

# Solano Emergency Medical Services Cooperative (SEMSC)

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Request For Proposal

for

Adult Level II Trauma Center Designation

**ADDENDUM: Proposers' Conference Q & A**

Issued: June 21, 2013

*Note: Answers contained in this addendum are incorporated as amendments to the RFP by reference.*

**Solano County Emergency Medical Services Cooperative (SEMSC)  
Level II Adult Trauma Center Request For Proposal (RFP)**

Question Number	RFP Item number	Proposer Question	SEMSC Response
<b>General RFP</b>			
1	<b>2.4.3.c</b>	What standard definition are you requiring for “Major Trauma Patients?”	The use of “major trauma patients” in the reference section is descriptive, rather than as a patient population defining term. Its use is in reference to family and patient-centered care for major trauma patients. Refer to question # 17 where a similar question is answered. The Solano County field triage criteria is an Injury Severity Score (ISS) greater than 15 and/or Step 1 or 2 from the Centers for Disease Control and Prevention / American College of Surgeons (CDC/ACS) field triage criteria.
2	<b>4.1.4</b>	The current wording implies that you are requesting clinical laboratory information for all emergency department patients and information on all trauma patients. Is this correct that you want it for both populations? If not can you please clarify what you are requiring?	It is not necessary to submit information about the entire Emergency Department population. Information submitted should be relative to trauma patients only.
3	<b>4.1.5</b>	The current wording implies that you are requesting blood and blood product information on all emergency department patients and all trauma patients. Is this correct that you want it for both populations? If not can you please clarify what you are requiring?	The area of emphasis is making sure that the trauma patient receives expedited testing and analysis for their care. These types of patients are usually the most critical in the Emergency Department. Information submitted should be relative to trauma patients only.
4	<b>4.1.6</b>	The current wording implies that you are requesting for radiology services information on all emergency	It is necessary to ensure that the trauma patient receives expedited imaging and interpretation of

		department patients and information on all trauma patients. Is this correct that you want it for both populations? If not can you please clarify what you are requiring?	those images. Information submitted should be relative to trauma patients only.
5	<b>4.1.7.d</b>	The current wording implies that you are requesting information on average response time for interpretation of results from time of request on all emergency department patients and information on all trauma patients. Is this correct that you want it for both populations? If not can you please clarify what you are requesting?	Information submitted should be relative to trauma patients only.
6	<b>4.4.c</b>	In this section you refer to Exhibit #3: Trauma Surgeons, however, in the actual exhibit the term used is General Surgeons. We are assuming that you only want trauma surgeons listed. Is that assumption correct?	The requirement is to list all participants who are involved in a trauma call. This includes those who are listed as trauma surgeons as well as those listed as general surgeons.
7	<b>4.5.6</b>	In reviewing the 2006 ACS manual (specified in the RFP) we do not find the term “trauma nursing audit.” Can you clarify what this is referring to?	Part of the verification process used by the American College of Surgeons (ACS) to be verified as a Level II Trauma Center includes reviewing the quality of nursing documentation in the Emergency Room, specifically the trauma flow sheet that’s used to document the Emergency Department phase of care. The trauma nursing audit will include, but is not limited to the following: <ul style="list-style-type: none"> <li>• serial vital signs;</li> <li>• time of arrival</li> <li>• documentation of serial vital signs monitoring;</li> <li>• documentation of procedures;</li> <li>• time to diagnostics; and</li> <li>• length of time spent in the Emergency Room</li> </ul>
8	<b>5.14.1.c</b>	In this statement the RFP indicates that “The qualified specialist in (2), above, shall be a member of the	This section of the RFP relates to ACS’ verification requirements for Level II Trauma Centers, having to

		<p>trauma team”. What specialist does this refer to, it is unclear?</p>	<p>do with Intensive Care Unit (ICU) services. For a Level II Trauma Center, it’s not required that there be a surgically-directed ICU service, but there must be a coherent ICU service run by ICU-specialized physicians. There must be a surgeon co-director of that ICU service with experience in ICU care even though that physician is not required to be ICU boarded in Critical Care. The aforementioned is in addition to an organized service for ICU care. There has to be someone available for life-threatening or critical illness or critical problems for trauma patients in the ICU, 24 hours a day, 7 days a week. While that person doesn’t have to be an ICU-verified specialist, there does have to be someone associated with the trauma service. Where the term “qualified specialist” was referenced was intended to mean the ICU person who may or may not have a 24-hour presence in the house, but the trauma team has to have someone there at all times to respond to emergencies. This will be a requirement for ACS verification as a Level II Center.</p>
9	<b>5.16.2</b>	<p>Is there a list of required participants for this “multidisciplinary trauma peer review committee that includes all members of the trauma team?” Per the definition provided, the trauma team includes all staff that participates in the care of the trauma patient to include phlebotomists, emergency department techs, etc. Are you asking for all to participate in the meetings or be represented in the meetings?</p>	<p>The ACS standard for verification as a Level II Trauma Center will be the presence of a multi-disciplinary peer review committee. The process improvement or the quality improvement program is one of the central components of what it takes to be verified as a Level II Center. The required participants at the multi-disciplinary program will be representatives from the trauma service (e.g. all trauma panel surgeons) and the specifically designated liaisons from the specialty services, who have to be there at least 50% of the time to meet verification standards. The specifically required</p>

			<p>people are outlined in the Optimal Resources Document. It would include the Emergency Department liaison, Radiology liaison, Orthopedic liaison, and Nurse Surgical liaison.</p> <p>It is adequate for each of the disciplines to have a designated representative present at the trauma meeting.</p>
10	<b>5.19</b>	<p>This element states that the surgeon will be in the emergency department on patient arrival, with adequate notification from the field. Do you mean within 15 minutes of arrival per Title 22 and ACS guidelines level II standards, or are you asking for a new standard? Also is there a definition for adequate notification from the field?</p>	<p>This is intended to be the same standard that's put forward by the ACS Verification Program. The expectation is that the trauma surgeon should be there when the patient arrives. The standard is that the surgeon will be there within 15 minutes of patient arrival at least 80% of the time. Adequate notification doesn't have a time standard. It is recommended and preferred to have the surgeon there on trauma victim arrival.</p> <p>Field personnel should notify the receiving trauma center as soon as it is determined they are responding to that facility in accordance with the Solano County Trauma Triage Algorithm.</p>
11	<b>5.25</b>	<p>Please clarify the term trauma director. Are you referring to the trauma medical director as in 5.23 and 5.24?</p>	<p>The term trauma director and trauma medical director are the same.</p>
12	<b>5.32</b>	<p>How does this requirement differ from 5.19 or is this the same requirement restated?</p>	<p>It is the same requirement.</p>
13	<b>5.57</b>	<p>The term radiographer is not defined in the 2006 ACS manual. Can we assume that this is a radiology technologist?</p>	<p>This question refers to the necessary presence of a radiology technologist in order to take the primary imaging. A Computer Tomography (CT) technician is also expected to be there and available 24 hours a day / 7 days a week.</p>
14	<b>5.68</b>	<p>There are two items numbered 5.68. How do you</p>	<p>This was a typographical error in numbering.</p>

		want us to differentiate between these items?	Please refer to these items as 5.68(a) and 5.68(b). Answers contained in this addendum are incorporated as amendments to the RFP by reference.
15	<b>Appendix 8</b>	For the data requirements are there inclusion/exclusion criteria for the specific items listed?	Appendix 8 refers to trauma patients as previously defined. <i>See answers to questions 1-5.</i>
16	<b>Appendix 8. d</b>	For reporting the number of trauma victims who are believed to meet trauma triage guidelines, can you clarify which guidelines you want us to use? (Solano County, CEMIS, NTDB)	The Centers for Disease Control and Prevention's Field Triage criteria is what should be used. The reporting of the number of trauma victims is required to remain consistent with the trauma patient definitions. CDC/ACS field triage criteria [MMWR: 61(1), January 13, 2012]
17	<b>Appendix 8. e.2, 8. f.6</b>	For these items please clarify the standard definition are you requiring for "Major Trauma Patients"	It is the Injury Severity Score greater than 15 and/or Step 1 or 2 from the CDC/ACS field triage criteria. Refer to the response for Question #1.
18	<b>Appendix 8.g</b>	Does the number of emergency admissions in 2011 and 2012 for the following categories refer to all emergency department admissions, or just trauma admissions? If you are requesting both, do you want these populations separated?	The number of admissions for both Emergency Department patients and trauma patients is required. The two populations should be listed separately. Data for years 2011 and 2012 is required (two full years of data).
19	<b>Exhibit 7</b>	The footnote for this exhibit states "all surgeons who staff trauma service must have 16CME." Can you clarify if 16CME are needed for all ED physicians (non-surgeons) and not just the liaison as is required by ACS?	All Emergency Department physicians and Specialty Department Liaisons staffing the Trauma Center, especially the Emergency Department, are required to accrue an average of 16 verifiable external trauma-related Continuing Medical Education hours annually, or 48-hours in a three year period of time.
<b>Catchment Area Questions</b>			
20		Please explain why the Catchment Area(s) are not included in the Request for Proposal (RFP) and how this omission best serves the citizens of Solano County?	It is impossible to know prior to receiving letters of intent and proposal submissions what the catchment area will be as the catchment area will change depending upon the geographic location of the

			proposing entity. Therefore, the analysis needs to be done once letters of intent have been submitted.
21		How can an applicant adequately plan for volume and cost of trauma services if the RFP proposal does not define the scope of the service area?	Please see response to question number 22 below, it is incumbent upon the hospitals to make those determinations and projections as this is a business decision.
22		Given the cost and fees involved in submitting a proposal and the significant investment made by the Level II Trauma Center, will the Catchment Area include at least all of Solano County?	In accordance with the Solano County trauma triage algorithm, which dictates transfer to the closest appropriate trauma center, the catchment area is determined by the location of the potential Level II Trauma Center(s) in relation to the next closest Level I or II Trauma Center(s). This means that the catchment area for this Level II Trauma Center in Solano County will not include all of Solano County, as some geographic areas in the northern and southern parts of the county will remain closer to existing Level I or Level II Trauma Center(s). This is in the primary interest of the patient obtaining the necessary medical care in the shortest amount of time.
23		Does the SEMSC intend to include any area outside of Solano County, such as Yolo County, in the Catchment Area?	The Solano Emergency Medical Services Cooperative does not have the authority to determine trauma catchment areas outside of Solano County borders. Therefore, that decision would be made solely by the Local Emergency Medical Services Agencies (LEMSAs) with jurisdiction for those counties.
<b>Labor and Delivery Requirement</b>			
24		Why are labor and delivery services being required in this RFP as a minimum standard for an Adult Level II Trauma Center when the American College of Surgeons (ACS) Standards do not require such services?	The primary reasons Labor and Delivery Services are required in the RFP are: <ol style="list-style-type: none"> <li>1. An assessment of Level II Trauma Centers in the US, and this region, has been conducted. The results show that Labor &amp;</li> </ol>

			<p>Delivery services are offered at all Level II Trauma Centers, thus it has become the de facto standard of care.</p> <p>2. SEMSC cannot move forward with a Level II Trauma Center Designation that would reduce the level of care currently received by residents of Solano County.</p>
25		How many trauma cases have been in Solano County in the past five years that require labor and delivery services?	<p>Statistically speaking, a pregnant woman is no more or less likely to be a trauma victim. The number of cases is less important than the ability to provide the care. SEMSC has determined that pregnant victims of trauma receive appropriate treatment and care in the most expedient manner possible.</p> <p>The US Centers for Disease Control and Prevention, MMWR, Recommendations and Reports dated January 23, 2009, Vol. 58, No. RR-1, recommends that injured women &gt;20 weeks pregnant be transported to a trauma center or hospital with obstetrical resources.</p>
26		What are the specific labor and delivery requirements for this RFP?	<p>In addition to other specialists already on site, a Labor &amp; Delivery team, at a minimum, consists of an Obstetrician, a Labor &amp; Delivery nurse, and post-partum Registered Nurse. They must be immediately available to provide routine and emergency neonatal delivery as well as continuous, appropriate on-site treatment and care for mother and baby following stabilization.</p>
27		Given the existing excess capacity in Solano County, the lack of clinical justification and the fact that one of the two known applicant hospitals already has Labor and Delivery services meeting Title 22 requirements, please outline the criteria that SEMSC	<p>Please see response to Question #24.</p> <p>A resource commitment to become a Level II Trauma Center is not insubstantial, and most of that is in fact centered around the ability to provide high-end care for relatively uncommon but life-</p>

		used to determine that Labor and Delivery services should be required in this RFP.	threatening sets of injuries. The number of patients who present as hypotensive, in need of emergency medical surgery intervention to an average trauma center is in the neighborhood of 7%. The number of patients who required a neurosurgeon immediately available to do a craniotomy in Solano County will likely be under 20. The same could be said about critically injured pregnant females but it's entirely consistent with the requirements of a Level II Trauma Center. And the ability to provide that level of specialty care across the board is what distinguishes a Level II Center from a Level III Center.
<b>General RFP Questions</b>			
28	<b>2.4.3</b>	Section 2.4.3 of the RFP states that the successful applicant will be determined in accordance with its ability to meet special requirements as identified by Solano County Emergency Medical Services (EMS), among other things. Does the RFP include these special requirements? If not what are these requirements?	Any and all special requirements are already identified in the RFP.
29	<b>2.4.3</b>	Section 2.4.3 of the RFP states that the successful applicant will be determined in accordance with its demonstrated commitment to patient family-centered care for major trauma. How will applicants be evaluated on this requirement?	Evaluation will be conducted through chart review and interviews with appropriate staff. There will be particular emphasis placed on pediatric patients.
30		There is a reference to "Section 3.3.8 – Part 8" on page 47 of the RFP, but there is no such section in the RFP. How should an applicant prepare trauma center cost and operating budget information for onsite review?	The section is not there and should be disregarded. Projected revenue and expenses including any/all capital costs and associated amortization should be provided.
31	<b>1.5.4 and</b>	Does an applicant's submission become available to	Per the RFP, Section 3.8 Confidentiality:

	<b>3.8</b>	the public upon submission or only when an award is made or RFP cancelled? Please see Sections 1.5.4 and 3.8	“All materials received related to this RFP will be kept confidential, until such time an award is made or the RFP is cancelled, at which time all materials received may be made available to the public.”
32	<b>4.2.3 b</b>	In Section 4.2.3 b, please provide specifics about “trauma surgical team”	In this particular section of the RFP it reads, “describe the protocols for alerting and mobilizing the in-house trauma team, the trauma surgical team.” These requirements for verification don’t specify which people necessarily have to be on the trauma team activation down to the level of person A or person B. It needs to include all of the pertinent members of the trauma team - the trauma surgical attending, the Emergency Room (ER) attending, any residents or other providers who may be part of that primary care team; the primary and secondary trauma nurses. It typically includes people who might be involved in major trauma at a slightly expanded region. Sometimes, but not necessarily including anesthesiology, radiology technician, laboratory technician and blood bank technician. There isn’t a specific set of people who belong on that team beyond the primary care or the primary team caring for the patient in the trauma bay. It’s not uncommon for there to be a stratified response within the hospital such that more people are paged to the highest level of activation and fewer people are paged to potentially less injured patients’; but that is in fact at the discretion of the hospital. Also refer to page 32, Resources for Optimal Care of the Injured Patient (2006) ACS.
32a		<i>Follow up question during conference:</i> The section immediately prior to this refers to trauma team. It appears that you’re talking about your OR	The answer to that is, not necessarily. What the standards require is that the operating room be available in a timely fashion when it’s needed. And

		<p>team. It doesn't specifically state OR response or it talks several points trauma surgical team. There are several questions in there about that and it looks like it's different from your trauma response team. It looks like your OR team is what's you're asking for in this.</p>	<p>what will be evaluated is – did a patient need to go to the operating room, and if they needed to go to the operating room, was it there, was it ready, and did you have it done. The process doesn't go into the nuts and bolts of how a particular hospital chooses to meet that requirement. Many of them do notify the operating room team that a high level trauma is coming in so they can make appropriate triage decisions about what they do with the operating room, but it's not a line item requirement that they be notified. And if you have a room and a team all standing by ready to go, maybe you don't need to notify them again; but it's not specified at that level of detail. And what will be measured is the availability of the operating room, based on historical ability to do so and the working plan to make it happen.</p>
33	<b>4.5.2 b</b>	<p>What does SEMSC mean in 4.5.2 b (page 26) when it asks for "The format of the activity" referring to the QI activities?</p>	<p>"The format of the activity" is asking for the proposer to describe the type and format of the activity/committee meeting; e.g., closed quality improvement meeting open only to providers, multi-disciplinary open forum meeting, didactic one-way educational system, didactic presentation, etc. The intent is to understand the nature of the meeting.</p>
34	<b>4.8 c</b>	<p>What the section 4.8 c "How is it reviewed?" mean when referring to Diversion/Saturation Policy?</p>	<p>This particular area is talking about the process or policies which the individual hospital or trauma center has in regards to transfer of a trauma patient to a higher level of care or what to do when they are on diversion or when they have a saturation policy. For example, operating rooms or the ICU is full and critically ill or injured patients that need to be transferred. The centers will have policies and</p>

			<p>processes for dealing with those kinds of eventualities. The “review” is specifically referring to the Performance Improvement in Patient Safety (PIPS) process. The PIPS program that will evaluate when you’re transferring, when you’re on diversion, or when you’re on saturation. This data will be tracked and trended and then reviewed to see if there are areas of improvement or if those particular policies and processes are being appropriately utilized. The total amount of time on diversion must be less than 5% of the time. This must be monitored by the PIPS program on an ongoing basis. For Level II verification, it will be required to list all episodes of trauma bypass and explain why they happen. The trauma team needs to be involved in decisions involving diverting trauma patients and there needs to be documented tracking of why it was done.</p>
35	<b>9.21</b>	<p>In 9.21, SEMSC asks for “the CME schedule for the past 12 months.” Is this the same schedule requested in element 4.4 (q)? or is SEMSC, asking for something else? If yes, what exactly does the SEMSC want included on the schedule and in what format?</p>	<p>Sections 9.21 &amp; 4.4 (q) are asking for the same information; CME schedule must include list of classes with the attendance rosters and number of Continuing Education hours earned in table format.</p>
36		<p>As SEMSC may issue amendments to the RFP up to the deadline for filing proposals, is there any procedure by which the applicant may modify its submittal, if necessary, after the deadline to accommodate any such amendments?</p>	<p>The need to modify proposals should not be an issue since all written clarification and amendments will be provided by June 21, 2013.</p>
37	<b>Appendix 5, 5.16.7</b>	<p>In Appendix 5, Section 5.16.7, lists as a minimum standard that SEMSC be provided access to all quality improvements or findings and may attend any and all quality improvements. Does this standard only apply to trauma quality improvements minutes, findings or</p>	<p>This applies only to trauma QI. All SEMSC representatives would be willing to sign confidentiality statements.</p>

		meetings? If not, how will the quality privilege be maintained?	
38	<b>Appendix 5</b>	Appendix 5, Level II Trauma Center Minimum Standards, defines “senior resident” as a “physician licensed in the state of California who has completed at least two (2) years of residency (PGY 3) under consideration ...” Title 22, Section 100245, however defines “senior resident” as “physician... who has completed at least three (3) years of residency or is in their last year of residency training...” Please clarify	The intent for general surgery residents, including the usage within the Optimal Resource Document, is PGY4 or PGY5 residents for the purposes of surgical senior resident. The language indicating at least 2 years, or in the final year of residency, was put in to accommodate other specialties in general surgery. A Chief Resident may only be PGY3; this language was included so that those people with non-surgical specialties could be considered senior residents.
<b>Data and Formatting</b>			
39		There are footnote-like annotations in the RFP (for example, page 19 item 4.1.2c, page 38 item 5.37, page 41 item 6.3) but the RFP does not contain footnotes, so what do these annotations mean?	These were errors and should be disregarded.
40		Are the Fiscal Data Requirements on page 47, d and e to be provided for onsite review only or does SEMSC want them included in the proposal?	The information should be included in the proposal, but be clearly marked as confidential as outlined on page 13 of the RFP package. The information will not be included in public record.
41		Page 11 says the proposal must have one-inch margins. Is this also a requirement for attachments (for example, printed policies and annual reports)?	SEMSC recognizes that formatting may be different for different documents that are already in existence and will not require the one (1) inch margins for facility-specific documents.
42		On page 11, SEMSC requests that PART 3 of the proposal be “a complete table of contents showing where each requirement is met.” Does SEMSC want the table of contents according to ACS requirements, Appendix 4, Appendix 5 or some combination of the three?	In order to facilitate the ease of location for the independent review panel, the table of contents should be formatted for ease of use and navigation of the submitted proposal.
43	<b>Appendix 8</b>	Appendix 8 (page 44): Data requirements specify data for 2011 and 2012 in column header. Does SEMSC	The data required is for years 2011 and 2012.

		mean 2012 and 2013 (to date) instead?	
44	<b>Appendix 8</b>	Appendix 8 also refers to “2012 to date”, does SEMSC mean “2013 to date?”	The data required is for years 2011 and 2012.
45		Does SEMSC want the Appendix 8: Data Requirements in any specific format, since the data “by month” will not fit in the provided columns?	Change the word “Total” to “Average” for only Appendix 8a. If there is supplementary data being presented other than what was requested, attach in an additional appendix or data sheet.
<b>The Proposed Contract</b>			
46		Given the costly investment in an Adult Trauma Level II Center of a successful applicant, please explain SEMSC’s reasoning for having a contract provision (Section 10) that allows SEMSC to terminate the contract for convenience?	The contract is for an initial two year term with an annual review and designation to continue. It is SEMSC’s intent to continue with these services as long as there is a public need and benefit. The termination for convenience clause has a 180 day notice period. While it’s SEMSC’s intent to continue this contract long term, changing circumstances and necessity may require proper notice and termination of this contract. Note that the notice period is significant compared to the initial term of the contract.
47		Again, in light of the costly investment that a successful applicant will make on behalf of the citizens of Solano County, please explain the SEMSC’s rationale for a Termination for Cause clause (Section 9) that contains only a 5 day minimum notice period, with no right to cure the problem, and with no materiality threshold?	Note that termination for cause section is section 8, not section 9, as indicated in the question. The contract provides that the termination for cause “shall not be less than five (5) days” after written notice. SEMSC’s notice period will be based on the gravity of the situation. Breaches involving mortality or morbidity will have a shorter notice period than a reporting violation. It is prudent and appropriate for SEMSC to have a “no less than a five (5) day” notice period based on the magnitude of services being provided under this contract.
48		Please explain how SEMSC would terminate only part of this contract “for cause” as Section 8 currently	SEMSC is reserving the right to terminate only part of the contract for cause. Circumstances, such as

		provides?	repeated breaches in a certain type of care, may warrant that that portion of the contract be suspended while being remedied or, in some circumstances, terminated. If the successful bidder is performing well for certain types of trauma II care, a complete termination may be overly broad.
<b>Bid Appeal Process</b>			
49		Does the County of Solano Board of Supervisors have a written policy on RFP appeals? If so, is the appeal contained in the RFP consistent with that policy?	The Solano County Board of Supervisors policies and procedures do not apply to this RFP as the Board of Supervisors has no jurisdiction over this issue.
50		Please confirm that this RFP complies with the California Administrative Procedure Act.	The California Administrative Procedures Act does not apply.
51		If an applicant chooses to appeal the award, when and how will the applicant receive access to and copies of materials related to the RFP, along with reports of the Independent Review Panel (IRP) and any relevant internal documents (e.g. emails)?	The bid process does not give the appealing party rights to any additional information other than that which would be available under a California Public Records Act request.
52		May an applicant that appeals call witness to testify during the hearing?	An applicant who appeals may call witnesses to testify during their appeal hearing.
53		Will an applicant that is not recommended to receive the trauma center designation be able to request and receive a debriefing conference with the SEMSC in order to discuss its proposal?	No debriefing conference will be offered or provided to the unsuccessful applicant.
<b>Proposer's Conference Speaker Cards</b>			
54		RFP states to be received no later than 3PM on July 15. The slide today indicated 12 Noon. Please clarify, thank you.	The RFP must be received by 12:00 PM PST on July 15, 2013.
55		If the Medical Center has a Qualified Obstetrician, a Labor & Delivery RN, and a Pediatrician immediately available to care for the critically injured pregnant patient, does this meet the RFP requirements for Labor & Delivery?	A review team will be looking for evidence that the capability to care for the critically injured pregnant patient exists within the hospital. This capability cannot be determined by having specified employees immediately available for assistance.

			Instead, it may be based on things such as, but not limited to: immediate ability to perform fetal monitoring, immediate provision of patient care by experienced obstetrics trained personnel, and the ability to provide emergent obstetrical interventions and procedures.
56		What date range will be requested for the August Chart Review: 2011-2012 or 2013 to Date?	Hospitals may choose the charts for review, as long as they represent 12 consecutive months. None of the charts should be older than 18 months, but should be of sufficient age that the patients have been discharged.
57		Can CV's be made available for onsite review or does the county want them all in the proposal?	The actual Curriculum Vitae materials may be made available on site.
58		Who are the "call-in physicians" referenced in Required Attachment 9.22? (RFP asks proposers to "provide supporting material showing compliance rates for call-in physicians")	Call-in physicians include the primary trauma surgeon and any sub-specialists or consulting physicians or care providers who are asked for.
59		Appendix 6, statement 6.7 (page 41) refers to Policy 1403. The policy is not available on the Solano County EMS website. What is the policy?	Policy 1403 was a typographical error in the original document. The policy applicable to data collection and reporting is Policy 2220.
60		What does Appendix 6, statement 6.13 (page 42) mean?	Should the successfully designated hospital fail a subsequent re-verification visit, it will maintain its best efforts to continue to operate consistently with a Level II Trauma Center designation until otherwise directed by the SEMSC.
61		NTDB vs. CEMISIS: "more rigorous" So do you want both? Because they are different.	Based on the Emergency Medical Services Authority's desire to transition from CEMISIS to NEMISIS, submission of both CEMISIS and NTDB data will be required, until such time as CEMISIS standards have fully transitioned.
62		Can CME documentation be available on site just as individual CV's?	Continuing Medical Education documentation can be made available onsite for verification.
63		When will an editable version of the proposed	An editable version will be made available by

		contract be made available to potential proposers?	November 1, 2013 to allow the selected applicant to submit proposed technical changes in a redlined version.
<b>Additional Submitted Questions</b>			
64		In 4.4(m), page 25, under Physician and Nurse Coverage, it states “For other personnel identified as part of the trauma team, identify advanced training, certification, and/or special skills in medicine, nursing, administrative services, etc.” What positions are you referring to other than Physicians and Nurses?	Examples of members of the Trauma Team other than Physicians and Nurses include, but are not be limited to: Respiratory Therapists, Laboratory Technologists, Radiology Technicians, and Social Workers.
65		Will the RFP scoring template be shared with applicants upon submittal of the Letter of Intent and fees?	The scoring template will not be shared with potential proposers upon their submittal of a letter of intent.
66		In the Pre-Proposer Conference you stated that EMS would not be making any further changes to the RFP after June 21, 2013. In that untracked changes to the RFP have been made, which are very difficult to identify without doing time consuming side by side comparisons, will this change and any other changes to the on-line official RFP be made in a “strikeover/ <u>redline</u> ” method or other readily identifiable method so that the public and proposers can easily tell what has been changed by EMS?	No additional changes are being made to the RFP. Answers contained in this addendum are incorporated as amendments to the RFP by reference.
67		The introductory paragraph to Appendix 10 (Proposed Contract) (page 50 of the RFP) states “[a]ny proposed changes to the proposed contract language <u>must</u> be identified as part of the proposal, using a “strikeover/ <u>underline</u> ” method. No proposed change to the contract which is not submitted as part of the proposal will be considered. All changes to this contract must be mutually accepted prior to Trauma Center designation.” Will an editable version of the proposed contract be provided to potential proposers	The Level II Trauma Center Agreement is required for designation by the Solano Emergency Medical Services Cooperative, which is the Regulatory Agency with the statutory authority to designate the selected facility. The agreement is not intended to be a “Negotiated contract,” rather it outlines the standards and requirements the selected facility will be held accountable to maintain. An editable version, capable of allowing for “strikeover/ <u>underline</u> ” will be made available by

		<p>prior to the deadline for RFP submittals on July 15, 2013 so that proposers can comply with the introductory paragraph? If so, when? If not, please revise the introductory paragraph to indicate that “<u>strikeover/underline</u>” will be due at a later date.</p>	<p>November 1, 2013, as a courtesy to the proposed awardee to propose technical changes, if necessary. Answers contained in this addendum are incorporated as amendments to the RFP by reference.</p>
68		<p>Section 3.5.5 of the RFP (page 12) similarly provides that changes to the language provided in the Declarative Statements of submittals for Appendices 6 also be submitted in a “<u>strikeover/underline</u>” method. Will an editable version of the proposed Appendix 6 be provided to potential proposers prior to the deadline for RFP submittals on July 15, 2013? If so, when? If not, please revise Section 3.5.5.</p>	<p>Appendix 6 is required for designation as a Level II Trauma Center by the Solano Emergency Medical Services Cooperative, which is the Regulatory Agency with the statutory authority to designate the selected facility. The appendix is not intended to be “Negotiated.” Rather it outlines standards and requirements the selected facility will be held accountable to maintain. An editable version, capable of allowing for “<u>strikeover/underline</u>” will be made available by November 1, 2013, as a courtesy to the proposed awardee to propose technical changes, if necessary. Answers contained in this addendum are incorporated as amendments to the RFP by reference.</p>