Addendum No. 1

RFP P452-22- ACUTE CARE INPATIENT HOSPITALIST PROGRAM

The purpose of this Addendum is to notify all potential respondents of any changes to the original RFP and to answer questions regarding the RFP. The answers provided in this Addendum hereby amend and/or modify the original RFP Document and Specifications. All Offerors are subject to the provisions of this addendum.

1. THE RFP PROPOSAL DUE DATE IS EXTENDED. RFP PROPOSALS ARE DUE WEDNESDAY MARCH 16, 2022 @ 2:00PM MST/MDT.

2. WRITTEN RESPONCES – QUESTIONS AND ANSWERS

Question 1. (Page 26, Section IV.B.iii.d. 2-3) May we present our HITRUST certification report in lieu of responding to Section IV? Q#2 (At its sole cost and expense Offeror will complete and submit Exhibit I-Information Security Plan Information) and #3 (Vendor should provide workflow diagram of application/system for security control point understanding)? If not, can you please clarify which specific application/system these questions reference?

UNMH RESPONSE: HITRUST certificate is helpful however it is not sufficient for UNMH IT review process, we ask all vendors to complete the requested IT security review. A full IT Security review will also be required of the highest scorer and prior to issuance of a final contract. UNMH is requesting information on what if any software systems the Offeror will be using, will there be any connectivity to UNMH systems, data exchange, onsite use of EMR, offsite use of EMR, etc.

Question 2. Are we required to fill out the security-plan document in our response or is this for information purposes once the contract is awarded?

UNMH RESPONSE: Yes, UNMH asks all vendors to complete the security plan document with your response. In addition, a formal security review will take place when RFP is awarded to successful offeror, prior to the issuance of a contract.

Question 3. Who is the incumbent?

UNMH RESPONSE: Please see RFP EXHIBIT A, Paragraph I. b. iii. There is no incumbent the RFP seeks an addition to the current program.

Question 4. How is the incumbent staffing the same model now? We are looking for # of providers for the same amount of patients in a 24 hour period.

UNMH RESPONSE: The RFP seeks an addition to the current program; the additional program will be staffed as deemed appropriate by the successful offeror. UNMH is looking for a vendor to provide a recommended model as noted in RFP EXHIBIT A- Paragraph I. B Current State and II. Purpose, for the proposed expansion program.

UNMH will continue to operate the current program. The successful offeror will manage the expected additional program.

Question 5. Is there a ratio that you would like to maintain with Hospitalist and pt. per day?

UNMH RESPONSE: The current ratio for our locum providers is 14 pts/day without admissions, this may change with addition of new proposed program. The successful offeror shall provide ratio recommendation for the supplemental program.

Question 6. What are the current shift hours? Is there a max?

UNMH RESPONSE: Current shifts for the academic program are for the current census are 7a-7p, a swing from 3p-11p, and a nocturnist shift from 7p-7a. There is no max. The offeror should provide details of recommended shifts for the additional non-academic program provided by the offeror.

Question 7. What do you like and dislike about the current model?

UNMH RESPONSE: The RFP seeks a qualified offeror to supplement the existing hospitalist program, the current issue is not a dislike with the current model, just a patient census that has exceeded what the academic program can provide coverage for.

Question 8. How does the collaboration work between the existing 70 hospitalist and 30 APP's and this new group coming in?

UNMH RESPONSE: The incoming group would need to collaborate with the existing academic group and should present how they intend to exist in collaborative fashion. The numbers listed above are for the Division of Hospital Medicine which operates in 3 facilities and has faculty with many other roles.

Question 9. Is there any current providers that are currently in the role you would like to keep or get rid of?

UNMH RESPONSE: The RFP seeks a qualified offeror to provide a supplemental program to the existing hospitalist program, UNMH does not intend to terminate or make changes to any current staff or the current program.

Question 10. Would the non-teaching teams be allowed to host residents for an elective rotation for those who want to pursue hospitalist roles post-graduation?

UNMH RESPONSE: The residency would be responsible for approving any elective rotation but there is nothing in place precluding this relationship.

Question 11. Is there a desire to continue to allow residents to perform internal moonlighting for cross-cover as you currently have today?

UNMH RESPONSE: The current moonlighting process offers an inconsistent staffing model with intermittent unfilled shifts and need for a lot of scheduling oversight which create stress on the system. Optional moonlighting that improves the system and provides voluntary opportunity for some residents, but is not required for basic function, is a more optimal model.

Question 12. What is the payor mix of the non-teaching patients? How has this trended over time?

UNMH RESPONSE: Currently, there is no sorting of teaching and non-teaching patients and payer mixes is currently the same.

Question 13. How do you allocate the patients for the non-teaching service – is it all patients above the cap?

UNMH RESPONSE: Currently a triagist working 24/7 triages patients to services based on caps and timing of admissions (i.e. call days). Most non-teaching teams are pushed towards their cap with overnight admissions currently. This may change depending on successful offeror ad on.

Question 14. Is the ICU closed during night hours?

UNMH RESPONSE: Yes.

Question 15. You mention that above the hard cap of 72-patients, the additional patients go to the non-teaching service. Do you have data on the time of day the cap is usually reached and additional admissions come to the non-teaching service on average?

UNMH RESPONSE: The reference to the 72-patient cap is referencing our current resident team caps. This may not remain the same with the addition of the proposed offeror program. There is not a specific time of day that resident team becomes cap, as admissions are spread out throughout a 24-hour period. See question 23 for additional information.

Question 16. Please explain your evening staffing.

UNMH RESPONSE: Our daytime hospitalists work 7a-7p and cross-cover their patients until 7p sign out. There is a swing who focuses on admissions from 3p-11p. There is a nocturnist who works 7p-7a. Triage is performed by multiple people throughout the day with 3p-6p being the long call resident team attending, the swing attending triaging from 6p-7p, and the nocturnist assuming triage duties at 7p. The busiest period for ED to request admissions if 4p-12p on average. Again, this is the current state and what is required to manage our current case load. This may change depending on successful offeror ad on.

Question 17. Please provide the scope of practice of APP's allowed by the med staff to determine how they are utilized?

UNMH RESPONSE: See below a General Overview of APP Scope of Practice at UNMH. We ask offeror to present their plan for utilization of APP's within the proposed program, following UNMH Bylaws. Also see question 24 for additional information.

- At UNMH an APP is the primary clinician and responder for patient issues between 0700-1900.
- Attending's are ultimately responsible for all patients and staff each patient with the APP. The attending may choose not to see each patient depending on APP experience and acuity of patients.
- APP writes all orders (unless discussed with attending).
- APP calls all consults (unless discussed with attending) and discusses case with consultants.
- APP communicates with family members.
- APPs write daily progress notes which must be completed on the same day of service.
- APP determines readiness for discharge and coordinates discharge planning with case management.
- APP completes transfer to SNF orders and medication reconciliation before patient is discharged.
- APP writes home discharge summaries which should be completed within 24 hours of discharge.

Question 18. It appears there is more faculty than needed for just the 72-patient resident census. What are the goals of # of patients per faculty member with residents and interns?

UNMH RESPONSE: The current 4 resident teams have 1 resident, 2 interns, 1 attending and 14 patient cap. We have an additional 6 residents that rotate through a 16pt inpatient team with an attending, a daytime triage/admitting role, and 2 nighttime cross-cover/admitting roles. Many faculty are not full time clinical and have many other leadership roles and FTE protected activities within the organization. We ask the successful offeror to provide recommendations for add on program.

Question 19. Will we have the opportunity to offer moonlighting opportunities for faculty when not working on teaching services similar to what they do now or during a transition/start up?

UNMH RESPONSE: The current faculty are given options to moonlight. The ability to moonlight for external group would need to be approved by Division Leadership and would be dependent on staffing needs on academic services. That said, the Division Leadership is supportive of our faculty being able to moonlight internally when staffing needs are met, and this likely would be a possibility.

Question 20. Can we please get the metric detail for the non-teaching service? It looks like the metrics provided are for the total volume (teaching + non-teaching)

a. Specifically, we need the following:
   i. 7 am census (ADC)
   ii. Enc/day
   iii. Utilization status for IP and Obs
   iv. Non-teaching only LOS
   v. Payor mix for the non-teaching cases

UNMH RESPONSE:

HOSPITAL MEDICINE NonResident	2018	2019	2020	2021
Total Discharges (InPt plus Obs)	1935	1821	3990	4705
Encounters per Day	34	42	74	92
Ave 7AM Census	30	36	63	80
Utilization Status (%)				
Inpatient (Viz)	74	74	83	84
Observation	26	26	17	16
Length of Stay (LOS)	6.60	7.07	7.06	7.37
Payer Mix (%)				
Medicare Fee For Service	29	30	25	21
Medicare Advantage	18	17	18	21
Medicaid Managed Care	27	25	26	29
Medicaid Other	8	8	8	7
Commercial	10	10	13	12
Self-Pay and County Medically Indigent	6	7	6	5
Other	1	1	2	2
VA	2	2	2	3

Question 21. Is Medicare Advantage included with Medicare or with Commercial? If with Commercial, what % of the total Commercial is made up of Medicare Advantage?

UNMH RESPONSE:
See answer to Question 20

Question 22. Are all Medicaid products included with Medicaid or are there Medicaid products included in other buckets? If so, what % of these buckets do these products make up?

UNMH RESPONSE:
See answer to Question 20

Question 23. How will the academic and non-academic services share admissions?
Is the non-academic service solely responsible for their patients at night or will there be the potential for shared cross-coverage?

UNMH RESPONSE: The Offeror will be responsible for nighttime cross-cover and admitting for their own patients. Admissions and cross-cover to the academic teams will be performed by members of the academic group. A proposal for shared cross-coverage that is mutually beneficial could be considered, but is not an expectation.

Question 24. Do hospital bylaws require physicians to see all APP patients each day?

UNMH RESPONSE: Hospital Rules and Regulations require daily supervision and oversight of APPs on a daily basis. Oversight in the inpatient setting require all patients primarily cared for by an APP to be seen by the supervising Attending on day of admission, day of discharge and for any consultation encounters. For subsequent day encounters, the Attending needs to staff the patient with the APP and provider clinical oversight as needed, but is not required to see the patient in person (unless clinical care needs dictate otherwise).

Question 25. Are there any current non-academic hospitalists who could be retained or would Offeror be building an entirely new team?

UNMH RESPONSE: This group should plan on staffing a new model. This would be separate from the existing and continuing academic program.

Question 26. (B-ii – Page 14, University of New Mexico Hospital) Clarify the number of facilities requiring Hospitalist coverage as defined in the RFP at the University of New Mexico Hospital Main campus?

UNMH RESPONSE: The current proposal is for one facility.

Question 27. (I-B-iii – Page 14, University of New Mexico Hospital) Will the existing ~~Chief of Vice Chief~~ (Division Chief) be in charge of this program, or will Offeror provide a Medical Director for the program?

UNMH RESPONSE: The existing leadership group will entertain proposals for medical directorship but cannot guarantee filling the role internally.

Question 28. (I-B-iii – Page 14, University of New Mexico Hospital) How many, if any, of the current physicians and/or APP's will be available for the start-up? How many will remain as part of the hospitalist direct care team?

UNMH RESPONSE: The RFP seeks a qualified offeror to provide a supplemental program to the existing hospitalist program, UNMH does not intend to terminate or make changes to any current staff or the current program. Movement of faculty or APPs from one group to another would be an optional and ideally need joint approval of faculty and leadership.

Question 29. (I-B-iii – Page 15, University of New Mexico Hospital- Current State ICU coverage) RFP mentions closed unit with intensivist's primarily managing care but not clear if HM provides any services there. After hours admissions? Cross-coverage?

UNMH RESPONSE: The ICU is an entirely closed unit without hospitalist management.

Question 30. (I-B-iii – Page 15 Current State- Nocturnist Coverage) Does he/she work for the direct care group, and thus, part of our team? Will we be able to continue to use residents for internal moonlighting? Approximately how many FTE's or shifts is that?

UNMH RESPONSE: Currently our nocturnist works for the full group in a triage/staffing role. See Question 11 for answer re: moonlighting. Currently we staff ~1-2 residents each night in moonlighting roles depending on APP staffing. Our night coverage includes 1 nocturnist, 2 APPs in cross-cover roles who perform admissions when able, 2 residents on rotation in cross-cover/admission roles for resident teams, and 1 resident moonlighting admitter. This level of coverage has been for the recent volumes of 150-200 patients on hospital medicine. The RFP seeks a qualified offeror to provide a supplemental program to the existing hospitalist program.

Question 31. (I-B-iii – Page 15 Current State) You indicate a range of 79-133 patients per day Hospitalist coverage. Please provide an exact patients per day to be utilized by all vendors for the purposes of the RFP?

UNMH RESPONSE: The "current state" relates to existing operations which will be continued by UNMH. The RFP seeks a qualified offeror to provide an additional new program to support on average 100 patients as noted in Exhibit A-II Purpose. The number of patients set at 100 is just an average. The actual number of patients for whom services will be provided may vary, and at times will be fewer and at times may peak at 120.

Question 32. (I-B-vii – Page 16 Hospital Medicine Metrics) You provided combined annual inpatient and observation discharges for years 2018-2021- Please provide exact annual ***inpatient*** volume for all vendors to use for the RFP?

UNMH RESPONSE: The "current state" relates to existing operations which will be continued by UNMH. The RFP seeks a qualified offeror to provide an additional new program to support on average 100 patients as noted in Exhibit A-II Purpose. The number of patients set at 100 is just an average. The actual number of patients for whom services will be provided may vary, and at times will be fewer and at times may peak at 120.

Question 33. (I-B-vii – Page 16, Hospital Medicine Metrics) You provided combined annual inpatient and observation discharges for years 2018-2021. Please provide exact annual ***observation*** volume for all vendors to use for the RFP?

UNMH RESPONSE: The "current state" relates to existing operations which will be continued by UNMH. The RFP seeks a qualified offeror to provide an additional new program to support on average 100 patients as noted in Exhibit A-II Purpose. The number of patients set at 100 is just an average. The actual number of patients for whom services will be provided may vary, and at times will be fewer and at times may peak at 120.

Question 34. (I-B-vii – Page 16, Hospital Medicine Metrics) You provided combined payor mix data for inpatients and observation patients- Please provide individual payor mix for inpatient and observation patients?

UNMH RESPONSE:

2021 NonResident Teams *Payer Mix by Status (%)*	Observation	Inpatient
Medicare Fee For Service	15.3	21.3
Medicare Advantage	24.7	21.6
Medicaid Managed Care	32.8	29.5
Medicaid Other	5.8	6.6
Commercial	13.1	11.9
Self-Pay and County Medically Indigent	5.9	5.0
Other	0.1	1.5
VA	1.7	2.7

Question 35. (I-B-vii – Page 16, Hospital Medicine Metrics) You provided a single category for Commercial payors- Please provide a breakdown by percent of commercial payors for inpatients and observation patients?

UNMH RESPONSE:

2021 NonResident Teams *Commercial Payer by Status (%)*	**Observation**	**Inpatient**
C33 - VAMC Refer Triwest	10.1	15.0
X44 - BCBS OOS	18.6	13.7
X94 - BCBS NM PPO	9.3	8.9
K75 - UHC Commercial	10.9	5.4
K71 - Pres HMO	2.3	5.2
I96 - Ins-Generic Primary	4.7	4.8
K98 - Total Community Care	3.1	4.8
K42 - TrueHealNMPL	3.9	4.7
G08 - Wexford	1.6	4.4

X92 - BCBS Govt Commercial	2.3	4.4
K94 - Molina HIX Bronze	3.1	4.0
K70 - Cigna PPO	0.8	3.8
R07 - PHS IP	3.9	3.8
X11 - BCBS UH Employees	8.5	3.1
K63 - UMR	2.3	2.5
K93 - Molina HIX Silver	5.4	2.5
X91 - BCBS UNM Emp Retiree	1.6	1.7
C70 - Tricare	1.6	1.7
A96 - Aetna	1.6	1.6
X90 - BCBS NM HIX All Plns	2.3	1.0
K77 - HMA	0.8	0.6
K96 - Molina HIX Gold	0.8	0.6
X80 - BCBS Blue Preferred	0.0	0.6
K66 - Pres Health Plan PPO	0.0	0.3
I08 - Humana	0.0	0.3
I33 - NM Mutual Casualty	0.0	0.3
K07 - Pres UNM Employees	0.8	0.1
X70 - BCBS UNM House Staff	0.0	0.1
K97 - Pres Health Plan HIX	0.0	0.1
I90 - NM Health Conn HIX	0.0	0.1

Question 36. (I-B-vii – Page 16, Hospital Medicine Metrics) You provided Average Daily 24-hour Census for the years 2018-2021- Please provide one ADC for all vendors to use for the RFP?

UNMH RESPONSE: The "current state" relates to existing operations which will be continued by UNMH. The RFP seeks a qualified offeror to provide an additional new program to support on average 100 patients as noted in Exhibit A-II Purpose. The number of patients set at 100 is just an average. The actual number of patients for whom services will be provided may vary, and at times will be fewer and at times may peak at 120.

Question 37. (I-B-vii – Page 17, Hospital Medicine Metrics) You provided Length of Stay (LOS) for the years 2018-2022- Please provide one average LOS for all vendors to use for the RFP?

UNMH RESPONSE: Please see the answer to Question 20. Data for the Non-Resident teams is provided. A trend was requested from 2018-2021. The mean LOS for the Non-Resident teams from 2018-2021 is 7.11 and may be used for the RFP.

Question 38. (I-B-vii – Page 17, Hospital Medicine Metrics) LOS: Home- Please defined Home LOS?

UNMH RESPONSE: The LOS for the group of patients discharged home and includes those with and without Home Health Care.

Question 39. (IV-B-i-c -2-4– Page 22- Consultations) How many consultations from the ED for assistance in management of complex patients, consultation of co-management of surgical patients are estimated? Assume these are added to the "100" number?

UNMH RESPONSE: It is very unusual to get consultations from the Emergency Department for just management, we primarily get admission request. Sometimes, an admission request will lead to recommendations to not admit with an alternate disposition plan being recommended by triage hospitalist. These would not be considered in the 100, those would be for patients that are admitted.

Historically, the resident teams would be responsible for surgical consultations and co-management that remain on surgical teams, the consult service was folded to manage Covid patients but anticipated to restart with this proposal. There may be opportunities to develop co-management agreements for surgical patients to be on medicine services and these would be considered within the '100' number.

Question 40. (IV-B-i-c – Page 23, Other Staff Members) Is this a reference to vendor staff members or UNMH?

UNMH RESPONSE: UNMH is requesting offeror to describe in detail any additional Offeror/Vendor staff that is on site during engagement. Offeror should include role of staff person, expectations, and requirements.

Question 41. (IV-B-iii-e – Page 27) What additional staffing resources will be required from UNMH? Please clarify IV-B-i-c and IV-B-iii-e?

UNMH RESPONSE: UNMH does not determine how each offeror will staff its operations at UNMH. UNMH requests Offerors to describe any additional staffing resources they will request from UNMH.

Question 42. Contract start-date- RFP due 3/9/21-contract sign 4/1/22 with a 90 day start- The timeline to contract start is very short following the RFP process. Is there any flexibility with the start date?

UNMH RESPONSE: Yes, there is flexibility in respect to the start date noted in the RFP, but UNMH hopes to commence the new program as quickly as possible. Please provided anticipated timelines for commencement of your program.

If there are any questions or inquiries in relation to this Addendum #1, Offerors may contact Shannon Rodgers at (505) 272-9571 or by email at sjrodgers@salud.unm.edu.