Does VA have an implementation plan already outlined for the phased rollout over the 3-5 year span, or is the VA looking for the contracted team to provide input on a plan?
No.

66) Section 3.3 – Risk Assessment; Page 9, Item 2: Can CMIO be defined and a listing of individuals that make up this group provided? Because of the complexities within VA and its systems, deviations to the out-of-the-box software are likely to exist. Regular interactions with the CMIO will need to take place in order to appropriately address changes.
This will be considered during development of governance.

67) Section 3.3 – Risk Assessment; Page 10, Item 4: Is the intent of this statement to ensure local facilities can adhere to unique aspects of scheduling at their facilities? By trading the needs of national standardization, is VA allowing sites to act too independently and not be held accountable to the policies and procedures rolled out at a national level?
The solution is expected to provide enforcement and monitoring of national policies while allowing for appropriate local variations.

68) Section 3.3 – Risk Assessment; Page 10, Item 7: Will the contracted team have an opportunity to recommend a list of stakeholders to be included on the "VA governance board"?
Yes.

69) Section 3.4 – Problem/Opportunity Statement; Page 12; The report indicates in a couple places, the first of which being in Section 3.4 and subsequently in Section 4.1.2, that a successful solution would allow for "centralized scheduled services". Is part of this project the consolidation and setup of a centralized scheduling office(s)? If so, the following items will need to be considered which are not currently addressed in the MASS Blueprint: physical space planning, management and staff transition and training,

telephone / automatic call distribution design, and service level agreement development between clinics and the centralized office.
No, however, the solution should be appropriate for centralized scheduling.

70) Section 4.2.1 – Process Overview for Medical Appointment Scheduling System Setup; Page 17: Statement made that "Master records are the backbone of most organizations and contain the information required to create and maintain a nation-wide "system of record" for core business entities to capture business transactions and measure results for these entities." VistA scheduling does not contain a unique identifier to link episodes of care together – a unique identifier to link all business processes together is not assigned until time of billing. Is it VA's intent to create a unique identifier that links a scheduled appointment all the way through the business process until an account is closed as part of this program? If so, is the expectation that the contracted team will complete that VistA programming?
It is required to be able to associate data in Scheduling to data in other VistA packages. It is not expected that the vendor will complete this implied VistA programming. However, the COTS scheduling solution must accommodate episode identification when it becomes available in VistA.

71) Section 4.3.1 – Process Overview for Veteran Information Management; Page 31: States the need for a capability to provide "consistent and automated access to near real-time Veteran data across independent 128+ VistA instances." Will VA provide the resources necessary to make the appropriate changes to VistA to ensure this requirement is met? Or, is the intent for the contracted team to have the necessary resources to ensure these changes can be made?
VA is interested in understanding how vendors would support this requirement.

72) Section 4.3.1 – Process Overview for Veteran Information Management; Page 31: States "The Austin Information Technology Center (AITC) controls the Master Veteran Index (MVI) where the majority of Veteran information is stored. Local VistA instances synchronize data to the MVI through various background processes." Will VA provide the resources necessary to ensure that interfaces with AITC are updated appropriately? If not, will there be AITC participation in the program?
Yes.

73) Section 4.4.1 – Process Overview for Request Management; Page 40: States "Requests are routed differently at each facility , yet the basic process is relatively the same.", and later "How they <requests> are received, criteria for assessment, routing rules and practices, and workflow are all driven by business rules and practices unique to a facility." In order to effectively propose a scheduling solution, it will be important to understand these differences?
    a. Are the requests routed electronically or manually?
    Requests are manually and electronically routed.
    b. Has the routing and/or business rules at each facility been documented?
    The rules are not documented at the national level, but local documentation may exist.

74) Section 4.5.5 – Appointment Management Process Flows and Business Needs (4); Page 58: States "The business requires an integrated graphical view of all available resources and services across facilities, time zones and scheduling horizons (daily, weekly, monthly) in order to locate and schedule the appropriate resources within the

Veteran's desired date." Are there specific parameters around this requirement that will limit the views based on geographic location (Region, VISN, etc.)?
Specific parameters have not been defined.

75) Section 5.2 – The Description of Terms table references six separate appointment request or wait "lists" that may currently be in use at VA facilities (Electronic Wait List (official wait list), Long Term Waiting List, Short Term Waiting List, Short Term Pending List, High Priority Reschedule List, and New Enrollee Appointment Request List). Is there someone accountable for identifying short-term, immediate owners for accountability and management of each list until a long-term solution for the consolidation and / or automation of each list has been developed? Will the contracted team have the ability to provide recommendations for this responsibility?
VA has an initiative to consolidate the lists at the facility level. This is anticipated to be incorporated into MASS as it is available.

76) Could VA please provide a list of external interfaces, the type of each of those and the data elements exchanged?
They will be determined, and will be clarified in the RFP.

77) Will the Government make available existing APIs that have already been developed for numerous COTS scheduling products at the VAMC or VISN level?
That will be determined, and will be clarified in the RFP.

78) Will the VA re-use existing requirements from the 21st Century Scheduling contest, or previous HealtheVet scheduling solution?
The Blueprint is a refinement of the requirements supplied for the contest. In the forthcoming solicitation package, there will be additional requirements provided as they are still evolving.

79) What is the exact scope of scheduling? Which domains will be included (i.e. bed scheduling, surgery, radiology).
Surgery will not be included; however, all outpatient scheduling will be included.

80) Will the Government provide direct access to stakeholders at "Alpha sites" to help configure the solution whether COTS or GOTS?
Yes.

81) Will the Government consider secure cloud offerings?
Yes.

82) The VA Scheduling system will have to interact with many systems. Are there other VA projects ongoing or planned that could substantially affect the scope or implementation of the Scheduling project?
That will be determined, and will be clarified in the RFP.

83) Regarding this text: "VHA has developed the VHA MASS Business Blueprint Document to illustrate the operational complexity of the current state and present future state describing scheduling-essential capabilities. This is designed as a reference document to capture - relevant future operational state medical scheduling information for a comprehensive upgrade of medical scheduling capabilities. VA has also developed

strategic technical requirements and architectural concepts which will posted as an amendment to the RFI in the near future in preparation of the events identified."
When does VA expect to provide the referenced "…strategic technical requirements and architectural concepts…" for us to take into account for our RFI response?
All material has been posted.

84) Could VA please provide points the number and types of interfaces for each of the integrations points to VistA? Also, we request that with the final RFP the VA provide the data elements exchanged for each of these integrations.
That will be determined, and will be clarified in the RFP.

85) Could VA share its plans for Veteran's demographic or other information to be synchronized with the AITC MVI from different facilities so that the latest information is available to MASS at the time of appointment scheduling? Or does VA expect the vendor to include an approach for synchronization?
That will be determined, and will be clarified in the RFP.

86) Are there currently typical care pathways defined for types of appointments that need to be implemented in the Solution?
Yes. However, the solution must accommodate local variations through configurable business rules.

87) Does VA intend for the providers also to be able to schedule appointments for themselves (surgeon schedules post-operative follow-up) and/or for other service providers (ED physician schedules primary care follow-up)?
Role-based access will include provider scheduling, though not these scenarios.

88) Are similar scheduling metrics to be captured from outside providers of care?
VA is interested in capturing data regarding timeliness of care delivery for those Veterans sent to non-VA providers.

89) Are urgent care clinics and emergency departments included in the scope of Encounter of Care Mgmt coverage?
Yes.

90) Is the Generate National and Historical Reports requirement one of providing appropriate access to data or does is also include actual capabilities to produce those reports?
It will include access to data initially, with potential to transition to the new COTS scheduling solution for generation of those reports.

91) Can you provide more information about the new program office (ACAP) and clarify the office's role in the MASS procurement?
The ACAP office is the business owner for MASS and will be responsible for integration of the COTS scheduling solution into business operations.

92) Will the government institute standard business processes and workflow for scheduling across the enterprise?
Yes. However, the solution must accommodate local variations through configurable business rules.

93) Will the government institute a governance board to address policy changes or business process constraints that may be required?
Yes.

94) What roles, responsibilities and means will the vendor have in order to coordinate between Scheduling and the VistA Evolution team, relative to the Enterprise Architecture (e.g., common services, SOA, data orchestration, etc.)?
The vendor team will be included in the governance processes that will include representatives from the various organizations.

95) When a COTS product does not meet all congressional mandates, what process does a vendor use to provide the gap analysis and/or mitigation strategy?
The COTS scheduling solution must meet all congressional mandates.

96) Will the VA provide essential performance metrics with the RFP release?
Yes.

97) Will the vendor be able to contribute to the analysis, whereby standardization indeed becomes too heavy a lift? And will the vendor be permitted to work iteratively and agilely with the stakeholders to provide mitigation strategies (proxy standards, configuration management, business process models, etc).
VA expects the solution provider to work with Central Office to determine how to enforce policy and directives within the solution. Additionally, the solution provider will work with facilities to configure the product to represent its business operations. Agile methodology will be a requirement.

98) Will the vendor be provided the relevant DSS data elements or access to a DSS test system?
www.herc.research.va.gov contains relevant data on DSS.

99) How often will the vendor be required to provide reports that will ultimately be for GAO and Congress?
This is not yet determined and will likely be addressed in the Solicitation as ad-hoc reporting. VA must continue to supply scheduling data to existing reporting entities. It anticipates using the COTS scheduling solution for operational reporting requirements. Analytic reporting should be supported through the VA data warehouse. Reports should be able to be run on demand, and any export or Extract, Transform, and Load (ETL) of data should be on a configurable schedule.

100) If there is an expectation to maintain VistA data feeds, will the vendor product be required to "write" to the specific fields in VistA in order to maintain cross package triggers?
That is being determined, and will be clarified in the RFP.

101) Assuming there will be a web-portal for patient scheduling, will this capability be integrated with the VA MyHealtheVet platform? Similarly will the system be integrated with the VA "Secure Messaging" system?
MyHealth***e***Vet portal will continue to be the Veteran portal. VA anticipates integration between the portal and the scheduling solution to ensure seamless integration of data and intuitive, seamless workflow for Veterans.

102) Will the "Master Record" backbone that captures business transactions to populate the "System of Record" (SoR), follow the same policies for the electronic medical record (EMR) SoR?
Master Record/System of Record relationships may differ based on the chosen solution.

103) The MASS Blueprint appears to be a requirements document for a bottoms up development effort. How does the VA intend to reconcile these requirements to the standard scheduling capabilities provided by a COTS solution that may only address 80%-90% of the requirements?
VA has focused "what" needs to be done, and not "how" it would be done in the COTS product. VA expects that agile iterations will be used during configuration to understand the tool and how to represent VA business rules in the tool.

104) Reference: MASS Blueprint, pg. 64 - Please provide additional information regarding requests for scheduling data from non-VA delivery sources.
   a. Is system integration and interface to 'non-VA healthcare delivery sources" included in the scope?
   It is part of phase 2 capability and has yet to be determined if it is part of the initial solicitation.
   b. If the scheduling system requests scheduling information, what are the requirements for the system to receive, store, display, or send a follow-up request if the non-VA system does not respond?
   These have not been determined and will be part of the phase 2 capability.
   c. Has the VA determined the standard to be used for scheduling data requests and receipt?
   No.

105) Reference: MASS Blueprint, pg. 67 - Access to "the complete picture of care" is a Medical Records Function. What is the Scheduling system requirement for the locating, requesting, receiving, displaying, or storing medical records information?
Scheduling process requires the scheduler to view orders when scheduling, and to document when orders are fulfilled via appointments. This information exchange and access is expected to be defined during agile iterations.

106) Reference: MASS Blueprint, pg. 65 - "The Coordinate External Health Care Services sub-capability requires the ability to coordinate services and access to care by providing Veterans, their families, and other healthcare stakeholders with integrated access to services by enabling the exchange of information inside the government network (such as with the DoD and CDC) or outside with other private providers. " Is a particular standard format mandated?
This capability will be part of phase 2 and will be detailed at that time.

107) Reference: MASS Blueprint, pg. 78 - "Providers must document rational and timeframes for medications, diagnostic tests, laboratory studies, return appointments, consultations and procedures before the Veteran leaves the examination room." How is this requirement related to follow-up scheduling? Is this is an example of a provider process change? Who will provide communication and training for providers?
This is information is for reference only and not a scheduling requirement.

108) Reference: MASS Blueprint, pg. 75 - What is the requirement for the scheduling system to "Efficiently exchange scheduling data with encounter data throughout scheduling process"?
Scheduling process requires the scheduler to view orders when scheduling, and to document when orders are fulfilled via appointments. This information exchange and access is expected to be defined during agile iterations.

109) Reference: MASS Blueprint, pg. 93 - In Section 4.9, the VA states "There are some data integrity issues as a result of non-standardized data in individual instances which cause difficulties for national level reporting, metrics, etc. As a new scheduling solution comes online, the data transmitted via the functional integration points outlined in this section must be evaluated and accommodated to ensure VHA data are not adversely affected. Part of the solution will be a more standardized approach to master data management." What is VA's requirement for standardization for global vice local scheduling?
VA expects the new solution to standardize enforcement and monitoring of scheduling directives and policies while also allowing for local configuration.

110) Reference: MASS Blueprint, pg. 93 - Also in Section 4.9, the VA states "business rules are embedded as part of the exchanges and will need to be examined" Will the VA provide a list of current scheduling business rules with the draft PWS or will the contractor be required to assist with the development of these business rules?
A portion of business rules will be included in the user story documentation. Flexible configuration at the local level will be required to accommodate a variety of business rules. It is expected that the tool configuration process will unveil additional business rules.

111) What is the operational process for handling urgent inbound patient requests? Does the VA have support staff to answer inbound patient phone calls or emails? For example, how does the VA respond if a patient calls needing to reschedule on the day of their appointment?
VA will follow current policy and practices for this scenario.

112) Is the VA interested in measuring patient satisfaction with the new scheduling system and appointment booking experience? If so, does the VA expect that the scheduling system will have the ability to contact patients and record this information? Does the VA measure patient satisfaction now? If so, how?
VA measures patient satisfaction and this measurement is not part of the requirements for the scheduling solution.

113) How would the VA approach implementation of a new scheduling system?
   a. Would the VA start with a pilot of the new solution?
      Please refer to the industry day slide decks regarding testing and roll-out. Additionally, the VA is seeking feedback on implementation.
   b. Would the VA pilot multiple potential solutions at once?
      Please refer to the industry day slide decks regarding testing and roll-out.
   c. Is the length of implementation an important qualifier for the VA when evaluating potential solutions?
      An implementation that is thorough, effective, quick and complete is desired.

114) The VA stated that there are over 1,000 VistA integration points and dependencies by over 71 VistA modules.
   a. Does the VA believe that all interactions with VistA (and other existing VA systems) will be through existing interfaces?
      That will be determined, and will be clarified in the RFP.
   b. If so, what happens if issues and/or limitations with the existing interfaces during the course of the contract?
      The RFP will address this question.
   c. Who would be responsible for fixing/expanding the interfaces?
      The RFP will address this question.
   d. If new interfaces with VistA will be required, will the MASS contractor be responsible for that development or will current VistA teams develop those new interfaces?
      The contractor will be responsible for developing and deploying interfaces as described in the RFP.

115) Does the VA foresee an integrated team approach between the new MASS contractor and other VA teams to ensure that the work is performed in a timely manner?
   Yes.

116) How many individuals does the VA have scheduling appointments? Is scheduling the admins only job functionality? How many appointments were scheduled in the current system in 2013?
   VA has approximately 50,000 staff scheduling appointments in a combination of full-time and part-time responsibilities. There were approximately 85,000,000 appointments scheduled in 2013.

3. CONCERNS/RISKS

1) Has the VA begun consideration of the fact that the deployment of this solution will impact union employees? A hard lesson learned when BCMA was first deployed was that lack of input from/interaction with the unions during design and development almost derailed the deployment of BCMA… A key concern then was that metrics could used to "punish" the employee (in that case the nurses). Since a significant part of the scheduling upgrade will be to make metrics available, it seems logical that the same concern could exist here.
   VA is fully aware of the organizational change issues involved in a project with the scope of MASS. VA is committed to working closely with all stakeholders to ensure the best possible outcome for all stakeholders while delivering on our commitments to our Veterans.

4. Industry Day Morning Session Questions:

1) What kind of oversight will be provided by VA enterprise management and what kind of autonomy will be allowed at region and VAMC level to ensure success of the necessary business process reengineering to successfully adopt a new COTS product and prevent it from becoming GOTS?
   VA will provide policy and direction to the organization, with enforcement/monitoring through the scheduling solution. VISN and Facility variations are expected, within the national constraints.

2) It will be very helpful to provide any data you have on supply and demand. What data on your supply side-resources-equipment. Also on demand side data on types of appointments and any trends. Just trying to get a sense of volume, types of data, etc.
   This data is not available for release at this time.

3) Please provide any details on projects underway that relate to this effort.
   No specific projects are underway, at this time, that are directly related to implementing MASS. However, multiple projects mentioned in the industry day briefing, such as CVT and mobile applications projects are indirectly related as future consumers and producers which will use MASS capabilities. Any updates will be reflected in the solicitation.

4) It is important for us to understand scheduling related projects that are covering some functions or will be key integrations. Any data on the scope and design of the near term relief projects underway is helpful.
   Information regarding related systems will be made available, as appropriate.

5) SQWM was mentioned and need to interface with it. Isn't SQWM not getting funded for next fiscal year?
   The status of other projects is outside the scope of this Q&A.

6) Have you looked at the current DoD Scheduling solution? They have continued to improve it since 2007.
   The DoD system is a VistA derivative and has the same limitations as VistA, which the scheduling solution is intended to rectify.

7) Will/Can the business requirements document be made available?
   Yes; they will be made available as part of the RFP process.

8) Are business rules currently documented? How are they documented?
   No; this will be part of the configuration of the product.

9) Are reminders/follow up part of scheduling or part of patient health record? In other words, does scheduling manage it or does it react to prompts from health record?
   Scheduling reminders are part of scheduling.

10) Will there be business rules that can be ignored by the scheduler? Are these exceptions identified?
    There will be local modifications to business rules and unique business rules at the location.

11) Slide 29 on VHA slide deck phases 1a, 1b 2, will phase 2 incorporate 1b or will it be independent? Is 1b throw away?
1b is not a throw away.

12) Will delivery of a centralized call center for scheduling be a requirement?
No; however, the solution should accommodate centralized scheduling processes.

13) Is the "Recall scheduling" system in scope to be replaced? Same question for new enrollment appointment request?
Yes, to both.

14) If the T4 contract is used, must all work be completed by 6/30/17, or other date specified by T4 ordering period?
If T4 is used, the order does not have to be completed by June 30, 2017.

15) Will there be additional one-on-one times made available. If so, how?
VA does not anticipate additional one-on-ones at this time. However, if the demand continues to grow, and this changes, this information will be posted on the FBO notice.

16) Will the VA consider a SOO approach instead of a set of defined requirement that each vendor must meet? With the complexity of a system and multitude of requirements it will be nearly impossible to meet all requirements. A SOO approach will provide far more flexibility and help vendors provide a successful solution.
VA does not anticipate using a SOO for this requirement.

17) Do you have requirements for how many patients each provider sees?
Typically 1,200 patient panel Primary Care.

18) Approximate number of appointments per patient per year.
The average for the population is 12-15 appointments per year.

19) Of the 50,000 schedulers, how many are full time schedulers? Not physicians, clinicians, etc.
+/- 35k

20) Veteran information management – this looks more like a marketing role. Why is this under scheduling?
Veteran Information Management is detailed in the Blueprint and is not a marketing capability.

21) In order to better expose VA services to veterans who have not yet enrolled would the VA be interested in opening schedules so that appointments can be booked online before even enrolling if sufficient technology existed to make this possible and addressed associated pitfalls? This would encourage VA usage by minimizing barriers to entry.
Yes **and** no; for most cases, no. By statute, Veterans must be eligible and enroll. However there are exceptions where it is necessary to schedule an exam appointment for Veterans not enrolled (e.g., Burn Pits).

22) The presentation by Dr. Davies was almost entirely clinic focused. Will MASS be responsible for scheduling for hospital based outpatient services (rehab, radiology)?

MASS is to accommodate outpatient medical scheduling. In VA, this takes place in Medical Centers and Community based outpatient clinics.

23) What are the requirements relative to the inputs of the scheduling system? Specifically, how is workforce planning and population demand factors being integrated into the scheduling solution requirements?
This is part of the business rules that VA anticipates will be captured during the configuration.

24) How aggressive will data standardization be applied to non-scheduling VistA applications as COTS roll out moves forward?
Data standardization of non-scheduling processes is not part of this effort.

25) Dr. Davies mentioned the new GUI coming out for Vista Scheduling package. This will replace the roll and scroll screens, How does the VA envision this Vista scheduling GUI to interact with the MASS COTS system?
VA expects the scheduling solution to provide a user interface to its product; the VistA GUI will not be needed.

26) Can CPRS consults and follow up appointments come in by way of an HL7 transaction?
A means to accept all types of requests for care, including integration of existing lists is part of requirement and documented in Blueprint.

27) Will all resource templates and configurations be maintained in both VistA and the COTS solution? Or just in COTS solution?
They will be maintained in the COTS solution only; not in VistA.

28) Explain more about the near term work on a front GUI installed 10/1/14 and how it relates to the COTS solution.
Schedule Calendar View (SCV) Application does not relate to the scheduling solution.

29) Explain difference between the EWL and nears list. Are these both for first primary care apt?
These definitions are provided in the Blueprint posted on FBO.

30) We have gotten in the past mixed opinions on: - are multiple appointments linked to a single consult?
Yes.

31) How reliable/accurate is a common MPI? To what extent does individual Vista instances have vet demographics that do not match common MPI?
MPI is accurate and authoritative for Identity. Individual VistAs may have Identity and demographic data that differs. Patient demographic data is synchronized by health enrollment. Person demographic data will be managed at an enterprise level. CDI will provide enterprise sources for demographic data.

32) When schedulers are centralized (possibly) at the VISN level, what % of schedules are made to a different VISN?
There is occasional scheduling across VISNs but tends to be more of a one on one; highly manual process. The overall percentage is unknown, but VA may have a need for this functionality in the future.

33) What is the ordering process?
Clinic Orders.
    a. Are appointment letters faxed/mailed?
    Mailed however appointment letters are part of an overall patient notification process that includes mail, email, and text.
    b. How many schedulers are at any one site? How are they assigned? Can they schedule across all?
    This depends on the size and number of services offered at the site.

34) How many telehealth appointments are there?
Volumetric data will be published with the RFP if available at that time.

35) Do you currently have call centers? If so, do they currently schedule for multiple locations? What is the largest call center and what facilities do they schedule for?
Some facilities have implemented call centers. These are not uniform across the enterprise and are opportunistic.

36) An IT system will help address some of the challenges VA is trying to fix. Changing processes, policies and employee attitudes are crucial for success. How is VA planning to address these Non-IT Factors. Will it be part of the contract scope?
The VA is evaluating many processes and policies as part of the scheduling need. Any efforts as such will not be part of the acquisition.

37) What is ESS?
Enterprise Shared Services.
    a. Please provide ESS Services Interface Guidelines.
    Guidelines are already part of the design pattern and are posted on FBO.

38) Please provide attendees list along with contract information for team's arrangements.
The Government will make a list of industry day companies available on FBO.

39) What is EMI and how does EMI differ from the IPO SOA suite and the Interface Engine?
They are the same.

40) Is there, or do you anticipate LDAP access to Enterprise provisioning system?
    a. Will it exist during scope of MASS project?
    That will be determined as part of the vendor's solution. Multiple avenues, including LDAP, may be used.

41) How is Nears list updated today?
It is updated through the enrollment process.

42) State that VA is looking for a COTS product. Yet it appears that VA does not believe that there is an existing solution to VA's needs. Please clarify this apparent conflict in solution vision.
VA seeks a COTS solution and recognizes that it has unique requirements.

43) Will the VistA adapters be built as part of the MASS contract or will they be supplied to the MASS contractor?

Vista Adapters will be built as part of the MASS acquisition. VistA adapters will not be supplied.

44) User Provisioning: Does that use LDAP or something else?
That will be determined as part of the vendor's solution. Multiple avenues, including LDAP, may be used.

45) What impact will the Sanders Bill requiring a study of the VA scheduling system have on the timing of this procurement?
The impact of this is still under review.

46) Will the MASS procurement process wait for the results of the scheduling technology task force stated in the Sanders/McCain Veterans Bill? Results should be provided to Congress 45 days after enactment.
The impact of this is still under review.

47) How are virtual clinic providers apportioned across clinics?
This is dependent on need, case-by-case basis and is not relevant to where they reside.

48) When working with VHA Connected Health, the team emphasized the need for building device agnostic applications so that no matter which device the application is accessed from the Veteran user would have the same experience. When developing front-ends for MASS this should be a requirement.
Noted.

49) Will phase 1b acquisition occur in parallel with the phase 1a acquisition?
Yes.

50) Do you view the scope of capability/Vet Info Mgmt as part of the MASS solution or a necessary capability to integrate?
It is anticipated that the COTS scheduling solution will provide some capability that will be required for integration.

51) Along with thinking of the requirement for a scheduling system, how much work has been done in looking at the underlying processes, and looking to re-engineer them? Often systems are a reflection of the underlying processes. Streamlined, efficient processes can lead to effective systems. Would this be in scope?
VA is looking into this. There is a workflow task VHA is currently undertaking, which is not part of this acquisition.

52) The statement was made constraint wise that this initiative cannot modify non-scheduling processes. Has some thought been put into adding capabilities of the PxRM package to integrate based on reminder evaluation or user interaction with reminder dialogues in TIU capturing contest for scheduling or allowing desired date entry.
Noted.

53) How does VA track and manage patient interactions? Is the system of record for encounters, codes, etc the scheduling system?
VA tracks each encounter in the current 545. The ability to track episodes of care from first encounter to resolve is desired.

54) What is the mix of primary care verse specialty care encounters at CBOC locations? At VAMC facility locations?
Fiscal Year-To-Date for primary care encounters is 6,851,623 and for specialty care it is 11,107,505. For April 2014, the number of primary care encounters is 1,009,000 and 1,767,712 for specialty care. April 2014 National similar across enterprise.

5. Questions from Industry Afternoon Session

1) What is the proposed acquisition strategy for this requirement?
   The acquisition strategy is still being determined. The Government will be reviewing the RFI responses as well as using information received in the Industry one-on-ones to determine the most advantageous acquisition strategy for this complex requirement.

2) Is the contractor permitted to propose key personnel direct experience for past performance?
   That type of information will be made available in the Solicitation.

3) Will there be a draft RFP for contractor review and comments?
   The Government is contemplating putting out a draft RFP.

4) Who owns the proposed MASS – Govt or Contractor?
   The data rights for any procured/developed software will be identified in the solicitation. All enterprise shared services newly built or updated will be government owned.

5) Has consideration been given to the proposed pricing schedule? Software as a service, contractor-owned/operated?
   Yes, the Government is reviewing the alternatives surrounding implementation.

6) Is cloud platform an alternative?
   The COTS component that includes the rules and workflow engines as well as the GUI could be cloud based inside or outside the VA firewall.

7) 50,000 scheduling staff? Please define. Schedulers, users, supervisors?
   This is defined as all VA staff that have access to the scheduling software.

8) Will VA consider using Regional Scheduling Offices?
   Yes.

9) Have you or MITRE staff visited successful medical scheduling facilities that use scheduling software in order to hear what the users of the software say about their product? If requirements are about to be set, how do they know they are the successful set of requirements?
   The requirements were derived from input after numerous visits to a cross section of facilities and through elicitation with field subject matter experts. The VA seeks a solution that is successful in industry that can also adapt to the unique and high priority needs of the VA.

10) What, if any, re-use will be made of last year's scheduling contest?
    The contest resulted in significant lessons learned of available open source products and the contestants' capabilities to integrate products into the VA's VistA system. This information was used to shape the Medical Appointment Scheduling System (MASS) Industry Day, held June 18, 2014, and will also be incorporated into the acquisition effort related to the May 30, 2014 FedBizOpps solicitation.

11) What is the plan for aligning the new scheduling module with the VistA Evolution Plan?
Please refer to publicly available documentation regarding VistA Evolution for clarification.

12) Will VA ask that the software be open-sourced via something like GitHub?
All potential approaches are of interest. Please suggest what you consider to be effective, efficient, and cost-effective solutions.

13) Who are the incumbents on the schedule manager app (SCV) and Patient Directed Scheduling App referenced in Dr. Davies "Need for Scheduling" presentation?
Longview International Technology Solutions, Inc.

14) On slide 28 of Dr. Davies "Need for scheduling" presentation, it notes that data will be kept locally. Why? Why not cloud based scheduling?
The solution must preserve the local context of scheduling data and not require reconciliation of local data to a broader context. Scheduling occurs locally, usually at the facility level. This must be preserved in the MASS solution.

15) Does MASS require FedRAMP or FISMA Moderate or High Compliancy for system security?
Security requirements will be provided with the solicitation.

16) What is the MASS acquisition vehicle? (T4?)
The MASS acquisition strategy has not been finalized.

17) Is VA TIC (Trusted Internet Connection) required? At the production and Dr.-COOP sites?
Security requirements will be provided with the solicitation.

18) In regards to scheduling, how did you decide on which features and capabilities are needed and their priority? Was this analysis done by a vendor, in house, or combination of both? Will scheduling involve requirements and workflow BPR assistance or has all of this been completed already?
Features and capabilities were defined by VA with contractor facilitation over the years of efforts to replace the current iteration of VistA scheduling. The Framework and end to end process represent the intended high level processes. VA expects COTS-specific configuration efforts for capture of national policy enforcement and local facility configuration of operations.

19) What vendor completed Indianapolis VAMC integration?
Unibased Systems Architecture provided the COTS scheduling system and Document Storage Systems, Inc. (DSS) provided the integration software.

20) Contracting approach will drive industry path and teaming. What will each contract be for and who will own it, VHA/OIT?
That will be determined, and will be clarified in the RFP.

21) Will this be a one and done award? No description provided regarding what work will be contracted for and by who.
The structure of the MASS acquisition is still under development.

22) Business strategy 1a, 1b, 2 – What is the expecting timing for these? APBI mentioned 15 months and unclear. How does the APBI statement relate to 1a, 1b and 2?
The timing of the Scheduling enhancements is still being developed.

23) Recommend VHA stand up and support PMO to assist with managing overall program. Requirements, testing, training, deployment all included.
Noted.

24) Training was heavily emphasized. Have you given consideration to acquiring specialized support for this to work in conjunction with the IT solution developer/provider?
Specialized clinical training will be a major aspect of the MASS program.

25) Has there been consideration to what types of PMO services you will require (besides PMAS)?
Yes.

26) Steve Green mentioned a PMO contract. Is there a planned acquisition schedule for that?
The timing-structure of the MASS acquisition is still under development.

27) What technology does CDW use? Does it include unstructured data? What BI tools does VA use?
Refer to VA Enterprise Architecture which is available at: http://www.ea.oit.va.gov/

28) Will the enterprise architecture for MASS be published?
The VA Enterprise Architecture is published at: http://www.ea.oit.va.gov/

29) How important are open source solutions to the EA for MASS?
VA wants to select from the best-in-breed, as appropriate, to meet/exceed the requirements.

30) Can you share more about the Indianapolis Scheduling Solution? What technology are they using? Who is implementing this?
The Indianapolis solution was referenced only as an archetype for enabling clinical business processes, by marrying a COTS product to VistA.

31) Can you provide a breakdown of schedule appointment volume and users by VISN?
Volumetric data will be published with the RFP if available at that time.

32) And what is expected concurrent user volume by VISN?
Volumetric data will be published with the RFP if available at that time.

33) Can you elaborate on the types of business rules that should be configurable across the system? Please provide some concepts and examples.
The configuration aspect is depicted in the VHA Blueprint document provided on FBO.

34) The volume of data is very large. Is a big data architecture a consideration? CDW is MS SQL database that will not scale for large data sets.
VA wants to select from the best in breed as appropriate to meet/exceed the requirements. VA has a NO-SQL enterprise database implementation.

35) What is the timeframe for ESS to be available and ready for integration with MASS? What is the rollout plan?
Some of the Enterprise Shared Service (ESS) will be available for integration with MASS. This information will be provided with the solicitation package.

36) Which of the systems that are part of, or connected to, the existing VistA systems are FISMA High and which are FISMA moderate?
The security requirements will be included in the published solicitation.

37) Will there be a separate procurement for helping VA with Business Process Re-Engineering and review of current business practices?
A separate procurement may be considered, but the acquisition strategy is still to be determined.

38) Will there be separate contract for testing?
A separate procurement may be considered, but the acquisition strategy is still to be determined.

39) The one-on-ones are booked. How do we request a session?
Contact the VA using published points of contact on FBO.

40) Will you be publishing the list of attendees with their contact info?
The Government will make a list of industry day companies available on FBO.

41) Will VA leverage T4 for procurement of MASS? If so, wont this reduce innovation through a closed competition pool of primes?
The Government is currently reviewing all of the possible acquisition strategies and will finalize it after the Industry Day and the One-on-Ones are completed and industry responses to the request for information (RFI) are received.

42) Will VA require an agile Enterprise Architecture as well as agile SDLC?
Please refer to the VA Enterprise Architecture documents publicly available, and the design pattern provided on FBO.

43) Will VA consider customized designed scheduling software instead of COTS?
VA is open to any proposed solution that meets requirements. VA expects to obtain industry best practices and innovations through acquisition of a commercially available, robust product.

44) It may be useful to develop separate training and test bed environment. Will VA consider that as scope of separate contract?
A separate procurement may be considered, but the acquisition strategy is still to be determined.

45) Is VA envisioning COTS scheduling vendor to be responsible for Integration with Vista Scheduling Adapter?
Yes.

46) Do you expect COTS Scheduling vendor to provide infrastructure or will that be a separate contract?

A separate procurement may be considered, but the acquisition strategy is still to be determined.

47) Has the VA conducted demand analysis on the existing data? If so, please advise the outcome tools used and comment on the overall utility of the exercise. If not, please advise why not – limitations, etc.
No.

48) What is the scheduling COTS system that was implemented at Indianapolis VAMC?
ForSite 2020 by Unibased Systems Architecture.

49) Will scheduling solution be capable of viewing Military Treatment facilities for rescheduling and cancelling appointments?
No.

50) Will scheduling be used for disability proofing?
No.

51) Will the scheduling solution be leveraged for non-medical requirement scheduling?
Yes.

52) Can VA provide the data back through FY10 through current on month by month basis by facility on # and types of appointments that did not meet target apt date needs?
This is out of scope for this effort.

53) The briefers continually referred to a COTS scheduler yet the details all point toward a very unique system that will evolve capability over time. Please clarify where the VA expects the COTS scheduler to fit into MASS.
VA expects the COTS product will be the core scheduling capability. Features of the COTS may depend on interface and data exchange capability, thus some features will be available to the user community over time.

54) How do you envision using analytics on scheduling data to optimize visits, ensure veterans show up, and in general, use the data to communicate with veterans and create the ultimate customer experience?
VA desires to use real time data to measure supply of provider care with demand for care from patients in order to effectively match providers and patients in a timely manner.

55) Multiple pain points are related to data management, sharing, and the use of predictive analytics. Please elaborate on these pain points.
All information is included in the Blueprint and the BRD.

56) Does VA plan to implement a COTS solution in a Big Bang approach or a phased modular approach using agile methodology?
It will be a phased approach, and VA will support agile methodology.

57) Does VA plan to utilize big data analytics as an underpinning for MASS? How important is analytics to MASS?
Analytics related to access to care is important to the scheduling community.

58) To what extent are there VA standard protocols for each Medical issue or diagnosis?
This is out of scope for this effort.

59) Where and how are these and other best practices documented?
This is out of scope for this effort.

60) Do you focus on expected/typical sequences or on branches and decisions?
This will be determined during product configuration effort.