ADDENDUM NO. 3 TO
RFP 9600-75: Population Health Software

Date: **11/13/17**

To: **All participants submitting Proposals for RFP # 9600-75**

From: **Kristen Aldrich, Deputy Purchasing Agent, Natividad Medical Center**

Subject: **Addendum No. 3 to RFP #9600-75**

This addendum includes the final set of questions and answers to date regarding this RFP 9600-75.

Q1: A few place in the RFP state "All prices and notations must be typed or written in BLUE ink." Does this just apply to Attachments I through IV, or does the blue ink also apply to responses for Proposal Sections 1 through 5?
A1: The Signature on the Signature page should be signed using a blue ink pen, and pricing submitted in the Attachments should be in blue ink as well (typed is ok).

Q2: What are the estimated number of Users for the Population Health Software?
A2: See the answer below to Question 39.

Q3: What relation/integration (if at all) does the system being sought through "RFP 9600-75, Population Health Software" have in relation to the solution being sought through "RFP 9600-71, Enterprise Master Patient Index"
A3: EMPI is a separate RFP and project. There will be integration efforts, as there would be with any interface.

Q4: I have seen a few different numbers on the total paper copies. I just want to confirm the total number is 7, 1 original plus 6 copies.
A4: Yes this is correct: 7 proposals (1 original plus six copies).

Q5: How many individual providers (as defined below) are employed at Monterey County agencies accessing the RFP Population Health Software platform? A "Provider" is defined as a medical professional who can bill for services under his or her name.
A5: PRIME: approximately 11, WPC: approximately 10

Q6: Please confirm that Bidders are permitted to submit proposed redlines to the Sample Agreement in the Exceptions section.
A6: Yes.

Q7: Please provide the Total number of covered lives in your State programs (PRIME, WPC, etc.). Currently our (Cerner) pricing for Population Health is at a per member per month rate.
A7: Approximately 15,000 PRIME, Approximately 600 WPC

Q8: Section 4.1.2 states that the Bidder must be able to **build and support** all 48 measures in Exhibits II and III. Are these measures set to be phased in over years, and if so, is the planned phasing available?
A8: See phase descriptions (Question A1, Resources/Implementation section) in Bidder Questionnaire. All metrics for WPC and PRIME need to be completed during phase I.

Q9: Will structured data be available for all clinical measures? If not, will the data be manually entered?
A9: Please see metrics specifications. The majority is structured data, a few are not.

Q10: Some of the metrics appear to be survey-based. Measures that are qualitative or survey based may not be calculable in the system, unless custom surveys are developed. Is that acceptable?
A10: Yes, we still need to be able to use tool for reporting purposes if data is fed manually.

Q11: Do the Universal Metrics listed in Exhibit II cover all of the metrics described the Whole Person Care Application?
A11: No, all Whole Person Care implementing agencies must report universal metrics and agency specific metrics. Universal metrics covers those for which all Whole Person Care implementing agencies (Counties) must provide. This term is used to distinguish these metrics from those specific to the each implementing agency.

Q12: Has NMC or the county already seen a demo of a system that currently meets all of the stated functional requirements of this RFP 9600-75?
A12: No

Q13: A stated functional requirement of this Population Health Software is master patient indexing (5.1.1.d). However, in addition to this RFP 9600-75, NMC/Monterey has also issued an RFP for an Enterprise Master Person Index System (9600-71). Does the county want the 9600-75 indexing to stand separately from the 9600-61 platform or connect and use that system for indexing functionality?
A13: The expectation would be that the systems integrate (connect) to utilize the EMPI indexing.

Q14: From how many sources systems will Natividad be sending data?
A14: Refer to section 5.1.1 of RFP

Q15: Included Populations

a. Will Natividad include its employee population in the plans managed by the platform? If yes, how many employees will be included? How many other (non-employees) are included in the employee plan?
b. How many total lives will Natividad manage with this platform?
c. How many insurance plans have 2,000 or more covered lives?
d. How many insurance plans have fewer than 2,000 covered lives?

A15:
a) not at this time
b) See Q7
c) See Q7
d) See Q7

Q16: What contracting term length is Natividad looking for?
A16: This is stated in Section 6.0 "CONTRACT TERM" of the RFP.

Q17: For section 4.1.1 c, in what format would this nonstandard data be received?
A17: This would be defined as part of the design process. There is some flexibility depending on the specific system and resources involved.

Q18: Is Natividad seeking direct data documentation for its care managers? Do you seek manual entry into the analytic system? Or do you seek a system that will receive and display data from Natividad's EHR?
A18: Yes, ideally all three would be possible.

Q19: For metrics/Measures sent from outside sources (PRIME and WPC), will they be able to send us data in requested standard formats? Ex: CSV, flat file,...
A19: Because they are independent agencies, we can request a format only.

Q20: What current tools are used for risk stratification? ACG, Milliman,...and can they share data or a customized set of algorithms?
A20: PRIME is utilizing LACE tool and manual risk stratification. The expectation is to utilize Milliman,Johns Hopkins or other proprietary tool provided by the population health software vendor selected.

Q21: What current tools are used for Care Plans? Proprietary tool that they can share content or customized?
A21: Currently generated internally

Q22: Do they have a standard electronic referral process currently, standard paper referral process, or a mix? Please describe
A22: Mix

Q23: How do they currently capture:
a) SOGI
b) Consents
A23:
a) Electronically and on paper and scanned.
b) On paper and scanned.

Q24: What is their Data Governance structure for necessary data elements needed for the project's scope?
A24: Please see PRIME data integrity policy attached below.

Adobe Acrobat Document

Q25: Do they have current protocols/workflows based upon patient risk?
A25: Yes

Q26: What is the total patient population and/or number of lives covered by Monterey County Health System and Natividad Medical Center?
A26: Approximate number of medical record numbers in each EHR:
MEDITECH 530,000
Epic 140,000
Avatar 40,000

Q27: (Ref Section 4.1.1) What are the data volumes in GB for each of the source systems?
A27: MEDITECH 1 TB, EPIC 322 GB, Avatar 300 GB

Q28: (Ref Section 4.1.1) What is the backend database system for each of the source systems?
A28: MEDITECH database and DR/SQL, EPIC: Cache for live system, SQL server for back end reporting DB, Avatar: Cache

Q29: (Ref Section 4.1.1) Are all source systems hosted in Monterey county data center? Are any of the source systems vendor-hosted SaaS platforms?
A29: MEDITECH: self-hosted, EPIC: third party vendor hosted(OCHIN), although we receive a copy of the reporting backend DB on a weekly basis, Avatar: SaaS vendor hosted

Q30: How many reporting users are expected to conduct ad hoc data analysis? Please provide total and peak concurrent.
A30: Initial estimate is 40, 10 concurrent

Q31: (Ref Section 10) Could you indicate whether having a sub-contractor who qualifies as a local vendor would satisfy the "local vendor" preference?
A31: The Local Preference is generally applicable to the bidder/proposing entity only. As a side note: If a Bidder/Proposer intends to subcontract out a portion of the work, this should be disclosed within the RFP Proposal. Per the Sample Agreement Section 10 “ASSIGNMENT AND SUBCONTRACTING”, Subcontractors are to be pre-approved by NMC so all subcontractors should be identified within the proposal and the portion of work that the Bidder/Proposer intends to sub out should also be stated in percentages. When a contract requires subcontractors or sub-consultants, the Contractor shall solicit proposals from qualified **local vendors** whenever possible. No contract awarded to a **local vendor** under this section shall be assigned or subcontracted in any manner that permits more than fifty percent (50%) or more of the dollar value of the contract to be performed by an entity that is **not** a **local vendor**. The following link is to the County’s local preference policy adopted in 2012: http://www.co.monterey.ca.us/cao/pdfs/LocalPreferencePolicy082912.pdf

Q32: (Ref Part D Functional requirements Section) Can you confirm if the requirements listed in this section are specific to only Care Coordination/Registry activities (e.g., tracking encounters/other events/date:time, etc.. as it strictly pertains to Care Coordination/Registry activities)?
A32: Yes

Q33: Are there other external funding sources (outside of WPC and/or Prime)?
A33: At this time no additional external funding sources have been confirmed.

Q34: Is there a requirement to track and align certain aspects of the system development to WPC vs Prime vs non-prime/WPC (e.g., ETL development may involve time that is dedicated to ensuring data for WPC metrics is cleaned/validated/enhanced it also may required the same activity but for different data elements in support of Prime, in this specific scenario the question would be , would the development time for WPC ETL development need to be calculated separately from Prime or others to ensure the work is fully auditable for compliance and/or evaluating cost/benefit analysis of the specific 1115 initiative?)
A34: Yes

Q35: Are the four primary EHR's listed for data aggregation all single instances or multiple? If multiple how many distinct data bases are associated with each vendor? (i.e. 4 total DB feeds or more)

- Epic
- Meditech
- CCAH
- Avatar (Netsmart)

A35: CCAH is a payor, not a health system. They will be providing data files, but are not an EHR. Single instance for MEDITECH, EPIC and Avatar

Q36: Secondary Aggregation needs;

- What discrete data elements are expected or anticipated to be aggregated from the non-EHR's i.e. Jail, Probation, Social Services, CARS data.
- Do you have a list of these data elements that you can provide?
- Can you provide the specific systems each entity uses?
- Are they single instances or multiple? (i.e. 4 total DB feeds or more)
- What Database architecture do they use (SQL, etc.?)

A36: We have not yet defined the discrete data elements associated with the non-EHR systems. These would be defined as part of the process of integrating them with a Population Health Platform based on value of the information to overall population health. We cannot provide a list at this time. There is the potential for many varieties of non-EHRs using varying system platforms. The RFP should be general enough to solve for multiple possibilities.

Q37: How many total patients/members are associated with the primary and secondary aggregation needed systems? i.e. Total member population of the data aggregation that is needed to take place.
A37: PRIME: 12000 from EPIC, 3000 from MEDITECH, 15000 total covered lives. WPC: members will total approximately 600 covered lives between now and 2020. We anticipate growth for both programs..

Q38: Can you provide specific patient /member counts from each data source?
A38: See Q37

Q39: How many total end users are anticipated to use the Population Health Platform? And How many specifically for:

- Medical Personnel?
- Behavioral Health/Social Workers?
- Care Managers/Coordinators
- Corrections?

A39: Depending on the functionality and robustness of the product there could be approximately: Medical Personnel: 300; Behavioral Health/Social Workers/Care Managers: 485; Corrections: 0

Q40: Do you expect individual user specific training to take place or is a consolidated or "train the trainer" approach acceptable?
A40: A comprehensive training plan is expected with a mix of individual training and train the trainer depending on need.

Q41: Will each distinct organizational entity need their own training or do you anticipate consolidating training sessions?

- I.e. Epic Users
- Meditech users
- CCAH Users
- Avatar users
- Jail
- Probation
- Social Services

A41: Yes, each program and organization will require individual training.

Q42: Are the EHR's on the same network?
A42: No

Q43: Is there a single instance of each EHR (Epic, Meditech, Avatar)?
A43: Yes

Q44: Does the Meditech instance have Meditech DR?
A44: Yes

Q45: What version of the EHR's are you on?
A45: MEDITECH client/server 5.6.7, Epic – Epic v2017 (Ochin customized), Avatar – MyAvatar 2017.01.00.build-1956

Q46: Do you have plans to upgrade the EHR's in the future? If so, when and to what version?
A46: NMC plans to migrate to MEDITECH's WebAcute and Ambulatory 6.1.x. Anticipate delivery into our test environment in 2019

Q47: How many care coordinators/care managers will use the system?
A47: This is answered above in Question 39.

Q48: How many at risk lives in their Managed MediCal contract through Central Coast Alliance for Health?
A48: See Q7

Q49: Estimate of the total number of patients across all systems we will extract data from?
A49: For total covered lives, see Q7; for total EHR populations, see Q26

Q50: Total number of end users logging into analytics to generate analysis?
A50: See Q30

Q51: (Regarding the RFP: Question 1, item #3 of Attachment 1-Pre-qualifications Questionnaire which asks *if our PHM software can support data aggregation from other non HL7 Standard data sources both government and non-government):* Can you share more information: For this non-HL7 standard data, what is the actual content? Is it clinical information, for example, in a non-standard format? Can you provide some examples of these data sources?
A51: Content on non-HL7 data is to be determined during project scope. The data will most likely not be clinical in nature.

Q52: How does Natividad expect the number of lives to growth over the course of the contract?
A52: We expect the number of covered lives to grow as the program progresses

--End of Q&A--

- ❖ This acknowledgement signature page of Addendum No. 3 must be submitted with your proposal.
- ❖ If this acknowledgement signature page is not submitted with your bid proposal, your entire proposal package may be considered non-responsive.

RECEIPT IS HEREBY ACKNOWLEDGED OF ADDENDUM NO. 3, RFP # 9600-75

_____	_____
Authorized Company Signature	Printed Name
_____	_____
Company Name	Date