ADDENDUM # 3

September 7, 2017
Address all questions to:
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RFP NO: 4000005894
TITLE: Emergency Ambulance Services
CLOSING DATE: November 6, 2017 / NOT LATER THAN 4:00 p.m.

This Addendum is issued to the above referenced to RFP make the following changes, additions, deletions, and/or clarifications:

1. Clarification: General

Question:
Regarding Response Time Changes
There is significant change to response times. The change is from 8 minutes for all calls, Urban, to 12 minutes for non-critical calls, without any discussion with fire services that will now have extended wait times. Additionally, it appears the contractor will decide what is a critical call. Can you help us understand this change?

Answer:
This question poses multiple issues, so will be answered in subsections:

First, response time requirements for critical calls have not changed under the RFP.

Second, the extension of response times for non-critical calls from 8:00 to 12:00 minutes, or longer, is now considered best practice in the EMS industry. The response time requirements outlined in the RFP are consistent with recommendations published by the US Department of Transportation National Highway Safety Administration’s Office of EMS which states:

*Standard setting organizations and geopolitical jurisdictions should consider establishing different response time expectations for high and low priority EMS responses. The traditional requirement for ALS response within 8 minutes 90% of the time is...*
In developing the RFP, the County chose to focus on achievement of a variety of clinical outcomes as the primary indicators of EMS system success - i.e., instead of response time as the primary indicator. With this in mind, the changes in response times for lower acuity calls is both logical and safer for patients, the community and responders.

Below are some of the most significant studies that have been recently published related to outcomes and response times:


Third, the Medical Director sets priorities for call types; the contractor does not choose which calls are critical in nature. MPDS software uses an algorithm to quickly determine which calls are classified as life-threatening. It is the Medical Director’s responsibility (not the Contractor’s) to determine the ambulance response to all triaged/classified calls.

Each fire first response agency will need to determine its response to the various classifications of calls - from critical to lower acuity to non-response. These decisions should be made in collaboration with the EMS Medical Director. As is current practice, individual fire agencies’ responses to calls triaged under the MPDS system will be loaded in the Versaterm CAD, and will not be subject to changes by the County or ambulance Contractor.

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The County acknowledges that there is a potential for extended first responder wait times for some calls that are classified as not requiring an 8:00 minute response. However, the MPDS triage system also creates a potential for eliminating first response on many lower acuity calls, thereby potentially freeing up fire resources.

2. Clarification: General

Question:
For the urban area, the section of the RFP below will allow the successful contractor to consistently provide a lower level of service to the Gresham Fire Response Area or any other singled out area without penalty or recourse. The target for any single sub-zone is only 80%, one month out of three, provided the contractor’s total area is meeting 90% mark. Can you help us understand the change?

Answer:
First, in developing the revised Ambulance Service Plan and RFP, the County looked in detail at response time compliance both for the overall Ambulance Service Area and in urban sub-zones. The County’s EMS consultant used historical data from the Multnomah County system to carry out industry-standard computer modeling of response times and deployment requirements in order to understand the impacts of current and alternative proposed response time criteria. This modeling focused on determining optimal unit locations, and then measuring the attainable response times from those locations. Using this approach, the model determined how many ambulance resources would be required to meet the 90th percentile compliance for the entire area, and where these resources should be placed. This analysis showed that placing ambulance resources at optimal locations for achieving overall response time resulted in the same level of response time performance in sub-zones as having specific response time criteria for sub-zones.

Second, under the current contract, sub-zone compliance is measured every six months. Under the RFP, measurement of sub-zone compliance is to be done monthly. Should any sub-zone not meet the sub-zone response time requirement for three consecutive months, the sub-zone compliance requirement will increase to 90% for that zone (again, measured monthly). In addition, if the County determines that there are any chronic non-equitable response patterns, it requires the Contractor submit a mitigation plan. Failure to mitigate under-performance can constitute a breach of the contract between the County and the ambulance provider. The County believes that, taken together, these approaches actually strengthen the County’s ability to assure geographic equity.

3. Clarification: General

Question:
The reduction in the number and changes in the location of the Urban Zones, is meant to dilute the impacts of hard to reach locations, and minimize impacts of calls at the furthest reaches of the Urban Zones on total response times. This is in direct conflict with the equity statements to assure the same level of services for all County residents. Can you help understand this change?
Answer:
The number and location of the urban response sub-zones in the RFP has not been changed from the current sub-zone configuration. So the assertion that there was an intent to dilute the impacts of hard to reach areas is not logical.

In addition, the evaluation of response times and unit location carried out by the County’s contracted EMS consultant did not provide any evidence that a deployment plan designed to meet overall response times in the urban part of the Ambulance Service Area resulted in any adverse impact on outlying urban areas.

4. Clarification: General

Question:
Regarding Contractor Communication Center
Can you (or the contract) guarantee that the proposed vendor-based dispatch system won’t cause an increase in dispatch times (first ring at dispatch to first due company tap-out)? Can you help us understand this change?

Answer:
The electronic assignment of first responder resources can occur at multiple points along the interrogation cycle - for example, the keystroke indicating that the address has been verified, or the point when the chief complaint has been entered. The determination of when fire resources are activated and/or dispatched is predetermined within the BOEC CAD software; it is not up to the ambulance Contractor. The RFP requires that the Contractor utilize the BOEC CAD. This requirement is intended to expedite the assignment of Fire resources, thus using the BOEC system in a manner that is consistent with current automated approach to recommending resources.

5. Clarification: General

Question:
Regarding 911 call triage and dispatch
Where in the United States has this model been used? For how long?

Answer:
The use of EMS contractor personnel to categorize and prioritize medical requests is common. Systems include the California counties of Contra Costa, Merced, and Monterey; Reno, Nevada; Tulsa and Oklahoma City, Oklahoma; Fort Worth, Texas; the majority of parishes (counties) in the State of Louisiana; the majority of counties in the State of New Jersey; Richmond, Virginia; Fort Wayne, Indiana; Little Rock, Arkansas; and Pinellas County, Florida. A number of the high performing systems listed have operated successfully for more than a quarter century.

6. Clarification: General

Comment:
The County Ordinance for the Ambulance Service Plan states that all calls are dispatched by 911.

(Reference) ORDINANCE NO. 1238

(D) All licensees receiving requests for ambulance services through their business telephone or by any other means other than BOEC, shall, using a triage system that is approved by MCEMS and aligned with the system employed at BOEC, determine if the call meets the emergency dispatch requirements. If the call meets these requirements, that call information is to be transferred to 911 for dispatch. Licensees are prohibited from dispatching an ambulance to a call that meets emergency dispatch criteria.

Response:
The RFP was designed to ensure that the actual dispatch occurs within the BOEC system. BOEC will still answer 911 emergency calls, and BOEC will still dispatch 911 Emergency Medical calls, using its Computer Aided Dispatch system (CAD). The County Ambulance Service Plan, which is the governing document, allows for BOEC or a secondary PSAP to triage medical calls. Under the RFP, the contractor will triage calls, and will assign ambulance resources. The contractor will communicate in real time with BOEC. Dispatch and tracking of both ambulances and fire units will still occur through BOEC.

7. Clarification: General

Comment:
The decision in the RFP to move the triage and dispatching of public and private resources to a private provider’s dispatch center is contrary to the national/state/local initiatives aimed at moving all resources to a single regional dispatching center. We experience the operational challenges and delay in dispatching private units in Washington County now due to two dispatching centers. Moving all 911 units into WCCCA is a primary objective of the EMS Advisory Council. The State of Oregon has a desire to limit the total number of PSAP’s in the state and other states have begun more aggressive legislation by limiting tax revenue in areas that have multiple centers. There have been some recent poor outcomes for patients that have a system in which the private ambulance transport provider is responsible for triage and dispatching of 911 medical incidents.

Response:
The mechanisms used for dispatch throughout the nation vary widely. There are fully integrated primary and secondary centers, centers in which all personnel work for a regional agency; consolidated centers with both public and private personnel co- located and separate centers in which voice and data are virtually linked.

There were multiple considerations in developing the approach described in the RFP. The current system does not provide independent real time electronic QI performance monitoring or allow the contractor to adequately allocate and deploy resources to achieve a higher level of performance and efficiency. The County’s intent is to create a patient centric system that focuses on clinical outcomes with fail safes to prevent deleterious outcomes.

Requiring the provider to utilize the BOEC CAD creates a virtual consolidation of call processing and dispatch functions. In addition, since BOEC has a direct view into the CAD, it can monitor activity of both fire and ambulance responders. The use of First Watch software is designed to increase the transparency of monitoring the system’s
performance including extending the live monitoring of the systems process to multiple stakeholders including the fire service.


Question:
Can you provide contact information for labor representatives for ambulance and communications center workers?

Answer:
The contact for the labor representative is:

David Tully
Labor Representative
Teamsters Local 223
dtully@teamsters223.com
503-256-5995

A copy of the current labor agreement is posted on the Multnomah County Purchasing website. See Item 10 of this addendum.


Question:
Regarding the MPDS Requirement
How was MPDS chosen? Is there any requirement to follow a procurement process?

Answer:
Multnomah County EMS chose MPDS and its associated software and Quality Improvement systems based on the recommendation of its EMS Consultant as well as its own evaluation of the capabilities of MPDS and alternative systems (including the County’s current triage guide). The County is not purchasing the MPDS system or software; instead it is setting use of MPDS as a criterion in the ambulance RFP. As a result there was no requirement to carry out a separate procurement process.

The rationale for choosing MPDS and its associated systems and software rested on their ability to support enhanced patient outcomes, electronically monitor performance for quality improvement purposes, support system efficiency, facilitate accountability, and improve transparency for system stakeholders. More specifically, MPDS is designed to improve prioritization and categorization of requests for EMS response. MPDS was first developed for and implemented by the Salt Lake City Fire Department in 1978. It is currently deployed in 26 countries, and is utilized in over 4,000 communications centers worldwide. MPDS is unique in utilizing ongoing analysis of patient outcome data as the basis for classifying calls, and for developing and modifying triage protocols. MPDS incorporates robust quality assurance components that facilitate evidence-based implementation and medical oversight of call triage and response. MPDS is able to interface with the existing BOEC Computer Aided Dispatch software (Versaterm), and is being successfully utilized in other jurisdictions that use the same Versaterm CAD. These interface capabilities are important for maintaining an integrated system approach to call triage and
response, and allowing appropriate independence in dispatch criteria for fire first responders and the ambulance contractor.

10. Addition: Section 5., Attachments List, Page 136.

**Add:**
Addendum 3, Attachment 5.22, Collective Bargaining Agreement

A copy of the current labor agreement is posted on the Multnomah County Purchasing website [https://multco.us/purchasing/opportunities/emergency-ambulance-services](https://multco.us/purchasing/opportunities/emergency-ambulance-services) under this solicitation and is labeled Addendum 3, Attachment 5.22 Collective Bargaining Agreement.

c: D. Knott, A. Monnig
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