



**Request for Letter of Interest Number 06-EPO-01**

**Development of Standards and Guidelines for  
Healthcare Surge during Emergencies**

**October 30, 2006**

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## I. Project Description

### A. Project Objective

The California Department of Health Services (CDHS) is seeking a consulting firm that would, under its direction, convene a broad group of stakeholders and interested parties to develop comprehensive guidelines and standards to enable healthcare facilities, communities, and licensed healthcare professionals to address the many complex issues of healthcare surge capacity planning and response during an emergency.

The deliverables under this project fall into two areas:

- Developing and managing a process that includes government agencies, stakeholders, and other relevant parties as participants in this project.
- Developing written standards and guidelines for delivery of medical care services in a surge environment.

The standards and guidelines developed in this project shall serve as the basis for emergency planning and operations of healthcare facilities, providers and communities during an unexpected emergency increase in demand for healthcare services. Standards may vary based on the type and size of the emergency. CDHS plans to disseminate or make available parts of the consultant's entire work product to all local health departments, communities, healthcare facilities, and individual licensed healthcare professionals, healthcare insurers and other key stakeholders for their use in planning for surge capacity. The consultant's work product may form the basis for statute(s) or regulation(s), or form the basis for emergency orders to be issued by the Governor or local health officers during a state or local emergency.

The primary areas for which written standards and guidelines are needed include but may not be limited to the following:

- Assess existing laws, regulations and ordinances governing licensure and standards of care for healthcare facilities, and licensed healthcare professionals. The consultant will develop processes, protocols, or template orders that address, or, to the extent possible, suspend or lift legal barriers and afford flexibility during an emergency and surge environment, followed by rapid resumption of standard procedures during recovery from an emergency;
- Assess liability protections for individual licensed healthcare professionals and healthcare facilities during emergency circumstances and develop processes, protocols, or template orders that provide increased protections to them including but not limited to use of volunteers, use of expanded scopes of practice, and use of other healthcare professionals licensed in or outside of California but without hospital credentialing or privileges.
- Assess reimbursement requirements including the Medicare Conditions of Participation, state licensure, healthcare plan and provider requirements, and standard payor agreements to address and streamline reimbursement of

- individual licensed healthcare professionals, healthcare facilities, and alternate care sites when emergency circumstances require operating outside of standard requirements for delivery of care;
- Develop standards and protocols for rapidly establishing and operating alternate care sites in non-medical facilities;
  - Develop templates for operational surge plans that can be used by individual healthcare facilities and alternate care sites. The templates must address workforce protocols to augment or share personnel, receive and distribute supplies and materials, provide communications capacity, and establish priorities for vaccinating or treating population groups (e.g. health care workers and those at increased risk). The consultant shall also prepare templates/model agreements/protocols for resource sharing, organized discharge of non-emergency patients on short notice, and establishment of quarantine and isolation capabilities. These templates/model agreements/protocols shall also address training of healthcare facility staff; preplanning and arrangements for use by non-facility sites such as schools, hotels or convention centers for off-site triage and acute care during emergency surges; systems for disseminating, storing and preparing prescription medications under surge circumstances; diversion plans; and systems for streamlined medical records documentation.

In recognition of the importance and urgency of this project, the State Budget Act for fiscal year (FY) 2006-07 appropriated \$5 million to accomplish the scope of work set out in this Request for Letter of Interest.

## **B. Process of Awarding the Contract for This Project**

Given the high priority and extraordinary need for standards and guidelines, under authority provided in the State Budget Act FY 2006-07, this request for Letter(s) of Interest shall result in selection by CDHS of a single consulting firm most qualified and able to creatively and proactively address the issues related to planning and operationalizing healthcare delivery during surge capacity. Given the urgent nature of addressing and planning for surge capacity, the consultant must be able to mobilize to address and deliver the contract requirements within an expedited timeframe of six months. In order to facilitate timely purchases and contract execution, the California Budget Act provided the following exemption from the state contracting procurement process: *“In order to ensure the protection of the public health, it is the Legislature's intent that all products and services to address the state's readiness related to surge capacity, be procured or ordered by September 1, 2006. If the Director of Health Services and the Director of General Services determine that utilizing the state's standard procurement practices will result in the state's inability to meet the September 1, 2006 deadline, all procurements and orders shall be exempt from Part 2 of Division 2 (commencing with section*

10100) of the Public Contract Code. “[Provision 5 of Section 23 of Assembly Bill 1811 (Stats. 2006, c. 48 [A. B. 1811], § 23)]

Requirements, processes, and procedures set forth in this Request for Letter of Interest do not constitute incorporation or affirmation of either the provisions of Part 2 of Division 2 of the Public Contract Code or any implementing regulation. Likewise, use of certain provisions and terminology in this Request for Letter of Interest is for administrative convenience only and does not, by that use, constitute adoption or incorporation of any provisions of Part 2 of Division 2 of the Public Contract Code or any implementing regulation. CDHS intends to award a contract to a single contractor and for its own administrative convenience, intends to follow the process and procedures set forth in this Request for Letter of Interest.

The following timeline shall be followed:

<b>Event</b>	<b>Date / Time (If applicable)</b>
Letter of Interest Release	October 30, 2006
Informational Meeting	November 8, 2006
Final day for submittal of questions	November 13, 2006
Letter of Interest Due	November 20, 2006
Review of Proposals	November 21-22, 2006
CDHS Interviews	November 27-29, 2006
Contract Award Date	December 1, 2006
Proposed Project Start Date	December 15, 2006
Contract Deliverables	June 15, 2006

### **C. Defining Surge Capacity**

Disasters resulting from a biological, chemical, radiologic agent, a natural event, or communicable disease outbreaks such as severe acute respiratory syndrome (SARS) or pandemic influenza will impose significant demands on California’s healthcare system. Providing health care during an emergency presents

significant challenges for healthcare facilities, licensed healthcare professionals, and communities. During emergency events, healthcare systems must convert quickly from their current patient capacity to “surge capacity,” a significant increase beyond usual capacity, to rapidly respond to and augment existing capabilities of the healthcare system. Both public and private healthcare institutions are critical components of any emergency response and must be able to “surge” or to expand operations and respond to an emergent and potentially ongoing demand for medical services during an emergency. Surge capacity requires bed capacity, staff, medical equipment and supplies, and the ability to maintain essential medical services.

#### **D. Need for Development of Standards and Guidelines for Healthcare Surge during Emergencies**

Healthcare standards in California are designed to assure quality of care and address a wide range of areas including fiduciary and organizational structure of healthcare facilities; physical structure of facility; qualifications and number of staff in the facility; education and experience for licensure of licensed healthcare professionals; level, quantity and maintenance of medical equipment; and development and enforcement of medical standards within a facility. These standards are delineated in statute, regulation, and guidelines issued and enforced by government and non-profit agencies to articulate the performance expected of healthcare facilities and licensed healthcare professionals during standard operations. However, during emergencies, reduction in mortality and morbidity requires extraordinary actions to provide medical care to a larger population within a shorter timeframe than the healthcare community is designed to handle. In these situations, the demands of the emergency may prevent compliance with the existing healthcare standards. Just as California has healthcare standards for use during standard operations, it is essential that California provide guidelines identifying or to the extent able, exempting the standards for healthcare delivery during emergencies.

The public’s expectation is that medical care during an emergency will primarily be provided in a hospital setting. While it is likely that acute care hospitals can meet most of demands in small emergencies, during catastrophic events, hospitals may be overwhelmed by the demands for emergency care. Hospitals may need to discharge existing patients or transfer them to alternate care sites to care for the most serious patients. In these situations, communities will need to convert other facilities to providing acute care. This may involve the use of areas of the healthcare facility not designated for patient care; temporarily upgrading the level of care provided at other facilities such as long term care facilities or clinics; or conversion of non-medical facilities to serve as alternate care sites. California’s 61 local health departments are responsible for planning alternate care sites within their jurisdiction. They may collaborate with hospitals, clinics, municipal meeting halls, schools, hotels, fairgrounds, and other locations in

identifying and operating the alternate care sites needed to serve their population.

While California's governmental agencies have operated within a well defined and practiced emergency response structure for many years, guidance is necessary for rapid response and surge capacity. All California counties participate in the Master Mutual Aid Agreement (MMAA) by which local government seeks assistance from neighboring counties before requesting assistance from the State. The Standardized Emergency Management System (SEMS), established in 1993, is the model on which the National Incident Management System (NIMS) is based. SEMS/NIMS provides the organizational structure for interaction among multiple governmental agencies involved in responding to an emergency. In contrast, California's healthcare facilities are largely private and operate outside the MMAA and SEMS structures. Further, the identified challenges of healthcare surge have not been comprehensively addressed by other states or the federal government.

Healthcare facilities and medical providers face several challenges to preparedness for emergencies. They are seeking specific direction from regulators on which quality of care standards may be waived or flexed during an emergency. They need to know how they will be reimbursed for care provided under "flexed" standards. They are concerned about liability protection in using altered standards of care. They are requesting technical assistance in developing and implementing surge plans for their facilities. The project discussed in this paper seeks to address these needs.

The issues involved in this project are difficult and complex and have been widely discussed in numerous national forums but not brought to resolution. Left unresolved, the issues will be addressed haphazardly during an actual emergency, weakening the response. California must act now to rapidly resolve these issues and develop standards and guidelines that are well understood by the health care community, stakeholders and emergency responders.

## **E. Current Surge Capacity in California**

Mounting a surge response to a moderate or catastrophic event requires medical staffing, medical equipment and supplies, beds, and a framework of standards and guidelines on how and when to implement those resources on a coordinated, integrated basis across facilities and jurisdictions.

Since 2003, California has received an annual grant from the federal Health Resources and Services Agency (HRSA) National Bioterrorism Hospital Preparedness Program to enable hospitals, clinics, emergency medical services, and poison control centers to strengthen their surge capacity to respond to medical emergencies. All 58 counties in California participate in the HRSA program as well as over 300 of California's acute care hospitals,

approximately 500 clinics, and local health departments and local emergency medical services agencies. HRSA has established critical benchmarks for all states to use in measuring their capacity to meet the demands for medical care during an emergency.

In February 2006, CDHS undertook the California Hospital Surge Capacity Survey (CHSCS), a statewide survey project to assess healthcare surge capacity among HRSA participants. The goal of the project was to determine whether California met benchmarks for patient surge capacity set by HRSA and to identify other gaps in California's ability to meet surge demands during an emergency including a catastrophic-pandemic influenza event. This project was initiated because analysis of previously collected healthcare surge capacity showed inconsistencies across counties in assumptions and definitions. Participation included over 340 hospitals, all local health departments, 30 local emergency medical services agencies, and more than 200 clinics. This was followed with an assessment of California's ability to respond to a pandemic, based on a computer modeling program established by the federal Centers for Disease Control and Prevention.

Findings indicated that many California hospitals are not prepared for a surge in demand for patient care. Historically, hospital emergency planning has focused on movement and evacuation of patients rather than an influx of patients. State licensing regulations and national accreditation standards are outdated and inconsistent with state and federal emergency response systems. While HRSA participating hospitals have accumulated communications equipment, decontamination systems, isolation capacity, personal protective equipment, small pharmaceutical caches for hospital staff, and surge supplies and equipment such as cots, generators, and blankets for increasing bed capacity, many do not have operational plans and preparations in place to coordinate use of these supplies during a surge effort:

- Less than half of the 340 hospitals participating in HRSA reported having documented full-scale surge plans for their facility or their community;
- Only 18 percent of hospital staff have received emergency response training such as Incident Command System (ICS) and SEMS/NIMS;
- Hospital exercises have primarily focused on evacuation of patients from the facility rather than an influx of patients;
- Hospital participation in surge capacity planning is voluntary and nearly 100 California acute care hospitals do not participate in HRSA surge planning.

## **II. Scope of Work**

CDHS is seeking a consultant to develop standards and guidelines on the issues discussed in this Request for Letter of Interest that may affect hospitals and other healthcare facilities, local health departments, communities and individual licensed

healthcare professionals during an emergency that exceeds the medical resources of the affected area. There are two components to the project: Process of Participation and Project Deliverables.

## **A. Process of Participation**

This project will be conducted through participation and information sharing with stakeholders and interested parties. Managing this process is a key component of the project. The consultant will propose an approach that enables participation by providers and stakeholders in this project.

The process proposed by the consultant must allow all interested parties to be informed and participate in the development of guidelines while being scalable in recognition that some deliberations may require a more manageably-sized group than will be possible with all interested parties.

Representatives from these organizations reflect the many dimensions of providing healthcare in California and will have thoughtful advice and information that needs to be included in developing standards. Participants who must be informed of and provided an opportunity to participate in all aspects of this project include but are not limited to the following:

- *Other State agencies involved in emergency response and quality of care:* the Emergency Medical Services Authority (EMSA); the Office of Statewide Health Planning and Development; Department of Managed Health Care; Department of Mental Health; state professional licensure boards for medical providers; Nurse Task Force; Governor's Office of Homeland Security and Governor's Office of Emergency Services.
- *Healthcare institutions and providers and their professional organizations:* California Hospital Association, California Medical Association, California Primary Care Association, California Association of Health Facilities, California Association of Public Hospitals and others as well as representative licensed healthcare professionals.
- *Local health departments and local emergency medical services agencies:* Government agencies with responsibility for healthcare surge at the local level.
- *Entities involved in developing standards for healthcare facilities:* In addition to the State agencies listed above, the Agency for Health Research and Quality, HRSA, and CDC at the federal Department of Health and Human Services, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and others.
- *Academic institutions and foundations:* the University of California, Rand Institute, the Institute of Medicine, Trust for America's Health, and other academic institutions, foundations with interest/experience in surge capacity, and non-profit organizations interested in healthcare surge capacity.

- *Consumer representatives*: Community advocacy organizations, organizations representing individuals with special needs, and healthcare unions.
- *Healthcare payors*: Representatives from private and government payors.
- *Legal advisors*: Attorneys representing healthcare institutions, providers and consumer advocacy groups as well as attorneys representing standards of care enforcement.

## **B. Project Deliverables: Issue Areas to Be Addressed**

The consultant will develop policies with operational tools, protocols and procedures, to be approved by CDHS that provide guidance/standards in the following issue areas:

### 1. Standards for Licensed Healthcare Professionals in an Emergency:

- a) Licensure flexibility: written standards are needed to address situations such as:
  - Licensed healthcare professionals on the medical staff of a healthcare facility working beyond usual scope of practice
  - Licensed healthcare professionals not currently on the medical staff of healthcare facility (for example, physicians who volunteer to work in an emergency)
  - Volunteer medical or allied health professions licensed in another state who volunteer to work in California during an emergency
  - Role of unlicensed or not active license (e.g. retired)
  - Verifying licensure of healthcare workers not currently employed (for example, RNs who volunteer to work in an emergency)
  - Workers compensation/background checks/immunizations for volunteer workers during emergencies
  
- b) Scope of practice flexibility: the extent to which existing requirements will be waived or lifted

### 2. Standards for Healthcare Facilities during an Emergency That Requires the Facility to Operate Outside Standard Operations and Conditions (Principles of Mass Casualty Care):

- a) Triggers for the waiver of healthcare requirements and the process to seek and secure waiver from state and/or federal regulators.
  - Providing services in excess of licensed capacity
  - Facility-supported alternate care sites or mobile field hospitals providing services in the absence of licensure

- Integration with other types of facility healthcare
- b) Staff-to-patient ratio requirements:
    - The authority and situations under which these requirements can be suspended or waived
  - c) Augmenting staffing needed during an emergency:
    - Operation of Medical Reserve Corps
    - Use of ESAR-VHP to obtain medical staff during an emergency
  - d) HIPAA and State privacy laws
    - What can be disclosed to whom during an emergency, e.g. Red Cross, media, families searching for loved ones or wanting info about health status of patients
    - Medical records issues such as what to do when medical records are destroyed during a disaster, development of short-form or abbreviated medical record form for use during an emergency
    - Existing emergency provisions under HIPAA.
  - e) Emergency Medical Treatment and Active Labor Act (EMTALA) issues and state law issues
    - When and how EMTALA is waived
    - How to address the situation, including reimbursement policies for the licensed healthcare professional and the healthcare facility, where a patient must be hospitalized at an out-of-network facility for medical care even if it's not an emergency
    - Transfers via non standard means
    - Transfers to higher and lower levels of care
  - f) Definition of special needs populations and provisions for their care during an emergency
  - g) Prioritization and deployment of scarce resources: beds, ventilators, implementation of vaccine prioritization, prophylactic medications (e.g. antibiotics and antivirals)
  - h) When and how to implement modified standards of care/austere care and triage protocols; how to communicate the modifications to the relevant clinical staff
  - i) Waiver of reporting requirements – disease notifications, suspicious injury reports when a criminal act is cause of disaster, crime scene/evidence collection requirements

- j) Alteration or suspension of admissions requirements: Patient Self Determination Act (PSDA), Notice of Privacy Practices (NPP), etc.
- k) Consent issues: When and under what authority consent requirements can be waived

3. Reimbursement: Reimbursement for licensed facilities and licensed healthcare professionals (e.g., hospitals, nursing homes, clinic, and physicians) and unlicensed facilities (e.g., alternate care sites)

- a) Provisions for reimbursement by third party payers, both private and public;
- b) What healthcare facilities should discuss with insurance carriers and third party payors before, during and immediately after a disaster
- c) How healthcare facilities and licensed healthcare professionals bill for services provided outside of the standard or typical practice environment
- d) When and how FEMA reimburses for the costs of healthcare
- e) National Disaster Medical Services (NDMS) activation and requirements for data collection.
- f) How care in non-traditional facilities can be billed?
- g) What if patient(s) must be transferred to another facility by ambulance – will a private healthcare plan pay if the reason for the transfer is not due to patient's medical condition, but due to other public health reason(s)?
- h) If hospitals have to put an ICU-level patient in a medical/surgical bed, can they bill the carrier at ICU rates?

4. Liability for Facilities and Licensed Healthcare Providers

- a) What liability protections are available and/or required for facilities and providers during emergency operations?
- b) Protection against liability for facility and staff working at alternate care sites;
- c) Can healthcare facility employees be forced to work? Can any outside entities force hospital employees to work?
- d) Can healthcare facility employees be forced to be immunized? To be examined? To wear PPE?
- e) Isolation/quarantine of employees

- f) Reimbursement for employees who are not allowed to work, salaries and other benefits provided?
- g) Workers' compensation cover acts of terrorism?
- h) Return to work examinations

#### 5. Alternate Care Sites

- a) Setting up and operating alternate care sites
  - o What are the recommended and minimum space and configuration requirements?
  - o What is the required staffing?
  - o Recommended set up and operation procedures
- b) Criteria for order of activation of non-licensed acute care facilities (e.g., alternate care sites, mobile field hospitals)
- c) How would guidance differ for alternate care sites that are and are not connected to a healthcare facility?

#### 6. Model Operational Surge Plans for Healthcare Facilities: (e.g., hospital, long term care facility, and clinic)

- a) Establish strategies for healthcare facilities to free up/open/create additional patient care capacity.
- b) Develop recovery strategies to bring operations back to pre-emergency levels of care over a period of time so that the community has available ongoing care, access to surgeries, laboratory services, etc.
- c) Develop staffing models and strategies to provide medical and health services to a large number of patients and alternate sites with an impacted workforce
  - o Health care worker staffing
  - o Shift changes
  - o Staffing patterns
  - o Use of ancillary personnel to augment licensed personnel
  - o Identification of critical staffing and appropriate reassignments
- d) Develop templates for each impacted department within a facility, for example:
  - o Emergency Department
  - o Food Services / Nutrition Services
  - o Laundry / Linen Services / Environmental Services
  - o Lab and Radiology
  - o Inpatient Units

- Outpatient Units
  - Pharmacy
  - Security
  - Human Resources
- e) Identify internal (to healthcare facilities) and external (community) communications systems, and develop protocols for coordinated communications including risk communications and health information dissemination that integrate multidisciplinary networks including but not limited to the following:
- Personnel information network
  - Collaboration with outside agencies including public health
  - Integration of emergency response agencies and entities including fire, law enforcement, EMS, utility companies, other hospitals.
- f) Develop systems to provide care, feeding and shelter to healthcare and other staff that remain in the facility for prolonged periods.
- Child care / dependent care/ pet care strategies
- g) Triage strategies for inpatient, outpatient, and alternative care settings and how these would be altered during mass casualty mode
- h) Criteria for allocating acute care beds and limiting transfers from long term care facilities to hospitals
- i) Develop strategies for managing mass fatalities
- j) Establish strategies for prioritization for allocation and utilization of scarce resources
- PPE
  - Patient care supplies (IV fluids, syringes, etc.)
  - Food supplies (including water) allocation and rationing.
    - i. Patients
    - ii. Staff
    - iii. Others
  - Blood supplies
  - Ventilators
  - ICU beds
- k) Develop strategies to identify staff fitness for duty
- l) Develop strategies for patient identification and tracking
- Registration alternatives
  - Medical record alternatives
- m) Establish triggers for activation of the Hospital Command Center that is HICS Compliant

- n) Develop mental health strategies for patients, staff, families and others
- o) Develop templates for Continuity of Operations plans with special emphasis on IT services and other essential services
- p) Develop strategies for security of the facility, staff, supplies and protection of the organization
- q) Establish strategies for purchasing and procurement
- r) Establish strategies for managing large amounts of infectious waste and non-infectious medical waste
- s) Develop operational tools for hospitals and facilities serving as alternate care sites that may be customized to meet individual facility needs. The operational tools must be specific to healthcare facility type and universal for all facilities within that type. Hospitals must be responsible for alternate care sites that are in place on the grounds of their facilities, whether in their parking lot or areas not normally used for patient care.
- t) Pharmacy Issues – develop protocols as appropriate to include the following:
  - o When can requirement for a physician’s order be waived?
  - o When can the requirement for individualized labels be waived?
  - o Can care be given in unlicensed sites during an emergency without violating state or federal law including but not limited to the Robinson-Patman Act?
  - o Can pharmacists refill prescriptions without having access to a medical record?
  - o When can pharmaceuticals be filled by a non-pharmacist without a pharmacist providing supervision? Mass dispensing?

### **C. Overview of Contractual Requirements**

The selected consultant, hereinafter referred to as “Contractor”, will execute a written agreement with CDHS within 14 days of notification that it has been selected for this project. The agreement will include the following activities for this project:

- A) Review results of the 2006 California Healthcare Surge Capacity Survey and other related studies, reports, standards, guidance, and other documents applicable to this project.
- B) Review federal and state laws and regulations that address standards of care requirements and emergency management requirements.

C) In conjunction with CDHS and subject to CDHS approval, define process for this project, using a clearly defined methodology that includes but is not limited to:

- Identify all stakeholders to participate in contract activities and the process for their participation
- Interview key experts to identify issues to be addressed
- Identify process to assure
  - transparency
  - broad stakeholder participation
  - confidentiality of discussion of sensitive information

D) Define the process for open participation by stakeholders in development of standards under which healthcare shall be provided in emergencies and all guidance, templates, manuals, and other documents that articulate the standards:

- Solicit input on draft standards and guidance and revise as appropriate based on stakeholder comments.
- Designate process for presenting standards and guidance and establish process for responding to stakeholder comments, including basis or rationale for incorporating or rejecting suggestions.

E) Convene workgroups to develop draft standards and guidance documents addressing legal, legislative, and regulatory issues for hospitals, healthcare facilities, and communities. Provide 1500 bound copies of final standards and guidance manuals.

F) Propose to CDHS a format and structure for the operational tools that address the templates, standards and guidelines required under this contract. Contractor shall provide 100 copies of operational tools.

- Develop guidance/standards in relation to levels of severity and duration of events and HRSA scenarios.
- Standards and guidelines must be compliant with the emergency management system established by SEMS, NIMS, and the Hospital Incident Command System (HICS).
- Incorporate work performed by other national and state agencies and ad hoc efforts such as those on alternate care sites and austere care.

G) Develop training plan and curriculum for licensed healthcare professionals and hospital administrative staff on standards, guidance, and tools. Contractor shall provide training materials.

- Develop matrix indicating training needs of healthcare professionals and hospital administrative staff
- Recommend various modes of training to provide maximum flexibility at the local level, including web-based and didactic training
- Determine when/for whom Just In Time training or cross-training is appropriate

CDHS shall have sole proprietary rights to all products developed under this project. Prior approval from CDHS is required prior to release of any documents or information related to any aspect of the project process or scope of work.

### **III. Proposed Contract Term**

The term of the resulting future agreement will be six months effective from the date of CDHS' execution of the agreement. The agreement term may change on mutual agreement of the contractor and CDHS due to unforeseen delays.

The resulting contract will be of no force or effect until it is signed by both parties. The successful applicant is hereby advised not to commence performance until all approvals have been obtained. If performance commences before all approvals are obtained, any services may be considered to be volunteered.

### **IV. Process for Submission of Letters of Interest and Selection of Consultant**

Pursuant to the authority described on page 4, CDHS has sole discretion to select a consultant to contract for the management of process, and guidelines and standards to address surge capacity during emergency circumstances. CDHS will use the process described below to select a consultant for this project.

CDHS reserves the right to include representative stakeholders in all aspects of the review and selection process.

Given the creativity, knowledge of California healthcare environment, federal and state legal requirements, and capable execution of the scope of work required to successfully complete this project, CDHS reserves the right to use all concepts and materials presented by interested consultants in their proposals and discussions included in this contractor selection process.

CDHS may implement proposals, or portions of proposals, submitted by any interested consultant. If a proposal, or portion of a proposal, of an unsuccessful consultant is implemented, that consultant will not be reimbursed or compensated in any manner for the use of its proposal.

#### **A. Information Meeting and Questions from Consulting Firms**

##### **1. Informational Meeting**

CDHS will hold an Informational Meeting for invited firms on November 8, 2006 in Sacramento at the East End Complex Auditorium, 1500 Capitol Avenue, Building 172. Participation will be limited to consulting firms invited by CDHS. The meeting will be held from 9AM to 3PM with a one hour lunch break. The purpose of the

meeting will be to:

- a) Outline the purpose of the project and review proposed scope of work
- b) Describe the need for open process inclusive of wide range of stakeholders
- c) Identify anticipated challenges
- d) Distinguish project goals as well as what the project does not entail
- e) Respond to questions from consulting firms in attendance

Questions concerning the logistics for the information hearing should be addressed to May Otow or Vicki Staley at (916) 650-6416. All other questions must be submitted via email to [motow@dhs.ca.gov](mailto:motow@dhs.ca.gov).

## **2. Submittal of Written Questions**

Invited firms may submit questions or requests for clarification about the services sought or the instructions/requirements. All questions must be sent to CDHS via fax or email. Please send your questions via email to [motow@dhs.ca.gov](mailto:motow@dhs.ca.gov) or fax to (916) 650-6420. Please type "Standards and Guidelines Questions" in the subject line of the email.

### **a. What to include in an inquiry**

- a. Your name, position, name of consulting firm, mailing address, email address, area code and telephone and fax numbers.
- b. A description of the subject or issue in question or discrepancy found.
- c. Section, page number or other information useful in identifying the specific problem or issue in question.
- d. Remedy sought, if any.

### **b. Deadline for questions**

Regardless of delivery method, written inquiries must be received no later than 4:00 p.m. PST on November 13, 2006.

## **3. Written responses to questions**

CDHS will issue written answers to the questions it receives to all interested consultants. CDHS will disregard any language from the consulting firm purporting to render all or portions of the inquiry as confidential.

## **B. Requirements for Submitting a Letter of Interest**

Interested consultants shall submit Letters of Interest that describe their proposal for undertaking the method and timeline for completing the scope of work for this project.

The consultant shall include in their Letter of Interest a certification that it has the capability and expertise to meet the rapid and urgent timeline and include assurances that it shall use best efforts within all means possible to execute an agreement with CDHS within 14 days of notice of selection.

## **1. Submittal Deadline**

Regardless of delivery method, the Letter of Interest must be received by 4:00 p.m. PST on November 20, 2006.

## **2. Content of the Letter of Interest**

Interested consultants should submit a Letter of Interest that is no more than 35 pages in length and includes:

- a) Description of Process of Participation and governance of the project with CDHS: Describe inclusion of stakeholders and identify key points of inclusion. Identify how initial stakeholder input will be gathered and then identify how stakeholders will be incorporated throughout the process. Describe the expectations for CDHS participation, decision-making, review time, etc. and the prerequisites needed from CDHS. (No more than 5 pages)
- b) Relevant Experience: Provide three best examples of relevant prior projects, including references, and short description of the firm. (No more than 5 pages)
- c) Creation of a Team: Describe key team members and strengths that each member brings to the team. Assign a full-time project manager to be located in Sacramento for the duration of this project. See selection criteria for minimum qualifications that must be included. Include resume for key team members. (No more than 5 pages, resumes not included in page count)
- d) Budget: Provide a table of staff by deliverable area, name and title and estimate number of hours and hourly rate for each team member, providing total cost for each staff member and total staffing costs. Other costs should be itemized using standard budget categories. (No more than 5 pages)
- e) Prioritization/Sequencing of Activities Listed in the Scope of Work to be accomplished in a 6 month time frame: Define the framework to be used (example: emergency scenario), the most important issues to be resolved, in what sequence, and which issues make sense to sequence after these initial issues are resolved. Prioritization can take place among identified areas or within the issues listed under each area (No more than 5 pages)
- f) Project Plan for Accomplishing Priority Activities Identified: Clearly and specifically outline activities, deliverables, and due dates. Define specifically the intended audience of each deliverable. (No more than 10 pages)

The Letter of Interest may be submitted by e-mail. Additionally, the consultant must submit a letter in hard copy with an original signature from an authorized representative of the firm, stating its interest in being considered for this project. The letter must also identify the name, telephone number, and e-mail address of the contact person for the consulting firm.

Consultants are advised to be clear and specific in their Letters of Interest.

In recognition that well developed Letters of Interest may require consultants to undertake research on issues to be addressed in this project, CDHS may reimburse the successful consultant up to \$50,000 for reasonable costs in developing the Letter of Interest upon the request of the consultant. Reimbursement provisions will be included in the contract between the contractor and CDHS. No reimbursement will be provided to unsuccessful consultants.

Consultants are advised that no portion of the Letter of Interest or any other item of required documentation may be marked "Confidential" or "Proprietary" as CDHS will disregard any language purporting to render all or portions of a proposal confidential.

## **C. Selection Process**

In enacting the provisions for selection of the consultant for this contract, the Legislature recognized that California's need to plan for healthcare surge in emergency situations requires urgency and creative solutions. CDHS shall select the consultant firm that CDHS, in its sole discretion, deems most qualified and able to proactively and creatively develop the deliverables outlined in this Request for Letter of Interest, based on information provided through the process described below.

### **1. Interviews of Selected Consulting Firms**

CDHS, in its sole discretion, will invite one or more consulting firms to participate in interviews on their Letters of Interest. Firms are asked to include the proposed Project Manager and up to 3 key team members in the interviews. Interviews will be two hours in length and held in Sacramento. Firms will be allowed 45 minutes to summarize the proposed process for conducting and completing the project and the scope of work they have prioritized for the 6 month timeline. CDHS will use the remainder of the time to ask questions on the Letter of Interest including the proposed budget, the firm's presentation at the interview, the experience of key team members, and any other aspect of the consultant's ability and commitment to undertake the project.

## **2. Notification of Selection**

CDHS will, in its sole discretion, select a single consulting firm as the contractor for this project and will notify the successful consulting firm in writing of its selection.

All terms of the contract will be negotiated between CDHS and the successful consulting firm. The successful consulting firm is expected to meet with CDHS within 48 hours of notification of its selection to discuss contract terms and execution.

If CDHS and the consulting firm that CDHS has chosen are unable, for any reason, to reach agreement on the contract terms, CDHS reserves the right, in its sole discretion, to award the contract to a different consulting firm.