CRISP DC

Solution Design & Technical Specifications

Updated February 25, 2026

Question	Response
What is your primary goal in adopting the Bed Availability and Referral Platform tool?	See 'Introduction_Instructions'
Which user roles are in scope and how many are there expected to be (bed managers, transfer center staff, referral coordinators, clinicians)?	The vendor's proposed solution must account for the full spectrum of end-user personas who will interact with the system across a variety of clinical, behavioral health, and community-based settings. This includes recognizing that data input may come from users with different roles, workflows, technical capabilities, and operational contexts. Vendors should design an approach that accommodates clinicians, care coordinators, administrative staff, crisis response teams, other frontline users, etc., ensuring that data entry processes are intuitive, efficient, and adaptable to the realities of each environment. The solution must demonstrate how it supports varied user needs while maintaining consistency, accuracy, and usability within a centralized HIE-enabled framework.
Is the solution required to also do patient tracking?	No, patient tracking refers to the process of monitoring a patient's location and status as they move through various stages of care within a healthcare facility. It is used to maintain visibility of where patients are, what step of care they are in, and how their treatment is progressing. For this project, we are interested in bed availability monitoring that refers to tracking the number of staffed, operational, and available beds across systems within the District.
Could you provide examples of how you envision CRISP DC users utilizing the tool depending on their role or organization?	The below user stories are examples of how users would be expected to utilize a solution but are not intended to be comprehensive. • As a hospital discharge planner, I use the bed registry daily for discharge planning with the patient and their care team so that I can identify available SNF/rehab beds quickly and reduce discharge delays by receiving confirmation of a bed placement. This improves patient flow and frees hospital capacity sooner. • As a behavioral health intake coordinator, I use the bed registry for every referral when addressing new patients' referrals with hospitals and outpatient providers to check

	which facilities have open beds at the right level of care and provide confirmation of this bed placement. This accelerates intake processes and improves continuity of patient care. • As a long-term care administrator, I use the bed registry weekly when monitoring census data and planning staffing with others from the facility's leadership team so that we can track availability trends across the region. This supports improved operational planning and better resources allocation. • As a nurse case manager at a hospital, I use the bed registry daily during multidisciplinary discharge huddles with physicians and discharge planners so that I can confirm timely availability of rehab or LTAC beds. This supports safer and more timely discharges.
Does CRISP DC expect vendors to design toward a single, consistent bed availability update pattern across facilities, or to support multiple update patterns concurrently (e.g., event-driven and periodic), and how should vendors reflect this expectation in their proposed approach?	CRISP DC's objective is to implement a centralized, HIE-enabled system that will be utilized by all District participants for a unified view of capacity and placement. Plans should include assumptions (e.g., normalization of facility data), dependencies (e.g., varying levels of technical readiness), contingency planning, risk identification and mitigation as well as measurement and evaluation. Where specific plan details are dependent on external decisions or input (e.g., communication and collaboration capabilities), vendors should note these explicitly, describe their impact, and provide a range-based estimate with a plan to refine once inputs are confirmed.
Should proposed solutions be designed to accommodate facilities that provide incomplete or non-automated bed availability data as part of the proposed solution, or should full automation and completeness be assumed for initial implementation?	
Should users be able to communicate and collaborate directly within the platform regarding referrals or cases, including notifications, secure messaging, document sharing, task assignment, and reminders?	
For solution design purposes, should vendors assume a baseline level of technical readiness and operational capacity across participating facilities, or plan to support varying levels of readiness as part of the proposed approach?	
Where is translation expected to occur - vendor or HIE? For example, we note the specific bed categories listed in the 'Vendor_FacetedSearchCriteria' worksheet (e.g.,	

Level of Care, Behavioral Health Needs). Given the variation in how facilities define these internally, does CRISP DC expect the vendor to normalize raw facility data into these specific faceted categories, or will the HIE provide a translation layer?	
Are you planning to establish a care coordination team internally, or do you plan to license the tool to individual hospitals and organizations that are contributing data?	
Hospitals may already be using a post-acute network and scheduling tool. If these other systems are already in place, would those remain in place and would vendors need to integrate with those systems?	
Is CRISP DC expecting a single statewide workflow, or are site-specific variations anticipated?	
What is the envisioned end-to-end system workflow for a bed manager, from capacity update through referral acceptance?	
What system(s) are bed management teams expected to primarily operate in day to day (HIE-hosted application vs local HIS/EHR or are you open to a dedicated platform for this)?	CRISP DC is seeking a solution that delivers the highest value through a centralized, coordinated approach that reflects how Health Information Exchanges (HIEs) operate in supporting cross organizational data sharing and real-time decision-making. As the District's designated HIE, CRISP DC serves as a trusted, neutral data convener, aggregating, normalizing, and distributing information across diverse clinical, behavioral health, and community settings. We therefore aim to implement a solution that can seamlessly integrate with existing HIE infrastructure, leverage standardized data sources and signals, and ensure a unified, district-wide view rather than fragmented or facility-specific workflows. Our priority is to identify a vendor whose proposed approach supports this centralized model, aligns with established HIE capabilities, and maximizes interoperability, scalability, and usability for all participating partners.
Is CRISP DC seeking a single vendor of record or explicitly encouraging composable solutions?	
How does CRISP envision this platform working alongside hospitals and health systems that have already procured referral systems (e.g., integration, parallel use, or replacement)?	
Have vendors previously attempted to address referral workflows similar to those described in this RFP using Direct Secure Messaging, or other approaches that might combine Direct and other message delivery methods? If so, what limitations were encountered, and how does the proposed solution address those challenges while supporting interoperability with existing systems?	
Are updates expected to be system-driven, user-entered, or a hybrid?	We encourage respondents to propose the most efficient and cost-effective solution. Vendors should provide their own estimate and approach based on prior implementation experience and industry best practices. Plans should include assumptions, dependencies, contingency planning, risk identification and
What services are provided by CRISP DC vs expected from the vendor (MPI, consent enforcement, audit logging)?	
Are phased deployments or pilots acceptable prior to statewide rollout?	

The RFP invites both 'end-to-end' and 'component-based' solutions. Does CRISP DC have a preference for a single vendor who can provide the entire platform, or is the priority to find the 'best of breed' for each component (Availability vs. Referral) regardless of vendor consolidation?	mitigation as well as measurement and evaluation. Where specific plan details are dependent on external decisions or input, vendors should note these explicitly, describe their impact, and provide a range-based estimate with a plan to refine once inputs are confirmed. CRISP DC expects vendors to outline how they would handle code mapping, standardization, and governance to support an accurate, centralized understanding of capacity within an HIE environment. This includes the recommended phased approach (see 'Vendor_Capabilities' 1.12) based on the proposed solution capabilities.
Requirement 1.5 specifies 'bidirectional data exchange' for referral workflows (initiation, routing, closure). Does CRISP DC prioritize deep EHR integration (e.g., writing status updates back into the hospital EMR) for Phase 1, or is a portal-based workflow for receiving facilities an acceptable initial state?	
Please provide a full description of the CRISP DC HIE platform, including all databases, software, and features utilized that require integrations.	
What validation or reconciliation processes exist when source systems disagree?	
Is a formal referral request model required (send, receive, triage, accept/reject, redirect)?	
Is CRISP DC expecting referrals to be initiated from within the HIE platform, or launched from source EHRs or in a dedicated platform?	
Are referral decisions expected to be written back to local HIS/EHR systems?	
Are SLAs, escalation rules, or audit trails required for referral handling?	
Is the solution expected to directly book or reserve a bed in a local HIS/EHR, or only signal intent/acceptance? If so, which systems are in scope and what integration patters are supported?	
Is CRISP DC assuming vendors will manage write-back risk, conflict resolution, and rollback scenarios?	
Which FHIR resources and profiles are mandatory for bed availability and referrals?	
Are non-FHIR interfaces (HL7 v2, proprietary APIs) expected to be supported?	
Will CRISP provide vendors with a finalized list of participating organizations (e.g. 60 mentioned in the RFP) and information about the technologies they currently use (e.g., EHRs, referral or care coordination platforms)?	
Are there expectations for structured versus free-text data capture, configurable workflows, status tracking, escalation, or reassignment when	

referrals are not addressed within defined timeframes?	
Should vendors assume a single unified referral model across these use cases, or distinct referral types with different workflows and outcomes, including referrals that may evolve into ongoing coordination or re-referrals? Should the platform be designed primarily as a transactional referral tool focused on identifying capacity and securing acceptance, or as a care coordination platform supporting longitudinal collaboration, shared accountability, and task management across organizations?	
Does CRISP see value in leveraging existing CRISP tools, including the CRISP DC Provider Directory (e.g. CRISP DC's source of truth for provider and organization information), as part of the referral platform? Should vendors assume that this tool would be made available to the referral platform?	
Since these capabilities are already in place, should the CRISP DC Provider Directory continue to be considered the system of record for DC providers and organizations, and leveraged to support referral targeting, filtering, and matching based on attributes such as care setting, specialty, designation, geography, and program participation (e.g. MCO participation,, birthing friendly locations, preferred provider language, mental health services)?	
Are there expectations for ongoing reporting, performance reviews, or operational oversight post-implementation?	
What reporting views or exports does the state expect (statewide, regional, facility-level)?	
How are temporary changes handled (ward closures, staffing shortages, surge capacity)?	
Who is responsible for enforcing patient consent, opt-out, and sensitive data rules—the vendor or the HIE?	
Should the platform support referrals associated with DC Department of Behavioral Health (DBH) programs, Crisis Intervention, Social Determinants of Health (SDOH) services, and Community-Based Organizations (CBOs)?	CRISP DC is seeking a Bed Availability and Referral Platform solution for the CRISP DC Health Information Exchange (HIE) to be deployed across multiple care settings (e.g., acute such as hospitals, sub-acute such as LTACH, and long-term care and

If so, are these entities (e.g. DBH staff) expected to actively manage referrals within the platform, or serve primarily as receiving organizations?	residential settings such as SNF, behavioral health, substance use, specialty care centers, etc.) in Washington, DC (The District). Also see 'Vendor_Background' - 6.1
Should the platform support different referral creation experiences and workflows based on referral type (e.g., bed placement, specialty referral, CBO services)?	
What types of referrals is the Bed Availability and Referral Platform intended to support, and what is the expected end state for those referrals? In other words, what type of referral is the primary focus of the project? Specialty? Facility-based? Other? Specifically, should the platform support: -Bed-placement–dependent referrals only (e.g., PAC placement) -Clinical referrals not dependent on bed availability, or/and, -Other capacity-based referrals (e.g., observation, step-down, crisis stabilization), -Specialty referrals (e.g. behavioral health, maternal health), -Case management referrals where placement may not be the immediate or sole objective	
Can the District provide a list (or estimated count) of: - Participating organizations - Facility types - Total bed counts by category	
How many HIS are there expected to integrate with and what are they?	
The approximate number of people that would need to be trained.	Vendors should outline strategies for scalable delivery, including, but not limited to, train-the-trainer models, virtual and asynchronous modules, role-based curricula, user guides, and ongoing reinforcement resources to ensure training can be executed effectively and sustainably as system adoption expands.

Operational Definitions

Question	Response
What constitutes "real-time" bed availability from CRISP DC's perspective?	For the purposes of this RFP, "real-time" bed availability refers to the vendor's ability to deliver timely, accurate, and continuously updated

How does the state define “real-time” bed availability (e.g., continuous system sync, scheduled updates, daily attestations)?	visibility into bed status across participating facilities through integration with the Health Information Exchange (HIE). Vendors should define what ‘real-time’ means within the context of their proposed solution, including the frequency of updates, latency expectations, data sources, integration methods, and any constraints that affect refresh intervals. The expectation is that the solution provides operationally meaningful bed status information to support rapid placement, capacity management, and care coordination activities across the District. For the purposes of this RFP, “bed availability” refers to the vendor’s capability to represent the current and near-term status of beds across participating facilities within the HIE environment. Vendors must define how their solution determines, classifies, and updates bed availability (including data sources, definitions, and business rules) so that users can make accurate placement and capacity decisions. “Referral components” encompass the technical and operational features needed to enable a full referral workflow, including but not limited to: • Referral initiation (creating a referral request, capturing required clinical and demographic data) • Transmission and routing of referral information to the appropriate entity • Receipt and acknowledgment by the receiving organization • Status tracking and updates (e.g., received, scheduled, completed) • Closed-loop confirmation when a referral is completed or cannot be fulfilled • Data standards used in referrals (e.g., CCD/C-CDA, FHIR, structured data fields) • Integration points with EHRs, HIE platforms, or care coordination systems • Notifications or alerts to providers or care teams • Reporting and analytics related to referral volume, timeliness, and outcomes
How does CRISP DC define “bed availability” across different care settings (acute, SNF, behavioral health)?	
Is availability binary, tiered (e.g., staffed vs licensed), or attribute-based (e.g., specialty, isolation, acuity)?	
What is the expected update frequency for bed status (real-time, near real-time, scheduled batch)?	
What is the expected update frequency for bed status (real-time, near real-time, scheduled batch)?	
What constitutes “real-time” from CRISP DC’s perspective (latency thresholds)?	
Please provide a detailed description of "referral components".	

Contracting & Ownership

CRISP DC

Question	Response
Who is the primary project owner and decision-maker for this initiative? With what department will the contract be executed?	The contract resulting from the solicitation will be executed by CRISP DC, Inc., the designated Health Information Exchange for the District of Columbia.
Please provide a copy of the contract that CRISP DC intends to execute with the selected vendor. Is CRISP DC willing to negotiate this contract?	See Contract CRISP DC's standard terms and conditions are attached to this RFP. In providing a response, the bidder must provide a redline of these terms and conditions, should the bidder wish to enter into negotiations. If a redline is not provided, CRISP DC will assume the bidder is willing to enter into the agreement, as is. Acceptance of a response does not indicate acceptance of the redlined terms and conditions.
Will CRISP DC require ownership or other rights in the winning vendor's solution? Please describe any rights being requested in the technology/platform including any contemplated licenses.	
Will the source of funds used to license the winning vendor's solution include federal or state funds? What financial arrangement does CRISP DC envision for the "buy" and "hybrid" options.	The funding will be provided by Government sources, see contract for more information. The contract resulting from the solicitation will be executed by CRISP DC, Inc., the designated HIE for the District of Columbia
What is the expected contract term, and are renewals or expansion clauses anticipated?	The anticipated contract term will align with the funding support approved for this initiative. At this time, the precise duration is not fully known and will be defined based on the funding levels authorized for the project. We expect that the initial contract period will reflect the funding currently allocated, with the possibility of renewals, extensions, or expansion contingent upon future funding availability and performance needs. Vendors should structure their proposals with an understanding that continuation beyond the initial period is dependent on subsequent funding approval and programmatic priorities.
Will the RFP be subject to any federal or state bid protest procedures?	No
Given that the RFP is requesting detailed plans and specifications regarding solicited solutions, what non-disclosure and confidentiality agreements is CRISP DC willing to sign to ensure protection for intellectual property, including trade secrets and proprietary information, contained in the proposals?	CRISP DC requests that vendors **DO NOT** include trade secrets, other proprietary intellectual property or any confidential information. We do require **sufficient technical and operational detail** to evaluate how the proposed solution will meet the stated requirements (e.g., architecture at a component level, data flows, standards and integration points, security controls, implementation and training approach, staffing model, timeline, SLAs/metrics, risk and governance plans, and total cost of ownership). ~~If the vendor believes confidential information is required~~
What firewalls and other safeguards will CRISP DC apply to the proposals to ensure that intellectual property in the proposals are not accessed or reviewed by any CRISP DC personnel or partners	

who are in a position to develop competing solutions based on information disclosed in the proposals.	~~to appropriately respond to the RFP, please alert us and we will provide our standard NDA.~~
Do CRISP DC personnel sign any confidentiality agreements or are they subject to any confidentiality and non-disclosure provisions that would require them to protect and not disclose any information that they may learn through this RFP process?	Yes
Given that CRISP DC is the District's designated HIE under the DC HIE system, will proposals and supporting materials be subject to DC's freedom of information act (FOIA) as public records? What assurances can CRISP DC provide that proposals and supporting materials will not be subject to DC's FOIA?	No, CRISP DC is not a government entity, therefore FOIA does not apply.

Budget

Question	Response
Is there an approved budget range allocated for this project?	No specific budget ceiling or range has been established for this project. We encourage respondents to propose the most efficient and cost-effective solution without being constrained by predefined limits. Our goal is to avoid inadvertently restricting innovation or the development of a high-value approach. Vendors should propose a cost-effective solution that reflects the most efficient and innovative approach.
Is there an anticipated NTE (not to exceed) budget?	

Data

Question	Response
What data is currently available (or expected) to support bed availability dashboards?	Vendors are expected to define how their solution utilizes available HIE data sources to accurately represent bed availability and to identify all additional integrations or data elements required to deliver a complete and reliable solution to satisfy the defined capabilities. All standard data feeds currently available through the District's Health Information Exchange (HIE) are accessible to support the development of a bed availability dashboard, as applicable. Vendors should assume that the solution will need to leverage, integrate, and operationalize these

	existing HIE data assets, and should propose an approach that includes the capabilities necessary to ingest, hydrate, normalize, and apply this data in support of the stated functional and technical requirements.
What data formats and standards will the bed availability data be provided in?	Vendors must specify the formats and standards their solution requires to represent and exchange bed availability, with justification for how these choices meet the functional and performance requirements.
Is there a single authoritative statewide bed/ward code set we can use to calculate capacity and availability? If so, who owns the code set and how is it governed?	There is currently no single authoritative statewide or national bed or ward code set for capacity reporting. Instead, CDC and HHS provide standardized capacity definitions, while HL7 continues to advance emerging coding standards. Vendors should stay aligned with both established and evolving frameworks to ensure their solutions remain scalable and future proof.
How many members or discharges to post-acute care does your organization support on a monthly and yearly basis?	Vendors should provide their own estimate and approach based on prior implementation experience and industry best practices. Plans should include assumptions, dependencies, contingency planning, risk identification and mitigation as well as measurement and evaluation. Where specific plan details are dependent on external decisions or input, vendors should note these explicitly, describe their impact, and provide a range-based estimate with a plan to refine once inputs are confirmed.
How many hospitals are currently feeding data into your HIE platform?	All District hospitals participate in the HIE
What are your data requirements for your ADT feed (e.g., bed status, bed updates)?	CRISP DC receives the typical data elements included in standard HL7 v2 ADT messages commonly exchanged within Health Information Exchanges. This includes the core patient demographics, encounter and visit details, and admission-discharge-transfer information routinely transmitted by participating facilities. Vendors should be aware of the data limitations and overall challenges with using extant data being collected or shared in the clinical data sharing ecosystem.
What is the minimum requirement for an organization to contribute an ADT feed, and in your most dynamic and robust implementation, what information are you receiving?	
Outside of the ADT feed, are you receiving any other robust structured data or specific clinical information?	CRISP DC receives the standard clinical, encounter, and administrative data commonly exchanged across Health Information Exchanges. The exact data elements available for any given facility or provider type may differ based on their technical infrastructure, workflows, and integration maturity.

	Vendors should design their solutions with the expectation that data contributions may vary across hospitals, behavioral health providers, post-acute facilities, ambulatory practices, and community-based organizations, and should propose approaches that can accommodate this variability while leveraging the data that is available. Vendors should be aware of the data limitations and overall challenges with using extant data being collected or shared in the clinical data sharing ecosystem.
From CRISP DC's perspective, where should vendors assume bed availability information will most commonly originate (e.g., facility systems, CRISP HIE data, third-party tools, or direct facility input), and are there existing data signals or integrations vendors should consider when designing their approach?	Vendors should assume that bed availability information could originate from multiple locations, depending on facility capabilities, system maturity, and operational workflow. Vendors are responsible for proposing an efficient, centralized solution that can accommodate required data sources, integration, and update mechanisms to ensure accurate and timely bed status information across the District.
How often is the data made available?	

Testing & Compliance

Question	Response
Can CRISP DC provide current FHIR profiles, implementation guides, and API specifications required for compliance?	We anticipate that the vendor will be providing the HIE with information about current bed availability. The HIE would work with the vendor to leverage that data efficiently based on recommendations from the vendor.
What latency and uptime SLAs exist for CRISP DC HIE services that this platform will depend on?	CRISP DC HIE follows industry best practice requirements, with all systems having greater than 99.7% uptime in production by SLA - typically exceeding that metric.
What are the data retention and audit requirements for vendor-managed components?	Vendors are expected to follow industry best practice requirements.
What security certifications or assessments (SOC 2, penetration testing, third-party audits) are required pre-go-live?	Please provide security certifications and assessments you have obtained. CRISP DC will follow up with more questions as necessary.
Will vendors have access to a sandbox/UAT environment that mirrors production HIE behavior?	Yes