

**ATTACHMENT - A  
 NASSAU COUNTY SCHOOL BOARD MEDICAL CLINIC  
 ON SITE MEDICAL CLINIC RFP WORKSHEET**

**A. Company Background and Administration**

1. Provide the following information about your company:

Company Name	
Company Address	
Primary Contact for RFP	
E-mail Address	
Telephone	
Fax	

2. List the personnel your company will assign to help administer the District's Clinic.

	Name	Location	Years with Company	Clinic Experience
Account Manager				
Manager of Nassau Clinic				
Implementation Manager				
Medical Director				
Other				

3. Respond to the following administrative questions.

	Response
1. Do you have procedures in place to protect member health information that is HIPAA compliant?	
2. Will you assume complete legal liability for the actions involving the Clinic?	
3. Do you have administrative procedures in place to accept co-pays and fees for services rendered?	
4. Will you conduct an annual member satisfaction survey?	

4. References: Respondent must have a proven track record that demonstrates success in providing services similar to those requested in this RFP. List at least **three** current or recent clients where services similar to those requested in this RFP have been or are being provided. Please list clients most similar in size to the School Board of Nassau County and services most similar in scope to those outlined in this RFP (please include relevant experience in public school systems if applicable).

Current Clients	Contact Name	Contact Title	Contact Telephone	Years as Client
1.				
2.				
3.				

**Company:**

**B. Services to be Provided**

Issue	Response
1. Will your Company provide all of the primary care medical services as listed in the Scope of Services?	
2. Describe how your Company will provide the ancillary medical services as listed in the Scope of Services.	
3. Describe how your Company will dispense medications on site or provide convenient filling of medications for members as listed in the Scope of Services. If dispensing on site, provide a list of the medications to be stocked.	
4. Describe how your Company will provide the health management services as listed in the Scope of Services.	

**C. Facilities and Staffing**

Issue	Response
1. Will your Company design, open and operate a Clinic in Nassau County in a location that is convenient for District members including the procurement of all facility and provider licenses? Indicate the proposed location of the two initial facilities. Outline your timeline for implementation assuming a contract is issued on July 29, 2010.	
2. Describe how your Company will manage and equip each clinic facility and include the responsibilities of your Company and the responsibilities of the District?	
3. Will your Company lease facilities, or utilize existing medical facilities in Nassau County? If your Company plans on using existing Nassau County medical facilities, describe the arrangement, disclose the facilities, and include dedicated hours of operation for the exclusive use of District members.	
4. Describe how your facilities will provide limited medication dispensing, laboratory services, and radiology services?	
5. Are the hours of operation flexible and set to meet the needs of District members? What hours is your Company proposing?	
6. Will staff members be contracted full time and regular part time employees of the Company? If your Company plans on using existing facilities, will the employees be hired by your Company or are they employees of the facilities?	
7. Will at least one of the Clinic be staffed with a full time certified physician specifically assigned to the particular Clinic?	
8. Describe the system your Company has in place for clinic personnel to follow best practices and evidence based medicine guidelines	
9. If your Company will be using employees of existing facilities, are the employees expected to utilize your clinic best practices and evidence	

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based medicine guidelines?	
10. Describe the system your Company has in place for clinic personnel to identify and act on gaps in medical and medication care. Include how your Company will audit utilization for gaps in care.	
11. Which staff members (i.e. nurse) will be contacting patients following medical encounters to discuss compliance and conditions?	
12. Will the Clinic periodically schedule specialty care providers with regular office hours? Describe how this will be determined.	
13. Indicate your Company's on site clinic staff turnover rate for professional staff and support staff over the past two year period.	
14. Indicate how your Company would work with the District's technical centers to allow students in applicable medical and pharmacy studies to gain practical experience in the onsite medical centers.	

**D. Electronic Interface Capabilities**

Issue	Response
1. Will your Company utilize electronic medical records that are accessible at all Nassau County School Board onsite medical Clinic?	
2. Will your Clinic be capable of accepting member eligibility electronically?	
3. Will District members be able to schedule appointments online? Describe the process.	
4. Will Clinic medical encounters and medication dispensing be interfaced with the health plan on a regular basis? Describe the process.	
5. Will the Clinic have ePrescribing capabilities?	
6. If your Company will be using existing Nassau County medical facilities, will the facilities be expected to have the same electronic interface capabilities as described in the above questions?	

**E. Network Referrals**

Issue	Response
1. Describe how your Company will identify a high performance provider network in Nassau County.	
2. Describe how your Company will manage the referral of members to the high performance provider network.	
3. Describe how your Company will identify a high performance facilities network in Nassau County.	
4. Describe how your Company will manage the referral of members to the high performance facilities network.	

**F. Communications and Reporting**

Issue	Response
1. Briefly describe how your Company will market clinic services to District members initially and then on a regular basis.	
2. Briefly describe how your Company will communicate with regional providers regarding the clinic and specific member follow up.	
3. List the reports that your Company will provide to the District.	
4. Will your Company provide comprehensive monthly member utilization and referral data to the District benefits consultants?	

**G. Clinic Cost**

**Average Monthly Plan Membership**

Please note that "Employee" includes Active Employee subscribers, COBRA subscribers, and Retiree subscribers. Members include covered lives.

**Proposed Clinic Location and Staffing**

Complete the chart below using the assumptions that your Company used for the facility costing of the medical Clinic. Assuming a contract is issued on July 29, 2010, indicate the dates for beginning the build out and the clinic opening dates.

Location	Clinic Locations		Facility Sq. Footage	Days and Hours of Operation	Begin Build Out	Clinic Opening Date
	Existing Provider Facility	District to Secure Facility				
Initial Locations for Year 1						
Clinic						
Locations for Future Growth						
<b>Total</b>						

Complete the chart below using the assumptions that your Company used for the staffing for the medical Clinic.

Staffing	Physician		ARNP or PA		RN/ Med. Asst.		Clerical		Health Advocate		Other	
	Number	Hrs per Week	Number	Hrs per Week	Number	Hrs per Week	Number	Hrs per Week	Number	Hrs per Week	Number	Hrs per Week
Initial Location for Year 1												
Clinic												
<b>Total</b>												

**Projected Services per Location for Year 1**

Complete the chart below using the assumptions your Company used for the number of visits expected

Location	Physicals	Primary Care	Ancillary Care	Biometric Screenings	Medications Dispensed	Disease/Condition Management
<b>Initial</b>						
Clinic						
<b>Total</b>						

Complete the following cost estimating sheets using the location, staffing, and utilization assumptions indicated above to determine the cost to the District (include all costs-fees and expenses).

**Start Up Costs**

Start Up Costs (All Facilities)	Cost to District	
	Estimated	Guaranteed Maximum
Facility Design		
Facility Build Out		
Facility Furnishings		
Facility Equipment		
Facility Supplies		
Information System Hardware		
Information System Software		
Licenses and fees		
Administrative		
Other (list category)		
<b>Total Aggregate Cost</b>		

**Monthly Costs**

Monthly Fees and Cost (All Facilities)	2010		2011		2012	
	Estimated	Guaranteed Maximum	Estimated	Guaranteed Maximum	Estimated	Guaranteed Maximum
Facility Costs						
Staffing						
Medical Supplies						
Laboratory						
Radiology						
Pharmacy						
Office Supplies						
Administrative Cost						
Other (list category)						
<b>Total Aggregate Cost</b>						
<b>Number of Clinic Office Visits Needed to Break Even (Clinic Cost and Health Plan Utilization Changes)</b>						

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**Clinic Cost**

List the aggregate annual cost for the Clinic as proposed below.

Annual Fees and Cost (All Facilities)	2010		2011		2012	
	Estimated	Guaranteed Maximum	Estimated	Guaranteed Maximum	Estimated	Guaranteed Maximum
Start Up Costs						
Medical Services and Staffing						
Facilities Cost						
Administrative and Management Fee						
<b>Aggregate Total</b>						
Based on a monthly membership of 1,100 covered lives						
<b>Per Member Per Year Cost</b>						
<b>Per Member Per Month Cost</b>						

**Variations in Medical Utilization**

Indicate the variation in utilization your Company would anticipate seeing in Year 2 and Year 3 of clinic operation.	
Assuming the variation listed above, what recommendations would your Company propose in locations and staffing?	

**H. Performance**

List the **Performance Guarantees** your Company has included in your proposal.

Issue/Service	Performance Guarantee	Amount at Risk
1. Please indicate the performance guarantees you are proposing regarding changes in utilization and reductions in health plan costs along with a guaranteed Return on Investment. Indicate the amount your Company will place at risk.		
2. Indicate other performance guarantees your Company will propose.		
3. Indicate the supporting documentation you will provide for your performance guarantees and specify the frequency of reporting outcomes to the District.		
4. Indicate your understanding that the guarantees will be in effect for the entire length of the contract.		

As an officer of the Company, I certify that the information contained in our proposal worksheet is accurate, and our Company will be bound by the contents of our proposal.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

You must complete the three worksheets contained in Attachment B Plan Services and Cost and return as part of your proposal.