NATIVIDAD MEDICAL CENTER
CONTRACTS/PURCHASING DIVISION
1441 CONSTITUTION BLVD
SALINAS, CA 93906

REQUEST FOR PROPOSALS
9600-75
For
Population Health Software
for Natividad Medical Center
and
the Monterey County Health Department

Proposals are due by 3:00 pm (PST) on Friday November 10, 2017

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SOLICITATION DETAILS SECTION

1.0 INTENT

1.1 The County of Monterey on behalf of Natividad Medical Center, hereinafter referred to as "NMC", is soliciting proposals from a qualified organization(s), hereinafter referred to as "CONTRACTOR", to provide NMC and the Monterey County Health Department (MCHD) with a Population Health software platform (hosted by CONTRACTOR or cloud-based) for data aggregation, analytics including risk stratification, registry, care coordination and reporting for population health management from multiple data sources.

1.2 This solicitation is intended for a single, exclusive AGREEMENT.

2.0 BACKGROUND INFORMATION

2.1 Natividad Medical Center (NMC) is a 172-bed Level II Trauma Center owned and operated by the County of Monterey, a government agency and has the Central Coast's only inpatient and outpatient acute rehabilitation program. NMC is fully accredited by The Joint Commission (TJC) to continuously provide high quality healthcare and is governed by a Board of Trustees, under the guidance of the Monterey County Board of Supervisors. In Fiscal Year 2016, NMC served the following number of patients:

Admissions: 8,690
Births: 2,499
Emergency Visits: 51,730
Outpatient Visits: 70,522
Surgeries: 3,558

2.2 As health care organizations shift nationally from fee for service to value based health care where systems are reimbursed for outcomes across a defined group of patients, population health has become a required component of health care operations. Population health provides a comprehensive framework for assessing and improving the health and well-being of a defined population by improving the quality of care and outcomes, and managing costs for a defined group of people. The defined group of people and the health management interventions can be identified by demographic differences, health needs such as chronic physical and mental health diseases, and social determinants of health. The Monterey County Health System (the Health System), which includes Natividad Medical Center, Health Department and behavioral health clinics, has embarked on two population health initiatives as defined by the 1115 Waiver, Public Hospital Redesign and Incentives in Medi-Cal(PRIME) and Whole Person Care (WPC). For WPC the Health System will additionally be partnering regional homeless partner agencies and three other County departments; the County Jail, Probation and Social Services as well as regional homeless providers.

2.3 The current Population Health Initiatives that are being addressed by Monterey County are 1) Whole Person Care and 2) PRIME

2.4 NMC and Health Department (HD) clinics objective is to select a technologic solution that facilitates the successful implementation of the Population Health Initiatives of the County of Monterey Health System.

3.0 CALENDAR OF EVENTS

3.1	Issue RFP	Wednesday October 4, 2017
3.2	Deadline to ask Questions	Friday October 20, 2017
3.3	**Proposal Submittal Deadline**	**Friday November 10, 2017**
3.4	Shortlist announced	On or before November 22, 2017
3.5	Scheduled Demonstrations (*ESTIMATED:* ***See Section 3.9 below for more info on demos)***	December 4—December 21, 2017 (exact dates and times shall be confirmed when shortlist is announced)
3.6	Estimated Notification of Final Selection	January 2018
3.7	Estimated AGREEMENT Date	**March 2018**

This schedule is subject to change as necessary.

3.8 **FUTURE ADDENDA:** CONTRACTORS, who received notification of this solicitation by means other than through a Natividad Medical Center mailing, shall contact the person designated in the NATIVIDAD POINTS OF CONTACT herein to request to be added to the mailing list. Inclusion on the mailing list is the only way to ensure timely notification of any addenda and/or information that may be issued prior to the solicitation submittal date. **IT IS THE CONTRACTORS' SOLE RESPONSIBILITY TO ENSURE THAT …THEY RECEIVE ANY AND ALL ADDENDA FOR THIS RFP** by either informing Natividad Medical Center of their mailing information or by regularly checking the NMC website at www.natividad.com (Vendors tab). Addenda will be posted on the website the day they are released.

3.9 **DEMONSTRATIONS:** After reviewing the written proposals received, NMC will announce a shortlist of qualified vendors who will then be invited to provide their system demonstrations for NMC representatives. Only those vendors who make the shortlist will be invited to provide demonstrations. Each vendor will be required to present their proposed Population Health Software Solution as it meets the objectives of this Request for Proposal (RFP) and to address any questions with the NMC representatives. System Demonstrations will not be scheduled until after the shortlist is announced. NMC intends

to announce the shortlist by November 22, 2017 and at that time shall invite the shortlisted vendors to participate in demonstrations. It is estimated that demonstrations will be scheduled between December 4 and December 21, 2017. All dates stated herein are subject to change and should this occur, NMC will release and Addendum announcing the changed/revised dates.

3.9.1 All system demonstrations shall be offered remotely to NMC utilizing the internet in whatever means CONTRACTOR would like to arrange. Traveling here in person to provide demonstrations is not necessary nor requested**.**

3.9.2 NMC shall not be responsible for any costs associated with a demonstration.

4.0 REQUIRED QUALIFICATIONS

4.1 **Only those CONTRACTORS who are able to meet ALL of the qualifications below shall be considered during this solicitation.** Each Proposer must acknowledge that it meets all of the qualifications below and shall be required to complete and submit **ATTACHMENT I** of this solicitation. **ATTACHMENT I must be included in the proposal submitted for consideration:**

4.1.1 Data Aggregation from various disparate sources. Specifically, ability to ingest and aggregate:

a. Electronic Health Record (EHR) and Health Information Exchange (HIE) HL7 standard data
b. Payor data
c. Non HL7 Standard data from other sources including the WPC partners from the homeless partner agencies utilizing their Coordinated Access and Referral System(CARS), County Jail, Probation and Social Services

4.1.2 Bidder must be able to build and support all County of Monterey Health System PRIME and Whole Person Care (WPC) metrics. For reference see attached:
EXHIBIT I - Whole Person Care Pilot Application
EXHIBIT II – Whole Person Care Pilot Metrics
EXHIBIT III - PRIME Metrics Summary
EXHIBIT IV - PRIME Reporting Manual DY12 Year End Reporting as released July 5, 2017(Note: this Exhibit IV is too large to attach to this RFP so a link is provided)
Please note these specifications in these documents are updated several times a year.

For additional reference and general information on California PRIME, see website: http://www.dhcs.ca.gov/provgovpart/Pages/PRIME.aspx

4.1.3 Bidder must have risk stratification functionality and risk adjustment tools utilizing Milliman, Johns Hopkins or other proprietary tool.

4.1.4 Bidder's solution must have Care Coordination and Registry features and functionality.

4.1.5 Bidder must have patient matching/Master Patient Index functionality.

4.1.6 Bidder must have a system that complies with the security requirements of the Health Insurance Portability and Accountability Act and California law.

4.1.7 Bidder's solution must be Cloud Based Software as a Service (SAAS)

4.1.8 Bidder's solution must have references that are currently using their product and the key features above.

4.0 NATIVIDAD POINTS OF CONTACT

4.1 Questions and correspondence regarding this solicitation shall be directed to the primary NMC Contact for this solicitation:

Kristen Aldrich, Deputy Purchasing Agent
NMC Contracts Division
1441 Constitution Blvd.
Salinas, CA 93906
EMAIL: aldrichk@natividad.com

4.2 All questions regarding this solicitation shall be submitted in writing via email. The questions will be researched and the answers will be communicated to all known interested CONTRACTORS after the deadline for receipt of questions.

4.3 The deadline for submitting written questions regarding this solicitation is indicated in the **CALENDAR OF EVENTS herein**. Questions submitted after the deadline will not be answered.

4.4 Only answers to questions communicated by formal written addenda will be binding.

4.5 Prospective CONTRACTORS shall not contact Natividad Medical Center or County officers or employees with questions or suggestions regarding this solicitation except through the primary contact person listed above. **Any unauthorized contact may be considered undue pressure and cause for disqualification of the CONTRACTOR.**

5.0 GENERAL REQUIREMENTS OF CONTRACTOR AND SYSTEM

5.1 The Population Health Software system ("system") shall enable the County of Monterey Health System to automate data aggregation, population health analytics and risk

stratification. It will additionally provide a platform for a registry and care coordination functionality agnostic of Electronic Health Record (EHR) or documentation system.

The Following are definitions and the key features/functions required for the proposed software system. Please use this information and definitions when completing **ATTACHMENT II- Bidder Questionnaire** of this solicitation.

5.1.1 Data Aggregation- Population Health Data Aggregation is the process in which information is gathered from multiple entities in the patient's/client's continuum of care for purposes of statistical analysis and improving the health of the population. Data sources include, but are not limited to, healthcare entities, payors, county jail, social services and other non-profit organizations.

a. Ease of aggregation from EHRs, payors and non EHR data sources(non HL7 standard), data normalization and resources needed
b. Data Aggregation and Data Normalization Process for implementation and for post live support phase
c. Data aggregation from the following County of Monterey Sources will be required:
    i. Primary Aggregation needed from four primary EHRs and payor(s); Epic, Avatar, MEDITECH and Central California Alliance for Health (CCAH)
    ii. Secondary aggregation needs; Jail, Probation, Social Services, CARS data from homeless partner agency systems,
    iii. Tertiary need from Labcorp and Quest
    iv. Future needs could include the regional HIE/HIO Relay Health/Central Coast Health Connect, other health care providers including local clinics, SNFS and other payors.
d. Ability to match patients across data sources, using Master Patient Index functionality.
e. Ability to de-identify information for external reporting purposes.

5.1.2 Care Coordination and Clinical Registry

a. **Care Coordination** which can be defined is a set of activities designed to assist patients and their support systems in managing their medical and psychosocial conditions more effectively. The goal of care coordination activities is to improve patients' functional health status, enhance the coordination of care, eliminate duplication of services, and reduce the need for high cost medical services. These activities are managed across the healthcare continuum through the use of a robust registry and care coordination documentation.
b. A clinical **Registry** provides information to health care professionals to improve the quality and safety of patient care. It is a tool for tracking the clinical outcomes of a defined patient population and helps facilitate care coordination activities. For example, the use of evidence-based practice guidelines can be monitored by allowing an organization to identify the number of patients receiving a recommended treatment(s). Registries can

also be utilized to compare the effectiveness of different treatments for the same disease or condition and can be designed to provide health providers and patients with reminders to check certain tests to reach pre-defined goals. Some features:

a. Strong End user Usability
b. Registry robustness
c. Care Coordinators/managers will be primary End users. All others Secondary
d. Flexible levels of user access
e. How and what level of communication does the product facilitate with secondary end users. / How does this functionality interface with EHRs and secondary sources
f. Robust care plan integration with the EHRS and other data sources
    i. facilitates the care teams ability to close gaps in care

5.1.3 Analytics and Risk Stratification

a. **Analytics** is the leverage of data enabling context specific insight that is actionable.
b. **Risk Stratification** is the act of identifying and predicting patients that possess or are at risk of developing high risk health problems. Subsequently, the care management of these patients is prioritized in order to prevent worse outcomes.
    i. Interface between Care Coordination and Registry modules with the Analytics module is important to County
    ii. The risk stratification functionality should ideally meet the needs of County initiatives including risk adjustment tools; Milliman, John Hopkins or equal caliber proprietary
    iii. With regards to metrics the standard content/library- HEDIS, ACO measures, etc. that is included is important
    iv. Ease of metric build including customization
    v. Cost of customization
    vi. Excellent End User interface including Administrators, IT analysts, Care Coordinators

5.1.4 Data Reporting – collecting and submitting data

a. This includes the reporting and dash boarding capacity of the software
b. Visualization layer part of the software or separate purchase

5.2 The County of Monterey Health System led by NMC is reporting on 48 metrics to meet the PRIME waiver requirements. The current reporting of this data is a custom made reporting solution that ingests data from various sources. NMC's primary source of data is NMC's MEDITECH EHR, the County Health Department clinics EPIC, and CCAH spreadsheets. This new system will replace this 'home grown' reporting system and support the 48 PRIME metrics. For reference please see the attached:
EXHIBIT III - PRIME Metrics
EXHIBIT IV - PRIME Reporting Manual DY12 Year End Reporting as released July 5, 2017
Please note these specifications are updated several times a year.

For reference and general information on California PRIME see website: http://www.dhcs.ca.gov/provgovpart/Pages/PRIME.aspx

5.3 The County of Monterey will begin reporting on its Whole Person Care metrics August 2017. Going forward, this application will need to report these metrics and data. See attached **EXHIBIT I – Whole Person Care Pilot Application** and **EXHIBIT II - Whole Person Care Pilot Metrics** for the details on the metrics and data sources that must be supported by CONTRACTOR'S application for the reporting of the WPC metrics.

6.0 CONTRACT TERM

6.1 The initial term of the AGREEMENT(s) will be for a period of three (3) Three years with the option to extend the Agreement for (2) additional one (1) year periods.
6.1.1 NMC does not have to provide a reason if it elects not to renew.

6.2 The AGREEMENT(s) shall contain a clause that provides that NMC reserves the right to cancel this AGREEMENT(s), or any extension of this AGREEMENT(s), without cause, with a thirty day (30) written notice, or immediately with cause.

6.3 If the AGREEMENT(s) includes options for renewal or extension and CONTRACTOR proposes to change its cost structure, CONTRACTOR must commence negotiations for any desired cost structure changes a minimum of ninety days (90) prior to the expiration date of the AGREEMENT(s).
6.3.1 Both parties shall agree upon cost structure changes in writing in order for such a change to become a binding part of the AGREEMENT.

7.0 PROPOSAL PACKAGE REQUIREMENTS

7.1 **CONTENT AND LAYOUT:**

7.1.1 Provide the information as requested and as applicable to the proposed services. The proposal package shall be organized as per the table below; headings and section numbering utilized in the proposal package shall be the same as those identified in the table. Proposal packages shall include at a minimum, but not limited to, the following information in the format indicated:

Proposal Package Layout; Organize and Number Sections as Follows:	
Section 1	COVER LETTER (INCLUDING CONTACT INFO)
	RFP SIGNATURE PAGE
	SIGNED RFP ADDENDA (IF ANY WERE ISSUED)

	PROPOSAL TABLE OF CONTENTS
Section 2	PRE-SCREENING QUESTIONNAIRE
Section 3	TERMS AND CONDITIONS OF USE (OF WEBSITE AND/OR LICENSE)
Section 4	EXCEPTIONS
Section 5	APPENDIX

Proposal Section 1 Contents:

Cover Letter: All proposals must be accompanied by a cover letter not exceeding the equivalent of two (2) single-sided pages and should provide Contact information and organizational information as follows:

Organizational Info: Description of the type of organization (e.g. corporation, partnership, including joint venture teams and subcontractors) and how many years it's been in existence providing its Population Health Software System. Also include a brief statement highlighting the strengths of your organization.

Contact Info: The name, address, telephone number, and fax number of your primary contact person during the solicitation process through to potential contract award.

Signed RFP Signature Page and Signed Addenda (this is applicable only if any addenda were released for this solicitation). Proposals submitted without this page will be deemed non-responsive. All signatures must be manual and in BLUE ink. All prices and notations must be typed or written in BLUE ink. Errors may be crossed out and corrections printed in ink or typed adjacent, and must be initialed in BLUE ink by the person signing the proposal.

Proposal Table of Contents

Proposal Section 2a, Proposal Requirements:

Confirm that all of the qualification requirements stated herein Section 4 are satisfied by completing the **ATTACHMENT I – Pre-Qualification Questionnaire** attached to this RFP.

Proposal Section 2b, Proposal Questionnaire:

Complete **ATTACHMENT II - Proposal Questionnaire** and **ATTACHMENT III – Proposal Price Schedules** attached hereto this RFP.

Proposal Section 3, Terms and Conditions of Use of Website and/or License:

Submit any and all website Terms and Conditions of Use and all EULA or Software License Terms and Conditions of Use that your organization typically asks its

clients to agree to. NMC does not guarantee it will agree to the all of the Terms and Conditions of Use submitted.

Provide a written statement to NMC acknowledging that, depending on the content of the Terms and Conditions of Use you submit, some of the sections may need to be modified or omitted, particularly terms or conditions which conflict with those found in the enclosed Sample Agreement terms and conditions.

If your organization will not require that NMC sign any Terms and Conditions of Use in order to use the vendor management system proposed, please provide a statement to this effect.

Proposal Section 4, Exceptions:

Submit any and all exceptions to this solicitation on separate pages, and clearly identify the top of each page with "EXCEPTION TO NATIVIDAD MEDICAL CENTER RFP #9600-75, SECTION X.X"; each Exception shall reference the RFP section number, and briefly explain the reason for taking Exception as appropriate. CONTRACTOR should note that the submittal of an Exception does not obligate Natividad Medical Center to revise the terms of the RFP or AGREEMENT.

Proposal Section 5, Appendix:

Appendices: CONTRACTOR may provide any additional information that it believes to be applicable to its proposal package and include such information in an Appendix section.

7.2 **ADDITIONAL REQUIREMENTS:** To be considered "responsive," submitted proposals shall adhere to the following:

7.2.1 Seven (7) sets of the proposal package; **one proposal marked "Original" plus six (6) copies shall be submitted** in response to this solicitation. Each copy shall include a cover indicating the company name submitting, and should reference "RFP #9600-75". In addition, submit one (1) electronic version of the entire proposal package on a CD, DVD, or USB memory stick. Additional copies may be requested by NMC at its discretion.

7.2.2 Proposals shall be prepared on 8-1/2" x 11" paper, preferably duplex printed and stapled together without binder or plastic enclosure (environmentally friendly). Fold out charts, tables, spreadsheets, brochures, pamphlets, and other pertinent information or work product examples may be included as Appendices.

7.2.3 Reproductions of the Monterey County Seal or Natividad Medical Center Logo shall not be used in any documents submitted in response to this solicitation.

7.2.4 CONTRACTOR shall not use white-out or a similar correction product to make late changes to their proposal or qualifications package but may instead line out and initial in BLUE ink any item which no longer is applicable or accurate.

7.2.5 To validate your proposal, **submit the SIGNATURE PAGE** (contained herein) **with your proposal**. Proposals submitted without that page will be deemed non-responsive. Proposal signature must be manual, in BLUE ink, and included with the original copy of the proposal. Photocopies of the Signature Page may be inserted into the remaining five (5) proposal copies. All prices and notations must be typed or written in BLUE ink in the original proposal copy as well. Errors may be crossed out and corrections printed in BLUE ink or typed adjacent, and must be initialed in BLUE ink by the person signing the proposal.

7.3 **CONFIDENTIAL OR PROPRIETARY CONTENT:** Any page of the proposal that is deemed by CONTRACTOR to be a trade secret by the CONTRACTOR shall be clearly marked "CONFIDENTIAL INFORMATION" or "PROPRIETARY INFORMATION" at the top of the page.

8.0 SUBMITTAL INSTRUCTIONS & CONDITIONS

8.1 **Submittal Identification Requirements: ALL BOXES AND/OR ENVELOPES MAILED OR DELIVERED CONTAINING PROPOSALS MUST BE SEALED AND BEAR ON THE OUTSIDE, PROMINENTLY DISPLAYED IN THE LOWER LEFT CORNER: THE SOLICITATION NUMBER RFP #9600-75 and CONTRACTOR'S COMPANY NAME.**

8.2 Mailing Address: Proposals shall be mailed to NMC at the mailing address indicated on the **Signature Page** of this solicitation.

8.3 Due Date: Proposals must be received by NMC ON OR BEFORE the time and date specified, at the location and to the person specified on the **Signature Page** of this solicitation. It is the sole responsibility of the CONTRACTOR to ensure that its proposal is received at or before the specified time. Postmarks and facsimiles are not acceptable. Proposals received after the deadline shall be deemed non-responsive and rejected.

8.4 Shipping Costs: Unless stated otherwise, the F.O.B. for tangible receivables shall be destination. Charges for transportation, containers, packaging and other related shipping costs shall be borne by the shipper.

8.5 Acceptance: Proposals are subject to acceptance at any time within 90 days after opening. NMC reserves the right to reject any and all proposals, or part of any proposal, to postpone the scheduled deadline date(s), to make an award in its own best interest, and to waive any informalities or technicalities that do not significantly affect or alter the substance of an otherwise responsible proposal or qualifications package and that would not affect a CONTRACTOR'S ability to perform the work adequately as specified.

8.6 Ownership: All submittals in response to this solicitation become the property of the Natividad Medical Center (County of Monterey). If a CONTRACTOR does not wish to submit a Proposal but wishes to acknowledge the receipt of the request, the reply envelope shall be marked "No Bid".

8.7 Compliance: Proposal or qualifications packages that do not follow the format, content and submittal requirements as described herein, or fail to provide the required documentation, may receive lower evaluation scores or be deemed non-responsive.

8.8 CAL-OSHA: The items proposed shall conform to all applicable requirements of the California Occupational Safety and Health Administration Act of 1973 (CAL-OSHA).

9.0 SELECTION CRITERIA

9.1 The selection of CONTRACTOR and subsequent contract award(s) will be based on the criteria contained in this Solicitation, as demonstrated in the submitted proposal. CONTRACTOR should submit information sufficient for NMC to easily evaluate proposals with respect to the selection criteria. The absence of required information may cause the Proposal to be deemed non-responsive and may be cause for rejection. The selection criteria shall be performed in the following phases:

9.2 First Phase: Pre-screening of Proposals with which the following will be considered;

- 9.2.1 Company history and Population Health Background and Experience
- 9.2.2 Contractor's Population Health Analytics Software Functionality and Usability
- 9.2.3 The Ease of Use and Customization Features of the Population Health Software
- 9.2.4 Training and Support Services
- 9.2.5 Technical Specifications and Details
- 9.2.6 Costs, Resources and Implementation Timeline and Process
- 9.2.7 Reference checks

9.3 Second Phase: Contractor's Population Health system web based demonstrations;

- 9.3.1 System Functionality
- 9.3.2 System Capabilities (including reporting, which is key)
- 9.3.3 User-friendliness of system

10.0 PREFERENCE FOR LOCAL CONTRACTORS

10.1 Local Preference Policy: The County desires, whenever possible, to contract with qualified Local Vendors to provide goods and services to the County. As per the Local Preference Policy (posted online at the following URL:

http://www.natividad.com/sites/default/files/FCKeditor/file/RFPs/CountyLocalPreferencePolicy.pdf

This solicitation utilizes a "best value" method of selection as opposed to a cost based selection only, therefore a ten percent (10%) preference will be applied to the scoring evaluation for an organization which qualifies as a Local Vendor. Local Vendor is defined as:

10.1.1 Vendor either owns, leases, rents or otherwise occupies a fixed office or other commercial building, or portion thereof, having a street address within Monterey County, Santa Cruz County, or San Benito County (the "Area"). Vendor possesses a valid and verifiable business license, if required, issued buy a city within the Area or by one of the three counties within the Area when the address is located in an unincorporated area within one of the three counties;

10.1.2 Vendor employs at least one full time employee within the Area, or if the business has no employees, the business must be at least fifty percent (50%) owned by one or more persons whose primary residence(s) is located within the Area;

10.1.3 Vendor's business must have been in existence, in Vendor's name, within the Area for at least two (2) years immediately prior to the issuance of either a request for competitive bids or request for proposals for the County;

10.1.4 Newly established businesses which are owned by an individual(s) formerly employed by a Local Vendor for at least two (2) years also qualifies for the preference; and

10.1.5 If applicable vendor must possess a valid resale license from the State Franchise Tax Board showing vendor's local address within the Area and evidencing that payment of the local share of the sales tax goes to either a city within the Area or to one of the three counties within the defined Area.

10.2 An organization which believes it meets the definition of a Local Vendor is advised to read the entire policy (link to policy posted in Section 10.1 above) AND for purposes of this procurement must register as a local vendor with the County via the Vendor Registration Link: Vendor Self Service (VSS) located online at:
http://www.co.monterey.ca.us/admin/vendorinfo.htm
AND, in this situation should submit the *Local Business Declaration Form* with their proposal (**RFP ATTACHMENT IV – Local Business Declaration Form** attached hereto this RFP.

11.0 CONTRACT AWARDS

11.1 Board of Supervisors: The award(s) made from this solicitation may be subject to approval by the Monterey County Board of Supervisors.

11.2 Interviews, presentations/demonstrations: NMC reserves the right to interview selected CONTRACTOR before an agreement contract is awarded. NMC may also request a presentation or demonstration by CONTRACTOR before an agreement is awarded. The costs of attending any interview, presentation or demonstration are the CONTRACTOR'S responsibility.

11.3 Incurred Costs: NMC is not liable for any cost incurred by CONTRACTOR in response to this solicitation.

11.4 Notification: Unsuccessful CONTRACTORS who have submitted a Proposal will be notified of the final decision as soon as it has been determined.

11.5 In NMC's Best Interest: The award(s) resulting from this solicitation will be made to the CONTRACTOR that submit(s) a response that, in the sole opinion of NMC who best serves the overall interest of NMC and the County of Monterey.

11.6 No Guaranteed Value: NMC does not guarantee a minimum or maximum dollar value for any AGREEMENT or AGREEMENTS which result from this solicitation.

12.0 SEQUENTIAL CONTRACT NEGOTIATION

12.1 NMC will pursue contract negotiations with the CONTRACTOR who submit(s) the best Proposal and is deemed the most qualified in the sole opinion of NMC and the County of Monterey, and which is in accordance with the criteria as described within this solicitation. If the contract negotiations are unsuccessful, in the opinion of either NMC/County of Monterey or CONTRACTOR, NMC may pursue contract negotiations with the entity that submitted a Proposal which NMC deems to be the next best qualified to provide the services, or NMC may issue a new solicitation or take any other action which it deems to be in its best interest.

13.0 COLLUSION

13.1 CONTRACTOR shall not conspire, attempt to conspire, or commit any other act of collusion with any other interested party for the purpose of secretly, or otherwise, establishing an understanding regarding rates or conditions to the solicitation that would bring about any unfair conditions.

14.0 RIGHTS TO PERTINENT MATERIALS

14.1 All responses, inquiries, and correspondence related to this solicitation and all reports, charts, displays, schedules, exhibits, and other documentation produced by the CONTRACTOR that are submitted as part of the proposal submittal will become the property of NMC when received by NMC and may be considered public information under applicable law. Any proprietary information in the submittal must be identified as such and marked "CONFIDENTIAL INFORMATION" or "PROPRIETARY INFORMATION". NMC will not disclose proprietary information to the public, unless required by law; however, NMC cannot guarantee that such information marked as "Confidential" or "proprietary" will be held confidential.

15.0 DEBARMENT/SUSPENSION POLICY

15.1 CONTRACTORS submitting a proposal should not be in current debarment status by the State of California. All CONTRACTORS submitting proposals in response to this solicitation will be cross checked against the California Department of Industrial Labor to ensure it is not in DLSE Debarment status. Any proposal submitted from a business entity with debarment status will not be considered for an agreement award.

16.0 AGREEMENT TO TERMS AND CONDITIONS

16.1 CONTRACTOR selected through the solicitation process will be expected to execute a formal AGREEMENT with NMC for the provision of the requested service. The AGREEMENT shall be written by NMC in a standard format approved by County Counsel, similar to the "SAMPLE AGREEMENT SECTION" contained herein. **Submission of a signed bid/proposal and the SIGNATURE PAGE will be interpreted to mean CONTRACTOR HAS AGREED TO ALL THE TERMS AND CONDITIONS set forth in the pages of this solicitation and the standard provisions included in the SAMPLE AGREEMENT Section herein.** NMC may but is not required to consider including language from the CONTRACTOR'S proposed AGREEMENT, and any such submission shall be included in the EXCEPTIONS section of CONTRACTOR'S proposal.

SAMPLE AGREEMENT SECTION

SAMPLE AGREEMENT BETWEEN NATIVIDAD MEDICAL CENTER (COUNTY OF MONTEREY) AND CONTRACTOR

This AGREEMENT is made and entered into by the County of Monterey on behalf of Natividad Medical Center, hereinafter referred to as "NMC", a political subdivision of the State of California, and *(CONTRACTOR NAME WILL BE STATED HERE)*, hereinafter referred to as "CONTRACTOR."

SAMPLE AGREEMENT 1.0 RECITALS

WHEREAS, NMC has invited proposals through the Request for Proposals (RFP #9600-75) for Population Health Software in accordance with the specifications set forth in this AGREEMENT; and

WHEREAS, CONTRACTOR has submitted a responsive and responsible proposal to perform such services; and

WHEREAS, CONTRACTOR has the expertise and capabilities necessary to provide the services requested.

NOW THEREFORE, NMC and CONTRACTOR, for the consideration hereinafter named, agree as follows:

SAMPLE AGREEMENT 2.0 PERFORMANCE OF THE AGREEMENT

2.1 After consideration and evaluation of the CONTRACTOR'S proposal, NMC hereby engages CONTRACTOR to provide the products and services set forth in RFP #9600-75 and in this AGREEMENT on the terms and conditions contained herein and in RFP #9600-75. The intent of this AGREEMENT is to summarize the contractual obligations of the parties. The component parts of this AGREEMENT include the following:

AGREEMENT,
RFP #9600-75 dated _____, including all attachments and exhibits
Addendum (or Addenda) #___
CONTRACTOR'S Proposal dated _____,
Certificate of Insurance
Additional Insured Endorsements

2.2 All of the above-referenced contract documents are intended to be complementary. Work required by one of the above-referenced contract documents and not by others shall be done as if required by all. In the event of a conflict between or among component parts of the contract, the contract documents shall be construed in the following order: AGREEMENT, RFP #9600-75 including all attachments and exhibits, Addendum/Addenda issued,

CONTRACTOR'S Proposal, Certificate of Insurance, and Additional Insured Endorsements.

2.3 CONTRACTOR warrants that CONTRACTOR and CONTRACTOR's agents, employees, and subcontractors performing services under this AGREEMENT are specially trained, experienced, competent, and appropriately licensed to perform the work and deliver the services required under this AGREEMENT and are not employees of NMC nor of the County of Monterey, or immediate family of an employee of Natividad Medical Center nor of the County of Monterey.

2.4 CONTRACTOR, its agents, employees, and subcontractors shall perform all work in a safe and skillful manner and in compliance with all applicable laws and regulations. All work performed under this AGREEMENT that is required by law to be performed or supervised by licensed personnel shall be performed in accordance with such licensing requirements.

2.5 CONTRACTOR shall procure all necessary permits and licenses and abide by all applicable laws, regulations and ordinances of the United States and of the State of California. The Agency will be in compliance with Title 22, OSHA, Federal and State Labor Laws and the Joint Commission on Accreditation of Health Care Organizations.

2.5.1 CONTRACTOR must maintain all applicable and required licenses throughout the term of the AGREEMENT.

2.6 CONTRACTOR shall furnish, at its own expense, all materials, equipment, and personnel necessary to carry out the terms of this AGREEMENT, except as otherwise specified in this AGREEMENT. CONTRACTOR shall not use Natividad Medical Center premises, property (including equipment, instruments, or supplies) or personnel for any purpose other than in the performance of its obligations under this AGREEMENT.

SAMPLE AGREEMENT 3.0 SCOPE OF SERVICES

[_____]

(Scope of Services will be developed by both NMC and CONTRACTOR at the time of a tentative award announcement and shall be consistent with the system requirements defined in this Solicitation. The scope of services and shall include description of goods and/or services provided including implementation timelines, functional deliverables and a billing structure. Additional conditions may be stated such as details regarding training, meetings, any "Acceptance Testing" or "Notice to Proceed" clauses and project management requirements if applicable.)

SAMPLE AGREEMENT 4.0 TERM OF AGREEMENT

4.1 The initial term shall be effective on __(date)__ through and including __(date)__, with the option to Agreement for (2) additional one (1) year periods.

4.1.1 NMC does not have to provide a reason if it elects not to renew.

4.2 NMC reserves the right to cancel this AGREEMENT(s), or any extension of this AGREEMENT(s), without cause, with a thirty day (30) written notice, or immediately with cause.

4.3 If the AGREEMENT(s) includes options for renewal or extension and CONTRACTOR proposes to change its cost structure, CONTRACTOR must commence negotiations for any desired cost structure changes a minimum of ninety days (90) prior to the expiration date of the AGREEMENT(s).

4.3.1 Both parties shall agree upon cost structure changes in writing in order for such a change to become a binding part of the AGREEMENT.

SAMPLE AGREEMENT 5.0 COMPENSATION AND PAYMENTS

5.1 It is mutually understood and agreed by both parties that CONTRACTOR shall be compensated under this AGREEMENT in accordance with the pricing sheet attached hereto this AGREEMENT as EXHIBIT __.

5.2 Prices shall remain firm for the initial term of this AGREEMENT and, thereafter, may be adjusted annually as provided in this paragraph. NMC does not guarantee any minimum or maximum amount of dollars to be spent under this AGREEMENT.

5.3 Negotiations for rate changes shall be commenced, by CONTRACTOR, a minimum of ninety days (90) prior to the expiration of this AGREEMENT.

5.4 Any discount offered by the CONTRACTOR must allow for payment after receipt and acceptance of services, material or equipment and correct invoice, whichever is later. In no case will a discount be considered that requires payment in less than 30 days.

5.5 CONTRACTOR shall levy no additional fees nor surcharges of any kind during the term of this AGREEMENT without first obtaining approval from NMC in writing.

5.6 Tax:

5.6.1 Pricing as per this AGREEMENT is inclusive of all applicable taxes.

5.6.2 County is registered with the Internal Revenue Service, San Francisco office, EIN number 94-6000524. The County is exempt from Federal Transportation Tax; an exemption certificate is not required where shipping documents show Monterey County as consignee.

SAMPLE AGREEMENT 6.0 INVOICES AND PURCHASE ORDERS

6.1 Invoices for all services rendered per this AGREEMENT shall be billed directly to the Natividad Medical Center Accounts Payable department at the following address:

Natividad Medical Center
Accounts Payable Department
P.O. Box 81611
Salinas, CA. 93912

6.2 CONTACTOR shall reference "Population Health Software Agreement" on all invoices submitted to NMC. CONTRACTOR shall submit such invoices once per month. The invoice shall set forth the amounts claimed by CONTRACTOR for the previous period, together with an itemized basis for the amounts claimed, and such other information pertinent to the invoice. NMC shall certify the invoice, either in the requested amount or in such other amount as NMC approves in conformity with this AGREEMENT, and shall promptly submit such invoice to the County Auditor-Controller for payment. County Auditor-Controller shall pay the amount certified within 30 days of receiving the certified invoice.

6.3 All NMC Purchase Orders issued for the AGREEMENT are valid only during the fiscal year in which they are issued (the fiscal year is defined as July 1 through June 30).

6.4 Unauthorized Surcharges or Fees: Invoices containing unauthorized surcharges or unauthorized fees of any kind shall be rejected by NMC. Surcharges and additional fees not included the AGREEMENT must be approved by NMC in writing via an Amendment.

SAMPLE AGREEMENT 7.0 STANDARD INDEMNIFICATION

7.1 CONTRACTOR shall indemnify, defend, and hold harmless the County of Monterey, including its officers, agents, and employees, from and against any and all claims, liabilities, and losses whatsoever (including damages to property and injuries to or death of persons, court costs, and reasonable attorneys' fees) occurring or resulting to any and all persons, firms or corporations furnishing or supplying work, services, materials, or supplies in connection with the performance of this AGREEMENT, and from any and all claims, liabilities, and losses occurring or resulting to any person, firm, or corporation for damage, injury, or death arising out of or connected with CONTRACTOR's performance of this AGREEMENT, unless such claims, liabilities, or losses arise out of the sole negligence or willful misconduct of County of Monterey. "CONTRACTOR's performance" includes CONTRACTOR's action or inaction and the action or inaction of CONTRACTOR's officers, employees, agents and subcontractors.

SAMPLE AGREEMENT 8.0 INSURANCE REQUIREMENTS

8.1 <u>Evidence of Coverage:</u>

8.1.1 Prior to commencement of this AGREEMENT, CONTRACTOR shall provide a "Certificate of Insurance" certifying that coverage as required herein has been

obtained. Individual endorsements executed by the insurance carrier shall accompany the certificate. In addition CONTRACTOR upon request shall provide a certified copy of the policy or policies.

8.1.2 This verification of coverage shall be sent to the County of Monterey's Contracts/Purchasing Department, unless otherwise directed. CONTRACTOR shall not receive a "Notice to Proceed" with the work under this AGREEMENT until it has obtained all insurance required and such, insurance has been approved by County of Monterey. This approval of insurance shall neither relieve nor decrease the liability of CONTRACTOR.

8.1.3 Qualifying Insurers: All coverage's, except surety, shall be issued by companies which hold a current policy holder's alphabetic and financial size category rating of not less than A- VII, according to the current Best's Key Rating Guide or a company of equal financial stability that is approved by County of Monterey's Purchasing Officer.

8.2 Insurance Coverage Requirements:

8.2.1 Without limiting CONTRACTOR's duty to indemnify, CONTRACTOR shall maintain in effect throughout the term of this AGREEMENT a policy or policies of insurance with the following minimum limits of liability:

8.2.1.1 Commercial general liability insurance, including but not limited to premises and operations, including coverage for Bodily Injury and Property Damage, Personal Injury, Contractual Liability, Broadform Property Damage, Independent Contractors, Products and Completed Operations, with a combined single limit for Bodily Injury and Property Damage of not less than $1,000,000 per occurrence.

8.2.1.2 Business automobile liability insurance, covering all motor vehicles, including owned, leased, non-owned, and hired vehicles, used in providing services under this AGREEMENT, with a combined single limit for Bodily Injury and Property Damage of not less than $1,000,000 per occurrence.

8.2.1.3 Workers' Compensation Insurance, if CONTRACTOR employs others in the performance of this AGREEMENT, in accordance with California Labor Code section 3700 and with Employer's Liability limits not less than $1,000,000 each person, $1,000,000 each accident and $1,000,000 each disease.

8.2.1.4 Professional liability insurance, if required for the professional services being provided, (e.g., those persons authorized by a license to engage in a business or profession regulated by the California Business and Professions Code), in the amount of not less than $1,000,000 per claim and $2,000,000 in the aggregate, to cover liability for malpractice or errors

or omissions made in the course of rendering professional services. If professional liability insurance is written on a "claims-made" basis rather than an occurrence basis, CONTRACTOR shall, upon the expiration or earlier termination of this AGREEMENT, obtain extended reporting coverage ("tail coverage") with the same liability limits. Any such tail coverage shall continue for at least three years following the expiration or earlier termination of this AGREEMENT.

8.3 Other Insurance Requirements:

8.3.1 All insurance required by this AGREEMENT shall be with a company acceptable to County of Monterey and issued and executed by an admitted insurer authorized to transact Insurance business in the State of California. Unless otherwise specified by this AGREEMENT, all such insurance shall be written on an occurrence basis, or, if the policy is not written on an occurrence basis, such policy with the coverage required herein shall continue in effect for a period of three years following the date CONTRACTOR completes its performance of services under this AGREEMENT.

8.3.2 Each liability policy shall provide that County of Monterey shall be given notice in writing at least thirty days in advance of any endorsed reduction in coverage or limit, cancellation, or intended non-renewal thereof. Each policy shall provide coverage for CONTRACTOR and additional insureds with respect to claims arising from each subcontractor, if any, performing work under this AGREEMENT, or be accompanied by a certificate of insurance from each subcontractor showing each subcontractor has identical insurance coverage to the above requirements.

8.3.3 *Commercial general liability and automobile liability policies shall provide an endorsement naming the County of Monterey, its officers, agents, and employees as Additional Insureds with respect to liability arising out of the CONTRACTOR'S work, including ongoing and completed operations, and shall further provide that such insurance is primary insurance to any insurance or self-insurance maintained by the County of Monterey and that the insurance of the Additional Insureds shall not be called upon to contribute to a loss covered by the CONTRACTOR'S insurance. The required endorsement form for Commercial General Liability Additional Insured is ISO Form CG 20 10 11-85 or CG 20 10 10 01 in tandem with CG 20 37 10 01 (2000). The required endorsement form for Automobile Additional Insured endorsement is ISO Form CA 20 48 02 99.*

8.3.4 Prior to the execution of this AGREEMENT by County of Monterey, CONTRACTOR shall file certificates of insurance with County of Monterey's contract administrator and County of Monterey's Contracts/Purchasing Division, showing that CONTRACTOR has in effect the insurance required by this AGREEMENT. CONTRACTOR shall file a new or amended certificate of insurance within five calendar days after any change is made in any insurance policy, which would alter the information on the certificate then on file. Acceptance or approval of insurance shall in no way modify or change the indemnification clause in this AGREEMENT, which shall continue in full force and effect.

8.3.5 CONTRACTOR shall at all times during the term of this AGREEMENT maintain in force the insurance coverage required under this AGREEMENT and shall send, without demand by County of Monterey, annual certificates to County of Monterey's Contract Administrator and County of Monterey's Contracts/Purchasing Division. If the certificate is not received by the expiration date, County of Monterey shall notify CONTRACTOR and CONTRACTOR shall have five calendar days to send in the certificate, evidencing no lapse in coverage during the interim. Failure by CONTRACTOR to maintain such insurance is a default of this AGREEMENT, which entitles County of Monterey, at its sole discretion, to terminate this AGREEMENT immediately.

SAMPLE AGREEMENT 9.0 NON-DISCRIMINATION

9.1 During the performance of this contract, CONTRACTOR shall not unlawfully discriminate against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, marital status, age (over 40), sex, or sexual orientation. CONTRACTOR shall ensure that the evaluation and treatment of its employees and applicants for employment are free of such discrimination. CONTRACTOR shall comply with the provisions of the Fair Employment and Housing Act (Government Code, §12900, et seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, §7285.0, et seq.).

9.2 The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, §12900, et seq., set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into this AGREEMENT by reference and made a part hereof as if set forth in full.

9.3 CONTRACTOR shall include the non-discrimination and compliance provisions of the clause in all AGREEMENTs with subcontractors to perform work under the contract.

SAMPLE AGREEMENT 10.0 ASSIGNMENT AND SUBCONTRACTING

10.1 Non-Assignment: CONTRACTOR shall not assign this contract or the work required herein without the prior written consent of NMC.

10.2 Subcontractors that have been approved by NMC: Any subcontractor utilized by CONTRACTOR shall comply with all of the County of Monterey requirements stated herein this Agreement including insurance and indemnification sections.

SAMPLE AGREEMENT 11.0 CONFLICT OF INTEREST

11.1 CONTRACTOR covenants that CONTRACTOR, its responsible officers, and its employees having major responsibilities for the performance of work under the AGREEMENT, presently have no interest and during the term of this AGREEMENT will not acquire any interests, direct or indirect, which might conflict in any manner or degree with the performance of CONTRACTOR'S services under this AGREEMENT.

SAMPLE AGREEMENT 12.0 COMPLIANCE WITH APPLICABLE LAWS

12.1 CONTRACTOR shall keep itself informed of and in compliance with all federal, state and local laws, ordinances, regulations, and orders, including but not limited to all state and federal tax laws that may affect in any manner the Project or the performance of the Services or those engaged to perform Services under this AGREEMENT. CONTRACTOR shall procure all permits and licenses, pay all charges and fees, and give all notices required by law in the performance of the Services.

12.2 CONTRACTOR shall report immediately to NMC, in writing, any discrepancy or inconsistency it discovers in the laws, ordinances, regulations, orders, and/or guidelines in relation to the Project of the performance of the Services.

12.3 All documentation prepared by CONTRACTOR shall provide for a completed project that conforms to all applicable codes, rules, regulations and guidelines that are in force at the time such documentation is prepared.

SAMPLE AGREEMENT 13.0 RECORDS AND CONFIDENTIALITY

13.1 Confidentiality: CONTRACTOR and its officers, employees, agents, and subcontractors shall comply with any and all federal, state, and local laws, which provide for the confidentiality of records and other information. CONTRACTOR shall not disclose any confidential records or other confidential information received from the NMC or prepared in connection with the performance of this AGREEMENT, unless NMC specifically permits CONTRACTOR to disclose such records or information. CONTRACTOR shall promptly transmit to NMC any and all requests for disclosure of any such confidential records or information. CONTRACTOR shall not use any confidential information gained by CONTRACTOR in the performance of this AGREEMENT except for the sole purpose of carrying out CONTRACTOR's obligations under this AGREEMENT.

13.2 NMC Records: When this AGREEMENT expires or terminates, CONTRACTOR shall return to NMC any NMC records which CONTRACTOR used or received from NMC to perform services under this AGREEMENT.

13.3 Maintenance of Records: CONTRACTOR shall prepare, maintain, and preserve all reports and records that may be required by federal, state, County of Monterey and NMC rules and regulations related to services performed under this AGREEMENT.

13.4 Access to and Audit of Records: NMC and the County of Monterey shall have the right to examine, monitor and audit all records, documents, conditions, and activities of CONTRACTOR and its subcontractors related to services provided under this AGREEMENT. The parties to this AGREEMENT may be subject, at the request of NMC or as part of any audit of County, to the examination and audit of the State Auditor pertaining to matters connected with the performance of this AGREEMENT for a period of three years after final payment under the AGREEMENT.

SAMPLE AGREEMENT 14.0 INFORMATION PORTABILITY AND ACCOUNTABILITY ACT—HIPAA COMPLIANCE

14.1 CONTRACTOR shall comply with and agrees to operate its business in a manner as necessary to permit NMC to comply with its obligations under the Health Insurance Portability and Accountability Act of 1996, Subtitle F, Public Law 104-191, relating to the privacy and security of confidential health information, and any final regulations or rules promulgated by the U.S. Department of Health and Human Services thereunder (collectively, the "HIPAA Standards") and the federal substance use disorder laws at 42 U.S.C. § 290dd-2 and any final regulations promulgated thereunder (collectively "Part 2").

14.2 CONTRACTOR and NMC shall agree to and execute the Business Associates Agreement attached hereto as **BUSINESS ASSOCIATE AGREEMENT** as a binding part of this AGREEMENT.

14.3 CONTRACTOR shall comply with and agrees to operate its business in a manner as necessary to permit NMC to comply with its obligations under California privacy and security laws, including but not limited to the Confidentiality of Medical Information Act at California Civil Code Section 56.00 *et seq*., the Lanterman-Petris-Short Act at California Welfare and Institutions Code Section 5328, and any other applicable State laws that govern the privacy or security of health or medical information.

SAMPLE AGREEMENT 15.0 FORCE MAJEURE

15.1 Neither NMC nor CONTRACTOR shall be liable for nonperformance or defective or late performance of any of its obligations under this Agreement to the extent and for such periods of time as such nonperformance, defective performance or late performance is due to reasons outside such Party's reasonable control (a "**Force Majeure Event**"), including, without limitation, acts of God, war (declared or undeclared), terrorism, action of any governmental authority, civil disturbances, riots, revolutions, vandalism, accidents, fire, floods, explosions, sabotage, nuclear incidents, lightning, weather, earthquakes, storms, sinkholes, epidemics, failure of transportation infrastructure, disruption of public utilities, supply chain interruptions, information systems interruptions or failures, breakdown of machinery or strikes (or similar nonperformance, defective performance or late performance of employees, suppliers or subcontractors);

provided, however, that in any such event, each Party shall in good faith use its best efforts to perform its duties and obligations under this Agreement.

15.2 If either NMC or CONTRACTOR wishes to claim protection with respect to a Force Majeure Event, it shall as soon as possible following the occurrence or date of such Force Majeure Event, notify the other Party of the nature and expected duration of the force majeure event and shall thereafter keep the other Party informed until such time as it is able to perform its obligations.

SAMPLE AGREEMENT 16.0 TRAVEL REIMBURSEMENT

16.1 Travel Reimbursement is not allowed for this AGREEMENT.

SAMPLE AGREEMENT 17.0 KEY DESIGNATED CONTACTS

17.1 Emergencies: CONTRACTOR acknowledges that NMC plans for the continuity of hospital operations during an emergency, especially sustained incidents, and that collaboration with CONTRACTOR is necessary to maintain continuity of operations. Accordingly, CONTRACTOR shall provide the name and contact information of a representative who shall be available 24 hours a day, 7 days a week, in the event of an emergency:

Name:_____
Title:_____
Phone:_____
(*must list a personal cell phone or other number whereby successful contact is ensured*)

During an emergency, contractor shall use its best efforts to provide NMC with all available supplies, materials, equipment and/or services on a priority basis. The Parties agree that time is of the essence. The delivery of CONTRACTOR's supplies, materials, equipment and/or services will be mutually agreed upon by NMC and CONTRACTOR at the time of order and will be determined based on need and existing conditions. It is understood that current conditions, such as power outages, road closures, and damages to CONTRACTOR's facility and/or equipment, will be taken into consideration.

17.2 Non emergencies: CONTRACTOR shall designate the following individual as NMC's key point of contact throughout the term of the Agreement. This individual shall be available to assist NMC between the hours of 8:00 AM and 5:00 PM (PST), seven days per week, 365 days per year (this includes holidays):

Name:_____
Title:_____
Phone:_____
Email: _____

SAMPLE AGREEMENT 18.0 GUARANTEE OF MALWARE-FREE GOODS

18.1 All software provided by CONTRACTOR to NMC shall be free of malicious code such as viruses, Trojan horse programs, worms, spyware, etc. Validation of this must be written into the contract. Malicious code or malware (short for malicious software) is defined as software (or firmware) designed to damage or do other unwanted actions on a computer system. Common examples of malware include viruses, worms, Trojan horses and spyware. Viruses, for example, can cause havoc on a computer's hard drive by deleting files or directory information. Spyware can gather data from a user's system without the user knowing it. This can include anything from the web pages a user visits to personal information, such as credit card numbers.

SAMPLE AGREEMENT 19.0 INTELLECTUAL PROPERTY RIGHTS

19.1 All data provided by NMC belongs to Natividad Medical Center (County of Monterey). All records compiled by CONTRACTOR in completing the work described in this AGREEMENT, including but not limited to written reports, studies, drawings, blueprints, negatives of photographs and photographs, graphs, charts, plans, source codes, specifications and all other similar recorded data, shall become and remain the property of NMC. Use or distribution of NMC data by CONTRACTOR is prohibited unless CONTACTOR obtains prior written consent from NMC.

19.2 For NMC data hosted or stored on equipment not owned by NMC, CONTRACTOR shall furnish all data to NMC upon request by NMC at any time during the term of this AGREEMENT and up to one year after the term has expired, in a useable format as specified by NMC and at no additional cost to NMC.

19.3 Notwithstanding anything to the contrary contained in this AGREEMENT, it is understood and agreed that CONTRACTOR shall retain all of its rights in its proprietary information including, without limitation, methodologies and methods of analysis, ideas, concepts, expressions, know how, methods, techniques, skills, knowledge and experience possessed by CONTRACTOR prior to this AGREEMENT.

SAMPLE AGREEMENT 20.0 MISCELLANEOUS PROVISIONS

20.1 CONTRACTOR: The term "CONTRACTOR" as used in this Agreement includes CONTRACTOR'S officers, agents, and employees acting on CONTRACTOR'S behalf in the performance of this Agreement.

20.2 Disputes: CONTRACTOR shall continue to perform under this Agreement during any dispute.

20.3 Time is of the Essence: Time is of the essence in each and all of the provisions of this Agreement.

20.4 Construction of Agreement: NMC and CONTRACTOR agree that each party has fully participated in the review and revision of this Agreement and that any rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not apply in the interpretation of this Agreement or any amendment to this Agreement.

20.5 Counterparts: This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same Agreement.

SAMPLE AGREEMENT 21.0 NOTICES

21.1 Notices required to be given to the respective parties under this AGREEMENT shall be deemed given by any of the following means: (1) when personally delivered to NMC contracts division manager or to CONTRACTOR'S responsible officer; (2) when personally delivered to the party's principle place of business during normal business hours, by leaving notice with any person apparently in charge of the office and advising such person of the import and contents of the notice; (3) 24 hours after the notice is transmitted by FAX machine to the other party, at the party's FAX number specified pursuant to this AGREEMENT, provided that the party giving notice by FAX must promptly confirm receipt of the FAX by telephone to the receiving party's office; or, (4) three (3) days after the notice is deposited in the U. S. mail with first class or better postage fully prepaid, addressed to the party as indicated below.

Notices mailed or faxed to the parties shall be addressed as follows:

TO NMC:	TO CONTRACTOR:
Natividad Medical Center	Name
CONTRACTS DIVISION	Address
1441 Constitution Blvd	
Salinas, CA 93906	
FAX No.: (831) 757-2592	FAX No._____
Tel No. (831) 755-4111	Tel No._____
	Email_____

SAMPLE AGREEMENT 22.0 LEGAL DISPUTES

22.1 CONTRACTOR agrees that this AGREEMENT, and any dispute arising from the relationship between the parties to this AGREEMENT, shall be governed and interpreted

by the laws of the State of California, excluding any laws that direct the application of another jurisdiction's laws.

22.2 Any dispute that arises under or relates to this AGREEMENT (whether contract, tort, or both) shall be resolved in the Superior Court of California in Monterey County, California.

22.3 CONTRACTOR shall continue to perform under this AGREEMENT during any dispute.

22.4 The parties agree to waive their separate rights to a trial by jury. This waiver means that the trial will be before a judge.

--END OF SAMPLE AGREEMENT SECTION--

SAMPLE BUSINESS ASSOCIATE AGREEMENT SECTION

SAMPLE BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("BAA") effective_____, 20__ ("Effective Date"), is entered into by and among between the County of Monterey, a political subdivision of the State of California, on behalf of Natividad Medical Center ("Covered Entity") and _____ ("Business Associate") (each a "Party" and collectively the "Parties").

SAMPLE BUSINESS ASSOCIATE AGREEMENT RECITALS

A. WHEREAS, Business Associate provides certain Services for Covered Entity that involve the Use and Disclosure of Protected Health Information ("PHI") that is created, received, transmitted, or maintained by Business Associate for or on behalf of Covered Entity.

B. WHEREAS, The Parties are committed to complying with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), and their implementing regulations, including the Standards for the Privacy of Individually Identifiable Health Information, 45 C.F.R. Part 160 and Part 164, Subparts A and E (the "Privacy Rule"), the Breach Notification Standards, 45 C.F.R. Part 160 and 164 subparts A and D (the "Breach Notification Rule"), and the Security Standards, 45 C.F.R. Part 160 and Part 164, Subpart C (the "Security Rule"), (collectively "HIPAA"), all as amended from time to time.

C. WHEREAS, The Parties are also committed to complying with the California Confidentiality Laws (defined below).

D. WHEREAS, To the extent that Business Associate is performing activities in connection with covered accounts for or on behalf of Covered Entity, the Parties are also committed to complying with applicable requirements of the Red Flag Rules issued pursuant to the Fair and Accurate Credit Transactions Act of 2003 ("Red Flag Rules").

E. WHEREAS, The Privacy and Security Rules require Covered Entity and Business Associate to enter into a business associate agreement that meets certain requirements with respect to the Use and Disclosure of PHI. This BAA, sets forth the terms and conditions pursuant to which PHI, and, when applicable, Electronic Protected Health Information ("EPHI") shall be handled, in accordance with such requirement.

NOW THEREFORE, in consideration of the mutual promises below and the exchange of information pursuant to this BAA, the Parties agree as follows:

SAMPLE BUSINESS ASSOCIATE AGREEMENT AGREEMENT

SAMPLE BUSINESS ASSOCIATE AGREEMENT 1.0 DEFINITIONS

1.1 All capitalized terms used in this BAA but not otherwise defined shall have the meaning set forth in the Privacy Rule, the Breach Notification Rule, or the Security Rule.

(a) "Breach" shall have the same meaning as "breach" as defined in 45 C.F.R. § 164.402 and shall mean the access, acquisition, Use, or Disclosure of PHI in a manner not permitted under the Privacy Rule that compromises the privacy or security of the PHI; the term "Breach" as used in this BAA shall also mean the unlawful or unauthorized access to, Use or Disclosure of a patient's "medical information" as defined under Cal. Civil Code § 56.05(j), for which notification is required pursuant to Cal. Health & Safety Code 1280.15, or a "breach of the security of the system" under Cal. Civil Code §1798.29.

(b) "California Confidentiality Laws" shall mean the applicable laws of the State of California governing the confidentiality of PHI or Personal Information, including, but not limited to, the California Confidentiality of Medical Information Act (Cal. Civil Code §56, et seq.), the patient access law (Cal. Health & Safety Code §123100 et seq.), the HIV test result confidentiality law (Cal. Health & Safety Code §120975, et seq.), the Lanterman-Petris-Short Act (Cal. Welf. & Inst. Code §5328, et seq.), and the medical identity theft law (Cal. Civil Code 1798.29).

(c) "Protected Health Information" or "PHI" shall mean any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual; (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information that can be used to identify the individuals, and (iii) is provided by Covered Entity to Business Associate or created, maintained, received, or transmitted by Business Associate on Covered Entity's behalf. **PHI includes EPHI**.

(d) "Services" shall mean the services for or functions on behalf of Covered Entity performed by Business Associate pursuant to a Services Agreement between Covered Entity and Business Associate to which this BAA applies.

SAMPLE BUSINESS ASSOCIATE AGREEMENT 2.0 PERMITTED USES AND DISCLOSURES OF PHI

Unless otherwise limited herein, Business Associate may:

(a) Use or Disclose PHI to perform Services for, or on behalf of, Covered Entity, provided that such Use or Disclosure would not violate the Privacy or Security Rules, this BAA, or California Confidentiality Laws;

(b) Use or Disclose PHI for the purposes authorized by this BAA or as otherwise Required by Law;

(c) Use PHI to provide Data Aggregation Services for the Health Care Operations of Covered Entity, if required by the Services Agreement and as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B);

(d) Use PHI if necessary for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate as permitted by 45 C.F.R. § 164.504(e)(4)(i);

(e) Disclose PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate as permitted under 45 C.F.R. § 164.504(e)(4)(ii), provided that Disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is Disclosed that it will remain confidential and be Used or further Disclosed only as Required by Law or for the purpose for which it was Disclosed to the person, and that such person will notify the Business Associate of any instances of which such person is aware that the confidentiality of the information has been breached;

(f) Use PHI to report violations of law to appropriate Federal and state authorities, consistent with 45 C.F.R. § 164.502(j)(1); and

(g) De-identify any PHI obtained by Business Associate under this BAA in accordance with 45 C.F.R. § 164.514 and Use or Disclose such de-identified information only as required to provide Services pursuant to the a Services Agreement between the Parties, or with the prior written approval of Covered Entity.

SAMPLE BUSINESS ASSOCIATE AGREEMENT 3.0 RESPONSIBILITIES OF THE PARTIES WITH RESPECT TO PHI

3.1. Responsibilities of Business Associate. With regard to its Use and/or Disclosure of PHI, Business Associate shall:

(a) Notify the Privacy Officer of Covered Entity, in writing, of: (i) any Use and/or Disclosure of the PHI that is not permitted or required by this BAA; (ii) any Security Incident of which Business Associate becomes aware; and (iii) any suspected Breach. Such notice shall be provided within five (5) business days of Business Associate's discovery of such unauthorized access, acquisition, Use and/or Disclosure. Notwithstanding the foregoing, the Parties acknowledge the ongoing existence and occurrence of attempted but ineffective Security Incidents that are trivial in nature, such as pings and other broadcast service attacks, and unsuccessful log-in attempts. The Parties acknowledge and agree that this Section 3.1(a) constitutes notice by Business Associate to Covered Entity of such ineffective Security Incidents and no additional notification to Covered Entity of such ineffective Security Incidents is required, provided that no such Security Incident results in a Breach. A ransomware attack shall

not be considered an ineffective Security Incident and shall be reported to Covered Entity, irrespective of whether such Security Incident results in a Breach. Business Associate shall investigate each Security Incident or unauthorized access, acquisition, Use, or Disclosure of PHI, or suspected Breach that it discovers and shall provide a summary of its investigation to Covered Entity, upon request. If Business Associate or Covered Entity determines that such Security Incident or unauthorized access, acquisition, Use, or Disclosure, or suspected Breach constitutes a Breach, then Business Associate shall comply with the requirements of Section 3.1(a)(i) below;

(i) Business Associate shall provide a supplemental written report in accordance with 45 C.F.R. § 164.410(c), which shall include, to the extent possible, the identification of each individual whose PHI has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, Used or Disclosed during the Breach, to Covered Entity without unreasonable delay, but no later than five (5) business days after discovery of the Breach;

(ii) Covered Entity shall have sole control over the timing and method of providing notification of such Breach to the affected individual(s), the appropriate government agencies, and, if applicable, the media. Business Associate shall assist with the implementation of any decisions by Covered Entity to notify individuals or potentially impacted individuals;

(b) In consultation with the Covered Entity, Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of such improper access, acquisition, Use, or Disclosure, Security Incident, or Breach. Business Associate shall take prompt corrective action, including any action required by applicable State or federal laws and regulations relating to such Security Incident or non-permitted access, acquisition, Use, or Disclosure. Business Associate shall reimburse Covered Entity for its reasonable costs and expenses in providing any required notification to affected individuals, appropriate government agencies, and, if necessary the media, including, but not limited to, any administrative costs associated with providing notice, printing and mailing costs, public relations costs, attorney fees, and costs of mitigating the harm (which may include the costs of obtaining up to one year of credit monitoring services and identity theft insurance) for affected individuals whose PHI or Personal Information has or may have been compromised as a result of the Breach;

(c) Implement appropriate administrative, physical, and technical safeguards and comply with the Security Rule to prevent Use and/or Disclosure of EPHI other than as provided for by this BAA;

(d) Obtain and maintain a written agreement with each of its Subcontractors that creates, maintains, receives, Uses, transmits or has access to PHI that requires such Subcontractors to adhere to the substantially the same restrictions and conditions with respect to PHI that apply to Business Associate pursuant to this BAA;

(e) Make available all internal practices, records, books, agreements, policies and procedures and PHI relating to the Use and/or Disclosure of PHI received from, created, maintained, or transmitted by Business Associate on behalf of Covered Entity to the Secretary of the Department of Health and Human Services ("Secretary") in a time and manner designated by

the Secretary for purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule. In addition, Business Associate shall promptly make available to Covered Entity such books, records, or other information relating to the Use and Disclosure of PHI for purposes of determining whether Business Associate has complied with this BAA or maintains adequate security safeguards, upon reasonable request by Covered Entity;

(f) Document Disclosures of PHI and information related to such Disclosure and, within thirty (30) days of receiving a written request from Covered Entity, provide to Covered Entity such information as is requested by Covered Entity to permit Covered Entity to respond to a request by an individual for an accounting of the Disclosures of the individual's PHI in accordance with 45 C.F.R. § 164.528. At a minimum, the Business Associate shall provide the Covered Entity with the following information: (i) the date of the Disclosure; (ii) the name of the entity or person who received the PHI, and if known, the address of such entity or person; (iii) a brief description of the PHI Disclosed; and (iv) a brief statement of the purpose of such Disclosure which includes an explanation of the basis for such Disclosure. In the event the request for an accounting is delivered directly to the Business Associate, the Business Associate shall, within ten (10) days, forward such request to the Covered Entity. The Business Associate shall implement an appropriate recordkeeping process to enable it to comply with the requirements of this Section;

(g) Subject to Section 4.4 below, return to Covered Entity within thirty (30) days of the termination of this BAA, the PHI in its possession and retain no copies, including backup copies;

(h) Disclose to its Subcontractors or other third parties, and request from Covered Entity, only the minimum PHI necessary to perform or fulfill a specific function required or permitted hereunder;

(i) If all or any portion of the PHI is maintained in a Designated Record Set:

(i) Upon ten (10) days' prior written request from Covered Entity, provide access to the PHI to Covered Entity to meet a request by an individual under 45 C.F.R. § 164.524. Business Associate shall notify Covered Entity within ten (10) days of its receipt of a request for access to PHI from an Individual; and

(ii) Upon ten (10) days' prior written request from Covered Entity, make any amendment(s) to the PHI that Covered Entity directs pursuant to 45 C.F.R. § 164.526. Business Associate shall notify Covered Entity within ten (10) days of its receipt of a request for amendment of PHI from an Individual;

(j) If applicable, maintain policies and procedures to detect and prevent identity theft in connection with the provision of the Services, to the extent required to comply with the Red Flag Rules;

(k) To the extent that Business Associate carries out one or more of Covered Entity's obligations under the Privacy Rule, Business Associate shall comply with the

requirements of the Privacy Rule that apply to Covered Entity in the performance of such obligations;

(l) Unless prohibited by law, notify the Covered Entity within five (5) days of the Business Associate's receipt of any request or subpoena for PHI. To the extent that the Covered Entity decides to assume responsibility for challenging the validity of such request, the Business Associate shall cooperate fully with the Covered Entity in such challenge; and

(m) Maintain policies and procedures materially in accordance with State Confidentiality Laws and industry standards designed to ensure the security and integrity of the Covered Entity's data and protect against threats or hazards to such security.

3.2 Business Associate Acknowledgment.

(a) Business Associate acknowledges that, as between the Business Associate and the Covered Entity, all PHI shall be and remain the sole property of the Covered Entity.

(b) Business Associate further acknowledges that it is obligated by law to comply, and represents and warrants that it shall comply, with HIPAA and the HITECH Act. Business Associate shall comply with all California Confidentiality Laws, to the extent that such state laws are not preempted by HIPAA or the HITECH Act.

(c) Business Associate further acknowledges that uses and disclosures of protected health information must be consistent with NMC's privacy practices, as stated in NMC's Notice of Privacy Practices. The current Notice of Privacy Practices can be retrieved online at: http://www.natividad.com/quality-and-safety/patient-privacy . Business Associate agrees to review the NMC Notice of Privacy Practices at this URL at least once annually while doing business with NMC to ensure it remains updated on any changes to the Notice of Privacy Practices NMC may make.

3.3 Responsibilities of Covered Entity. Covered Entity shall, with respect to Business Associate:

(a) Provide Business Associate a copy of Covered Entity's notice of privacy practices ("Notice") currently in use;

(b) Notify Business Associate of any changes to the Notice that Covered Entity provides to individuals pursuant to 45 C.F.R. § 164.520, to the extent that such changes may affect Business Associate's Use or Disclosure of PHI;

(c) Notify Business Associate of any changes in, or withdrawal of, the consent or authorization of an individual regarding the Use or Disclosure of PHI provided to Covered Entity pursuant to 45 C.F.R. § 164.506 or § 164.508, to the extent that such changes may affect Business Associate's Use or Disclosure of PHI; and

(d) Notify Business Associate of any restrictions on Use and/or Disclosure of PHI as provided for in 45 C.F.R. § 164.522 agreed to by Covered Entity, to the extent that such restriction may affect Business Associate's Use or Disclosure of PHI.

SAMPLE BUSINESS ASSOCIATE AGREEMENT 4.0 TERM AND TERMINATION

4.1 Term. This BAA shall become effective on the Effective Date and shall continue in effect unless terminated as provided in this Section 4. Certain provisions and requirements of this BAA shall survive its expiration or other termination as set forth in Section 5 herein.

4.2 Termination. If Covered Entity determines in good faith that Business Associate has breached a material term of this BAA, Covered Entity may either: (i) immediately terminate this BAA and any underlying Services Agreement; or (ii) terminate this BAA and any underlying Services Agreement within thirty (30) days of Business Associate's receipt of written notice of such breach, if the breach is not cured to the satisfaction of Covered Entity.

4.3 Automatic Termination. This BAA shall automatically terminate without any further action of the Parties upon the termination or expiration of Business Associate's provision of Services to Covered Entity.

4.4 Effect of Termination. Upon termination or expiration of this BAA for any reason, Business Associate shall return all PHI pursuant to 45 C.F.R. § 164.504(e)(2)(ii)(J) if, and to the extent that, it is feasible to do so. Prior to returning the PHI, Business Associate shall recover any PHI in the possession of its Subcontractors. To the extent it is not feasible for Business Associate to return or destroy any portion of the PHI, Business Associate shall provide Covered Entity with a statement that Business Associate has determined that it is infeasible to return or destroy all or some portion of the PHI in its possession or in possession of its Subcontractors. In such event, Business Associate shall: (i) retain only that PHI which is necessary for Business Associate to continue its proper management and administration or carry out its legal responsibilities; (ii) return to Covered Entity the remaining PHI that the Business Associate maintains in any form; (iii) continue to extend the protections of this BAA to the PHI for as long as Business Associate retains PHI; (iv) limit further Uses and Disclosures of such PHI to those purposes that make the return or destruction of the PHI not feasible and subject to the same conditions as set out in Section 2 above, which applied prior to termination; and (vi) return to Covered Entity the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

SAMPLE BUSINESS ASSOCIATE AGREEMENT 5.0 MISCELLANEOUS

5.1 Survival. The respective rights and obligations of Business Associate and Covered Entity under the provisions of Sections 2.1, 4.4, 5.7, 5.8, 5.11, and 5.12 shall survive termination of this BAA until such time as the PHI is returned to Covered Entity or destroyed.

In addition, Section 3.1(i) shall survive termination of this BAA, provided that Covered Entity determines that the PHI being retained pursuant to Section 4.4 constitutes a Designated Record Set.

5.2 **Amendments**; Waiver. This BAA may not be modified or amended, except in a writing duly signed by authorized representatives of the Parties. To the extent that any relevant provision of HIPAA, the HITECH Act, or California Confidentiality Laws is materially amended in a manner that changes the obligations of the Parties, the Parties agree to negotiate in good faith appropriate amendment(s) to this BAA to give effect to the revised obligations. Further, no provision of this BAA shall be waived, except in a writing duly signed by authorized representatives of the Parties. A waiver with respect to one event shall not be construed as continuing, or as a bar to or waiver of any right or remedy as to subsequent events.

5.3 **No Third Party Beneficiaries**. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

5.4 **Notices**. Any notices to be given hereunder to a Party shall be made via U.S. Mail or express courier to such Party's address given below, and/or via facsimile to the facsimile telephone numbers listed below.

If to Business Associate, to:

_____
Attn:_____
_____
_____
Phone:_____
Fax:_____

If to Covered Entity, to:

Natividad Medical Center
Attn: Compliance/Privacy Officer
1441 Constitution Blvd.
Salinas, CA 93906
Phone: 831-755-4111
Fax: 831-755-6254

Each Party named above may change its address and that of its representative for notice by the giving of notice thereof in the manner hereinabove provided. Such notice is effective upon receipt of notice, but receipt is deemed to occur on next business day if notice is sent by FedEx or other overnight delivery service.

5.5 **Counterparts; Facsimiles**. This BAA may be executed in any number of counterparts, each of which shall be deemed an original. Facsimile copies hereof shall be deemed to be originals.

5.6 Relationship of Parties. Notwithstanding anything to the contrary in the Services Agreement, Business Associate is an independent contractor and not an agent of Covered Entity under this BAA. Business Associate has the sole right and obligation to supervise, manage, contract, direct, procure, perform, or cause to be performed all Business Associate obligations under this BAA.

5.7 Choice of Law; Interpretation. This BAA shall be governed by the laws of the State of California. Any ambiguities in this BAA shall be resolved in a manner that allows Covered Entity and Business Associate to comply with the Privacy Rule, the Security Rule, and the California Confidentiality Laws.

5.8 Indemnification. Business Associate shall indemnify, defend, and hold harmless the County of Monterey (the "County"), its officers, agents, and employees from any claim, liability, loss, injury, cost, expense, penalty or damage, including costs incurred by the County with respect to any investigation, enforcement proceeding, or third party action, arising out of, or in connection with, a violation of this BAA or a Breach that is attributable to an act or omission of Business Associate and/or its agents, members, employees, or Subcontractors, excepting only loss, injury, cost, expense, penalty or damage caused by the negligence or willful misconduct of personnel employed by the County. It is the intent of the Parties to provide the broadest possible indemnification for the County. This provision is in addition to, and independent of, any indemnification provision in any related or other agreement between the Parties.

5.9 Applicability of Terms. This BAA applies to all present and future Service Agreements and Business Associate relationships, written or unwritten, formal or informal, in which Business Associate creates, receives, transmits, or maintains any PHI for or on behalf of Covered Entity in any form whatsoever. This BAA shall automatically be incorporated in all subsequent agreements between Business Associate and Covered Entity involving the Use or Disclosure of PHI whether or not specifically referenced therein. In the event of any conflict or inconsistency between a provision of this BAA and a provision of any other agreement between Business Associate and Covered Entity, the provision of this BAA shall control unless the provision in such other agreement establishes additional rights for Business Associate or additional duties for or restrictions on Business Associate with respect to PHI, in which case the provision of such other agreement will control.

5.10 Insurance. In addition to any general and/or professional liability insurance required of Business Associate, Business Associate agrees to obtain and maintain, at its sole expense, liability insurance on an occurrence basis, covering any and all claims, liabilities, demands, damages, losses, costs and expenses arising from a breach of the obligations of Business Associate, its officers, employees, agents and Subcontractors under this BAA. Such insurance coverage will be maintained for the term of this BAA, and a copy of such policy or a certificate evidencing the policy shall be provided to Covered Entity at Covered Entity's request.

5.11 Legal Actions. Promptly, but no later than five (5) business days after notice thereof, Business Associate shall advise Covered Entity of any actual or potential action, proceeding, regulatory or governmental orders or actions, or any material threat thereof that becomes known to it that may affect the interests of Covered Entity or jeopardize this BAA, and

of any facts and circumstances that may be pertinent to the prosecution or defense of any such actual or potential legal action or proceeding, except to the extent prohibited by law.

5.12 **Audit or Investigations**. Promptly, but no later than five (5) calendar days after notice thereof, Business Associate shall advise Covered Entity of any audit, compliant review, or complaint investigation by the Secretary or other state or federal agency related to compliance with HIPAA, the HITECH Act, or the California Confidentiality Laws.

--END OF SAMPLE BUSINESS ASSOCIATE AGREEMENT SECTION--

RFP SIGNATURE PAGE, ATTACHMENTS AND EXHIBITS

RFP SIGNATURE PAGE

NATIVIDAD MEDICAL CENTER (COUNTY OF MONTERY)
CONTRACTS DIVISION

RFP # 9600-75
ISSUE DATE: October 4, 2017

RFP TITLE: **POPULATION HEALTH SOFTWARE**

PROPOSALS ARE DUE IN THE OFFICE OF THE CONTRACT MANAGER BY 3:00 P.M., LOCAL TIME, ON:
Friday November 10, 2017

MAILING ADDRESS:
NATIVIDAD MEDICAL CENTER
CONTRACTS DIVISION
1441 CONSTITUTION BLVD.
SALINAS, CA. 93906

QUESTIONS ABOUT THIS RFP SHOULD BE DIRECTED TO:
Kristen Aldrich, NMC Contracts Division
Email: aldrichk@natividad.com

☐ CONTRACTOR MUST INCLUDE THE FOLLOWING IN EACH PROPOSAL 7 hardcopies of the proposal (1 signed original plus 6 additional copies) and 1 electronic copy

☐ ALL REQUIRED CONTENT AS DEFINED PER RFP SOLICITION REQUIREMENTS SECTION 7 HEREIN

- ☐ **ATTACHMENT I – Pre-Qualification Questionnaire**
- ☐ **ATTACHMENT II – Proposal Questionnaire**
- ☐ **ATTACHMENT III – Proposal Price Schedules**
- ☐ **ATTACHMENT IV – Local Business Declaration form (ONLY if applicable, do not submit if you do not qualify as a "Local Business")**

☐ This Signature Page must be included with your submittal in order to validate your proposal.
Proposals submitted without this signed page will be deemed non-responsive.

☐ **CHECK HERE IF YOU HAVE ANY EXCEPTIONS TO THIS SOLICITATION.**

BIDDERS MUST COMPLETE THE FOLLOWING TO VALIDATE PROPOSAL
I hereby agree to furnish the articles and/or services stipulated in my proposal at the price quoted, subject to the instructions and conditions in the Request for Proposal package. I further attest that I am an official officer representing my firm and authorized with signatory authority to present this proposal package.

Company Name:				Date:	
Signature:		Phone:		Fax:	
Printed Name:		Title:			
E-mail:					
Street Address/PO Box:		City:	State	ZIP:	

ATTACHMENT I- PRE-QUALIFICATIONS QUESTIONNAIRE

Please indicate YES or NO for each item.

Only those bidders who meet all of the pre-qualifications as set forth with Section 4 of the RFP 9600-PH shall be considered for a contract award.

Questions	YES	NO
1. Does your Population Software Health solution support Data Aggregation from various disparate sources? Specifically, ability to ingest and aggregate: 1) Electronic Health Record (EHR) and Health Information Exchange (HIE) HL7 Standard data 2) Payor data 3) Other Non HL7 Standard data sources from both government and nongovernment agencies **ALL** must be YES to answer YES.		
2. Does your Population Software Health solution include patient matching Master Patient Index functionality?		
3. Does your Population Software Health solution have the ability to build and integrate data to support the PRIME Metrics being reported by Monterey County/Natividad Medical Center? For the PRIME metrics that need to be supported, please see Exhibit III and IV – NMC/County of Monterey PRIME Metrics and Prime Metric Specs		
4. Does your Population Health Software Solution have the ability to build and integrate data to support the Monterey County Whole Person Care (WPC) metrics? For the requirements and metrics that need to be supported, please see Exhibit I and II - Monterey County Whole Person Care Pilot Application and Whole Person Care Metrics list		
5. Does your Population Health Software Solution have risk stratification functionality and risk adjustment tools utilizing Milliman, Johns Hopkins or other proprietary tool?		
6. Does your Population Health Software Solution have Care Coordination and Registry features and functionality?		
7. Is your Population Health Software solution cloud hosted and available as Software As A Service (SAAS) subscription based solution?		
8. Can you provide references for your product that use the Data Aggregation, Risk Stratification, Care Coordination and Reporting features?		
9. Does your Population Health Software's security features support compliance with the Health Insurance Portability and Accountability Act (HIPAA) and the Confidentiality of Medical Information Act (CMIA) , including but not limited to, the Privacy Rule and Security Rule? Does it support compliance with		

	Federal Substance Abuse Laws pursuant to 42 C.F.R. § 2.64, Parts 1 and 2? Does it support compliance with California state laws for mental health records pursuant to the Lanterman-Petris-Short Act (LPS) in Welfare & Institutions Code Section 5328 et.seq.? Does it support compliance with California state laws for HIV lab test results under the Health & Safety Code, including but not limited to Sections 11812, 120978, 125080 and, 125085?		
10.	Will your organization commit to providing us a yearly HIPAA Report of Compliance (HROC)?		

End of Attachment 1

County of Monterey | **Population Health Software Solution**
Request for Proposal: Company Background

Request for Proposal		
By:	<company>	
1	**Company Details**	**Comments/Notes**
A	**Company and Population Health Background**	
1	Describe your organization's background and experience with Population Health.	
2	Describe any KLAS/Gartner leadership recognition or other industry reward/accolades that indicate your quality, leadership and expertise in the healthcare industry, particularly related to reporting software and Population Health.	
3	Describe and list clients using your Population Health software. Describe the strengths of your software and support services. Describe the most significant areas of weakness of your product identified by clients.	
4	Briefly describe how your organization approached entry into Population Health	
5	What other organizations are using the product(s)? How are their organizational needs similar to the needs described at the Monterey Count Health System in this RFP?	
6	How many customers are running the proposed solution for this RFP? Please list all customers that are utilizing your product in the state of California. Please list all organizations that are utilizing your product in the public sector nationally.	
7	Please provide three or more references of customers that are currently using the proposed solution.	
8	Do you have experience with DSRIP/PRIME/WPC in CA or elsewhere? A. If you have worked with organizations on PRIME/DSRIP/WPC have you provided the PRIME or WPC metrics for other organizations as standard content or have they been customized?	
9	There are four key areas of required functionality, 1) Data aggregation from multiple EHRs, Payors, and non-HL7 standard data sources 2) Population health analytics including risk stratification, 3) Registry and an EHR agnostic care management platform. 4) Data reporting Describe how your solution addresses all of these areas.	
10	Please describe how your product addresses privacy and security. Particulary in relation to the following laws: HIPAA Privacy Rule and Security Rule; Federal Substance Abuse Laws pursuant to 42 C.F.R. § 2.64, Parts 1 and 2; California state laws for mental health records pursuant to the Lanterman-Petris-Short Act (LPS) in Welfare & Institutions Code Section 5328 et.seq.; California state laws for HIV lab test results under the Health & Safety Code, including but not limited to Sections 11812, 120978, 125080 and, 125085?	
11	Describe the maturity of your product. With regards to this product, where are you all focusing the most ongoing development and why? What functionality has been most recently developed or acquired?	
12	How many customers are running the proposed solution for this RFP?	
13	Do you have any customers that have de-installed the proposed solution in the last 24 months? How many and please elaborate why the de-installs occurred	

County of Monterey | **Population Health Software Solution**
Request for Proposal: Company Background

Request for Proposal		
By:	<company>	
1	**Company Details**	**Comments/Notes**
14	List of all previous, pending or threatened litigation, arbitration, administrative or other proceedings involving your Company, any subsidiary or any joint venture involving your Company or any subsidiary, or any officer or director (including parties, remedies sought and nature of action).	
15	List and describe all previous, pending or threatened government or other investigations involving your Company, any subsidiary or any officer or director.	
16	List any regulatory or compliance issues previously or currently being addressed by your company where there were any notices or other correspondence concerning any known or alleged violation of Federal, state or local laws, regulations, agreements and/or commitments.	
17	List any current licensure, past or current HIPAA breach reporting, non-discrimination claims against you/your organization and those having occurred in the past five years, especially any resulting in claims or legal judgments against you.	

County of Monterey		Population Health Software Solution Request for Proposal: Functionality
Request for Proposal		
By:	<company>	
2	Core Functional Requirements	Comments/Notes
A	Population Health Analytics/Care Coordination Software Functionality/Usability	
1	Describe your products capabilities and functionality of Population Health Data Aggregation A. Data aggregation from disparate sources is required. This includes EHRs utilizing standard HL7, Payors, and non-HL7 standard government and non-government agency databases and systems. Please describe your systems abilities to aggregate from all these sources B. For PRIME and Whole Person Care(WPC), below are the specific data sources that are required to aggregate. Please address how each required data source connection would be addressed using your product. Please describe any additional cost for each of these. 1) MEDITECH Client/Server, 2) Epic-OCHIN, 3) Netsmart Avatar 4) The Monterey County Health Systems' managed MediCal payor, Central Coast Alliance for Health, 5) Three county agency departments on a non EHR database; (Jail, Probation, social services) 6) Our homeless partner agencies operating on the Coordinated Access and Referral System(CARS) extracted from the Homeless Management Information System (HMIS) 7) Outside lab sources including QUEST and Labcorp, 8) Relay Health Information Exchange (HIE), Central Coast Health Connect.	
2	Describe your products Care Coordination/Management and Clinical Registry capabilities and functionality in context of PRIME and WPC A. With gaps closure in mind, how does your product facilitate the care plan and gap closure with the integration of multiple, disparate data sources? B. How does your tool facilitate communication including care plans to Primary and secondary end users, such as other care coordinators, physicians, medical assistants or other partners? Please describe care plans in detail. C. Does your care management platform provide care plans/care guidelines? Describe in detail how the care plan will be communicated to the care team including physicians, care managers, etc. Please describe all associated costs for the case management solution including care plans and guidelines.	
3	Describe your products capabilities and functionality with regards to Analytics and Risk Stratification. A. With regards to risk stratification how many lives are represented/touched with your tool? B. Describe your risk stratification functionality and risk adjustment tools. Do you utilize Milliman, Johns Hopkins or other proprietary tool?	
4	Please describe your products reporting dashboard. Is it customizable?	
5	Describe how reports are run.	
6	Please describe how reporting could be utilized to identify referrals sent, received, and refused.	
7	Please describe how users can generate reports and statistics on demographics and coverage.	
8	Please describe how cases can be displayed as a list, chart, or other graphical summary.	
9	Please describe how tasks and/or reminders can be displayed as a list, chart, or other graphical summary.	
10	Please describe tools that users can utilize to customize their display of cases, tasks, reminders, and assignments (and/or referrals) if applicable.	

County of Monterey	Population Health Software Solution Request for Proposal: Functionality
Request for Proposal	
By:	<company>

2	Core Functional Requirements	Comments/Notes
11	With respect to the metrics that are identified in Exhibit II - Whole Person Care Pilot Metrics, and Exhibit III - PRIME Metrics Summary: A. Please describe how all metrics identified will be built and incorporated into your Population health product. B. Describe the process, information required, customization process, and any additional costs, if applicable.	
12	Describe how patient matching /eMPI (master patient index) is addressed with your product? How are duplicates addressed?	
13	Does the solution allow for system administrators to add, modify or delete demographic field names represented in discrete fields?	
14	Does the solution record date of birth, sexual orientation/gender identification (SOGI), Race and ethnicity, primary/preferred language, records multiple addresses phone numbers multiple Medical Record Numbers (MRNS), and social determinants of health including homeless status based on the WPC pilot description?	
15	Describe the degree of customization that is possible in recording and reporting discrete data elements in your solution	
B	**Ease of Use/Customization and Services**	
1	Describe Overall Ease of Use and Ease of Customization. Address dashboards, metrics, ad hoc queries, customized reports, custom functionality, etc.	
2	List all content libraries and/or reports, such as HEDIS and ACO metric reports, provided with the base product. Attach sample copies of each.	
3	Describe process to build a report; both from the content library and customized reports.	
4	How does your system allow for data access and reporting beyond your built-in reports? A. Will we be able to query the system for data with our own tools? B. Is all system data available or are there limitations? C. Which protocols do you support for data access?	
5	Is your product capable of customer requested customizations to processes or workflow. What support is provided for process/workflow redesign? Is this a separate engagement or is it available as part of the implementation?	

Request for Proposal		
By:	<company>	
3	Core Functional Requirements	Comments/Notes
A	Functionality	
1	Does solution notifies user(s) of new cases?	
2	Does the system support alerts-based on customer specified criteria? And to whom are alerts sent?	
3	Can solution notifies user(s) and supervisor(s) of assigned or transferred cases?	
4	Can recipients of notifications be modified by program managers, supervisors, and system administrators?	
5	Describe the process of importing and exporting data into the system.	
6	Does solution have an external business partner portal for information entry and reporting by business partners (i.e. healthcare providers, meal services providers, social services providers, legal services providers) separate from the internal case manager access	
7	Please describe how your product addresses consent management.	
8	Does the product have the ability to manage consent for records that cannot be disclosed without patient authorization or consent? Particulary in regards to HIPAA Privacy Rule and Security Rule, the Federal Substance Abuse Laws pursuant to 42 C.F.R. § 2.64, Parts 1 and 2, California state laws for mental health records pursuant to the Lanterman-Petris-Short Act (LPS) in Welfare & Institutions Code Section 5328 et.seq. and California state laws for HIV lab test results under the Health & Safety Code, including but not limited to Sections 11812, 120978, 125080 and, 125085.	
B	Forms	
1	Does the solution provide letter templates? If provided, can they auto-populate with case information that can be customized or developed according to the Monterey County Health System specifications (please elaborate on additional cost, if any, in comments/notes)	
2	Does the software allow for migration of currently used forms (i.e. health coaching instructions for patients, provider referral forms, and hospital discharge follow up forms)?	
C	Person Representation (Case or Staff)	
1	Does the solution allow system administrators, managers, and/or users to add, modify, or delete demographic fields, such as name, DOB, sexual orientation/gender identification, race and ethnicity, homeless status, addresses (or approximate location, if no address available), effective dates of addresses, phone numbers, etc. Are changes tracked?	
2	Does the solution capture identification numbers, such as multiple MRNs from different systems, such as Coordinated Access and Referral Systems (CARS) ID, California Reportable Disease Information Exchange (CalREDIE) ID, etc.	
D	Case Representation	
1	Does the solution record all encounters, visits, and other events (or attempted events, such as a phone call attempts)?	
2	Does the solution record the Date and Time of Encounter, Visits, and other Events? Does the solution have the ability to timestamp documents?	

County of Monterey | **Population Health Software Solution**
Request for Proposal: Resources/Implementation

Request for Proposal			
By:	<company>	<solution>	
4	Service	Comments/Notes	
A	**Resources and Implementation**		
1	The Monterey County Health System expects the timeline for implementation to be based on deliverable of all PRIME and WPC metrics. It is expected that the project not be considered complete until that occurs. Please provide a proposed timeline for the following Proposed Phases (all proposed maximum durations are subject to change, at the sole discretion of the Monterey County Health System): 1) Phase I which will include the integration/interface of MEDITECH, EPIC-OCHIN and Avatar for all PRIME and WPC metrics (timeline should not exceed 12 months) 2) Phase 2 which will include the County Jail, Probation and Social Services and the Homeless Information Management system, (not to exceed 18 months from start) 3) Phase 3 which would include Quest and Labcorps. (not to exceed 24 months from start) Describe how, if selected, you will accommodate this requirement.. All costs associated with that benchmark should be detailed.		
2	Detail any third party services that will be necessary during implementation and for post implementation support.		
3	Describe the proposed project and change management procedures to be used for the project		
4	Provide a proposed project charter, project plan, work breakdown schedules and resourcing, noting key deliverables		
5	Provide a detailed list of Monterey County Health System and external resources needed for implementation and post implementation support. Please include resources you provide for implementation and support. Describe the Monterey County Health System's required FTE resourcing for both implementation and support; Specify types of resources needed such as analysts, clinical personnel, DBAs, report writers, etc. Please address the timing of what resources are needed when.		
6	Indicate the specific senior executive from your organization responsible for this project's success. • Provide a resume, years of experience supporting projects like ours and years of experience with the company • Indicate number of other customer accounts this person may be responsible for during our project • Provide profiles of the project team that are anticipated for this project • Indicate number of other customer accounts the project team members may be responsible for during our project		
B	**Training**		
1	Does your organization provide post implementation education services. Include a discussion of the types of media offered (e.g., classroom, CBT, webinars) as applicable.		
2	Describe the training database available in your system. Is it a mirror image of the production application and/or the system's test database?		
3	How often is documentation updated and how are updates provided?		
E	**Product Support**		
1	How will your company address the frequent updates and enhancements to PRIME and Whole Person Care metric specifications that are mandated at the local, state, and federal level? The metric specification updates two or more times per year.		

County of Monterey	Population Health Software Solution Request for Proposal: Resources/Implementation

Request for Proposal			
By:	<company>	<solution>	
4	Service	Comments/Notes	
2	Describe how your company provides technical support to your customers: A. How is your technical support team structured? B. How do your customers open support cases? C. How are your customer support teams organized or tiered? D. How are support cases handled or transitioned between tiers or business units? E. Are there any limitations in the support your company provides?		
3	How and when are customer support and technical issues escalated within your product support unit? Under what circumstances are support tickets eligible for escalation?		
4	What are your normal hours of operation, including time zone?		
5	Does you company provide after-hours support to customers? If so: A. Specify your after-hours support times? B. What is the criteria to be eligible to utilize after-hours support? C. Is there an additional cost for after-hours support? Please describe.		
6	What is your committed first contact response time?		
7	Across all customers for this product for the last 12 months, what has been your: A. Average Speed of Answer B. Average Abandonment Rate		
8	Describe how system documentation is provided. For example, online, internet? How often is documentation updated?		
E	Service Level Agreement (SLA)		
1	Detail your performance metrics for Service Level Agreements (SLAs) for measuring application availability, performance, and network connectivity. Describe how application availability is calculated. Attach a copy of your SaaS SLA.		
2	Provide the Service Level Agreement for support services, including your method for prioritization of incidents as well response time and resolution time key performance indicators. Attach a copy.		
3	How do you account for missing SLA targets? What credits or penalties are your standard practices for: A. Not meeting application response time commitments? B. Not meeting Disaster recovery and business continuity targets (RTO, RPO)? C. Not meeting application availability SLAs? D. Not meeting customer support SLAs?		
4	Will you report SLA metrics to Monterey County Health System and with what frequency?		

County of Monterey		Population Health Software Solution Request for Proposal: Technical
Request for Proposal		
By:	<company>	
5	Architecture	Comments/Notes
A	Standard Contract Provisions	
1	Please describe technical environment and endpoint requirements to run and maintain your software. A. Describe your Software as a Service (SaaS) hosting environment. B. Describe all technical infrastructure requirements or dependencies. C. Which end-point operating systems does your product support? D. State which web browsers your product is compatible with. E. Are there any on-premises server, hardware or software requirements to operate your product?	
2	What are the expected steady state and burst condition bandwidth requirements required to achieve optimal system performance?	
3	Describe the data normalization process. What Monterey County Health System resources would be required for this process?	
4	By module, function and/or web page, what is your committed application response time for processing application requests?	
5	Describe your disaster recovery and business continuity procedures and processes. Attach a copy of your plan. A. What is the systems Restore Point Objective (RPO) for customer/patient data? B. What is your target Return to Operations (RTO)? C. How often does your company test its disaster recovery and business continuity processes and procedures? D. Describe your product's technical resiliency in event of disaster. E. Describe your datacenter's resiliency in event of loss of power, internet or supporting infrastructure.	
6	Describe how you schedule downtime for routine maintenance A. How much advance notice do you provide your customers prior to scheduled downtime? B. Do you have a set maintenance window? If so, please describe. C. Over the last three years, what has been the average duration of your scheduled maintenance? What has been the maximum duration of scheduled maintenance? D. For each of the last three years, what has been your total unscheduled downtime (in minutes, hours)?	
7	Does your organization provide database tools to allow end-user access for queries and extraction or output of data into other file formats?	
8	Is your application "mobile enabled" or capable? If so: A. Which mobile devices and mobile device operating systems do you support? B. Is there a dedicated app? C. Which mobile web browsers do you support? D. Is any patient data from the application stored on the device after the session is terminated? If so, how will it be protected?	
9	What is the frequency of software versions and releases?	
10	Describe your processes for testing application changes, customer enhancements or application updates, both pre and post go-live. Are you employing a test or development environment?	
C	Privacy	
1	Describe how your company and product meets HIPAA and California privacy and security laws.	
2	Describe how you are physically or logically separating your SaaS environment to avoid commingling of patient data with other customers.	

County of Monterey	Population Health Software Solution Request for Proposal: Technical
Request for Proposal	
By:	<company>

5	Architecture	Comments/Notes
3	Does your system support Role Based Access? Describe the granularity of this capability.	
4	Please describe in detail your systems access reporting and audit capabilities. Will the customer have access to perform these functions?	
5	Does your system support 3rd party audit tools, such as IATRIC's Security Audit Manager?	
6	Detail your organization's response protocol to a data breach. When will customers be notified of security related events? Please list all data breaches within the last ten years.	
7	Describe how and in what format customer data is returned to the customer as the contract expires or is terminated. Is there a cost?	
8	Are any components of your product or service subcontracted, such as datacenter or server hosting? If so, please describe and list the subcontractors.	
9	Do you have Business Associate Agreements in place for any subcontractors who will have access to the system in the course of develivering this service?	
10	Will the Monterey County Health System's data be utilized, including deidentified or aggregated, for any other purpose besides providing this service?	
11	If your organization participates in Offshore activities, please describe the Offshore functions. Describe the PHI that will be provided Offshore. Describe why PHI is necessary to accomplish Offshore objectives. Describe alternatives considered to avoiding providing PHI Offshore, and why each alternative was rejected.	
B	**Security**	
1	Describe the technical, physical and administrative controls your system employs to protect and secure patient information.	
2	How does your system secure data in transit and at rest?	
3	Do you provide for the delegation of user provisioning administration to the customer?	
4	How is your system ensuring end-to-end data integrity? Which technology and standards have you deployed to insure data integrity?	
5	How are you assuring the security of customer and patient data being accessed by subcontractors?	
6	Describe your policy in keeping your systems (operating system and supporting applications) patched, updated and on a supported software? Does your company guarantee that they will maintain the system in this state at all times?	
7	Does your company commit to supporting your products compatibility with customer's end-point operating system and web browser patches, updates and service packs within seven days from its release? If not, what is your timeline for validating and supporting these updates?	
8	List the 3rd party security audits such SAS 70, or SSAE 16 immediately available to the Monterey County Health System upon request.	
9	Describe any use of incident protection and detection software.	
10	How does your system support single sign-on? Does the application(s) support integration with the Imprivata single sign-on tool?	

County of Monterey		Population Health Software Solution Request for Proposal: Technical
Request for Proposal		
By:	<company>	
5	Architecture	Comments/Notes
D	Interoperability	
1	Describe any pre-defined interfaces that promote interoperability including automatic wizards	
2	Describe your overall design approach to developing, testing, implementing and upgrading system interfaces	
3	What interface engines do your existing clients used? Do any clients use Corepoint?	
4	Describe how you support systems that do not use standard interfaces	
5	List supported Technical Standards such as IHE, DIRECT, DICOM, XML. Include detailed information if appropriate (e.g. IHE XDS.b, versions)	
7	List supported code sets such as ICD10, LOINC, SNOMED, CPT, HCPCS	
8	Does your system support integration with 3rd party EMPIs? If so, which 3rd party products have you successfully integrated with?	

County of Monterey	Population Health Software Solution Request for Proposal: Pricing

Request for Proposal		
By:	<company>	<solution>
6	Project Accountability & Plan	Comments/Notes
A	Project Plan	Feel free to do Pricing on a separate attachment
1	Provide a detailed explanation of all costs associated with providing the requested services if your organization is selected. Please also submit all associated costs in ATTACHMENT III - Proposal Price Schedules.	
2	State the future costs of adding additional users or geographic sites (e.g. new clinic). Will this pricing change over the course of this contract? If so, by how much?	
3	If there are costs associated with adding new users and/or sites, does it require a prior purchase order or is there a capability to "True-up" on a quarterly or yearly basis? Do you provide enterprise prcing for all associated clinics, partners and endusers	
4	Provide details for cost related to changes, enhancements, or new development for PRIME and WPC to data structure, forms, reports and business rules.	
5	If your product is not incorporated into a single module, what are the costs associated with each module or function that's needed to meet the County's needs?	
6	Will all hardware, supporting infrastructure and server software licensing be included in the monthly SaaS fee? If not, please state the cost.	
7	Are there any licensing requirements for adding new interfaces? If yes, please explain and provide costs.	
8	All Travel and Expenses should be included in the cost of service.	
9	List any additional services that you foresee may be necessary, if any, and list the proposed costs for such services.	
10	The county expects a three year agreement with the option to renew two additional years. Please clearly provide: A. On year, three year and five year costs. B. Please break out one time costs and recurring costs and costs per interface/connection. C. Details of all the costs of the software components, services and options are expected. D. Include a three and five-year Total Cost of Ownership that is inclusive of all reoccurring costs, non-reoccurring costs, fees, and licenses required to support the product.	
11	If there are separate interface/connection fees please describe the interface/connection of the following Proposed PRIME and WPC partners: Phase 1;MEDITECH, Epic- OCHIN, and Avatar Phase 2 Monterey County Jail, Probation and Social Services, and Homeless Agency CARS and Homeless Management Information System data Phase 3 Labcorp, Quest Future Phase; HIE/HIO Relay Health/Central Coast Health Connect	
12	Will your company agree to County Standard Terms and Conditions and Business Associates Agreement (BAA)? These are provided in the main RFP document. If not how will they need to be modified?	
13	Please ensure all the PRIME and WPC metrics needed by the Monterey County Health System are part of the base subscription. A. Indicate all costs for the metrics to be supported and any customizations and costs for customizations. B. Indicate costs for the interfaces that need to be supported.	
14	Clearly describe the software support costs and levels for this product. Initial and ongoing.	

County of Monterey	Population Health Software Solution Request for Proposal: Pricing

Request for Proposal		
By:	<company>	<solution>
6	Project Accountability & Plan	Comments/Notes
15	What third party software is recommended or required to integrate or be used with your product? Provide detail and costs? Are you willing to indemnify the County of Monterey Health System for 'patent trolling' claims and offer alternative software solutions to keep the system running while such claims are resolved?	
16	As it is possible that the Monterey County Health System will need additional service hours beyond standard implementation as our population health program grows, please provide an hourly rate for professional services beyond the standard implementation and support for PRIME and WPC which should be included. The initial pool of available hours should be 1000 hours beyond what is standard for implementation.	
17	Provide information on any other pertinent services, if any, that you will offer that will reduce costs or enhance revenue for the County.	

END OF ATTACHMENT II

RFP 9600-75 Attachment III

Monterey County Health System

Population Health RFP

Schedule 1

Fee Summary and 3- 5 year Cost of Ownership*

***No manual entries (other than Comments) are required on this spreadsheet.**

Software License and Implementaiton Fees:	Price Year 1	Price Year 2	Price Year 3	Price Year 4	Price Year 5	Comments
Vendor Software (Detail on Schedule 2)	$ -	$ -	$ -	$ -	$ -	
Third Party Software (Detail on Schedule 7)	$ -	$ -	$ -	$ -	$ -	
Professional Services:						
Interface Services (Detail on Schedule 3)	$ -	$ -	$ -	$ -	$ -	
Customization Services (Detail on Schedule 4)	$ -	$ -	$ -	$ -	$ -	
Implementation and Configuration Services (Detail on Schedule 5)	$ -	$ -	$ -	$ -	$ -	
Training Services (Detail on Schedule 6)	$ -	$ -	$ -	$ -	$ -	
Other Fees (Detail on Schedule 8)	$ -	$ -	$ -	$ -	$ -	
TOTAL FIXED PRICE FOR PROJECT	$ -	$ -	$ -	$ -	$ -	
Software Maintenance & Support:						
Vendor Software (Detail on Schedule 2)	$ -	$ -	$ -	$ -	$ -	
Third Party Software (Detail on Schedule 7)	$ -	$ -	$ -	$ -	$ -	
TOTAL SOFTWARE MAINTENANCE & SUPPORT	$ -	$ -	$ -	$ -	$ -	
Total Cost by Year	$ -	$ -	$ -	$ -	$ -	

Proposed Three year Total Cost of Ownership	$ -
Proposed Five year Total Cost of Ownership	$ -

Check the formulas to ensure all prices on Schedules 2 through 10 are properly captured.

Monterey County Health System

Population Health RFP

Schedule 2

Vendor's License Fee Detail / Annual Maintenance and Support Detail

Detailed Software License and Subscription/Maintenance Fees: (List all modules)	Footnote Reference*	One-Time Fees Year 1	One-Time Fees Year 2	One-Time Fees Year 3	One-Time Fees Year 4	One-Time Fees Year 5	Annual Subscription and Maintenance Fees Year 1	Year 2	Year 3	Year 4	Year 5
		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

TOTAL VENDOR SOFTWARE $ -

Maximum annual percentage increase for Third Party's Maintenance and Support for Years 6 through 10.

*Footnote References - List any explanations or comments keyed to footnote references you enter above:

Monterey County Health System

Population Health RFP

Schedule 3

Interface / Connection Fees *

Interface/Connection Services and Fees:	Fee Year 1	Fee Year 2	Fee Year 3	Fee Year 4	Fee Year 5	Explanation / Comment
Total Interfaces (assigned to specific interfaces)	$ -	$ -	$ -	$ -	$ -	

Interface Services (Lump-sum for all other specified interface needs)	
Total Interface Services	$ -

** Proposers may elect to not allocate Interface Service fees among the specific interfaces. This can be done by filling in only the line toward the bottom of the schedule captioned: "Interface Services (Lump-sum for all other specified interface needs)". Proposers are also free to provide a proposal with a combination of Interface Services some assigned to specific interfaces plus a lump-sum for all other interfaces.*

Monterey County Health System

Population Health RFP

Schedule 4

Additional Professional Service Fees including Customization Fees

Item #	Description	Fee* Year 1	Fee* Year 2	Fee* Year 3	Fee* Year 4	Fee* Year 5	Comment/Explanation
		$ -	$ -	$ -	$ -	$ -	

Total Customization Price $ -

** The Monterey County Health System discourages customization, but if needed use this form*

Monterey County Health System

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Schedule 5

Implementation and Configuration Services Fee Detail*

Implementation and Configuration Fees	Fee Year 1	Fee Year 2	Fee Year 3	Fee Year 4	Fee Year 5	Explanation/Comment
Total Implementation & Configuration Fees (Allocated to modules)	$ -	$ -	$ -	$ -	$ -	

Implementation and Configuration Fees (Lump-sum for all other)	
Total Implementation and Configuration Fees	$ -

** Proposers may elect to not allocate Implementation and Configuration fees among the specific modules. This can be done by filling in only the line toward to bottom of the schedule captioned: "Implementation and Configuration Price (Lump-sum for all other)". Proposers are also free to provide aproposal with a combination of Implementation Services some assigned to specific modules plus a lump-sum for all other modules.*

Monterey County Health System

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Schedule 6

Training Services Fee Detail

Training Fees	Year (between 1 and 5)	Training Days	Average Fee per Day	Fee	Explanation/Comment
				$ -	
				$ -	
				$ -	
				$ -	
				$ -	
				$ -	
				$ -	
				$ -	
				$ -	
				$ -	
				$ -	
				$ -	
				$ -	
				$ -	
				$ -	
				$ -	
				$ -	
				$ -	
				$ -	
				$ -	
Total Training fees		**-**		**$ -**	

Training Year 1	**$ -**
Training Year 2	**$ -**
Training Year 3	**$ -**
Training Year 4	**$ -**
Training Year 5	**$ -**

Monterey County Health System

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Schedule 7

Third-Party License Fees / Annual Maintenance and Support Detail

Software License for Third Party Software:	Footnote Reference	Fee Year 1	Fee Year 2	Fee Year 3	Fee Year 4	Fee Year 5	Annual Subscription and Maintenance Fees Year 1	Year 2	Year 3	Year 4	Year 5
TOTAL THIRD-PARTY SOFTWARE FEES		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

TOTAL THIRD-PARTY SOFTWARE FEES $ -

Maximum annual percentage increase for Third Party's Maintenance and Support for Years 6 through 10.

*Footnote References - List any explanations or comments keyed to footnote references you enter above:

Monterey County Health System

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Schedule 8

Any Other Fees Required for Implementation Not Covered in Previous Schedules

Item #	Description	Fee Year 1	Fee Year 2	Fee Year 3	Fee Year 4	Fee Year 5	Comment/Explanation
Total Other Fees		$ -	$ -	$ -	$ -	$ -	

Monterey County Health System

Population Health RFP

Schedule 9

Any Optional Software and Fees

*** NOTE: items from this schedule do not roll up to the summary sheet**

Item #	Description	Fee*	Comment/Explanation
		$ -	

Total Other Fees $ -

End of Attachment III

ATTACHMENT IV:
COUNTY OF MONTEREY LOCAL BUSINESS DECLARATION FORM

If a business entity is claiming to be a "Local Vendor" as defined by the "Monterey County Local Preference Policy", adopted by the Monterey County Board of Supervisors on August 29, 2012, it must certify they meet the definition of "Local Vendor" as defined and in accordance to the adopted policy. Any business entity claiming to be a local business as defined by the policy, shall so certify in writing herein that they meet all of the criteria listed within the policy, which can be accessed online at the following link:

Policy Link:
http://www.co.monterey.ca.us/government/departments-a-h/administrative-office/contracts-purchasing/procurement-related-policies

County shall not be responsible or required to verify the accuracy or any such certifications, and shall have sole discretion to determine if a bidder meets the definition of "local vendor" as provided herein.

Any business which falsely claims a preference pursuant to Monterey County Local Preference Policy shall be ineligible to bid on county purchases or contracts for a period of three (3) years from the date of discovery of the false certification(s).

Any business eligible for the local preference who desires to have the preference applied during the award selection process shall return this completed Local Business Preference Declaration form with its proposal or qualifications package response. Upon request, bidder agrees to provide additional information to substantiate this certification.

Select that which is applicable to your business entity (at least one in order for a business to be considered local):

☐ It either owns, leases, rents or otherwise occupies a fixed office or other commercial building, or portion thereof, having a street address within the Area. Vendor possesses a valid and verifiable business license, if required, issued by a city within the Area or by one of the three counties within the Area when the address is located in an unincorporated area within one of the three counties as defined as "Area"; and

☐ It employs at least one full time employee within the "Area", or if the business has no employees, the business shall be at least fifty percent (50%) owned by one or more persons whose primary residence(s) is located within the "Area"; and

☐ It's business has been in existence, in its current name, within the "Area" for at least two (2) years immediately prior to the issuance of either a request for proposals or request for qualifications or request for quotations for the County; and

☐ It is a newly established business which is owned by an individual(s) formerly employed by a Local Business for at least two (2) years.

As per the policy: **"Area"** shall mean Monterey County, San Benito County, and Santa Cruz County.

Note; If applicable your organization must possess a valid resale license from the State Franchise Tax Board showing its local address within the "Area" and evidencing that payment of the local share of the sales tax goes to either a city within the "Area" or to one of the three counties within the defined "Area"

On behalf of my business entity (i.e.; organization) I certify under penalty of perjury that I have both read and confirm that my business entity meets the requirements as outlined within the County's Local Preference Policy for the procurement in question.

Business Legal Name (and Dba name if any):

_____

_

Business ***Address:***

_____

City:_____ ***State:***_____ ***Zip Code:*** _____

Signature of Authorized

Representative:_____ ***Date:***

_____ ***Title of***

Authorized Representative:

_____

_____

Telephone Number: (__)_____ ***E-Mail:***

_____

This form must be submitted within a bidder's proposal or qualifications package in order for the County to apply the applicable local preference.

Bidders who do <u>not</u> qualify as a local business as per the policy should <u>not</u> submit this form.

Whole Person Care Pilot Application

Original Application Submitted July 1, 2016

Revised Application Submitted October 20, 2016

Section 1: WPC Lead Entity and Participating Entity Information

1.1 Whole Person Care Pilot Lead Entity and Contact Person (STC 117.b.i)

Organization Name	Monterey County Health Department (MCHD)
Type of Entity	County Health Department
Contact Person	Elsa Jimenez, MPH
Contact Person Title	Director of Health
Telephone	831-755-4526
Email Address	Jimenezem@co.monterey.ca.us
Mailing Address	1270 Natividad Road, Salinas CA 93906

1.2 Participating Entities

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
1. Medi-Cal managed care health plan	Central California Alliance for Health (CCAH)	Alan McKay, CEO	Identify and refer qualifying Alliance Medi-Cal members, and provide related health outcome data. WPC partners will refer patients/clients to CCAH for insurance eligibility determination and coverage. CCAH will refer WPC-qualifying patients/clients to the WPC Pilot Program and the Program will then enroll or waitlist the patient/client according to acuity and Program capacity.

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
2. Health Services Agency/Department	Monterey County Health Department: Administration, Clinic Services, Public Guardian, and Public Health Bureaus	Elsa Jimenez, Director of Health/ County Public Conservator Julie Edgcomb, Clinic Services Bureau Chief Dr. Ed Moreno, Health Officer/Public Health Bureau Chief	Non-federal share funder. Executive Sponsor/Lead Entity/ fiscal manager/Whole Person Care Program Director/care coordination management. Identification & referrals of Medi-Cal enrollees with a combination of mental health (MI) diagnoses, multiple mental health unit (MHU) admittance, co-morbidity involving top 5 reasons for hospital emergency department (ED) and inpatient expenditures, frequent ED use, substance use disorder (SUD), and/or multiple prescription use. Provider of in-kind nurse CHW/case managers. Provider of health outcome data. Provider of physical location for service delivery. MCHD Clinic Services (CS) and Public Health (PH) Bureaus are direct service providers and will bi-directionally share data through the eMPI and Case Management solutions. MCHD Director of Health will chair the Executive Committee for the WPC. The CS and PH will participate in monthly Governance and Executive Committee meetings, and in routine case management meetings as appropriate.

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
3. Specialty Mental Health Agency	Monterey County Health Department, Behavioral Health Bureau	Dr. Amie Miller, Bureau Chief	Non-federal share funder. Identification & referrals of persons with a combination of mental illness, multiple MHU admittance, SUD, clients who are homeless or at-risk. User of Master Person Index. Provider of in-kind mental health CHW/case managers. Provider of behavioral health outcome data. Provider of location for service delivery. MCHD Behavioral Health Bureau (BHB) is a direct service provider and will bi-directionally share data through the eMPI and Case Management solutions. The BHB will participate in monthly Governance and Executive Committee meetings, and in routine case management meetings as appropriate.
4. Public Agency	Monterey County Department of Social Services (DSS)	Elliot Robinson, Director	Non-federal share funder. Identification & referrals of persons who are homeless or at-risk; persons who are vulnerable without social supports. Provider of in-kind social worker CHW/case managers. Provider of social supports outcome data. Provider of physical location for service delivery. Monterey County Department of Social Services is a direct service provider. As a referring partner, they may be allowed to input data in a highly restrictive manner, or may be allowed view-only access to highly restrictive fields of patient-level data. DSS will participate in monthly Governance meetings, and in routine case management meetings as appropriate.

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
5. Safety-net Hospital	Natividad Medical Center (NMC)	Dr. Debi Siljander, Medical Director of Clinical Integration and Integration Dr. Chad Harris, Chief Medical Information Officer	Non-federal share funder. Identification & referrals of Medi-Cal enrollees with a combination of MI diagnoses, multiple MHU admittance, co-morbidity involving top 5 reasons for hospital ED and inpatient expenditures, frequent ED use, SUD, homeless or at-risk, and/or multiple Rx use. Provider of health outcome data. User of shared Master Person Index. Provider of physical location for service delivery. Partner in coordinating discharge nurse case managers. NMC is a direct service provider and will bi-directionally share data through the eMPI and Case Management solutions. NMCB will participate in monthly Governance and Executive Committee meetings, and in routine case management meetings as appropriate.
6. Coalition of homeless services providers	Coalition of Homeless Services Providers (CHSP)	Katherine Thoeni, Executive Officer	HUD Continuum of Care Coordinator; recipient of HUD funding. Administrative lead for the 10-Year Plan to end homelessness in Monterey and San Benito Counties. Lead agency for HMIS, Housing Inventory Count, and Point in Time Count. Funded partner for staffing, operations, software licensing and subscription, training, and IT hardware. CHSP will participate in monthly Governance meetings and co-chair the monthly Executive Committee meetings. CHSP is not a direct service provider, will not share data or attend case management meetings.

Additional Organizations (Opt)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
7. Housing, mental health, and addiction services	Community Homeless Solutions (CHS)	Reyes Bonilla, Executive Director	Provider of direct services for homeless, mentally ill, and/or drug addicted persons. Provider of social supports outcome data. Provider of physical location and mobile outreach for service delivery. Provider of in-kind social worker CHW/case managers. Funded partner for staffing and operational expenses, local travel (mobile outreach). CHS is a direct service provider and will input patient-level data into a siloed system that is a component of our Behavioral Health data system. CHS will participate in monthly Governance meetings and in routine case management meetings as appropriate.
8. Mobile outreach and social supports	Interim, Inc.	Barbara L. Mitchell, Executive Director	Identification & referrals of persons with mental illness and are homeless or at-risk. Contributor of technical assistance in housing development. Provider of social supports outcome data. Provider of physical location for service delivery. Provider of in-kind social worker CHW/case managers. Interim is a direct service provider and will input patient-level data into a siloed system that is a component of our Behavioral Health data system. Interim will participate in monthly Governance meetings and in routine case management meetings as appropriate.

Additional Organizations (Opt)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
9. Partner providing shelter, food, and an array of social services for individuals who are homeless or at-risk, potentially with co-morbidities, without social supports, or SUD.	Franciscan Workers of Junipero Serra (Dorothy's Place) Community Human Services Gathering for Women	Jill Allen, Exec. Director Robin McCray, Exec. Director Carol Greenwald, MSW, MPS, Director	These are referring agencies for homeless or at-risk persons who meet the criteria of the focus population; current providers of case management services; providers of physical locations for service delivery. The Franciscan Workers utilize the Vulnerability Assessment (Vi- SPDAT) to inform its case management services for approximately 65 persons. Funded partner for staffing, operational expenses, and training. The Franciscan Workers are direct service providers and will not share data. As a referring partner they may be allowed to input data in a highly restrictive manner, or may be allowed view-only access to highly restrictive fields of patient-level data. They may be invited to attend case management meetings as appropriate, and will be invited to attend Governance meetings. Community Human Services and Gathering for Women will be WPC referral sources.

10. Local law enforcement and probation	Monterey County Sheriff's Department and Probation Department	Stephen T. Bernal, Sheriff-Coroner Marcia Parsons, Chief Probation Officer	Identification & referrals of persons in jail who are pending release and who are homeless or at-risk, and who also have co-morbidity or SUD. The Probation Department is a referral source that will input patient-level data into a siloed system that is a component of our Behavioral Health data system. They may be invited to attend case management meetings as appropriate. They will be invited to attend Governance meetings.

Additional Organizations (Opt)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
11. Housing Authority	Housing Authority of Monterey County	Jean Goebel, Executive Director	Provider of Housing Choice Vouchers (vouchers are not included in the proposed WPC Pilot Budget). Technical assistance for tax credit and other affordable housing programs, referring agency for persons homeless or at-risk. The Housing Authority is a direct service provider but will not share data. They will not attend case management meetings but will be invited to attend Governance meetings.

12. Affordable Housing Developer	MidPen Housing	Betsy Wilson, Director of Housing Development	Partner in the development of permanent supportive housing (developer and manager). Provider of physical location for service delivery. MidPen Housing is a direct service provider but will not share data. As a referring partner they may be allowed to input data in a highly restrictive manner, or may be allowed view-only access to highly restrictive fields of patient-level data. They will not attend case management meetings but will be invited to attend Governance meetings.

1.3 Letters of Participation and Support

Attached are letters of commitment from the following entities:

- Behavioral Health Bureau, MCHD
- Central California Alliance for Health
- Coalition of Homeless Services Providers
- Franciscan Workers of Junipero Serra (Dorothy's Place)
- Gathering for Women
- Housing Authority of Monterey County
- Interim, Inc.
- MidPen Housing
- Monterey County Department of Social Services
- Monterey County Probation Department
- Natividad Medical Center
- Public Health Bureau, MCHD
- Salinas City Manager
- Salinas Valley Memorial Healthcare System
- Supervisor Parker, County of Monterey

Section 2: General Information and Target Population

2.1 Geographic Area, Community and Target Population Needs

Geographic area and need: The 2015 Monterey County Homeless Census counted 2,308 homeless people in the county, with 71% being unsheltered and 9% in emergency shelter, 23% who said the cause of homelessness was alcohol or drug use (and 59% if they were chronically homeless), 28% reported having psychiatric or emotional conditions, 19% reported chronic health problems, and 77% had spent a night in jail in the last 12 months. County Behavioral Health staff served 1,179 clients with substance abuse disorders and 1,178 individuals over 18 years with serious or persistent mental health disorders in FY15. In Monterey County in 2014, 5.7% or 4,000 residents were <200% of the FPL and reported having serious psychological distress during the past year (CHIS, 2014).

Planning with participating entities: Our WPC partnership has met weekly since 3/30/16. Core

participants include the MCHD Director, Clinic Services, Behavioral Health, and Public Health Bureau Chiefs, analysts, and IT experts; Monterey County Social Services Director and analysts; and NMC's Assistant Director, Operations Manager, MDs, and IT analysts. The group has collaboratively identified:

- WPC focus population definition and geographic scope
- WPC governance structure and tasks for WPC Pilot Executive Committee - chaired by the MCHD Director of Health, and the Workgroups (Data, Social & Clinical, Housing, Evaluation, and Finance Workgroups
- Mapping how WPC governance will interface with the Leadership Council of the Coalition of Homeless Services Providers (HUD fund recipients), their Lead Me Home 10-year Plan to create a comprehensive housing pipeline, and their Housing Management Information System (HMIS)
- Community partners that address social determinants of health
- Community partners who will act as WPC referring sources and WPC service locations
- Various health information solutions for data integration and reporting
- Sources for matching funds from county agencies and eligible community partners
- Use of Community Health Workers; certificate training for Community Health Workers
- Model for the NMC WPC population health management process

WPC Pilot, structure, target populations and addressing their needs: The County of Monterey has a population health model (which is included in the application) that addresses our strategy for population health management, including IT/Care Management needs. The WPC is a pilot in our high risk population. The initial WPC focus population (high utilizers) will be exclusively homeless and chronically homeless Medi-Cal recipients or Medi-Cal eligible persons with no medical health home (including those released from jail) and having 3 or more of the following characteristics: diagnosed mental illness, 4 or more MHU admissions in the prior year, diagnosed SUD, 2 or more chronic health diagnoses, 3 or more ED visits within the prior 6 months, 2 or more hospital admissions within the prior 6 months, or 5 or more prescribed medications.

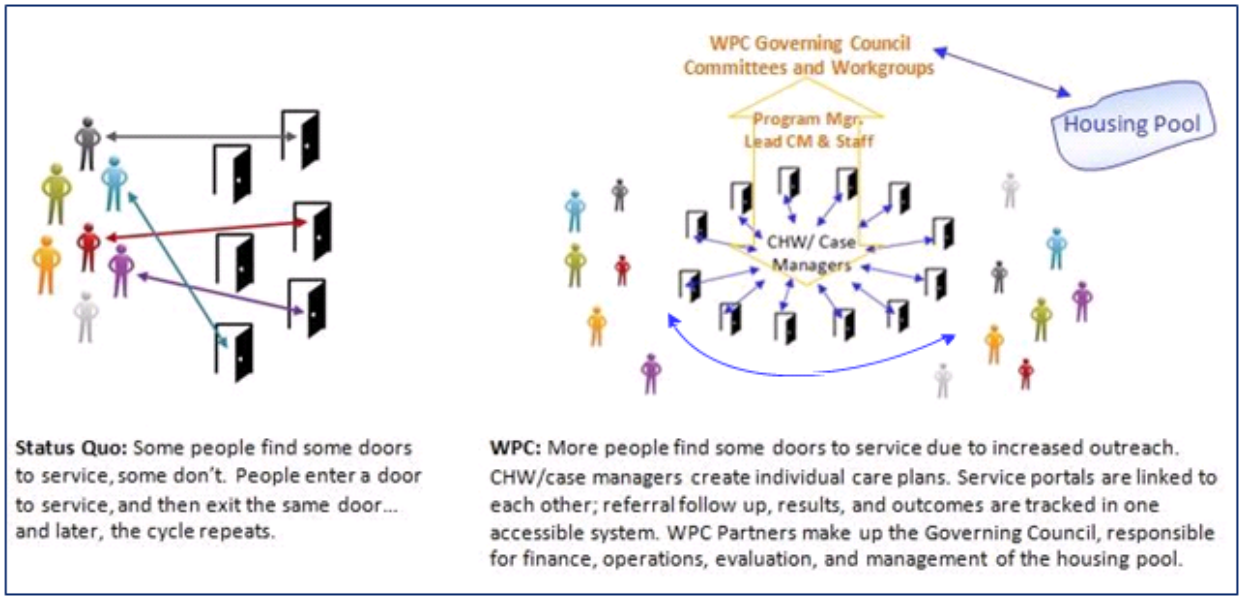
Medication categories include antidepressants, antipsychotics, mood stabilizers, diabetes medication, antihypertensives, cholesterol lowering medications, inhaled corticosteroids and bronchodilators, seizure medications and anticoagulants.

The WPC Pilot structure will integrate the management and resources of existing safety net hospital and primary care/specialty clinics, public health nursing teams, Housing Authority, Department of Social Services,

Behavioral Health, and the Coalition of Homeless Services Providers (CHSP) with a proposed system of community health workers who will provide high-utilization patients with case management, individual health improvement plans, and warm handoffs to linked services. Oversight for the new community health worker system will be provided by MCHD Director of Nursing and staff. Overarching will be a representing governance structure headed by the WPC Pilot Executive Committee. The housing pool, which will not be funded through the WPC, will be managed by the CHSP Leadership Council. The WPC Pilot will strengthen the system of care in Monterey County by creating two essential components: a case management system, and a Master Person Index that can be accessed by all WPC partners. Monterey County's system of care has been in the process of developing a health information exchange for many years, and the WPC Pilot will bring that work to full fruition.

Reducing avoidable utilization of other systems: With WPC comprehensive case management, EDs, hospitals, and MHUs will experience reduced utilization by the focus population, and associated cost savings. Primary and specialty clinics, urgent cares, SUD and mental health providers, health educators, and an array of social services providers will see an increase in service requests from the focus population.

How current system problems will be addressed: Currently, high ED/hospital utilizers enter one door to a medical, social, or housing provider, and then exit the same door. Services between high utilizer supporting agencies/organizations are ***not linked***. The new WPC system ***will link*** a high ED/hospital utilizer to enter any of a multitude of doors that will lead to a CHW/case manager who will provide trauma-informed, individualized service coordination, backed by a health/social determinants data sharing system, and governed by a structure of public/private medical, social, and housing entities and a 10-year plan to address homelessness.



Status Quo: Some people find some doors to service, some don't. People enter a door to service, and then exit the same door… and later, the cycle repeats.

WPC: More people find some doors to service due to increased outreach. CHW/case managers create individual care plans. Service portals are linked to each other; referral follow up, results, and outcomes are tracked in one accessible system. WPC Partners make up the Governing Council, responsible for finance, operations, evaluation, and management of the housing pool.

WPC Status Quo and Linked Care Coordination System

Vision for building/strengthening collaborative community partners:

Monterey County leaders, under the auspices of the Coalition for Homeless Services Provider (CHSP), in a multi-organizational, multi-governmental, and multi-sector relationship, have worked closely since 2010 to create wrap-around services for high utilizers, specifically those who are homeless. As a powerful governing structure, CHSP with MCHD and the WPC Pilot will bring the hospital, primary and specialty care, and mental health sectors into this coordinated system, thereby strengthening the homeless continuum of care with health and prevention. The connection of coordinated health and social CHW/case managers to housing and basic needs providers will bind and strengthen two systems into one that is far more effective for the focus population. WPC Pilot will also bring a shared information technology platform for health outcome data exchange that, when interfaced with the HMIS, will greatly increase the efficiency of our efforts.

Vision for sharing lessons learned:

Past Centers for Disease Control and Prevention (CDC) grants convened awardees to share lessons learned in a format similar to Communities of Practice. MCHD and our core WPC Pilot partners would be willing participants in such a convening. MCHD annually presents program process and outcomes at American Public Health Association and American Evaluation Association conferences and will share our WPC Pilot successes and challenges in those venues.

Vision for sustainable infrastructure (communications/delivery system) beyond the Pilot phase: Monterey

County's WPC Pilot will benefit from MCHD's use of the Spectrum of Prevention and upstream practices for more than a decade to develop long-term improvements and comprehensive, sustainable change, as evidenced by our Health in All Policies achievements. Monterey County collaboratives use Collective Impact for numerous health, education, and social community initiatives, and MCHD has an FSG- trained Collective Impact expert on its executive leadership team. An internal team of evaluation professionals have been working within MCHD for 12 years; their WPC process and outcome evaluations will greatly inform WPC longevity planning and logistical improvements.

The investment in building the infrastructure to facilitate real time data sharing and exchange will be sustained beyond the pilot to continue benefitting care coordination and management of high cost utilizers that enter the system, as the shared case management solution across multi-sector entities will improve care coordination.

2.2 Communication Plan

The governance structure, with MCHD as the Lead Entity/Pilot Care Coordinator and the Coalition of Homeless Services Providers as the coordinator of partnering social services/housing CHW/case managers, will convene regularly scheduled monthly meetings of partner representatives to manage the Pilot's operational integrity, problem-solving, communication/idea sharing, decision-making, participate in PDSA and evaluation activities, and progress toward milestone achievements. The WPC Pilot Executive Committee will meet with the same frequency to track the work of ad hoc workgroups. Other Executive Committee responsibilities are to oversee contracts; operate the CHW/case management system, Master Person Index, and shared data platform; develop policies/procedures; address compliance, monitor evaluation results, and apply PDSA improvements to the WPC Pilot operations. Workgroups will consist of finance, external communications, Data, Social & Clinical, Housing, and Evaluation.

Decision-making will be by the Executive Committee with input from the broader WPC Pilot Workgroups. A successive governance plan will be incorporated in the WPC Pilot collaborative MOU that will be signed by all partners. The WPC Pilot administrative functions will be headed by the MCHD Program Director with expertise in collective impact methods. The WPC Pilot partners will use the Microsoft Office Suite and the Google Docs suite of communication tools (Docs, Sheets, Slides, Forms, Drawings); the FranklinCovey formats for agenda/minutes, 5-minute meeting planner and 5-minute presentation planner; Free Conference Call and SKYPE for off-site case review participants; Survey Monkey for voting processes; and

SmartBoards in conference rooms.

2.3 Target Population(s)

Our WPC Pilot focus population will be exclusively homeless and chronically homeless Medi-Cal recipients or Medi-Cal eligible persons (including those released from jail) who have the following characteristics: diagnosed substance abuse history, diagnosed mental illness, and lack of a medical health home. Further criteria include having four or more MHU admissions in the prior year, two or more chronic health diagnoses, three or more ED visits within the prior 6 months, two or more hospital admissions within the prior 6 months, or five or more prescribed medications. Medication categories include antidepressants, antipsychotics, mood stabilizers, diabetes medication, antihypertensives, cholesterol lowering medications, inhaled corticosteroids and bronchodilators, seizure medications and anticoagulants. The intent is to enroll and assign to case workers to 500 individuals for the duration of the WPC Pilot. After the first year of full operation, we may broaden the focus population intake criteria.

The definition of "homeless" we are using for the WPC Pilot is the HUD McKinney-Vento Homeless Assistance Act definition:

A single individual (or head of household) with a disabling condition who has either:

- Experienced homelessness for longer than a year, during which time the individual may have lived in a shelter, Safe Haven, or a place not meant for human habitation.
- Or experienced homelessness four or more times in the last three years.

The definition of "chronically homeless" we are using for the WPC Pilot is the 2016 HUD HEARTH definition:

A homeless individual with a disability who lives either in a place not meant for human habitation, a safe haven, or in an emergency shelter, or in an institutional care facility if the individual has been living in the facility for fewer than 90 days and had been living in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately before entering the institutional care facility. The individual or family has a head of household with a diagnosable:

- Substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability.

The individual also must have been living as described above continuously for at least 12 months, or

on at least four separate occasions in the last 3 years, where the combined occasions total a length of time of at least 12 months. Each period separating the occasions must include at least 7 nights of living in a situation other than a place not meant for human habitation, in an emergency shelter, or in a safe haven.

Individuals who are homeless usually have a co-occurring mental health and substance use disorder as shown by the 2016 data assessment of homeless individuals displaced from encampments in Chinatown area of Salinas, California. That study showed that 50% of the homeless population had medical needs, 14% had mental health needs, and 26% had substance use disorder needs (these percentages are not exclusive).

For baseline data collection that will be due March 2017, we have already conducted preliminary work to help identify our target population, which includes an independent review of Managed Medi-Cal claims and health status, behavioral health claims and health status data, Clinic Services claims and health status data, and HMIS data. Data sets will be queried to identify the high cost utilizers and then stratified for homeless, mental health, SUD to identify top 500 individuals meeting WPC Pilot selection criteria. A major challenge identified is ability to share data amongst all participating entities. As such, concurrently with independent review and stratification of each of these disparate data sets, the Executive Team is in discussions with legal counsel regarding provisions for a shared MOU to be signed by all participating entities to facilitate data sharing and integration activities during the Pilot years. Once MOUs are executed with all participating entities, data sharing activities will be implemented to facilitate the identification of 500 high utilizers accessing multi systems who will be invited to participate in WPC Pilot (we expect as much as 50% may be lost to service during the course of their first 12 months in the program).

Section 3: Services, Interventions, Care Coordination, and Data Sharing

The WPC strategies already existing in Monterey County are:

• CHW/case managers for high utilizers (providing physical and mental health, social services, and housing fields) • HIE, currently functioning between multiple hospitals and outpatient clinics, with other FQHC and behavioral health providers in upcoming phases • Integrated (physical and mental health) clinics	• Permanent supportive and transitional housing (physical/mental health and substance use fields) • Medical respite housing on the Monterey Peninsula • The Coalition of Homeless Services Providers (using Vi-SPDAT, CARS, HMIS, HIC and PIT systems and assessments) • Veterans housing and case management

The WPC services below describe commitments of the core WPC Pilot partners with expectations to decrease avoidable ED and hospitalization by high user groups. We will intake about 500 individuals for the duration of the WPC Pilot who will use all services. Intake for comprehensive and coordinated case management for the high utilizers, and greater high utilizers housing resources, will occur on a rolling basis. The proposedInfrastructure grant will assist with financing a housing community that will provide High Utilizer Support Resources through the provision of permanent supportive housing for high utilizers of the health care system. Housing, in combination with onsite case management services, will improve health outcomes of these members by facilitating access to appropriate care.

Additionally, these partners have committed to program governance, data sharing, program evaluation, and other activities to achieve the Pilot's intended outcomes.

Category	Services
Lead Entity	**Monterey County Health Department** will provide financial management and accountability, convene the WPC Pilot Executive Committee, oversee nursing case worker and CHW/case manager workforce; lead PDSA monitor outcomes and reporting activities, manage the Pilot's operational integrity, problem-solving, communication/idea sharing, decision-making, participate in PDSA and evaluation activities, and progress toward milestone achievements. Provisions by MCHD Public Health Bureau will be delivered through **non-federally funded** sources.
Referrals from Hospitals	**Natividad Medical Center,** our county's safety-net hospital, will provide the WPC program with non-federal matching funds (NMC and SVMHS), patient referrals, nurse CHW/case managers, data contribution to the Master Person Index, and a physical location for providing case management supports to the focus population. Provisions by NMC will be delivered through **non-federally funded** sources. **Community Health Innovations (Community Hospital of the Monterey Peninsula), and Salinas Valley Memorial Healthcare System** will provide patient referrals.
Health Plan	**Central California Alliance for Health** will provide claims data and health outcome data to monitor progress of Pilot participants.
Case Management	**MCHD Behavioral Health Bureau** will provide **non-federally funded** case management support services to individuals with severe mental illness; provide non-federal matching funds; track and monitor mental health and SUD outcomes; provide physical location for service provision.
Case Management	**MCHD Public Health Bureau** commits to provide its Director of Public Health Nursing as the WPC Pilot Program Director, and a team of registered nurses, licensed vocational nurses, and Community Health Worker/Patient Navigators as the core of the physical health carecoordination. Provisions by MCHD Public Health Bureau will be delivered through **non-federally funded** sources. **MCHD** is assigning a Business Technology Analyst III to oversee data integration and quality control, and a Public Health Epidemiologist to provide data analysis and reporting.
Case Management	**Community Human Services (CHS)** is a funded partner that will provide staffing and mobile outreach efforts to reconnect chronically homeless individuals who meet other WPC care criteria with the care coordination system.

Social Services	**Monterey County Department of Social Services** (DSS) will provide the WPC program with **non-federal matching funds**, social workers, and a physical location for providing case management supports to the focus population.

Category	Services	
	Coalition of Homeless Service Providers, as the designated HUD Homeless Continuum of Care coordinator, will serve as lead agency for the CARS, HMIS, HIC, and PIT.	
Housing	**Monterey County Housing Authority** will provide technical assistance to the WPC Pilot Governing Group and focus population referrals to the WPC Pilot. **MidPen Housing** will provide a permanent supportive housing community that will include high utilizer case management and individual plans to improve physical/mental health and strengthen social supports. MidPen Housing has extensive experience in housing a variety of populations, including High Utilizer populations, in San Mateo and Santa Clara Counties. **Interim Inc.** will provide affordable housing for people with mental illness, outreach to homeless persons with mental illness, wellness navigators to serve the WPC Pilot enrollees with mental illness, and residential treatment with peer support.	
Additional Referring Organizations	• Monterey County Sheriff/Probation Depts. • Franciscan Workers (Dorothy's Place)	• Community Homeless Solutions • Gathering for Women
Pilot Governance	MCHD will act as the Lead Entity for the WPC Pilot care coordination effort. MCHD and CHSP will form an overarching Executive Committee that will be chaired by the MCHD Director of Health and comprised by representatives of the partnering agencies. The Executive Committee will be supported by designated staff and standing Work Groups.	

Housing-related services: The Coalition of Homeless Services Providers (CHSP) is a funded partner in the WPC Pilot, serving the designated HUD Homeless Continuum of Care Coordinator. Individuals meeting the target population and enrolled in the WPC Pilot will be referred to the CHSP providers' staff for assessment and linkage to most appropriate housing service for individual. The WPC Pilot Program Director will work closely with the identified CHSP service provider to assure individuals' needs for housing services are met. Pilot projects funds will used for coordinating housing services to meet the needs of the pilot participants. These coordinated housing support services, funded through CARS and

community-based case management budget items, willinclude assessment of housing needs, matching with most appropriate housing service provider, tenant education and coaching, onsite intense case management services for tenants, and landlord training and coaching to assure success of housing placement.

Housing Pool: While the establishment of a housing pool with the Coalition of Homeless Services Providers as the fiscal agent will be explored, **no WPC funds will be used to create or maintain it.** Partners will include MCHD, DSS, CHS, several nonprofit organizations, and property owners. The goal of the Monterey County Housing Pool Program (HPP), a supportive housing rental subsidy program, will be to "scattered site" supportive housing units that provide stable housing options for vulnerable individuals and families, with an emphasis on those transitioning from homelessness or institutional settings.

Components of the HPP are already underway and led by CHSP. CHSP is the lead for the Coordinated Entry System which uses an evidence-based assessment tool (VI-SPDAT) to "rank" the vulnerability of homeless individuals and families and place them on a Master List. Programs that receive HUD/VA/ESG funding will replace standard waiting lists and streamline program enrollment to those that are most vulnerable. CHSP also has a Housing Pipeline Committee which works with landlords to accept households with economic classification of 0-30% of the American Median Income (AMI) and works to track housing development projects and look for opportunities to increase housing unit availability for vulnerable individuals. For example, CHSP partners are or will employ Housing specialists who work with landlords to accept clients into housing. Another method to be explored as part of the Coalition's work is where the Committee works with landlords to create a potential list for a housing pool and notify WPC partners of available unit(s) on a monthly basis. If a WPC client is on the Master List and identified as being up for potential housing, WPC partners will work with CHSP or a designated partner to negotiate lease terms for that client. The case managers in the WPC program will work with identified prospective tenant WPC clients and coordinate all move-in components (lease, security deposit, rent payment, move-in). The WPC client will be followed up with on-going housing retention and case management services through WPC and landlords will be supported with a single point-of-contact with CHSP or the designated partner for all tenant issues as well as having high occupancy rates and on-time rental payments. CHSP or the designated partner will be part of the WPC team working through the case manager with the WPC client.

Specific Interventions and Strategies: MCHD's Public Health Bureau CHW/case managers will conduct a

comprehensive assessment to be adapted from existing tools used in public health and behavioral health of individuals referred from local hospitals and public safety entities once participation agreements are in place. MCHD CHW/case managers will serve as the lead care coordinators, providing referrals to other partner CHW/case managers for specialty services. MCHD CHW/case managers will also provide transportation, facilitate linkage and referrals, and serve as patient navigators. All supporting CHW/case managers will have access to the case management solution gaining access to real time information on participant status.

Bidirectional integration of CHW/case managers with specialties in physical health, mental health, substance use disorder, social services, housing, housing supports, and life skills will ensure the WPC Pilot program high utilizer enrollees receive a wide variety of needed services that keep the healthy, out of EDs and hospitals, and housed in more stable environments.

Through the Coalition of Homeless Service Providers, participants will undergo a screening and housing assessment process to determine participants' preferences and help surface any potential barriers to successful tenancy. Assessment findings will be used to build an individualized housing support plan. Data will be tracked in the HMIS. In addition, these screening tools will facilitate prioritization of limited supportive and permanent housing resources. Based on assessment findings and housing support plan, participants will be linked to most appropriate housing service provider for facilitation with completion of applications and/or search process for securing financing and housing. Housing service providers will support tenant to successfully maintain tenancy once housing is secured by providing education and training to tenant and landlord on responsibilities, rights, and role of tenant and landlord. The assigned housing coordinator will provide coaching to the tenant on how to maintain good working relationships with landlords, assist in resolving any disputes that arise between landlord and tenant, and be as hands on as needed to maintain tenancy. The housing coordinator will maintain an active relationship with the participants' CHW/case manager.

The CHW/case manager will help participants schedule a follow up medical and mental health and SUD appointment as soon as possible but no later than 30 days from date of release from jail or discharge from hospital. If a participant does not have an established primary care physician or medical home, the case manager will help facilitate establishment of one at one of the seven MCHD Clinic Services clinic sites. Linkage to primary care and mental health services is critical in assuring participants are seen regularly by

their provider and are able to get prescriptions and other necessary clinical procedures completed to improvehealth outcomes. Transportation to and from appointments **other than those involving Medi-Cal reimbursement** will be arranged (bus, taxi) as needed to assure success.

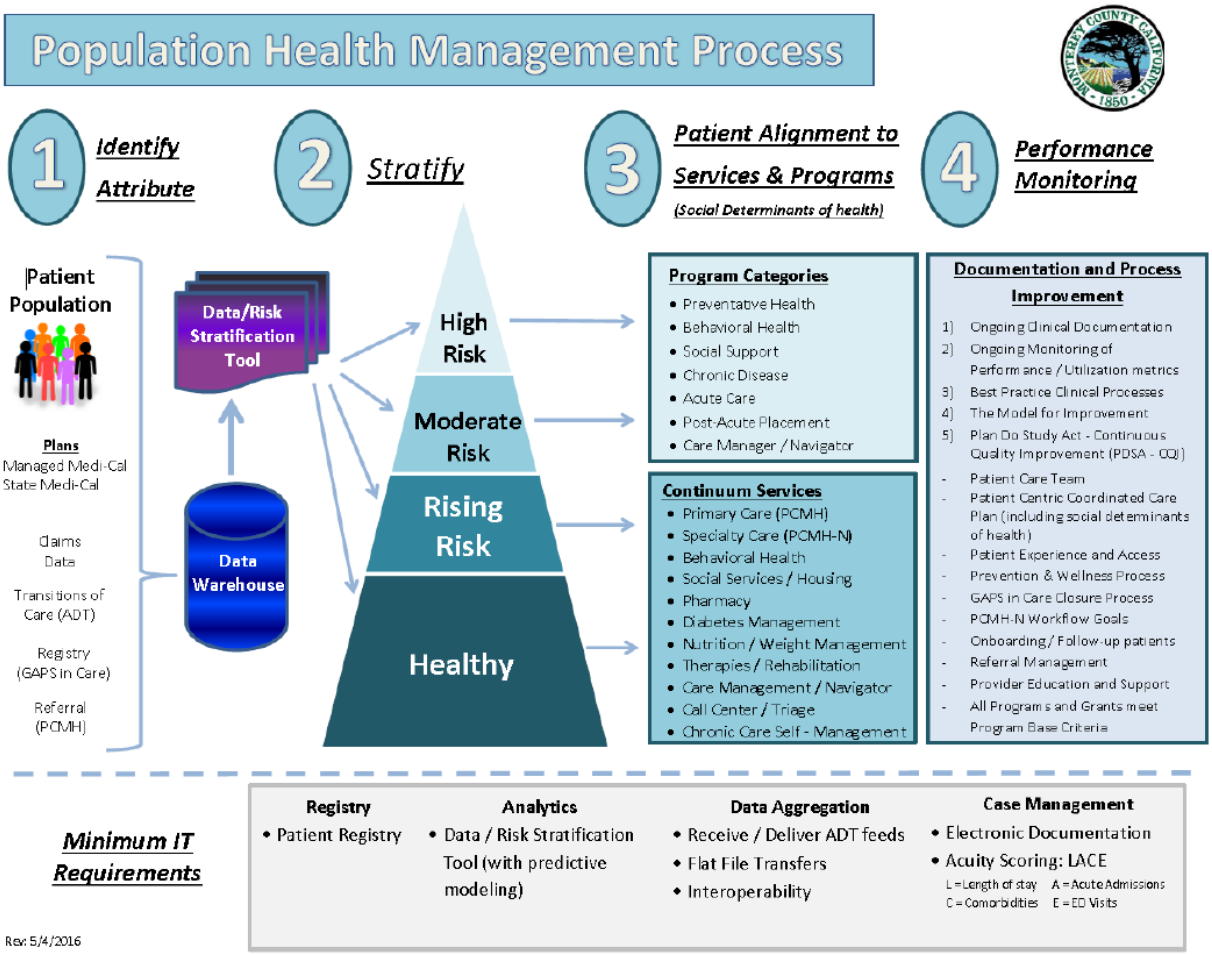
In addition to facilitating case coordination activities, the core team will provide training and education to participants on self-management techniques, nutrition and physical activity, how to advocate and take active role in the management of their conditions, health literacy, and chronic/communicable/wellness health topics as needed for participant to improve health outcome.

Care Coordination: The MCHD Pubic Health Bureau is Director of Nursing with serve as the WPC Pilot Program Director, and will supervise the lead case management and community health worker team serving program participants on cross system care coordination efforts. Referrals for care coordination services will come from various service providers with initial focus on prioritizing referrals from local hospitals and public safety entities.

CHW/case managers will coordinate with Natividad Medical Center and Salinas Valley Memorial Healthcare System staff during discharge planning activities for those individuals identified to be homeless and meeting one or more of the criteria. CHW/case managers will meet with individual to evaluate interest in participating in the Program. By becoming involved at the time of discharge planning, a more appropriate transition plan is in place prior to participant being discharged from hospital. Elements to be included as part of discharge planning include completion by CHW/case managers, a comprehensive healthcare, behavioral health, housing, and LTSS assessment; coordination with Coalition for Homeless Services Providers for completion of housing assessment with vulnerability scoring matrix, prioritization of referral for short and/or permanent supportive housing services for participants with highest vulnerability scores; scheduling follow up appointment with primary care provider or linkage to a primary care provider if one is not secured; referral to behavioral health service provider; and referral to services providers for other social needs identified in comprehensive assessment. In addition, case management staff will work closely with Sheriff-Coroner's Office staff to provide similar array of assessment, linkage, and referral services to those individuals identified as homeless and meeting one or more of the criteria within 30-45 days of their release date. **No services will be provided to the individual while he/she is incarcerated**. Case management staff will provide criteria to the Sheriff-Coroner's staff for referral purposes upon the prisoner release.

The Public Health CHW/case managers will serve as lead care coordinators (core team) for individuals enrolled in the pilot project. They will conduct initial comprehensive assessment using tool adapted from those used in the behavioral health system and public health system that captures medical, social, and behavioral needs. The core team will provide referrals to service providers, coordinate with service providers to assure referral is met, arrange for transportation by bus or taxi needed to appointments that are **not** covered by Medi-Cal, and re-assess individual as needed to assure all needs are identified and a service plan is in place. The core team will continue to work closely with clients to assure consistent stability in their health, behavior, and housing outcomes to prevent relapse. If client is on probation, core team will work with public safety staff to assure client's needs are being met in an effort to reduce recidivism.

The graphic below illustrates the WPC patient flow from identification through stratification, WPC services, and MCHD WPC pilot performance monitoring. In Program Year 2 our patient identification will be implemented through a manual operation based on data extraction from disparate systems. We expect our eMPI and Case Management solutions to be in place and fully operational in approximately PY 2-3. At that time, the illustrated Data/Risk Stratification Tool and Data Warehouse elements (boxed in **green**) will work as depicted below.


Population Health Management Process
1 Identify Attribute
2 Stratify
3 Patient Alignment to Services & Programs
(Social Determinants of health)
4 Performance Monitoring
Patient Population
Plans
- Managed Medi-Cal
- State Medi-Cal
Claims Data
Transitions of Care (ADT)
Registry (GAPS in Care)
Referral (PCMH)
Data/Risk Stratification Tool
Data Warehouse
High Risk
Moderate Risk
Rising Risk
Healthy
Program Categories
• Preventative Health
• Behavioral Health
• Social Support
• Chronic Disease
• Acute Care
• Post-Acute Placement
• Care Manager / Navigator
Continuum Services
• Primary Care (PCMH)
• Specialty Care (PCMH-N)
• Behavioral Health
• Social Services / Housing
• Pharmacy
• Diabetes Management
• Nutrition / Weight Management
• Therapies / Rehabilitation
• Care Management / Navigator
• Call Center / Triage
• Chronic Care Self - Management
Documentation and Process Improvement
1) Ongoing Clinical Documentation
2) Ongoing Monitoring of Performance / Utilization metrics
3) Best Practice Clinical Processes
4) The Model for Improvement
5) Plan Do Study Act - Continuous Quality Improvement (PDSA - CQI)
- Patient Care Team
- Patient Centric Coordinated Care Plan (including social determinants of health)
- Patient Experience and Access
- Prevention & Wellness Process
- GAPS in Care Closure Process
- PCMH-N Workflow Goals
- Onboarding / Follow-up patients
- Referral Management
- Provider Education and Support
- All Programs and Grants meet Program Base Criteria
Minimum IT Requirements
Registry
• Patient Registry
Analytics
• Data / Risk Stratification Tool (with predictive modeling)
Data Aggregation
• Receive / Deliver ADT feeds
• Flat File Transfers
• Interoperability
Case Management
• Electronic Documentation
• Acuity Scoring: LACE
L = Length of stay A = Acute Admissions
C = Comorbidities E = ED Visits
Rev: 5/4/2016

3.1 Data Sharing

MCHD has formed a Data Workgroup represented by key participant agencies and stakeholders. The Data Work group are developing an IT plan that aligns with and addresses the overall Monterey Countypopulation health and Longitudinal care strategy including that of the PRIME initiative. This IT plan is comprised of data aggregation, registry, analytics and care management solutions. The workgroup understands the challenges of agency collaboration, data aggregation, and the proprietary systems and data sources that may be effective and functional individually but collectively siloed systems. In addition, each of the systems has individual data privacy requirements. The workgroup has identified the following objectives to be addressed as part of this project and has developed the following implementation plan.

I. Formal Agency Participation Agreement needed: Memorandum of Understanding (MOU) thatwill include the roles/responsibilities of each agency that will participate. Master Data Sharing Agreement that will be a subset of the MOU or a stand-alone with agencies added during the development of the pilot program. Understanding the challenges that exist with data governance, data sharing, and the legal boundaries that exist, MCHD has taken the initiative to engage County Counsel and outside Counsel that serve as subject matter experts in meeting HIPAA requirements and the boundaries surrounding the sharing of Substance Abuse information. This due diligence in ensuring that legal counsel is involved to better prepare the County to address the program requirements, and conduct the technical assessment of potential care coordination solutions, while factoring in the critical component in successfully implementing a unified solution that enables interoperability amongst multiple agencies.

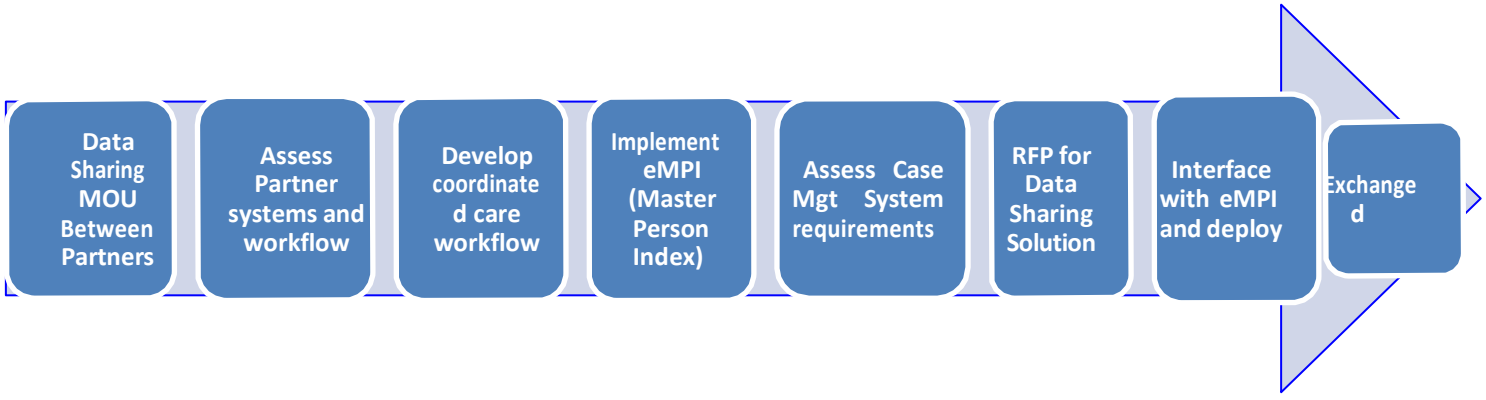
II. Proprietary Program/Service Assessment: Technology requirements to be developed will include an assessment of participating agencies' existing resources for service providers, contacts, information, and referral options that will define the workflow in an automated solution. This will evolve into the WPC Pilot's Program Director for the care coordination solution.

Technical Assessment of Source Data: The participating agencies have proprietary systems developed and in use for their agencies service provision. Although independently they are robust systems, they are siloed. To ensure the success of this pilot program, a unified Case Management Solution that is data source agnostic will enable this pilot program to begin tracking the program participants and develop clear multi-disciplinary workflows. Accountability, reporting, and the measurement of outcomes require a unified solution utilized by all of the participating agencies.

MCHD takes a project implementation approach with lessons learned after working through the development of current data interfaces connecting proprietary systems that share only discreet data elements and tables necessary to meet the programmatic requirements and better monitor data across multiple platforms. These individual use cases has enabled MCHD to consider the logistics, the legal parameters proprietary to each dataset, and the subsequent value of monitoring the outcomes. Integrated services across multiple disciplines to maintain continuity of care has been the impetus for previous individual data sharing projects.

The experiences in implementing the existing interfaces and projects in progress enables collaboration within multi-disciplinary teams both programmatically and technically. This has enabled MCHD to recognize the challenges of data sharing and data governance that may often impede program deployment and impact the provision of effective case management across disparate systems. This pilot project will enable MCHD to be agile in determining the solutions needed with a technical approach to build a scalable solution that will support the provision of case management across the participating agencies.

III. Protected Health Information in a multi-disciplinary/multi-agency pilot program will require data security and data privacy protocols incorporated into the workflow, application access with role based access defined, and participant consent for data sharing necessary only for the provision of services. MCHD has included County Counsel and outside counsel throughout the course of the development of this proposal and is in the process of developing Health Information Technology (HIT) Policies that support the recent HIT security assessment conducted by a consultant. The MOU that will ensue will define clear agency participation and defined role-based data access controls that will include: Organization, Employee, Role, Access Level, and Functions with a recurring audit plan that meets the requirement of the County of Monterey Data Security Policy.



Section 4: Performance Measures, Data Collection, Quality Improvement and Ongoing Monitoring

4.1. Performance Measures

The performance measures for each our WPC Pilot participating partners, grouped by entity type, are presented in the tables below. The entity types include Administration, hospitals, medical clinics, mental health service providers, and housing and housing support services providers. We have identified quantitative targets for each program year.

For the Pilot program itself, our process measures are

- establishing care coordination
- conducting effective case management
- creating referral policies and procedures across all partner entities
- continuing use of PDSA and application of lessons learned

The Pilot's quantifiable outcome measures are:

- increases in the numbers of WPC high utilizers who receive at least 12 months of coordinated case management
- The increasing number of beneficiaries with a comprehensive care plan

The quantifiable standard health outcome metrics across all five program years are:

- increases in the percentages of WPC Pilot high utilizers who have follow up medical, mental health, and SUD appointment no later than 30 days from date of release from jail or discharge from hospital
- reductions in WPC Pilot high utilizers hospital readmissions within one year of WPC Pilot enrollment
- reduction in ED use by WPC Pilot high utilizers

Other quantitative outcome measures are listed for hospital providers (ED and in-patient metrics), medical and mental health providers, and housing and housing supportive services providers. Each of the MCHD WPC Pilot interventions and our focus population are represented in these performance measures. Our overarching vision is for all partner agencies to accurately participate in reporting their performance data, have knowledge of the performance outcomes achieved by other partner entities, and have understanding of how the Pilot is achieving its overall objectives of developing a fully-functioning coordinated case management system, reductions in ED and hospitalizations by high utilizers, and more stable housing solutions for the Pilot's focus population.

MCHD analysts will provide all partner entities with data reporting forms, and MCHD analysts will house and analyze data using Excel spreadsheets for the Executive Team's interpretation. Performance measure results, by individual partner, aggregated by function, and aggregated for the Pilot overall, will be posted to a Google Docs platform that will be accessible by all partner entities. If results are less than satisfactory, a PDSA process will be exercised to discover what barriers, bottlenecks, resource challenges, or other impediments can be facilitated.

On a quarterly basis, MCHD analysts will provide the Pilot's Executive Team with tables, charts, and graphs for easily understood visualizations of progress toward the Pilot's goals. Quarterly reports, consisting of the above plus narrative regarding the Executive Committee's interpretation and next steps to be taken, will also be submitted to DHCS at required intervals. Annual reports will be drawn from these materials. Annual reports will be shared with all community stakeholders, posted on publically accessible places, and shared with public health and evaluation communities of practice.

1.1.a Universal Metrics

- ✓ **Health Outcomes Measures**
- ✓ **Administrative Measures**

Universal Metrics - Health Outcomes and Administrative Metrics

Metrics	PY 1	PY 2	PY 3	PY 4	PY 5
i. Health Outcomes Ambulatory Care – Adult ED Visits (HEDIS)* (measured by aggregated focus population visits)	Adult ED Visits: **x=baseline**	Adult ED Visits: **x-2%**	Adult ED Visits: **x-4%**	Adult ED Visits: **x-5%**	Adult ED Visits: **x-7%**
ii Health Outcomes Adult Inpatient Utilization-General Hospital/Acute Care (IPU) (HEDIS)* (measured by aggregated focus population inpatient days)	Adult Inpatient utilization: **x=baseline**	Adult Inpatient utilization: **x-2%**	Adult Inpatient utilization: **x-4%**	Adult Inpatient utilization: **x-5%**	Adult Inpatient utilization: **x-7%**
iii Health Outcomes Follow-up After Hospitalization for Mental Illness (Adults) (FUH) (HEDIS) (measured by the number of discharged clients given a follow up appointment within 7 days and a treatment plan within 30 days)	Adult Follow up After Hospitalization for Mental Illness: **x=baseline**	Adult Follow up After Hospitalization for Mental Illness: **x+2%**	Adult Follow up After Hospitalization for Mental Illness: **x+4%**	Adult Follow up After Hospitalization for Mental Illness: **x+5%**	Adult Follow up After Hospitalization for Mental Illness: **x+7%**
iv Health Outcomes Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Adults) (IET) (HEDIS) (measured by the number of focus population who have been informed of SUD services and been given an SUD assessment)	Initiation and engagement of AOD for Adults: **x=baseline**	Initiation and engagement of AOD for Adults: **x+2%**	Initiation and engagement of AOD for Adults: **x+4%**	Initiation and engagement of AOD for Adults: **x+5%**	Initiation and engagement of AOD for Adults: **x+7%**

***Includes quarterly utilization of PDSA with measurement and necessary changes.**

Universal Metrics - Health Outcomes and Administrative Metrics - continued

Metrics	PY 1	PY 2	PY 3	PY 4	PY 5
v. **Administrative:** **Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team, within 30 days of:** **1. Enrollment into the WPC Pilot*** **2. The beneficiary's anniversary of participation in the Pilot (to be conducted annually)***	1. Enrollment into WPC Pilot: **x=baseline %** 2. Beneficiary's anniversary of participation in the Pilot: **x=baseline**	1. Enrollment into WPC Pilot: **x= 100%** 2. Beneficiary's anniversary of participation in the Pilot: **x=baseline + 5%**	1. Enrollment into WPC Pilot: **x= 100%** 2. Beneficiary's anniversary of participation in the Pilot: **x=baseline + 10%**	1. Enrollment into WPC Pilot: **x= 100%** 2. Beneficiary's anniversary of participation in the Pilot: **x=baseline + 15%**	1. Enrollment into WPC Pilot: **x= 100%** 2. Beneficiary's anniversary of participation in the Pilot: **x=baseline + 20%**
vi. Administrative: **a. Care coordination, case management, and referral infrastructure*** ***Reporting Partners: Lead entity (MCHD) and the Coalition of Homeless Services Providers***	Submission of documents establishing care coordination, case management, referral policies and procedures across all partners: **complete or materially complete by end of PY1**	Number of WPC high utilizers who receive at least 12 months of coordinated case management: **50** Beneficiaries with a comprehensive care plan: **100**	Number of WPC high utilizers who receive at least 12 months of coordinated case management: **55** Beneficiaries with a comprehensive care plan: **110**	Number of WPC high utilizers who receive at least 12 months of coordinated case management: **70** Beneficiaries with a comprehensive care plan: **140**	Number of WPC high utilizers who receive at least 12 months of coordinated case management: **75** Beneficiaries with a comprehensive care plan: **150**

***Includes quarterly utilization of PDSA with measurement and necessary changes.**

Universal Metrics - Health Outcomes and Administrative Metrics - continued

Metrics	PY 1	PY 2	PY 3	PY 4	PY 5
vi. Administrative: **b. Monitoring procedures for oversight of how the policies and procedures set forth in iv.1a are being operationalized, including a regular review to determine any needed qualifications. ****	Upon completion of all documents establishing care coordination, case management, and referral policies and procedures, **PDSA will be utilized semi-annually**	**PDSA will be utilized semi-annually**	**PDSA will be utilized semi-annually**	**PDSA will be utilized semi-annually**	**PDSA will be utilized semi-annually**
C. compile and analyze information and findings from the monitoring procedures set forth in iv.1b.	Upon monitoring the completed documents establishing care coordination, case management, and referral policies and procedures, **findings will be will be compiled and analyzed semi-annually, and a PDSA will be utilized semi-annually to modify such as needed.**	**Findings will be will be compiled and analyzed semi-annually, and a PDSA will be utilized semi-annually to modify such as needed.**	**Findings will be will be compiled and analyzed semi-annually, and a PDSA will be utilized semi-annually to modify such as needed.**	**Findings will be will be compiled and analyzed semi-annually, and a PDSA will be utilized semi-annually to modify such as needed.**	**Findings will be will be compiled and analyzed semi-annually, and a PDSA will be utilized semi-annually to modify such as needed.**

**** Includes semi-annual utilization of PDSA with measurement and necessary changes.**

Universal Metrics - Health Outcomes and Administrative Metrics - continued

Metrics	PY 1	PY 2	PY 3	PY 4	PY 5
vii. Administrative: a. Submit documents demonstrating data and information sharing policies and procedures across the WPC Pilot lead and all participating entities. b. Monitor procedures for oversight of how the policies and procedures set forth in v.1(a) are operationalized – including a regular review to determine any needed modifications** c. Compile and analyze information and findings from the monitoring procedures set forth in v.1(b)	a. documents demonstrating data sharing policies and procedures will be submitted at the end of PY1 b. PDSA will be utilized semi-annually to determine any needed modifications c. PDSA will be used semi-annually to update policies and procedures as needed	a. Lead agency will provide proof of all participating agency use of data and information sharing policies and procedures. b. PDSA will be utilized semi-annually to determine any needed modifications c. PDSA will be used semi-annually to update policies and procedures as needed	a. Lead agency will provide proof of all participating agency use of data and information sharing policies and procedures. b. PDSA will be utilized semi-annually to determine any needed modifications c. PDSA will be used semi-annually to update policies and procedures as needed	a. Lead agency will provide proof of all participating agency use of data and information sharing policies and procedures. b. PDSA will be utilized semi-annually to determine any needed modifications c. PDSA will be used semi-annually to update policies and procedures as needed	a. Lead agency will provide proof of all participating agency use of data and information sharing policies and procedures. b. PDSA will be utilized semi-annually to determine any needed modifications c. PDSA will be used semi-annually to update policies and procedures as needed

** Includes semi-annual utilization of PDSA with measurement and necessary changes.

Variant Metrics

Variant Metric	PY 1	PY 2	PY 3	PY 4	PY 5
Health outcomes metrics across all five programyears ***Reporting Partners: Hospitals, mental health providers, medical provider, and comprehensive case managers***	**Health Outcomes:** Timely case management enrollment **Target population:** All WPC Pilot Participants **Numerator:** Follow up medical, mental health, and SUDappointments no later than 30 days from date of release from jail or discharge from hospital. **Denominator:** All WPC Pilot Participants **PY 1: 80%**	**Health Outcomes:** Timely case management enrollment **Target population:** All WPC Pilot Participants **Numerator:** Follow up medical, mental health, and SUDappointments no later than 30 days from date of release from jail or discharge from hospital. **Denominator:** All WPC Pilot Participants **PY 2: 84%**	**Health Outcomes:** Timely case management enrollment **Target population:** All WPC Pilot Participants **Numerator:** Follow up medical, mental health, and SUDappointments no later than 30 days from date of release from jail or discharge from hospital. **Denominator:** All WPC Pilot Participants **PY 3: 88%**	**Health Outcomes:** Timely case management enrollment **Target population:** All WPC Pilot Participants **Numerator:** Follow up medical, mental health, and SUDappointments no later than 30 days from date of release from jail or discharge from hospital. **Denominator:** All WPC Pilot Participants **PY4: 92%**	**Health Outcomes:** Timely case management enrollment **Target population:** All WPC Pilot Participants **Numerator:** Follow up medical, mental health, and SUDappointments no later than 30 days from date of release from jail or discharge from hospital. **Denominator:** All WPC Pilot Participants **PY 5: 96%**
	Health Outcomes: 30 day All Cause Hospital Readmissions **Target population:** All WPC Pilot Participants **Numerator:** Count of 30-day readmission **Denominator:** Count of index hospital stay (HIS) **PY1:** Baseline	**Health Outcomes:** 30 day All Cause Hospital Readmissions **Target population:** All WPC Pilot Participants **Numerator:** Count of 30-day readmission **Denominator:** Count of index hospital stay (HIS) **PY2:** Baseline - I event	**Health Outcomes:** 30 day All Cause Hospital Readmissions **Target population:** All WPC Pilot Participants **Numerator:** Count of 30-day readmission **Denominator:** Count of index hospital stay (HIS) **PY3:** Baseline - 2 events	**Health Outcomes:** 30 day All Cause Hospital Readmissions **Target population:** All WPC Pilot Participants **Numerator:** Count of 30-day readmission **Denominator:** Count of index hospital stay (HIS) **PY4:** Baseline-3 events	**Health Outcomes:** 30 day All Cause Hospital Readmissions **Target population:** All WPC Pilot Participants **Numerator:** Count of 30-day readmission **Denominator:** Count of index hospital stay (HIS) **PY5:** Baseline- 4 events

Variant Metrics - continued

Health Outcome Metric - Coordinated Case management Use of PDSA: **quarterly in PY 2-5**	**Health Outcomes:** coordinated case management **Target population:** All WPC Pilot participants **Numerator:** All WPC Pilot participants **Denominator:** All WPC Pilot participants **PY1:** Fully define the scope of comprehensive case management, provider roles, management systems.	**Health Outcomes:** coordinated case management **Target population:** All WPC Pilot participants **Numerator:** All WPC Pilot participants **Denominator:** All WPC Pilot participants **PY1: 100** WPC participants receive at least 12months of coordinated case management. **200** WPC participants have a comprehensive care plan	**Health Outcomes:** coordinated case management **Target population:** All WPC Pilot participants **Numerator:** All WPC Pilot participants **Denominator:** All WPC Pilot participants **PY1: 200** WPC participants receive at least 12months of coordinated case management. **300** WPC participants have a comprehensive care plan	**Health Outcomes:** coordinated case management **Target population:** All WPC Pilot participants **Numerator:** All WPC Pilot participants **Denominator:** All WPC Pilot participants **PY1: 300** WPC participants receive at least 12months of coordinated case management. **400** WPC participants have a comprehensive care plan	**Health Outcomes:** coordinated case management **Target population:** All WPC Pilot participants **Numerator:** All WPC Pilot participants **Denominator:** All WPC Pilot participants **PY1:300** WPC participants receive at least 12months of coordinated case management. **500** WPC participants have a comprehensive care plan
Health Outcome Metric - Hospital Coordination ***Reporting Partners: Hospital providers(ED and in-patient)***	**Health Outcomes:** hospital coordination **Target population:** All WPC Pilot participants **Numerator:** All WPC Pilot participants **Denominator:** All WPC Pilot participants **PY1:** Medication list provided on discharge: **0%** Timely documentation transition toclinics/PCP: **0%** MHU re- hospitalization within 30 days: **x=baseline**	**Health Outcomes:** hospital coordination **Target population:** All WPC Pilot participants **Numerator:** All WPC Pilot participants **Denominator:** All WPC Pilot participants **PY1:** Medication list provided on discharge: **5%** Timely documentation transition toclinics/PCP: **5%** MHU re- hospitalization within 30 days: **x -1%**	**Health Outcomes:** coordinated case management **Target population:** All WPC Pilot participants **Numerator:** All WPC Pilot participants **Denominator:** All WPC Pilot participants **PY1:** Medication list provided on discharge: **10%** Timely documentation transition toclinics/PCP: **10%** MHU re- hospitalization within 30 days: **x-2%**	**Health Outcomes:** coordinated case management **Target population:** All WPC Pilot participants **Numerator:** All WPC Pilot participants **Denominator:** All WPC Pilot participants **PY1:** Medication list provided on discharge: **15%** Timely documentation transition toclinics/PCP: **15%** MHU re- hospitalization within 30 days: **x-3%**	**Health Outcomes:** coordinated case management **Target population:** All WPC Pilot participants **Numerator:** All WPC Pilot participants **Denominator:** All WPC Pilot participants **PY1:** Medication listprovided on discharge: **20%** Timely documentation transition to clinics/PCP: **20%** MHU re- hospitalization within 30 days: **x-4%**

Variant Metrics - continued

Health Outcome Metrics: Depression and SMI **Reporting Partners:** medical clinics and mental health services providers	**Health Outcome:** Required for Pilots using PHQ-9 **Target population:** WPC participants with depression diagnosis **Numerator:** Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five **Denominator:** Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter	**Health Outcome:** Required use of PHQ-9 **Target population:** WPC participants with depression diagnosis **Numerator:** Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five **Denominator:** Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter **PY2:** baseline-1 time	**Health Outcome:** Required use of PHQ-9 **Target population:** WPC participants with depression diagnosis **Numerator:** Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five **Denominator:** Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter **PY1:** baseline-2 times	**Health Outcome:** Required use of PHQ-9 **Target population:** WPC participants with depression diagnosis **Numerator:** Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five **Denominator:** Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter **PY1:** baseline-3 times	**Health Outcome:** Required use of PHQ-9 **Target population:** WPC participants with depression diagnosis **Numerator:** Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five **Denominator:** Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter **PY1:** baseline-4 times
	Health Outcome: Required for Pilots with SMI population **Target population:** WPC participants with risk of suicide **Numerator:** Patients who had suicide risk assessment completed at each visit **Denominator:** All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder **PY1:** 60%	**Health Outcome:** Required for Pilots with SMI population **Target population:** WPC participants with risk of suicide **Numerator:** Patients who had suicide risk assessment completed at each visit **Denominator:** All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder **PY1:** 65%	**Health Outcome:** Required for Pilots with SMI population **Target population:** WPC participants with risk of suicide **Numerator:** Patients who had suicide risk assessment completed at each visit **Denominator:** All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder **PY1:** 69%	**Health Outcome:** Required for Pilots with SMI population **Target population:** WPC participants with risk of suicide **Numerator:** Patients who had suicide risk assessment completed at each visit **Denominator:** All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder **PY1:** 73%	**Health Outcome:** Required for Pilots with SMI population **Target population:** WPC participants with risk of suicide **Numerator:** Patients who had suicide risk assessment completed at each visit **Denominator:** All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder **PY1:** 75%

Variant Metrics - continued

Health Outcome Metric - Disease Prevention and self-management **Reporting Partners:** medical clinics and providers	**Health Outcome:** HbA1c Poor Control <8% across all program years **Target population:** WPC participants with diabetes diagnosis **Numerator: Within the denominator,** WPC Pilot participants who had poorly controlled diabetes (HbA1c ><8%) **Denominator:** WPC Participants 18-75 years of age with diabetes (type 1 and type 2) **PY1:** 50%	**Health Outcome:** HbA1c Poor Control <8% across all program years **Target population:** WPC Participants with diabetes diagnosis **Numerator: Within the denominator,** WPC Pilot participants who had poorly controlled diabetes (HbA1c ><8%) **Denominator:** WPC Participants 18-75 years of age with diabetes (type 1 and type 2) **PY2:** 46%	**Health Outcome:** HbA1c Poor Control <8% across all program years **Target population:** WPC Participants with diabetes diagnosis **Numerator: Within the denominator,** WPC Pilot participants who had poorly controlled diabetes (HbA1c ><8%) **Denominator:** WPC Participants 18-75 years of age with diabetes (type 1 and type 2) **PY3:** 44%	**Health Outcome:** HbA1c Poor Control <8% across all program years **Target population:** WPC Participants with diabetes diagnosis **Numerator: Within the denominator,** WPC Pilot participants who had poorly controlled diabetes (HbA1c ><8%) **Denominator:** WPC Participants 18-75 years of age with diabetes (type 1 and type 2) **PY4:** 42%	**Health Outcome:** HbA1c Poor Control <8% across all program years **Target population:** WPC Participants with diabetes diagnosis **Numerator: Within the denominator,** WPC Pilot participants who had poorly controlled diabetes (HbA1c ><8%) **Denominator:** WPC Participants 18-75 years of age with diabetes (type 1 and type 2) **PY5:** 40%

Variant Metrics - continued

Health Outcome Metric - Disease Prevention and self-management **Reporting Partners:** medical clinics and providers	**Health Outcome:** Control blood pressure across all program years **Target population:** WPC participants with hypertension diagnosis **Numerator:** Within the denominator, WPC Pilot participants whose BP was adequately controlled during the measurement year based on the following criteria: • Members age 18-59 with BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <150/90 mm Hg **Denominator:** Members age 18-85 with hypertension **PY1:** 50%	**Health Outcome:** Control blood pressure across all program years **Target population:** WPC participants with hypertension diagnosis **Numerator:** Within the denominator, WPC Pilot participants whose BP was adequately controlled during the measurement year based on the following criteria: • Members age 18-59 with BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <150/90 mm Hg **Denominator:** Members age 18-85 with hypertension **PY2:** 54%	**Health Outcome:** Control blood pressure across all program years **Target population:** WPC participants with hypertension diagnosis **Numerator:** Within the denominator, WPC Pilot participants whose BP was adequately controlled during the measurement year based on the following criteria: • Members age 18-59 with BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <150/90 mm Hg **Denominator:** Members age 18-85 with hypertension **PY3:** 56%	**Health Outcome:** Control blood pressure across all program years **Target population:** WPC participants with hypertension diagnosis **Numerator:** Within the denominator, WPC Pilot participants whose BP was adequately controlled during the measurement year based on the following criteria: • Members age 18-59 with BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <150/90 mm Hg **Denominator:** Members age 18-85 with hypertension **PY4:** 58%	**Health Outcome:** Control blood pressure across all program years **Target population:** WPC participants with hypertension diagnosis **Numerator:** Within the denominator, WPC Pilot participants whose BP was adequately controlled during the measurement year based on the following criteria: • Members age 18-59 with BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <150/90 mm Hg **Denominator:** Members age 18-85 with hypertension **PY5:** 60%

Health Outcome Metric - Disease Prevention and self-management **Reporting Partners:** mental health providers	**Health Outcome:** Substance abuse Prevention **Target population:** All WPC participants with substance use disorder **Numerator:** WPC population receiving tobacco assessment and substance use assessment and counseling **Denominator:** All WPC participants with substance use disorder **PY1:** Tobacco Assessment and Counseling: **60%** Alcohol and Drug Misuse (SBIRT): **60%**	**Health Outcome:** Substance abuse Prevention **Target population:** All WPC participants with substance use disorder **Numerator:** WPC population receiving tobacco assessment and substance use assessment and counseling **Denominator:** All WPC participants with substance use disorder **PY1:** Tobacco Assessment and Counseling: **65%** Alcohol and Drug Misuse (SBIRT): **65%**	**Health Outcome:** Substance abuse Prevention **Target population:** All WPC participants with substance use disorder **Numerator:** WPC population receiving tobacco assessment and substance use assessment and counseling **Denominator:** All WPC participants with substance use disorder **PY1:** Tobacco Assessment and Counseling: **70%** Alcohol and Drug Misuse (SBIRT): **70%**	**Health Outcome:** Substance abuse Prevention **Target population:** All WPC participants with substance use disorder **Numerator:** WPC population receiving tobacco assessment and substance use assessment and counseling **Denominator:** All WPC participants with substance use disorder **PY1:** Tobacco Assessment and Counseling: **75%** Alcohol and Drug Misuse (SBIRT): **75%**	**Health Outcome:** Substance abuse Prevention **Target population:** All WPC participants with substance use disorder **Numerator:** WPC population receiving tobacco assessment and substance use assessment and counseling **Denominator:** All WPC participants with substance use disorder **PY1:** Tobacco Assessment and Counseling: **80%** Alcohol and Drug Misuse (SBIRT): 8**0%**

Variant Metrics - continued

Variant Metric	PY 1	PY 2	PY 3	PY 4	PY 5
Housing Services for homeless/at-risk homeless participants	**Health Outcome:** Housing Services **Target population:** WPC participants who are homeless or at risk for homelessness **Numerator:** Number of participants referred for housing services that receive services **Denominator:** Number of participants referred for housing services that receive services **PY1:** baseline	**Health Outcome:** Housing Services **Target population:** WPC participants who are homeless or at risk for homelessness **Numerator:** Number of participants referred for housing services that receive services **Denominator:** Number of participants referred for housing services that receive services **PY1:** 20 people	**Health Outcome:** Housing Services **Target population:** WPC participants who are homeless or at risk for homelessness **Numerator:** Number of participants referred for housing services that receive services **Denominator:** Number of participants referred for housing services that receive services **PY1:** 30 people	**Health Outcome:** Housing Services **Target population:** WPC participants who are homeless or at risk for homelessness **Numerator:** Number of participants referred for housing services that receive services **Denominator:** Number of participants referred for housing services that receive services **PY1:** 40 people	**Health Outcome:** Housing Services **Target population:** WPC participants who are homeless or at risk for homelessness **Numerator:** Number of participants referred for housing services that receive services **Denominator:** Number of participants referred for housing services that receive services **PY1:** 40+ people
Housing-Specific Metric: Develop 40 permanent supportive rental housing units for focus population in the "ground zero" location for chronic homelessness in Monterey County. Staff the site with 2-3 qualified, fulltime case managers with 1 living on site. ***Reporting Partners: Housing support services providers***	**Health Outcome:** Housing Services **Target population:** WPC participants who are homeless or at risk for homelessness **Numerator:** Number of participants referred for housing services that receive services **Denominator:** Number of participants referred for housing services that receive services **PY1:** Pre-development	**Health Outcome:** Housing Services **Target population:** WPC participants who are homeless or at risk for homelessness **Numerator:** Number of participants referred for housing services that receive services **Denominator:** Number of participants referred for housing services that receive services **PY2:** Secure financing; design 40 units for permanentsupportive housing.	**Health Outcome:** Housing Services **Target population:** WPC participants who are homeless or at risk for homelessness **Numerator:** Number of participants referred for housing services that receive services **Denominator:** Number of participants referred for housing services that receive services **PY3:** Construction and tenant pre-identification	**Health Outcome:** Housing Services **Target population:** WPC participants who are homeless or at risk for homelessness **Numerator:** Number of participants referred for housing services that receive services **Denominator:** Number of participants referred for housing services that receive services **PY4:**Tenant move-in. Achieve 100% lease-up. Begin case management and wide array of supportive services.	**Health Outcome:** Housing Services **Target population:** WPC participants who are homeless or at risk for homelessness **Numerator:** Number of participants referred for housing services that receive services **Denominator:** Number of participants referred for housing services that receive services **PY5:** Ongoing case management at the housing site with 70% retention rate.

4.2 Data Analysis, Reporting and Quality Improvement

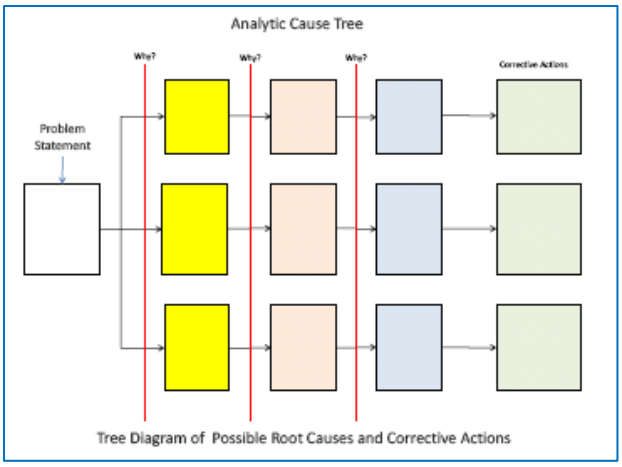
Ongoing data collection, reporting, and analysis of the WPC Pilot's interventions, strategies, participant health outcomes, and return on investment will be accomplished using existing and new data sources. Initial partnership work has included identification of current universal and potential variant metrics that are maintained in each partner's data system (data systems are displayed in the table below)

WPC Pilot Partner	Current Database(s)	Using Identity Matching Tool?	Future User of Case Management Tool
Monterey County Health Department, Nurse Case Management and Clinic Services	EPIC	In process	Yes
Monterey County Health Department Behavioral Health Bureau	Avatar	In process	Yes
Monterey County Department of Social Services	Automated Welfare System, Consortium IV	Future goal	Yes
Natividad Medical Center	Meditech	Yes	Yes
Coalition of Homeless Services Provider	Homeless Management Information System	Future goal	Yes
Interim, Inc.	Avatar	In process	Yes
Franciscan Workers of Junipero Serra	HMIS	Future goal	Yes
Monterey County Sheriff's Department	TrakNet, Automated Fingerprint Identification System	Future goal	Yes
Monterey County Probation Department	Smart Probation	Future goal	Yes

Initially, Epidemiologists will develop an analytic approach, including the program questions and fields to track from the various data sets from the participating partners. Algorithms will be developed using the partner's datasets and used to query them to track individuals in each system that match the Pilot criteria and are enrolled in the Pilot. Within the first year, the participating health care partners will have an Identity Matching Tool (Master Person Index) to track individuals enrolled in the Pilot and have developed an RFP for a Case Management System and contracted with a company to use their unified case management solution for the WPC Pilot.

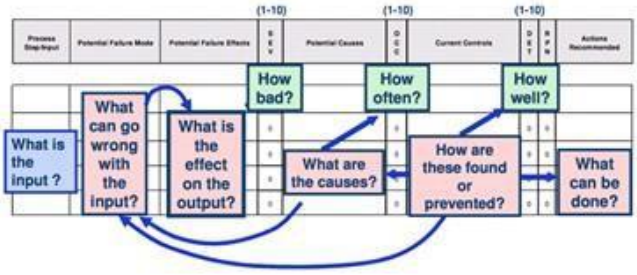
Data sharing agreements will be developed over the first year to enable partners to share patient data. The

solution will be how the patient-centered coordinated care plan is developed and onboarding/follow-up, referral management, and social determinants outcomes are monitored by the WPC Pilot Program Director, CHW/case managers, Social Workers, and other service providers. The solution will provide population level reports as well as individual case tracking. The reports will be used as part of the data analysis to determine the effectiveness of the Pilot's interventions and strategies, along with the data collected as part of quality improvement and change management (outlined below). In addition, while initially patient outcomes will be monitored from individual databases, the goal will be to use the Identity Matching Tool to create a data warehouse for tracking Pilot outcomes. Several of the MCHD partners identified for the WPC Pilot have work diligently for the last several years to bring siloed data systems together for analysis of root causes, determining factors, and bigger picture solutions. For example, MCHD's Behavioral Health Bureau and the DSS Children's Welfare System have been engaged since 2010 to share data between their respective data systems for the purpose of developing an informed view of Monterey County's foster youth population. The result has been a Memorandum of Understanding to share data for dependent children, a matching algorithm, and a monthly manual matching process for almost 500 children and youth in foster care. These collaborators are also now participating in the national Stewards of Change program and discussions on integration have begun to use their Human Services2.0 Handbook. This process will be the framework for producing the integrated population level data for the WPC Pilot data analysis and reporting approach. Algorithms will be developed by MCHD epidemiologists using SAS analytics and resulting analyses used by the Executive and Case Management Teams for quality improvement and change management.



MCHD uses Plan-Do-Study-Act (PDSA) as its quality improvement (QI) process since 2011, per MCHD's Performance Management and Quality Improvement Plan developed in support of national Public Health Accreditation. This plan uses the Turning Point Performance Management System Framework. More than 130 MCHD directors, managers, and lead staff have formal PDSA and QI training in a "Train the Trainers" model and have worked on at least one QI team. Managers have exercised PDSA as an iterative process, with involvement of MCHD's internal evaluators who

analyze collected process and outcome data. MCHD has had Public Health Foundation under contract for the past 3 years, providing instruction and refresher courses in using program performance measurement and corrective action tools, such as the Diagnostic Force Field Analysis, the Analytic Cause Tree (above), and Error Proofing technique (below). Other tools and forms provided by DHCS for Pilot improvement and reporting will be employed.



Key Questions to Implement Proper Error-Proofing	
What steps/processes are important?	Function, requirements
What can go wrong?	Potential failure mode, PDPC
How could the failure affect the customer (internal, external)?	Effects of failure
How serious is the effect of the failure mode on the customer?	Severity (rating 1-10; 10 = most severe)
Why would failure occur?	Cause of failure
How often will it happen?	Occurrence (rating 1-10; 10= highest probable rating)
What are the controls used by the process?	Recommend Action(s)→Error-Proofing
What is the probability that current process control will detect a problem?	Detection→Error-Proofing (ranks 1-10; 1=certain, 10 = absolute uncertainty)
What can be done to improve the process?	Recommend Action(s)→ Error-Proofing
What is the Risk Priority Number (RPN)?	RPN=Occurrence x Severity x Effectiveness - Detection

In its change management process, the WPC Pilot Executive Team will use the Toolkit developed by Harvard's Technology and Entrepreneurship Center's Leadership for a Networked World, the Human Services Value Curve. This model provides a roadmap for improving human services outcomes, value, and legitimacy through a lens of four different business models. It comes with 20 different assessment tools to help develop a transformative approach to collaborative, creative and innovative service delivery. In addition, the team will develop a risk communications plan for all interested parties (internal and external partners), a risk management plan, a timeline for the stages of the Pilot, a status reporting tool, regular checkpoints for conversations with key individuals in the Pilot, and a staged implementation/deployment plan for the Pilot. The MCHD WPC Pilot has already had several months of critical discussions and planning sessions and achieved significant buy-in to the Pilot plan (see letters of support). These planning and implementation meetings will continue after the Pilot launches as part of the change management process. The iterative quality improvement process will also provide periodic reports that will be used to do midcourse corrections or any necessary modifications to the Pilot implementation process. The Pilot team will use the data collection tools outlined above to track metrics, and will combine these metrics with survey and assessment tools developed for the project by the evaluation team to identify and implement needed adjustments to the program.

4.3 Participant Entity Monitoring

The MCHD WPC Pilot Program Director, a subset of CHW/case managers, representatives of the Executive Committee, and evaluators with PDSA and QI training experience will constitute an Evaluation Workgroup to conduct and oversee ongoing monitoring, analysis, and corrective activities related to the Pilot's universal and variant metrics. Process measures will be used in the Pilot's first year, and outcome measures will be initiated once the Master Person Index is fully functional. Process measures will include fidelity to the Executive Committees functionality, Pilot's timeline, Year 1 contracted deliverables (Master Person Index, Case Management System), implementation of the Pilot communication plan, and partnership referral readiness. In Pilot Year 1, the Evaluation Workgroup will meet bimonthly, and designated members will participate in annual State Learning Collaborative in-person activities held during years 2-5.

A critical element to the Pilot's success will be implementation of the case management tool and subsequent oversight of the care coordination, case management, and referral infrastructure.
This will include referral communications, policies and procedures between the CHW/case managers and personal navigators. Our WPC Pilot Program Director, who is MCHD's Director of Nursing, will be responsible for other existing case management initiatives serving individuals with chronic physical health conditions including diabetes and obesity, first time at risk mothers, and newborns.

We envision a weekly case review format convened by the WPC Pilot Program Director. The Evaluation Workgroup will have available to them all the management tools described above in 2.2 Communication Plan. The Evaluation Workgroup updates will be a standing item on the Executive Committee's monthly agenda, and written summary reports will be issued quarterly. Summary reports will contain, among other items, process and outcome performance, case counts and case manager-to-client ratios, results of PDSA activities using the State-developed template, and draft reports prepared for DHCS.

Corrective actions will be formally issued to vendors, contractors, or partners when root causes to barriers and process efficiencies have been identified. The MCHD WPC Pilot may terminate agreements or contracts should persistent poor performance continue.

Section 5: Financing

5.1 Financing Structure

The Executive Team will oversee the intake and payment of funds as guided by the Finance workgroup. The Program Director will serve as the Contract Analyst and assure administrative procedures are followed. MCHD will develop MOUs or Agreements with non-federal funding partners and subcontracting agencies with clear scope of work deliverables and payment provisions. Subcontracted agencies will submit quarterly invoices based on MOU or Agreement Payment Provisions which may be bundled, fee for services, or incentive-based as outlined in the attached budget worksheets and narratives.

Existing MCHD Administration fiscal staff will establish purchase orders and process payments as approved by the Program Director in accordance with County Auditor-Controller policies and procedures. Additionally, fiscal staff will develop an excel worksheet tracking tool identifying non-federal funders and funded partners, annual amounts, receipt and disbursement of funds by fiscal year. The Program Director will work closely with Finance Workgroup as related to payment provisions in executed MOUs and Agreements.

The Finance Workgroup will have representatives from each of the non-federal funding partners including MCHD Clinic Services, Behavioral Health and Public Health Bureaus; Monterey County Department of Social Services; Monterey County's Natividad Medical Center; Salinas Valley Memorial Healthcare System; and other key participating entities. The Finance workgroup will initially meet monthly initially and later, quarterly, once MOUs are in place to monitor progress in meeting deliverables and budgeted services, funding contributed for IGT and flow of funds to participating entities once payments are made by DHCS. For Years 2 – 5, mid-year and annual progress reports will be due to DHCS within 60 days of end of reporting period. DHCS will issue a request to MCHD for IGT funds within 30 days of determination of interim payment. MCHD will submit IGT within 7 days of receipt of DHCS payment request. DHCS will make payment to MCHD within 14 days of transfer of IGT. The Program Director and Finance Workgroup will assure compliance with DHCS timelines.

In order to assure funds committed are readily available and sufficient for WPC Pilot services, MCHD will establish specific accounting identifiers (program codes) in the County's financial system to track funds received and disbursement of funds for the WPC Pilot project. As noted above, the Program Director and Finance Workgroup will be responsible for assuring committed funds are received by non-federal share

partners and that funded partners are performing according to their MOU and Agreement scope of work and payment provisions. The non-federal share partners will transfer funds for the WPC Pilot in equal biannual disbursements by end of January and end of July for each of the five Pilot years as will be noted in respective MOU.

By investing in an infrastructure to support comprehensive care coordination and data sharing and exchange, we will create a foundation to support value based payment approaches in the future. Investing in strategies that focus on high risk high utilizers will reduce expenditures via reduced ED and inpatient stays, improved health outcomes, and savings and opportunities for reinvesting in prevention services. These strategies will better prepare the healthcare partners for imminent healthcare payment reform.

MCHD's WPC Pilot funding structure includes partner funding for collecting and reporting performance metrics. These numerical outcome and process reports will be facilitated through data collection methods and tools developed by MCHD's in-house evaluation analysts. Data will be reported by all WPC Pilot partners on a quarterly basis, and results will be rolled up from individual partner to partnership function, and then the Pilot overall. Pay for reporting is in three equal amounts for reporting depression/suicide risk assessment, ED visits, and avoidable hospitalizations, as we consider these three elements to be of equal value to reaching WPC Pilot goals. The pay-for-reporting amounts are consistent across program years 2-5.

5.1.1. IT Infrastructure Financing

The premise for the IT infrastructure is to determine the solutions essential for this project that would alleviate the need for source data systems to change but develop a program and data architecture that will enable existing systems to interface. In order to support a multi-agency and multi-disciplinary team pilot as proposed in this application, the data infrastructure in this proposal requires a case management solution that does not currently exist.

The case management system (CMS) will enable the program coordinators to access information across multiple data systems for individuals that are enrolled in the pilot program. The CMS will enable participating

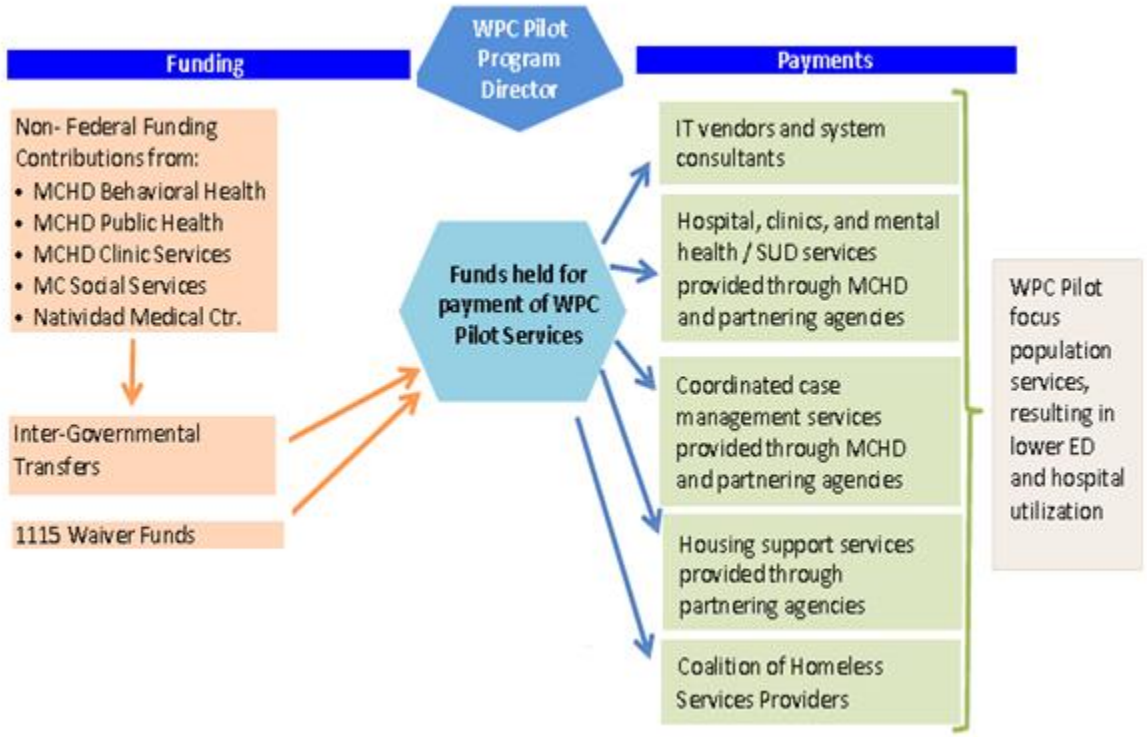
agencies and program coordinators to query, input data, and track the services provides and resources available without needing to change the proprietary source systems of the participating agencies. The CMS and eMPI will enable the County to enroll individuals in the pilot program with the need to gain control of data across siloed systems to support major expansion of service delivery.

The recommended solution and the associated estimate will be defined as the county proceeds with the RFP required to engage a vendor and solution necessary to support this pilot program. The opportunity provided by this project enables the MCHD to implement a full solution with the estimated costs with the understanding that the challenges of aggregating data from source systems, develop a workflow that is symbiotic between agencies that have not traditionally participated in a data solution that enables service delivery across multiple service disciplines is indeed innovative. The approval of this recommended data infrastructure that does not exist will enable the MCHD to develop, refine, and ensure this pilot is sustainable beyond the program term. Although the estimated number of participants may appear to be conservative, a pilot program involving multiple agencies requires a phased approach with a focus on the development of the workflow across multiple independent data systems, the legality of sharing information of shared clients that are in grave need of seamless service delivery system, the program governance, and agency participation to include the roles/responsibilities first. This logistical approach will enable the County to then focus on increasing the number of clients served in the program.

5.2 Funding Diagram

Below is a diagram of the WPC Pilot Program funding stream illustrating how funds flow from federal and non-federal sources into a holding position where, as directed by the WPC Pilot Program Director, they are disbursed in payments to vendors, consultants, and partnering direct services providers. **Please note that no funds are sourced from or paid to CCAH, our managed care plan.**

Fiscal Oversight by WPC Pilot Executive Team with input from WPC Pilot Finance Workgroup



5.3 Non-Federal Share

Non-Federal shares to the WPC Pilot are committed from these partner entities:

Partners committing non federal funds	Amounts
Monterey County Health Department	$1,422,863
Monterey County Dept of Social Services	$465,600
Monterey County Natividad Medical Center	$795,000

5.4 Non-Duplication of Payments and Allowable Use of Federal Financial Participation

The WPC pilot funding will support development of infrastructure necessary to improve care coordination for high risk, high utilizing Medi-Cal beneficiaries in an effort to reduce costs from avoidable ED visits and inpatient stays and improve health outcomes for this population. The funding will support establishment of care coordination teams, supportive housing supports, other critical coordinated wrap around services and most importantly, establishment of technology solutions to facilitate data sharing and data exchange amongst partnering agencies. These non Medi-Cal reimbursable services will add value to Medi-Cal covered services provided to Medi-Cal beneficiaries enrolled in the Pilot, and will greatly contributing to improved health outcomes. Pilot participants who have been identified to be Medi-Cal beneficiaries will be highlighted in electronic data systems, thereby assuring that federal financial participation is **only** for Medi-Cal beneficiaries.

Further, the vast majority of the activities and interactions of the care coordination teams will not duplicate Medi-Cal's targeted case management (TCM) benefit. Specifically, intensive case management of individuals' high ED and hospitalization use complicated with mental illness, addiction, co-morbidities and lack of a primary care home departs significantly from the encounter-based structure of TCM. In the vast majority of cases the encounters between individuals qualifying for intensive case management as described above, would not be eligible for reimbursement under TCM, as TCM workers either would not meet the education/experience requirements for TCM case workers/team members would be in a supervisory role and would have few, if any, direct contact with clients. Moreover, the scope of care support and coordination activities available through WPC is intended to be more robust than available through Medi-Cal **TCM. WPC teams will engage in activities such as peer supports, trust-building, motivational supports,**

disease specific education, and general reinforcement of health concepts, which are distinct from and outside the TCM benefit. WPC will also provide direct social and other services that would not be recognized as TCM, such as [food and nutrition supports, benefits advocacy or tenancy supports.

For these reasons, we have concluded that the vast majority of WPC Pilot activities will not duplicate services available through Medi-Cal TCM. As assurance, our WPC case managers will receive training and periodic reminders on the differences between TCM and WPC criteria, and be instructed that TCM will always be considered first, with WPC as the payer of last resort.

In response to concerns of duplication of payment, we have applied a TCM budget adjustment to several of the programs to reduce our request for WPC funds. Each TCM budget adjustment can be found in the corresponding service description.

5.5 Funding Request

Please see following pages for the Budget Summary and Budget Narrative.

Budget Summary

WPC Budget Template: Summary and Top Sheet	Federal Funds (Not to exceed 90M)	IGT	TOTAL FUNDS
WPC Applicant Name:	Monterey County Health Department		
	Federal Funds *(Not to exceed 90M)*	**IGT**	**Total Funds**
Annual Budget Amount Requested	2,683,463	2,683,463	5,366,926

PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	Funds
PY 1 Total Budget	5,366,926
Approved Application (75%)	4,025,195
Submission of Baseline Data (25%)	1,341,732
PY 1 Total Check	OK

PY 2 Budget Allocation	Funds
PY 2 Total Budget	5,366,926
Administrative Infrastructure	990,150
Delivery Infrastructure	941,000
Incentive Payments	1,200,000
FFS Services	32,500
PMPM Bundle	793,251
Pay For Reporting	1,010,025
Pay for Outcomes	400,000
PY 2 Total Check	OK

PY 3 Budget Allocation	Funds
PY 3 Total Budget	5,366,926
Administrative Infrastructure	237,956
Delivery Infrastructure	805,160
Incentive Payments	1,200,000
FFS Services	125,000
PMPM Bundle	1,741,500
Pay For Reporting	857,310
Pay for Outcomes	400,000
PY 3 Total Check	OK

PY 4 Budget Allocation	Funds
PY 4 Total Budget	5,366,926
Administrative Infrastructure	237,956
Delivery Infrastructure	896,336
Incentive Payments	1,200,000
FFS Services	125,000
PMPM Bundle	1,741,500
Pay For Reporting	766,134
Pay for Outcomes	400,000
PY 4 Total Check	OK

PY 5 Budget Allocation	Funds
PY 5 Total Budget	5,366,926
Administrative Infrastructure	237,956
Delivery Infrastructure	896,336
Incentive Payments	1,200,000
FFS Services	125,000
PMPM Bundle	1,741,500
Pay For Reporting	766,134
Pay for Outcomes	400,000
PY 5 Total Check	OK

WPC Budget Narrative PY1

WPC Budget Narrative

WPC Applicant Name: **Monterey County Health Department**

Program Year 1	Budget Amount
Approved Application (75%)	4,025,194
Submission of Baseline Data (25%)	1,341,731
PY 1 Total Budget	**5,366,926**

WPC Budget Narrative PY2

WPC APPLICANT NAME: Monterey County Health Department

PY 2 Budget Total **5,366,926**

Administrative Infrastructure

Staff	Annual Cost/Unit	Unit	Total
Project Manager (0.50 FTE) - Responsible for oversight and implementation of pilot project; contract oversight; supervises case managers; and receives direction from Pilot Executive Team. **First 6 months included as Administrative costs due to ramping up of staffing. Last 6 months included in PMPM bundle.**	170,000	0.25	42,500
Project Assistant (1.0 FTE) - reports to Project Manager; day to day coordination of WPC Pilot services; staffs governance structure and workgroup. **First 6 months included as Administrative costs due to ramping up of staffing. Last 6 months included in PMPM bundle.**	116,000	0.50	58,000
Complex Care Managers - PHNs (4.0 FTE) - Public Health Nurses responsible for comprehensive assessment, development of service plan, and case coordination for most complex patients; receives referrals from partner agencies; makes referrals to housing service providers; provide health education and health literacy; teaches patients self-management techniques and tools. **First 6 months included as Administrative costs due to ramping up of staffing. Last 6 months included in PMPM bundle.**	150,000	2.00	300,000
Community Health Workers (4.0 FTE) - non clinical support staff responsible for providing transportation to non Medi-Cal covered services; serve as patient navigator; assist case manager in coordination activities. **First 6 months included as Administrative costs due to ramping up of staffing. Last 6 months included in PMPM bundle.**	69,000	2.00	138,000
Business Technology/Data Analysts (2.0 FTE) - responsible for working with County and Department Information Technology Managers on IT solutions to be implemented; help identify IT solutions; perform complex data analytics; prepare customized programming as needed. **One FTE: First 6 months included as Administrative costs due to ramping up of staffing. Last 6 months included in Infrastructure costs. One FTE: 12 months in Administrative costs.**	145,000	1.50	217,500
Public Health Epidemiologist II (1.0 FTE) - responsible for data analysis; reporting of evaluation metrics	125,000	0.50	62,500
Sub-total			**818,500**

Staff	Annual Cost/Unit	Unit	Total
Services/Supplies/Indirect Costs			
Data Processing and Telecommunications Support	2,500	6.75	16,875
Hardware and Software for staff	1,500	6.75	10,125
Local Travel/Training	10,000	0.50	5,000
Training Curricula for Community Health Workers; purchase/development of curriculum; provision of certificated training program **(included 100% in CHW line time in budget summary worksheet, PY2 Cell B12)**	30,000	1.00	30,000
Purchase of Vehicle for conducting business and transportation of clients for non Medi-Cal Covered Services	30,000	2.00	60,000
General office supplies, printing, educational materials	5,000	0.50	2,500
Sub-total			124,500
Indirect Costs (5% of total Administrative Costs)	943,000	0.05	47,150
TOTAL ADMINISTRATIVE INFRASTRUCTURE			**990,150**

Delivery Infrastructure			
Column1	**Annual Cost/Unit**	**Unit**	**Total**
Information Technology Solutions and Staff			
Case Management Software - shared repository of case management data; ability to pull data from proprietary external data systems. Costs include: software license, implementation, hardware costs, training, professional services, vendor hosted and supported ($121,000 for solution). Business Technology/Data Analyst (1.0 FTE)- responsible for working with County and Department Information Technology Managers on IT solutions to be implemented; help identify IT solutions; perform complex data analytics; prepare customized programming as needed ($86,143). First 6 months included as Administrative costs due to ramping up of staffing. Last 6 months included in Infrastructure costs.	193,500	1	193,500
Coordinated Assessment and Referral System (CARS)/ Homeless Management System (HMIS) - primary support for housing assessment data for homeless and care coordination services; establish network of agencies; purchase software and support implementation; staff to *Lead Me Home* Committee; conducts homeless census. Costs include: staffing costs, operational expenses, software license and subscription; training; hardware costs	515,000	1	515,000
Community based Case Management Services - receive referrals from Core Case managers; conduct Vulnerability Assessment for homeless, connect homeless to Coordinated Assessment and Referral System, conduct case management services related to housing, refers clients to Coalition of Service Providers for placement. Costs include: staffing costs, operational expenses, training. PY2 is our startup year; therefore 50% of this item is included in Infrastructure and the remaining 50% is included in PMPM. It is anticipated there will be salary savings due to startup period; therefore PY 2 is lower than PYs 3-5.	200,000	1	200,000
Mobile Outreach Team - staffing mobile outreach efforts to reconnect chronically homeless individuals into care coordination system. Costs include: staffing costs; local travel; and operational costs. PY2 is our startup year; therefore 50% of this item is included in Infrastructure and the remaining 50% is included in PMPM. It is anticipated there will be savings due to startup period; therefore PY 2 is lower than PYs 3-5. Additionally, will take some time to enroll members thus not needing mobile outreach team until later in PY 2.	32,500	1	32,500
TOTAL DELIVERY INFRASTRUCTURE			**941,000**

Incentive Payments			
Column1	**Annual Cost/Unit**	**Unit**	**Total**
Primary Care Clinic - payment for scheduling follow up appointment within 30 days of discharge from inpatient stay or release from jail; linkage to primary care medical home helps improve health outcomes, provides necessary resources and supports for ongoing medical treatment. Clinic will meet measure for 20 patients for second 6 months of year. **Payment trigger:** Monterey County Health Clinics will receive $20,000 per WPC enrollee scheduled for and successful participation in follow-up appointment within 30 days post discharge or release. Biannual payments will be made.	20,000	20	400,000
Hospital Incentive - payment for reduction in inpatient readmission rates within 30 days; referral to coordinated care services will improve health outcomes and reduce avoidable inpatient stays. Hospital will meet measure for 20 patients for second 6 months of year. **Payment trigger:** Natividad Medical Center will be eligible for $20,000 per WPC enrollee successfully linked to care coordination without a readmission within 30 days. Biannual payments will be made.	20,000	20	400,000
Behavioral Health Clinic - payment for reduction in mental health unit readmission rates within 30 days; follow up care improves health outcomes, provides necessary resources, and supports for ongoing mental health treatment and therapy. Behavioral Health will meet measure for 20 patients for second 6 months of year. **Payment trigger:** Monterey County Behavioral Health Clinics will receive $20,000 per WPC enrollee scheduled for and successful participation in follow-up appointment within 30 days post discharge or release. Biannual payments will be made.	20,000	20	400,000
	TOTAL INCENTIVE PAYMENTS		**1,200,000**

FFS Services - N/A	Annual	Unit	Total
Mobile Outreach Team - staffing mobile outreach efforts to reconnect chronically homeless individuals into care coordination system. Costs include: staffing costs; local travel; and operational costs. PY2 is our startup year; therefore 50% of this item is included in Infrastructure and the remaining 50% is included in PMPM. It is anticipated there will be savings due to startup period; therefore PY 2 is lower than PYs 3-5. Additionally, will take some time to enroll members thus not needing mobile outreach team until later in PY 2. Service will be reimbursed per encounter (attempt to locate and reconnect pilot participants to care coordination system as requested by Core Case Management Team). Reimbursements will be made quarterly.			
Staff			
Project Manager	85,000	0.05	4,250
Outreach Workers	59,000	0.40	23,600
Services/Supplies/Indirects			
Data Processing and Telecommunications Support and hardware and software	2,500	0.55	1,375
Local Travel/Training, vehicle maintenance	1,500	1.00	1,500
General office supplies, educational materials	381	1.00	381
Indirect Costs **(5% of total Mobile Team)**	27,850	0.05	1,393
Total Mobile Outreach Team			**32,500**
	# Encounters	**Fee/Encounter**	**Total**
Fee For Service (Per encounter or time spent outreaching to pilot members when lost to service)	61	532.78	**32,500**

PMPM Bundle	Annual	Unit	Total
Community based Case Management Services - Housing Supports- receive referrals from Care Case managers; conduct Vulnerability Assessment for homeless, connect homeless to Coordinated Assessment and Referral System, conduct case management services related to housing, refers clients to Coalition of Service Providers for placement. Costs include: staffing costs, operational expenses, training. PY2 is our startup year; therefore 50% of this item is included in Infrastructure and the remaining 50% is included in PMPM. It is anticipated there will be salary savings due to startup period; therefore PY 2 is lower than PYs 3-5.	200,000	1	200,000
Complex Care Management Team			
Program focus is on patient centered coordination; transitional care interventions between services/systems; patient engagement; patient education on health topics, literacy, and self-management strategies; patient navigation services; and assurance referrals are made and kept. Total annual costs are split between Administrative and PMPM (6 months each).			
Staff			
Project Manager	170,000	0.25	42,500
Project Assistant	116,000	0.50	58,000
Case Managers	150,000	2.00	300,000
Community Health Workers	69,000	2.00	138,000
Services/Supplies/Indirects			
Data Processing and Telecommunications Support and hardware and software	4,000	4.75	19,000
Local Travel/Training	10,000	0.50	5,000
General office supplies, educational materials	5,000	0.50	2,500
Indirect Costs **(5% of total Complex Care Mgmt. Team)**	565,000	0.05	28,250
Total for Complex Care Management Team			**593,251**
Member months (6 months)	**100**	**600**	**988.75**

Pay for Reporting			
Column1	**Annual Cost/Unit**	**Unit**	**Total**
Reporting Number of ED Visits - active monitoring of avoidable ED visits will help target care coordination services to appropriate clients to link to primary care medical home thus increasing appropriate use of ED. **Payment trigger: Weekly reporting of ED visits by participating hospital. 50% of payment to be made every 6 months.**	70,000	1	70,000
Reporting Number Inpatient Utilization - active monitoring of avoidable inpatient days will help target care coordination services to appropriate clients to link to primary care medical home thus increasing appropriate use of hospital inpatient services. **Payment trigger: Weekly reporting of inpatient days by participating hospital. 50% of payment to be made every 6 months.**	70,000	1	70,000
Reporting Follow up after hospitalization for mental illness - active monitoring of mental health unit days and linking patients to outpatient mental health services will increase avoidable mental health unit days. **Payment trigger: Weekly reporting of follow up after hospitalization for mental illness. 50% of payment to be made every 6 months.**	70,000	1	70,000
Reporting Number of participants who are informed of SUD services - initiation and engagement and completion of assessment of clients needing substance use disorder treatment services will increase likelihood of road to recovery. **Payment trigger: Weekly reporting of SUD assessments completed. 50% of payment to be made every 6 months.**	70,000	1	70,000
Reporting Number of participants enrolled into WPC and number with comprehensive care plan within 30 days of enrollment. **Payment trigger: Monthly reporting of enrollees and development of comprehensive care plan. 50% of payment to be made every 6 months.**	70,000	1	70,000
Reporting progress made towards meeting administrative procedures (policies and procedures, compilation and analysis of data, progress towards data sharing, etc.) **Payment trigger: Bi-annual and annual reporting of progress towards and accomplishments of meeting administrative metrics. 50% of payment to be made every 6 months.**	120,025	1	120,025
Reporting Health Outcome Metric: WPC participants will have comprehensive diabetes care: HbA1c poor control > 9.0%. **Payment trigger: Measure will be met for 50% or less of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.**	70,000	1	70,000

Reporting Percentage of Avoidable Hospitalizations - active monitoring of avoidable hospitalization visits will help target care coordination services to appropriate clients to link to primary care medical home. **Payment trigger: Weekly reporting of inpatient stays by participating hospital. 50% of payment to be made every 6 months.**	70,000	1	70,000
Health Outcome Metric-Hospital. Medication list provided at discharge. Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	70,000	1	70,000
Health Outcome Metric-Hospital. Timely documentation transition to clinics/PCP. Payment trigger: Measure will be met for 5% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	70,000	1	70,000
Health Outcome Metric-Hospital. Depression remission at 12 months. Payment trigger: Measure will be met for baseline minus 1% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	70,000	1	70,000
Health Outcome Metric-Hospital. MHU re-hospitalization within 30 days. Payment trigger: Measure will be met for baseline minus 1% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	70,000	1	70,000
Health Outcome Metric: Patients with controlled hypertension. Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	70,000	1	70,000
Housing Metric - Reporting on progress towards developing 40 permanent supportive rental housing units for WPC population. Payment trigger: Metrics will be met annually as outlined in WPC proposal. 100% of payment will be annually.	50,000	1	50,000
TOTAL PAY FOR REPORTING			1,010,025

Pay for Outcomes			
Pay for Outcomes	**Annual Cost/Unit**	**Unit**	**Total**
Health outcomes: 80% or greater follow up mental health, medical, and SUD appointment within 30 days post hospitalization improves compliance with discharge planning. **Payment trigger: Measure will be met for 100% of patients enrolled in WPC pilot. 50% of payment to be made every 6 months.**	75,000	1	75,000
Health Outcome Metric: Suicide Risk Assessment and Alcohol and Drug Misuse - SBIRT - compliance with using screening tools improves ability for care team to identify vulnerabilities and appropriately connect to care coordination, therapy, social supports, and other necessary services to prevent suicide and get into appropriate alcohol and drug treatment services; 100% compliance will reduce avoidable ED visits, Mental Health Unit stays, and improve health outcomes. **Payment trigger: Tool will used with 60% of patients enrolled in WPC pilot. 50% of payment to be made every 6 months.**	75,000	1	75,000
Health Outcome Metric: WPC participants will receive **tobacco assessment and counseling**. **Payment trigger: Measure will be met for 90% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.**	75,000	1	75,000
Health Outcome Metric: WPC participants will receive **12 months of coordinated case management**. **Payment trigger: Measure will be met for 25-40% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.**	75,000	1	75,000
Health Outcome Metric: WPC participants will have a **comprehensive care plan**. **Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.**	100,000	1	100,000
TOTAL PAY FOR OUTCOMES			**400,000**

WPC Budget Narrative PY3

WPC Applicant Name: Monterey County Health Department

PY 3 Budget Total **5,366,926**

Administrative Infrastructure			
Staff	**Annual Cost/Unit**	**Unit**	**Total**
Public Health Epidemiologist II - responsible for data analysis; reporting of evaluation metrics	125,000	0.50	62,500
Business Technology/Data Analyst (1.0 FTE) - responsible for working with County and Department Information Technology Managers on IT solutions to be implemented; help identify IT solutions; perform complex data analytics; prepare customized programming as needed	160,000	1.00	160,000
Sub-total			222,500
Services/Supplies/Indirect Costs			
Data Processing and Telecommunications Support	2,500	1.50	3,750
General office supplies, printing, educational materials	250	1.50	375
Indirect Costs (5% of total Admin Costs)	226,625	0.05	11,331
Sub-total			15,456
TOTAL ADMINISTRATIVE INFRASTRUCTURE			**237,956**

Delivery Infrastructure	Annual Cost/Unit	Unit	Total
	Annual Cost/Unit	Unit	Total
Information Technology Solutions			
Case Management Software - shared repository of case management data; ability to pull data from proprietary external data systems. Costs include: software license, implementation, hardware costs, training, professional services, vendor hosted and supported ($121,000 for solution). **Business Technology/Data Analyst (1.0 FTE)**- responsible for working with County and Department Information Technology Managers on IT solutions to be implemented; help identify IT solutions; perform complex data analytics; prepare customized programming as needed ($172,286).	293,286	1	293,286
Coordinated Assessment and Referral System (CARS)/ Homeless Management System (HMIS) - primary support for housing assessment data for homeless and care coordination services; establish network of agencies; purchase software and support implementation; staff to *Lead Me Home* Committee; conducts homeless census. Costs include: staffing costs, operational expenses, software license and subscription; training; hardware costs	511,874	1	511,874
TOTAL DELIVERY INFRASTRUCTURE			**805,160**

Incentive Payments			
Column1	**Annual Cost/Unit**	**Unit**	**Total**
Primary Care Clinic - payment for scheduling follow up appointment within 30 days of discharge from inpatient stay or release from jail; linkage to primary care medical home helps improve health outcomes, provides necessary resources and supports for ongoing medical treatment. Clinic will meet measure for 20 patients for second 6 months of year. **Payment trigger:** Monterey County Health Clinics will receive $20,000 per WPC enrollee scheduled for and successful participation in follow-up appointment within 30 days post discharge or release. Biannual payments will be made.	20,000	20	400,000
Hospital Incentive - payment for reduction in inpatient readmission rates within 30 days; referral to coordinated care services will improve health outcomes and reduce avoidable inpatient stays. Hospital will meet measure for 20 patients for second 6 months of year. **Payment trigger:** Natividad Medical Center will be eligible for $20,000 per WPC enrollee successfully linked to care coordination without a readmission within 30 days. Biannual payments will be made.	20,000	20	400,000
Behavioral Health Clinic - payment for reduction in mental health unit readmission rates within 30 days; follow up care improves health outcomes, provides necessary resources, and supports for ongoing mental health treatment and therapy. Behavioral Health will meet measure for 20 patients for second 6 months of year. **Payment trigger:** Monterey County Behavioral Health Clinics will receive $20,000 per WPC enrollee scheduled for and successful participation in follow-up appointment within 30 days post discharge or release. Biannual payments will be made.	20,000	20	400,000
TOTAL INCENTIVE PAYMENTS			**1,200,000**

FFS Services - N/A				
Mobile Outreach Team - staffing mobile outreach efforts to reconnect chronically homeless individuals into care coordination system. Costs include: staffing costs; local travel; and operational costs. PY2 is our startup year; therefore 50% of this item is included in Infrastructure and the remaining 50% is included in PMPM. It is anticipated there will be savings due to startup period; therefore PY 2 is lower than PYs 3-5. Additionally, will take some time to enroll members thus not needing mobile outreach team until later in PY 2. Service will be reimbursed per encounter (attempt to locate and reconnect pilot participants to care coordination system as requested by Core Case Management Team). Reimbursements will be made quarterly.				
Staff				
Project Manager		85,000	0.20	17,000
Outreach Workers		59,000	1.50	88,500
Services/Supplies/Indirects				
Data Processing and Telecommunications Support and hardware and software		2,500	1.70	4,250
Local Travel/Training, vehicle maintenance		8,974	1.00	8,974
General office supplies, educational materials		1,000	1.00	1,000
Indirect Costs **(5% of total Mobile Team)**		105,500	0.05	5,275
Total Mobile Outreach Team				**125,000**
	# Encounters		**Fee/Encounter**	**Total**
Fee For Service (Per encounter or time spent outreaching to pilot members when lost to service)	235		532.78	**125,000**

PMPM Bundle			
Complex Care Management Team	**Cost**	**Unit**	**Total**
Program focus is on patient centered coordination; transitional care interventions between services/systems; patient engagement; patient education on health topics, literacy, and self-management strategies; patient navigation services; and assurance referrals are made and kept. Total annual costs are split between Administrative and PMPM (6 months each).			
Staff			
Project Manager	170,000	0.50	85,000
Project Assistant	116,000	1.00	116,000
Case Managers	150,000	4.00	600,000
Community Health Workers	69,000	4.00	276,000
Services/Supplies/Indirect			
Data Processing and Telecommunications Support and hardware and software	4,000	9.50	38,000
Local Travel/Training	10,000	1.00	10,000
General office supplies, educational materials	5,000	1.00	5,000
Indirect Costs (5% of total Complex Care Mgmt. Team)	1,130,000	0.05	56,500
Total for Complex Care Management Team			**1,186,500**
Member months (12 months)	**110**	**1320**	**898.864**

Community Based Case Management Services - Housing Support - receive referrals from Care Case managers; conduct Vulnerability Assessment for homeless, connect homeless to Coordinated Assessment and Referral System, conduct case management services related to housing, refers clients to Coalition of Homeless Service Providers for placement. Costs include: staffing costs, operational expenses, training.			
Staff			
Executive Director	110,000	0.25	27,500
Program Director	75,000	0.50	37,500
Clinical Supervisor	208,000	0.20	41,600
Case Managers	48,000	2.50	120,000
Advocates	45,000	4.85	218,250
Services/Supplies/Indirect			
General office supplies, educational materials, printing, mailing, duplication	15,000	1.00	15,000
Data Processing and Telecommunications Support and hardware and software	2,500	1.00	2,500
Facility costs, utilities	60,221	1.00	60,221
Local Travel	6,000	1.00	6,000
Indirect Costs (5% of total Community based Team)	528,571	0.05	26,429
Total for Case Management-Housing Support			**555,000**
Member months (12 months)	**110**	**1320**	**420.45**
TOTAL PMPM			**1,741,500**

Pay for Reporting	Annual Cost/Unit	Unit	Total
Reporting Number of ED Visits - active monitoring of avoidable ED visits will help target care coordination services to appropriate clients to link to primary care medical home thus increasing appropriate use of ED. **Payment trigger: Weekly reporting of ED visits by participating hospital. 50% of payment to be made every 6 months.**	60,000	1	60,000
Reporting Number Inpatient Utilization - active monitoring of avoidable inpatient days will help target care coordination services to appropriate clients to link to primary care medical home thus increasing appropriate use of hospital inpatient services. **Payment trigger: Weekly reporting of inpatient days by participating hospital. 50% of payment to be made every 6 months.**	60,000	1	60,000
Reporting Follow up after hospitalization for mental illness - active monitoring of mental health unit days and linking patients to outpatient mental health services will increase avoidable mental health unit days. **Payment trigger: Weekly reporting of follow up after hospitalization for mental illness. 50% of payment to be made every 6 months.**	60,000	1	60,000
Reporting Number of participants who are informed of SUD services - initiation and engagement and completion of assessment of clients needing substance use disorder treatment services will increase likelihood of road to recovery. **Payment trigger: Weekly reporting of SUD assessments completed. 50% of payment to be made every 6 months.**	60,000	1	60,000
Reporting Number of participants enrolled into WPC and number with comprehensive care plan within 30 days of enrollment. **Payment trigger: Monthly reporting of enrollees and development of comprehensive care plan. 50% of payment to be made every 6 months.**	60,000	1	60,000
Reporting progress made towards meeting administrative procedures (policies and procedures, compilation and analysis of data, progress towards data sharing, etc.) **Payment trigger: Bi-annual and annual reporting of progress towards and accomplishments of meeting administrative metrics. 50% of payment to be made every 6 months.**	117,310	1	117,310

Reporting Health Outcome Metric: WPC participants will have comprehensive diabetes care: HbA1c poor control > 9.0%. **Payment trigger: Measure will be met for 50% or less of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.**	60,000	1	60,000
Reporting Percentage of Avoidable Hospitalizations - active monitoring of avoidable hospitalization visits will help target care coordination services to appropriate clients to link to primary care medical home. **Payment trigger: Weekly reporting of inpatient stays by participating hospital. 50% of payment to be made every 6 months.**	60,000	1	60,000
Health Outcome Metric-Hospital. Medication list provided at discharge. Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	60,000	1	60,000
Health Outcome Metric-Hospital. Timely documentation transition to clinics/PCP. Payment trigger: Measure will be met for 5% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Health Outcome Metric-Hospital. Depression remission at 12 months. Payment trigger: Measure will be met for baseline minus 1% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Health Outcome Metric-Hospital. MHU re-hospitalization within 30 days. Payment trigger: Measure will be met for baseline minus 1% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Health Outcome Metric: Patients with controlled hypertension. Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	60,000	1	60,000
Housing Metric - Reporting on progress towards developing 40 permanent supportive rental housing units for WPC population. **Payment trigger: Metrics will be met annually as outlined in WPC proposal. 100% of payment will be annually.**	50,000	1	50,000
TOTAL PAY FOR REPORTING			**857,310**

Pay for Outcomes	Annual Cost/Unit	Unit	Total
Health outcomes: 80% or greater follow up mental health, medical, and SUD appointment within 30 days post hospitalization improves compliance with discharge planning. **Payment trigger: Measure will be met for 100% of patients enrolled in WPC pilot. 50% of payment to be made every 6 months.**	75,000	1	75,000
Health Outcome Metric: Suicide Risk Assessment and Alcohol and Drug Misuse - SBIRT - compliance with using screening tools improves ability for care team to identify vulnerabilities and appropriately connect to care coordination, therapy, social supports, and other necessary services to prevent suicide and get into appropriate alcohol and drug treatment services; 100% compliance will reduce avoidable ED visits, Mental Health Unit stays, and improve health outcomes. **Payment trigger: Tool will used with 60% of patients enrolled in WPC pilot. 50% of payment to be made every 6 months.**	75,000	1	75,000
Health Outcome Metric: WPC participants will receive **tobacco assessment and counseling**. **Payment trigger: Measure will be met for 90% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.**	75,000	1	75,000
Health Outcome Metric: WPC participants will receive **12 months of coordinated case management**. **Payment trigger: Measure will be met for 25-40% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.**	75,000	1	75,000
Health Outcome Metric: WPC participants will have a **comprehensive care plan**. **Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.**	100,000	1	100,000
TOTAL PAY FOR OUTCOMES			**400,000**

WPC Budget Narrative PY4
WPC Applicant Name: Monterey County Health Department

PY 4 Budget Total	**5,366,926**

Administrative Infrastructure			
Staff	**Annual Cost/Unit**	**Unit**	**Total**
Public Health Epidemiologist II - responsible for data analysis; reporting of evaluation metrics	125,000	0.50	62,500
Business Technology/Data Analyst (1.0 FTE)- responsible for working with County and Department Information Technology Managers on IT solutions to be implemented; help identify IT solutions; perform complex data analytics; prepare customized programming as needed	160,000	1.00	160,000
Sub-total			222,500
Services/Supplies/Indirect Costs			
Data Processing and Telecommunications Support	2,500	1.50	3,750
General office supplies, printing, educational materials	250	1.50	375
Indirect Costs (5% of total Admin Costs)	226,625	0.05	11,331
Sub-total			15,456
TOTAL ADMINISTRATIVE INFRASTRUCTURE			**237,956**

Delivery Infrastructure			
Column1	**Annual Cost/Unit**	**Unit**	**Total**
Information Technology Solutions			-

Case Management Software - shared repository of case management data; ability to pull data from proprietary external data systems. Costs include: software license, implementation, hardware costs, training, professional services, vendor hosted and supported ($121,000 for solution). **Business Technology/Data Analyst (1.0 FTE)**- responsible for working with County and Department Information Technology Managers on IT solutions to be implemented; help identify IT solutions; perform complex data analytics; prepare customized programming as needed ($172,286).	293,286	1	293,286
Coordinated Assessment and Referral System (CARS)/ Homeless Management System (HMIS) - primary support for housing assessment data for homeless and care coordination services; establish network of agencies; purchase software and support implementation; staff to *Lead Me Home* Committee; conducts homeless census. Costs include: staffing costs, operational expenses, software license and subscription; training; hardware costs	603,050	1	603,050
TOTAL DELIVERY INFRASTRUCTURE			**896,336**

Incentive Payments			
Column1	**Annual Cost/Unit**	**Unit**	**Total**
Primary Care Clinic - payment for scheduling follow up appointment within 30 days of discharge from inpatient stay or release from jail; linkage to primary care medical home helps improve health outcomes, provides necessary resources and supports for ongoing medical treatment. Clinic will meet measure for 20 patients for second 6 months of year. **Payment trigger:** Monterey County Health Clinics will receive $20,000 per WPC enrollee scheduled for and successful participation in follow-up appointment within 30 days post discharge or release. Biannual payments will be made.	20,000	20	400,000
Hospital Incentive - payment for reduction in inpatient readmission rates within 30 days; referral to coordinated care services will improve health outcomes and reduce avoidable inpatient stays. Hospital will meet measure for 20 patients for second 6 months of year. **Payment trigger:** Natividad Medical Center will be eligible for $20,000 per WPC enrollee successfully linked to care coordination without a readmission within 30 days. Biannual payments will be made.	20,000	20	400,000
Behavioral Health Clinic - payment for reduction in mental health unit readmission rates within 30 days; follow up care improves health outcomes, provides necessary resources, and supports for ongoing mental health treatment and therapy. Behavioral Health will meet measure for 20 patients for second 6 months of year. **Payment trigger:** Monterey County Behavioral Health Clinics will receive $20,000 per WPC enrollee scheduled for and successful participation in follow-up appointment within 30 days post discharge or release. Biannual payments will be made.	20,000	20	400,000
TOTAL INCENTIVE PAYMENTS			**1,200,000**

FFS Services - N/A	Annual Cost/Unit	Unit	Total
Mobile Outreach Team - staffing mobile outreach efforts to reconnect chronically homeless individuals into care coordination system. Costs include: staffing costs; local travel; and operational costs. PY2 is our startup year; therefore 50% of this item is included in Infrastructure and the remaining 50% is included in PMPM. It is anticipated there will be savings due to startup period; therefore PY 2 is lower than PYs 3-5. Additionally, will take some time to enroll members thus not needing mobile outreach team until later in PY 2. Service will be reimbursed per encounter (attempt to locate and reconnect pilot participants to care coordination system as requested by Core Case Management Team). Reimbursements will be made quarterly.			
Staff			
Project Manager	85,000	0.20	17,000
Outreach Workers	59,000	1.50	88,500
Services/Supplies/Indirects			
Data Processing and Telecommunications Support and hardware and software	2,500	1.70	4,250
Local Travel/Training, vehicle maintenance	8,974	1.00	8,974
General office supplies, educational materials	1,000	1.00	1,000
Indirect Costs **(5% of total Mobile Team)**	105,500	0.05	5,275
Total Mobile Outreach Team			**125,000**
	# Encounters	**Fee/Encounter**	**Total**
Fee For Service (Per encounter or time spent outreaching to pilot members when lost to service)	235	532.78	**125,000**

PMPM Bundle	Annual Cost/Unit	Unit	Total
Complex Care Management Team			
Program focus is on patient centered coordination; transitional care interventions between services/systems; patient engagement; patient education on health topics, literacy, and self-management strategies; patient navigation services; and assurance referrals are made and kept. Total annual costs are split between Administrative and PMPM (6 months each).			
Staff			
Project Manager	170,000	0.50	85,000
Project Assistant	116,000	1.00	116,000
Case Managers	150,000	4.00	600,000
Community Health Workers	69,000	4.00	276,000
Services/Supplies/Indirect			
Data Processing and Telecommunications Support and hardware and software	4,000	9.50	38,000
Local Travel/Training	10,000	1.00	10,000
General office supplies, educational materials	5,000	1.00	5,000
Indirect Costs (5% of total Complex Care Mgmt. Team)	1,130,000	0.05	56,500
Total for Complex Care Management Team			**1,186,500**
Member months (12 months)	**140**	1680	**706.250**

Community Based Case Management Services - Housing Support - receive referrals from Care Case managers; conduct Vulnerability Assessment for homeless, connect homeless to Coordinated Assessment and Referral System, conduct case management services related to housing, refers clients to Coalition of Service Providers for placement. Costs include: staffing costs, operational expenses, training.			
Staff			
Executive Director	110,000	0.25	27,500
Program Director	75,000	0.50	37,500
Clinical Supervisor	208,000	0.20	41,600
Case Managers	48,000	2.50	120,000
Advocates	45,000	4.85	218,250
Services/Supplies/Indirect			
General office supplies, educational materials, printing, mailing, duplication	15,000	1.00	15,000
Data Processing and Telecommunications Support and hardware and software	2,500	1.00	2,500
Facility costs, utilities	60,221	1.00	60,221
Local Travel	6,000	1.00	6,000
Indirect Costs (5% of total Community based Team)	528,571	0.05	26,429
Total for Case Management-Housing Supports			**555,000**
Member months (12 months)	**140**	**1680**	**330.357**
TOTAL PMPM			**1,741,500**

Pay for Reporting			
Column1	**Annual Cost/Unit**	**Unit**	**Total**
Reporting Number of ED Visits - active monitoring of avoidable ED visits will help target care coordination services to appropriate clients to link to primary care medical home thus increasing appropriate use of ED. **Payment trigger: Weekly reporting of ED visits by participating hospital. 50% of payment to be made every 6 months.**	50,000	1	50,000
Reporting Number Inpatient Utilization - active monitoring of avoidable inpatient days will help target care coordination services to appropriate clients to link to primary care medical home thus increasing appropriate use of hospital inpatient services. **Payment trigger: Weekly reporting of inpatient days by participating hospital. 50% of payment to be made every 6 months.**	50,000	1	50,000
Reporting Follow up after hospitalization for mental illness - active monitoring of mental health unit days and linking patients to outpatient mental health services will increase avoidable mental health unit days. **Payment trigger: Weekly reporting of follow up after hospitalization for mental illness. 50% of payment to be made every 6 months.**	50,000	1	50,000
Reporting Number of participants who are informed of SUD services - initiation and engagement and completion of assessment of clients needing substance use disorder treatment services will increase likelihood of road to recovery. **Payment trigger: Weekly reporting of SUD assessments completed. 50% of payment to be made every 6 months.**	50,000	1	50,000

Reporting Number of participants enrolled into WPC and number with comprehensive care plan within 30 days of enrollment. **Payment trigger: Monthly reporting of enrollees and development of comprehensive care plan. 50% of payment to be made every 6 months.**	50,000	1	50,000
Reporting progress made towards meeting administrative procedures (policies and procedures, compilation and analysis of data, progress towards data sharing, etc.) **Payment trigger: Bi-annual and annual reporting of progress towards and accomplishments of meeting administrative metrics. 50% of payment to be made every 6 months.**	116,134	1	116,134
Reporting Health Outcome Metric: WPC participants will have comprehensive diabetes care: HbA1c poor control > 9.0%. **Payment trigger: Measure will be met for 50% or less of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.**	50,000	1	50,000
Reporting Percentage of Avoidable Hospitalizations - active monitoring of avoidable hospitalization visits will help target care coordination services to appropriate clients to link to primary care medical home. **Payment trigger: Weekly reporting of inpatient stays by participating hospital. 50% of payment to be made every 6 months.**	50,000	1	50,000
Health Outcome Metric-Hospital. Medication list provided at discharge. **Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.**	50,000	1	50,000

Health Outcome Metric-Hospital. Timely documentation transition to clinics/PCP. Payment trigger: Measure will be met for 5% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Health Outcome Metric-Hospital. Depression remission at 12 months. Payment trigger: Measure will be met for baseline minus 1% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Health Outcome Metric-Hospital. MHU re-hospitalization within 30 days. Payment trigger: Measure will be met for baseline minus 1% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Health Outcome Metric: Patients with controlled hypertension. Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Housing Metric - Reporting on progress towards developing 40 permanent supportive rental housing units for WPC population. **Payment trigger: Metrics will be met annually as outlined in WPC proposal. 100% of payment will be annually.**	50,000	1	50,000
TOTAL PAY FOR REPORTING			**766,134**

Pay for Outcomes			
Column1	**Annual Cost/Unit**	**Unit**	**Total**
Health outcomes: 80% or greater follow up mental health, medical, and SUD appointment within 30 days post hospitalization improves compliance with discharge planning. **Payment trigger: Measure will be met for 100% of patients enrolled in WPC pilot. 50% of payment to be made every 6 months.**	75,000	1	75,000
Health Outcome Metric: Suicide Risk Assessment and Alcohol and Drug Misuse - SBIRT - compliance with using screening tools improves ability for care team to identify vulnerabilities and appropriately connect to care coordination, therapy, social supports, and other necessary services to prevent suicide and get into appropriate alcohol and drug treatment services; 100% compliance will reduce avoidable ED visits, Mental Health Unit stays, and improve health outcomes. **Payment trigger: Tool will used with 60% of patients enrolled in WPC pilot. 50% of payment to be made every 6 months.**	75,000	1	75,000
Health Outcome Metric: WPC participants will receive **tobacco assessment and counseling**. **Payment trigger: Measure will be met for 90% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.**	75,000	1	75,000
Health Outcome Metric: WPC participants will receive **12 months of coordinated case management**. **Payment trigger: Measure will be met for 25-40% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.**	75,000	1	75,000
Health Outcome Metric: WPC participants will have a **comprehensive care plan**. **Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.**	100,000	1	100,000
TOTAL PAY FOR OUTCOMES			**400,000**

WPC Budget Narrative PY5

WPC Applicant Name: Monterey County Health Department

PY 5 Budget Total **5,366,926**

Administrative Infrastructure

Staff	Annual Cost/Unit	Unit	Total
Public Health Epidemiologist II - responsible for data analysis; reporting of evaluation metrics	125,000	0.50	62,500
Business Technology/Data Analyst (1.0 FTE)- responsible for working with County and Department Information Technology Managers on IT solutions to be implemented; help identify IT solutions; perform complex data analytics; prepare customized programming as needed	160,000	1.00	160,000
Sub-total			222,500
Services/Supplies/Indirect Costs			
Data Processing and Telecommunications Support	2,500	1.50	3,750
General office supplies, printing, educational materials	250	1.50	375
Indirect Costs (5% of total Admin Costs)	226,625	0.05	11,331
Sub-total			15,456
TOTAL ADMINISTRATIVE INFRASTRUCTURE			**237,956**

Delivery Infrastructure				
Delivery Infrastructure	**Annual Cost/Unit**	**Unit**		**Total**
Information Technology Solutions				-
Case Management Software - shared repository of case management data; ability to pull data from proprietary external data systems. Costs include: software license, implementation, hardware costs, training, professional services, vendor hosted and supported ($121,000 for solution). **Business Technology/Data Analyst (1.0 FTE)**- responsible for working with County and Department Information Technology Managers on IT solutions to be implemented; help identify IT solutions; perform complex data analytics; prepare customized programming as needed ($172,286).	293,286		1	293,286
Coordinated Assessment and Referral System (CARS)/ Homeless Management System (HMIS) - primary support for housing assessment data for homeless and care coordination services; establish network of agencies; purchase software and support implementation; staff to *Lead Me Home* Committee; conducts homeless census. Costs include: staffing costs, operational expenses, software license and subscription; training; hardware costs	603,050		1	603,050
TOTAL DELIVERY INFRASTRUCTURE				**896,336**

Incentive Payments			
Column1	**Annual Cost/Unit**	**Unit**	**Total**
Primary Care Clinic - payment for scheduling follow up appointment within 30 days of discharge from inpatient stay or release from jail; linkage to primary care medical home helps improve health outcomes, provides necessary resources and supports for ongoing medical treatment. Clinic will meet measure for 20 patients for second 6 months of year. **Payment trigger:** Monterey County Health Clinics will receive $20,000 per WPC enrollee scheduled for and successful participation in follow-up appointment within 30 days post discharge or release. Biannual payments will be made.	20,000	20	400,000
Hospital Incentive - payment for reduction in inpatient readmission rates within 30 days; referral to coordinated care services will improve health outcomes and reduce avoidable inpatient stays. Hospital will meet measure for 20 patients for second 6 months of year. **Payment trigger:** Natividad Medical Center will be eligible for $20,000 per WPC enrollee successfully linked to care coordination without a readmission within 30 days. Biannual payments will be made.	20,000	20	400,000
Behavioral Health Clinic - payment for reduction in mental health unit readmission rates within 30 days; follow up care improves health outcomes, provides necessary resources, and supports for ongoing mental health treatment and therapy. Behavioral Health will meet measure for 20 patients for second 6 months of year. **Payment trigger:** Monterey County Behavioral Health Clinics will receive $20,000 per WPC enrollee scheduled for and successful participation in follow-up appointment within 30 days post discharge or release. Biannual payments will be made.	20,000	20	400,000
TOTAL INCENTIVE PAYMENTS			**1,200,000**

FFS Services - N/A	Annual Cost/Unit	Unit	Total
Mobile Outreach Team - staffing mobile outreach efforts to reconnect chronically homeless individuals into care coordination system. Costs include: staffing costs; local travel; and operational costs. PY2 is our startup year; therefore 50% of this item is included in Infrastructure and the remaining 50% is included in PMPM. It is anticipated there will be savings due to startup period; therefore PY 2 is lower than PYs 3-5. Additionally, will take some time to enroll members thus not needing mobile outreach team until later in PY 2. Service will be reimbursed per encounter (attempt to locate and reconnect pilot participants to care coordination system as requested by Core Case Management Team). Reimbursements will be made quarterly.			
Staff			
Project Manager	85,000	0.20	17,000
Outreach Workers	59,000	1.50	88,500
Services/Supplies/Indirects			
Data Processing and Telecommunications Support and hardware and software	2,500	1.70	4,250
Local Travel/Training, vehicle maintenance	8,974	1.00	8,974
General office supplies, educational materials	1,000	1.00	1,000
Indirect Costs **(5% of total Mobile Team)**	105,500	0.05	5,275
Total Mobile Outreach Team			**125,000**

	# Encounters	Fee/Encounter	Total
Fee For Service (Per encounter or time spent outreaching to pilot members when lost to service)	235	532.78	125,000

PMPM Bundle	Annual Cost/Unit	Unit	Total
Complex Care Management Team			
Program focus is on patient centered coordination; transitional care interventions between services/systems; patient engagement; patient education on health topics, literacy, and self-management strategies; patient navigation services; and assurance referrals are made and kept. Total annual costs are split between Administrative and PMPM (6 months each).			
Staff			
Project Manager	170,000	0.50	85,000
Project Assistant	116,000	1.00	116,000
Case Managers	150,000	4.00	600,000
Community Health Workers	69,000	4.00	276,000
Services/Supplies/Indirects			
Data Processing and Telecommunications Support and hardware and software	4,000	9.50	38,000
Local Travel/Training	10,000	1.00	10,000
General office supplies, educational materials	5,000	1.00	5,000
Indirect Costs (5% of total Complex Care Mgmt. Team)	1,130,000	0.05	56,500
Total for Complex Care Management Team			**1,186,500**
Member months (12 months)	**150**	1800	**659.17**

Community Based Case Management Services - Housing Support - receive referrals from Care Case managers; conduct Vulnerability Assessment for homeless, connect homeless to Coordinated Assessment and Referral System, conduct case management services related to housing, refers clients to Coalition of Service Providers for placement. Costs include: staffing costs, operational expenses, training.

Staff			
Executive Director	110,000	0.25	27,500
Program Director	75,000	0.50	37,500
Clinical Supervisor	208,000	0.20	41,600
Case Managers	48,000	2.50	120,000
Advocates	45,000	4.85	218,250
Services/Supplies/Indirect			
General office supplies, educational materials, printing, mailing, duplication	15,000	1.00	15,000
Data Processing and Telecommunications Support and hardware and software	2,500	1.00	2,500
Facility costs, utilities	60,221	1.00	60,221
Local Travel	6,000	1.00	6,000
Indirect Costs (5% of total Community based Team)	528,571	0.05	26,429
Total for Case Management-Housing Supports			**555,000**
Member months (12 months)	**150**	**1800**	**308.333**
TOTAL PMPM			**1,741,500**

Pay for Reporting			
Column1	**Annual Cost/Unit**	**Unit**	**Total**
Reporting Number of ED Visits - active monitoring of avoidable ED visits will help target care coordination services to appropriate clients to link to primary care medical home thus increasing appropriate use of ED. **Payment trigger: Weekly reporting of ED visits by participating hospital. 50% of payment to be made every 6 months.**	50,000	1	50,000
Reporting Number Inpatient Utilization - active monitoring of avoidable inpatient days will help target care coordination services to appropriate clients to link to primary care medical home thus increasing appropriate use of hospital inpatient services. **Payment trigger: Weekly reporting of inpatient days by participating hospital. 50% of payment to be made every 6 months.**	50,000	1	50,000
Reporting Follow up after hospitalization for mental illness - active monitoring of mental health unit days and linking patients to outpatient mental health services will increase avoidable mental health unit days. **Payment trigger: Weekly reporting of follow up after hospitalization for mental illness. 50% of payment to be made every 6 months.**	50,000	1	50,000
Reporting Number of participants who are informed of SUD services - initiation and engagement and completion of assessment of clients needing substance use disorder treatment services will increase likelihood of road to recovery. Payment trigger: Weekly reporting of SUD assessments completed. 50% of payment to be made every 6 months.	50,000	1	50,000
Reporting Number of participants enrolled into WPC and number with comprehensive care plan within 30 days of enrollment. Payment trigger: Monthly reporting of enrollees and development of comprehensive care plan. 50% of payment to be made every 6 months.	50,000	1	50,000
Reporting progress made towards meeting administrative procedures (policies and procedures, compilation and analysis of data, progress towards data sharing, etc.) Payment trigger: Bi-annual and annual reporting of progress towards and accomplishments of meeting administrative metrics. 50% of payment to be made every 6 months.	116,134	1	116,134
Reporting Health Outcome Metric: WPC participants will have comprehensive diabetes care: HbA1c poor control > 9.0%. **Payment trigger: Measure will be met for 50% or less of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.**	50,000	1	50,000

Reporting Percentage of Avoidable Hospitalizations - active monitoring of avoidable hospitalization visits will help target care coordination services to appropriate clients to link to primary care medical home. **Payment trigger: Weekly reporting of inpatient stays by participating hospital. 50% of payment to be made every 6 months.**	50,000	1	50,000
Health Outcome Metric-Hospital. Medication list provided at discharge. Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Health Outcome Metric-Hospital. Timely documentation transition to clinics/PCP. Payment trigger: Measure will be met for 5% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Health Outcome Metric-Hospital. Depression remission at 12 months. Payment trigger: Measure will be met for baseline minus 1% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Health Outcome Metric-Hospital. MHU re-hospitalization within 30 days. Payment trigger: Measure will be met for baseline minus 1% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Health Outcome Metric: Patients with controlled hypertension. Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Housing Metric - Reporting on progress towards developing 40 permanent supportive rental housing units for WPC population. **Payment trigger: Metrics will be met annually as outlined in WPC proposal. 100% of payment will be annually.**	50,000	1	50,000
	TOTAL PAY FOR REPORTING		**766,134**

Pay for Outcomes	Annual Cost/Unit	Unit	Total
Health outcomes: 80% or greater follow up mental health, medical, and SUD appointment within 30 days post hospitalization improves compliance with discharge planning. **Payment trigger: Measure will be met for 100% of patients enrolled in WPC pilot. 50% of payment to be made every 6 months.**	75,000	1	75,000
Health Outcome Metric: Suicide Risk Assessment and Alcohol and Drug Misuse - SBIRT - compliance with using screening tools improves ability for care team to identify vulnerabilities and appropriately connect to care coordination, therapy, social supports, and other necessary services to prevent suicide and get into appropriate alcohol and drug treatment services; 100% compliance will reduce avoidable ED visits, Mental Health Unit stays, and improve health outcomes. **Payment trigger: Tool will used with 60% of patients enrolled in WPC pilot. 50% of payment to be made every 6 months.**	75,000	1	75,000
Health Outcome Metric: WPC participants will receive **tobacco assessment and counseling**. **Payment trigger: Measure will be met for 90% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.**	75,000	1	75,000
Health Outcome Metric: WPC participants will receive **12 months of coordinated case management**. **Payment trigger: Measure will be met for 25-40% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.**	75,000	1	75,000
Health Outcome Metric: WPC participants will have a **comprehensive care plan**. **Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.**	100,000	1	100,000
	TOTAL PAY FOR OUTCOMES		**400,000**

Letters of Support

Letters of support for the Monterey County Health Department Whole Person Care Pilot Application may be obtained from:

Patricia Zerounian, MPP
Management Analyst III
Monterey County Health Department
1270 Natividad Road
Salinas, CA 93906
831/755-4583
zerounianp@co.monterey.ca.us

WPC Budget Template: Summary and Top Sheet

WPC Applicant Name: Monterey County Health Department

Annual Budget Amount Requested	Federal Funds *(Not to exceed 90M)*	IGT	Total Funds
Annual Budget Amount Requested	2,683,463	2,683,463	5,366,926
PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)			
PY 1 Total Budget	5,366,926		
Approved Application (75%)	4,025,195		
Submission of Baseline Data (25%)	1,341,732		
PY 1 Total Check	OK		
PY 2 Budget Allocation			
PY 2 Total Budget	5,366,926		
Administrative Infrastructure	990,150		
Delivery Infrastructure	941,000		
Incentive Payments	1,200,000		
FFS Services	32,500		
PMPM Bundle	793,251		
Pay For Reporting	1,010,025		
Pay for Outomes	400,000		
PY 2 Total Check	OK		
PY 3 Budget Allocation			
PY 3 Total Budget	5,366,926		
Administrative Infrastructure	237,956		
Delivery Infrastructure	805,160		
Incentive Payments	1,200,000		
FFS Services	125,000		
PMPM Bundle	1,741,500		
Pay For Reporting	857,310		
Pay for Outomes	400,000		
PY 3 Total Check	OK		
PY 4 Budget Allocation			
PY 4 Total Budget	5,366,926		
Administrative Infrastructure	237,956		
Delivery Infrastructure	896,336		
Incentive Payments	1,200,000		
FFS Services	125,000		
PMPM Bundle	1,741,500		
Pay For Reporting	766,134		
Pay for Outomes	400,000		
PY 4 Total Check	OK		
PY 5 Budget Allocation			
PY 5 Total Budget	5,366,926		
Administrative Infrastructure	237,956		
Delivery Infrastructure	896,336		
Incentive Payments	1,200,000		
FFS Services	125,000		
PMPM Bundle	1,741,500		
Pay For Reporting	766,134		
Pay for Outomes	400,000		
PY 5 Total Check	OK		

End of Exhibit I

RFP 9600-75 EXHIBIT II

	FORMAT	DESCRIPTION	SOURCE
I. UNIVERSAL METRICS			
	A. Health Outcomes		
1	#	Number of Emergency Department Visits	MEDITECH / HIE
2	#	Number of Hospital Inpatient Days	MEDITECH / HIE
3	mm/dd/yy	Follow-up Behavioral Health Appointment after Hospitalization for Mental Illness	AVATAR
4	mm/dd/yy	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	AVATAR
	B. Administrative		
1	LastName FirstName CIN mm/dd/yy	Client Enrolled for Services	EPIC
2	mm/dd/yy	Client 1-year Anniversary Date	calculation based on EPIC enrollment date
II. VARIANT METRICS			
	A. Hospital Metrics		
1	mm/dd/yy	Client Admitted to Hospital (each event)	MEDITECH / HIE
2	mm/dd/yy	Client Discharged from Hospital (each event)	MEDITECH / HIE
3	# days	Client Inpatient Days	MEDITECH / HIE
4	# events	All Cause Readmission to Hospital within 30 days of Discharge	MEDITECH / HIE
5	# events	Client Medication List Uploaded upon Patient Hospital Discharge	MEDITECH / HIE
6	# events	Client Medication List Uploaded upon Patient MHU discharge	MEDITECH / HIE
7	# events	Client Medication List Uploaded upon Patient ED release	MEDITECH / HIE
	B. Case Management Metrics		
1	# clients	Clients with a Comprehensive Care Plan @ 30 days post enrollment. Solution should have capacity to store a comprehensive Care Plan in a retrievable way.	EPIC
2	mm/dd/yy	Follow-up Clinic Appointment within 30 days of Each Hospital Discharge	EPIC
3	mm/dd/yy and score	PHQ-9 Depression Assessment	EPIC & AVATAR
4	mm/dd/yy and score	Clients with HbA1c <8%	EPIC
5	mm/dd/yy and score	Clients age 18-59 with Bp <140/90 mm HG , with diabetes Dx flag or parse by diabetes Dx for BP measure. This dictates which of the 3 are used	EPIC
6	mm/dd/yy and score	Clients age 60-85 with Bp <140/90 mm HG	EPIC
7	mm/dd/yy and score	Clients age 60-85 with Bp <150/90 mm HG	EPIC
	C. Behavioral Health Metrics		
1	# Clients	Clients Given Tobacco Assessment	AVATAR
2	# Clients	Clients Offered Tobacco Use Counseling	AVATAR
3	# Clients	Clients Engaged in Tobacco Use Counseling	AVATAR
4	# Clients	Clients Given Substance Use Assessment	AVATAR
5	# Clients	Clients Offered Substance Use Counseling	AVATAR
6	# Clients	Clients Engaged in Substance Use Counseling	AVATAR
7	mm/dd/yy and score	SBIRT Suicide Risk Assessment	EPIC
8	mm/dd/yy	Suicide Risk Assessment for enrolled members	AVATAR
9	# Clients	Depression remission at 12 months.	AVATAR

	FORMAT	DESCRIPTION	SOURCE
10	mm/dd/yy, referred provider, discharge plan.	Documentation of Transition to Primary Care Provider.	Meditech
11	# Clients	MHU Rehospitalization within 30 days	Meditech
12	# Clients, conditions	Avoidable Hospitalizations. Solution should have the capacity to test all hospitalizations against a defined list of Avoidable events. We should have the ability to define this list.	Meditech
13	mm/dd/yy	Follow-up BH (Mental Health) Appointment within 30 days of Each Hospital Discharge	AVATAR
14	mm/dd/yy	Follow-up BH (SUD) Appointment within 30 days of Each Hospital Discharge	AVATAR
III. SOCIAL METRICS			
	A. Outreach		
1	mm/dd/yy	Client touched by Interim mobile outreach team (CHS)	AVATAR
2	mm/dd/yy	Client touched by BH mobile outreach team	AVATAR
3	mm/dd/yy	Client touched by BH Hot Spotting team	AVATAR
4	mm/dd/yy	Client touched by Homeless Peer Navigator outreach team (Franciscan Workers)	AVATAR
5	mm/dd/yy	Client touched by CSUMB MSW Outreach team	AVATAR
	B. Housing		
1	mm/dd/yy	Clients Assessed for Housing Security by case management team	EPIC
2	mm/dd/yy	# clients assessed by the Coalition of Homeless Services Providers for vulnerability using VI-SPDAT assessment tool	External Non-covered Partner
3	mm/dd/yy	Clients Referred Appropriate Housing and Homeless Services Providers	External Non-covered Partners
4	Text	Client Outcomes of Receiving Housing Support Services from homeless services providers	External Non-covered Partners
5	mm/dd/yy	Client served by Sobering Center	TBD
6	mm/dd/yy	Client served by Medical Respite Center	TBD
	C. Social Services		
1	mm/dd/yy	Clients Assessed for Social Services Needs by case management teams	EPIC
2	mm/dd/yy	Clients Referred to DSS for Appropriate Services	EPIC
3	Text	Client Outcomes of Receiving Social Services	TBD
4	percent	Housing Support Services. (Count Referred)/(count Served)	EPIC/External Non-covered Partners

End of Exhibit II

Domain 1: Outpatient Delivery System Transformation and Prevention

	Metric #	NQF #'s	Metric Name	Measure Steward
	1.1: Integration of Behavioral Health and Primary Care (Target Population = PRIME Eligible Population)			
1	1.1.1.a	N/A	Alcohol and Drug Misuse (SBIRT)	Oregon CCO
2	1.1.2	N/A	Care coordinator assignment	Variation of Univ of Wash./Coordinated Care Initiative
3	1.1.3.d	0059	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	NCQA
4	1.1.4	0710	Depression Remission at 12 Months CMS159v4	MN Community Measurement
5	1.1.5.f	0418	Screening for Clinical Depression and follow-up	CMS
6	1.1.6.t	0028	Tobacco Assessment and Counseling	AMA-PCPI
	1.2: Ambulatory Care Redesign: Primary Care (Target Population = PRIME Eligible Population)			
7	1.2.1.a	N/A	Alcohol and Drug Misuse (SBIRT)	Oregon CCO
8	1.2.3.c	0034	Colorectal Cancer Screening	NCQA
9	1.2.4.d	0059	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	NCQA
10	1.2.5.b	0018	Controlling Blood Pressure	NCQA
11	1.2.7.i	0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	NCQA
12	1.2.8	PQI90	Prevention Quality Overall Composite PQI #90	AHRQ
13	1.2.9	N/A	Primary Care Redesign project metrics stratified by REAL and SO/GI categories	SNI
14	1.2.11	N/A	REAL data completeness	SNI
15	1.2.12.f	0418	Screening for Clinical Depression and follow-up	CMS
16	1.2.13	N/A	SO/GI data completeness	SNI
17	1.2.14.t	0028	Tobacco Assessment and Counseling	AMA-PCPI
	1.3: Ambulatory Care Redesign: Specialty Care			
		Target Pop = PRIME Eligible Population and those for whom Specialty Care Expertise has been requested at least once during the demo year.		
		Certain metrics, target population does not necessarily apply, the denominator is defined by the metric denominator)		
18	1.3.1	N/A	Closing the referral loop: receipt of specialist report (CMS50v3)	CMS
19	1.3.2	N/A	DHCS All-Cause Readmissions	DHCS
20	1.3.3	0041	Influenza Immunization	NCQA
21	1.3.4	N/A	Post procedure ED visits/admissions	SFHN
22	1.3.5	N/A	Referral Reply Turnaround Rate	LACDHS, SFHN
23	1.3.6	N/A	Specialty Care Touches: Specialty expertise requests managed via non-face to face specialty encounters	LACDHS, UCD
24	1.3.7	0028	Tobacco Assessment and Counseling	AMA-PCPI
	1.5: Million Hearts Initiative (Target Population = PRIME Eligible Population)			
25	1.5.1.b	0018	Controlling Blood Pressure	NCQA
26	1.5.2.i	0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	NCQA
27	1.5.3	#317	PQRS # 317 Preventative Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CMS / PQRS
28	1.5.4.t	0028	Tobacco Assessment and Counseling	AMA-PCPI

Domain 2: Targeted High Risk or High Cost Population

	2.1: Prevention: Perinatal Care			
		Target Population = PRIME Eligible Population OR any woman with 2 prenatal visits with the PRIME Entity during the measurement period		
29	2.1.6	NQF 1517	Prenatal Care (PPC)	
30			Postpartum Care (PPC)	
	2.2: Care Transitions: Integration of Post-Acute Care			
		Target Pop = PRIME Eligible Population AND experience at least one inpatient discharge from any acute care facility during the measurement year		
31	2.2.1	N/A	DHCS All-Cause Readmissions	DHCS
32	2.2.3	0097	Medication Reconciliation: 30 days	NCQA
33	2.2.4	0646	Reconciled Medication List Received by Discharged Patients	AMA-PCPI
34	2.2.5	0648	Timely Transmission of Transition Record	AMA-PCPI
	2.3: Complex Care Management for High Risk Populations			
		Target Pop = PRIME Eligible Pop AND age 18 and over AND 4 or more chronic medical conditions during the year preceeding the measurement		
		period as defined by the Chronic Condition Indicator		
35	2.3.1	N/A	Care coordinator assignment	Variation of Univ of Wash. Metric
36	2.3.2	0097	Medication Reconciliation – 30 days	NCQA
37	2.3.3	PQI90	Prevention Quality Overall Composite PQI #90	AHRQ
38	2.3.4	0648	Timely Transmission of Transition Record	AMA-PCPI
	2.6: Chronic Non-Malignant Pain Management e			
		Target Population = PRIME Eligible Population AND have a diagnosis of moderate to severe pain lasting >90 days, as of the last day of the measurement period		
39	2.6.1	N/A	Alcohol and Drug Misuse (SBIRT)	Oregon CCO
40	2.6.2	N/A	Assessment and Management of Chronic Pain: Patients with chronic pain prescribed an opioid who have an opioid agreement form and an annual urine toxicology screen	Institute for Clinical Systems Improvement p.68
41	2.6.3	N/A	Patients with chronic pain on long term opioid therapy checked in PDMPs	DHHS Presentation
42	2.6.4	0418	Screening for Clinical Depression and follow-up	CMS Adult Core Set Tech Specs
43	2.6.5	N/A	Treatment of Chronic Non-Malignant Pain with Multi-Modal Therapy	N/A

Domain 3: Resource Utilization Efficiency

	3.4: Resource Stewardship: Blood Products			
		Target Population = PRIME Eligible Population OR individuals with any acute care utilization (including Urgent Care, ED, and Inpatient encounters)		
		at the PRIME entity during the measurement period		
44	3.4.8	N/A	ePBM-01 Pre-op Anemia Screening, Selected Elective Surgical Patients	AABB/TJC
45	3.4.9	N/A	ePBM-02 Pre-op Hemoglobin Level, Selected Elective Surgical Patients	AABB/TJC
46	3.4.10	N/A	ePBM-03 Pre-op Type and Crossmatch, Type and Screen, Selected elective Surgical Patients	AABB/TJC
47	3.4.11	N/A	ePBM-04 Initial Transfusion Threshold	AABB/TJC
48	3.4.12	N/A	ePBM-05 Outcome of Patient Blood Management, Selected Elective Surgical Patients	AABB/TJC

End of Exhibit III

RFP 9600-75 EXHIBIT IV

PRIME Reporting Manual DY12 Year End Reporting as released July 5, 2017

Due to the very large file size of this Exhibit IV, the content is not attached to this RFP but may be viewed/obtained at the following URL:

https://safetynetinstitute.org/wp-content/uploads/2017/07/prime-reporting-manual-dy12-year-end-final.pdf