ESF-8 MEDICAL STAFF FOR DISASTERS FOR ALL HAZARD RESPONSE

Request for Proposal # 3000011796

1. I am reviewing a copy of the above referenced RFP released on 01/04/19. I wanted to understand if this replaces or carves out our existing contracts in any way or is this supplemental?
    - **Answer: This RFP does not replace or carve out existing service contracts. LDH does not have enough of the identified medical staff to sustain all MSNS operations.**

2. Medical Special Needs Shelter (pg. 13): What is the square footage used to determine shelter size for 300 evacuees?
    - **Answer: LDH determines shelter size based on a minimum of 45 square feet of usable space per client. For 300 clients, this would amount to 13,500 ft^2 (square feet) of total usable space. However, it is assumed that approximately 30% of the total space in the shelter will not be "usable" due to the inclusion of aisles, hallways, etc. In order to account for that, we divide 13,500 ft^2 by 70% to arrive at the total actual square footage of 19,286 ft^2 that the shelter should have:**

      13,500 ft^2 / 0.7 = 19,286 ft^2

3. Please provide clarification regarding this paragraph. Who would potentially request the contractor to provide EMAC services and under what circumstances would the Louisiana State Health Officer have control over who else the contractor provides EMAC services to?

   Emergency Management Assistance Compact (EMAC): The proposal states "The Contractor(s) may be requested to provide assistance to other states via the Emergency Management Assistance Compact (EMAC). Louisiana's State Health Officer will have sole discretion to determine if EMAC activation is feasible based upon review of the scope and scale of an event, available resources, and potential impacts. The same contractual requirements of the Response Phase will apply if the Contractor(s) is required to provide assistance via the EMAC."

    - **Answer: The Louisiana State Health Officer is the only one that would request the contractor to provide EMAC services on behalf of Louisiana. LDH emergency contracts are only activated upon the authorization of the State Health Officer. Neither he nor the State would have any authority or responsibility over a contractor's separate EMAC contract/agreement with another state or federal agency.**

4. Will the Contractor be responsible for feeding the patients?
    - **Answer: No. Food for shelterees /patients will be provided by Louisiana Workforce Commission in support of Emergency Support Function (ESF) 6. The Louisiana Department of Children & Family Services is the lead for ESF 6 that coordinates mass care that includes providing food at state run shelters such as the MSNS.**

5. Will the Contractor be responsible for sleeping arrangements (air mattresses, cots, etc) and bedding/linens for the patients?
    - **Answer: No, ESF6 provides these items.**

6. Who is responsible for providing security on site at the MSNS shelters?
    - **Answer: ESF13 would provide security. Louisiana State Police is the lead for coordinating/providing security at state run shelters such as the MSNS**.

7. Will EMS be present on standby at the clinic?
    - **Answer: LDH has shelter ambulance contracts. Upon contract activation due to state shelter activation, 2 Advanced Life Support (ALS) units are stationed 24/7 at state run shelters such as the MSNS, for medical transport and for medical assistance inside the facility.**

8. Will LDH have or provide Satellite phone in the event cell towers go down?
    - **Answer: Yes, The state will ensure MSNS communications are working. The state has multiple redundant communications platforms i.e. radio-voice and satellite- phone and data that would be used to accomplish this for the MSNS shelter.**

9. Page 17 - States "Logistics - The Contractor will be responsible for all supply provisions and costs for travel expenses including lodging and meals for staff while on active and inactive duty during an event." May we assume the "supply provisions" only relates to the Medical Team's personal provisions, not medical supplies for shelter operations?
    - **Answer: Yes.**

10. Page 14 - What is "Certified or Respiratory Therapists"? Is this meant to say Certified or Registered Respiratory Therapist?
    - **Answer: Yes, it should have read "Certified or Registered Respiratory Therapists".**

11. Is this a new service?
    - **Answer: Providing medical staff to MSNS is not a new service.**

12. Please provide me with the Company name
    - **Answer: The current contractor is Response Systems, Incorporated**

13. How many hours were used last year?
    - **Answer: No hours were used, as the response contract was not activated last year to respond to an in-state disaster.**

14. Please provide me with the billing rates of the outgoing contractors.
    - **Answer: For the first 5 Days of a Deployment, the contractor is paid at a daily rate of $76,159.894. After the first 5 days of the Deployment, the contractor is paid at a daily rate of $71,643.08. These rates are not inclusive of travel and meal expenses, which are reimbursed in accordance with state travel regulations.**

15. Are we able to review a copy of the Medical Special Needs Shelter (MSNS) triage criteria?

- **Answer: See form**

MEDICAL SPECIAL NEEDS SHELTER (MSNS) TRIAGE

Date: _____ **Time:** _____
Parish: _____ **Region:** _____
Name of Shelteree: _____
DOB: _____ **Age:** _____ **Wt:** _____
Address: _____

Home Phone: _____ **Cell:** _____
Parish of residence: _____
Caregiver Name: _____ **Contact Number:** _____
DO YOU HAVE A HISTORY OF HEALTH PROBLEMS? _____
If **NO**, not a candidate.
If **YES**, explain: _____

Location of Triage: ☐ Telephone ☐ MSNS ☐ Other
Special unique population: ☐ Yes ☐ No

Allergies (Med or Food): _____

Medications (include PRN, inhalants, and OTC):

Have medications been taken today? ☐ Yes ☐ No
Special diet: _____
Special equipment: (i.e. walker, hospital bed, wheelchair, air mattress, catheters, ostomy supplies, apnea monitor, suctioning supplies, etc.) _____

Name & Phone of Doctor or Clinic: _____

Answer the following with a check mark and give comments as needed

	Condition	Yes	No	Comments (examples of additional probing questions)
1.	Ventilator dependent	☐	☐	If **YES**, not a candidate for the MSNS.
2.	Meds that require daily or every other day lab monitoring?	☐	☐	If **YES**, not a candidate for MSNS
3.	Contagious disease	☐	☐	If **YES**, not a candidate for the MSNS
4.	Immunosuppressed	☐	☐	If **YES**, not a candidate for the MSNS
5.	Daily IV Meds?	☐	☐	If **YES**, not a candidate for the MSNS
6.	Pregnant - High Risk	☐	☐	If **YES**, not a candidate for the MSNS EDC: _____ Weeks Pregnant: _____
7.	Cardiac conditions or other respiratory conditions **Responses may require further discussion with Medical Director**	☐	☐	**History of heart attack?** ☐ Yes or ☐ No **If YES, when:** _____ How often do you have chest pain? _____ Has the pain changed in any way? (i.e. Is this your "usual" chest pain?) _____ Is it easily relieved with nitroglycerin? ☐ Yes ☐ No What has your doctor said about this pain? _____ Do you have shortness of breath? ☐ Yes ☐ No Number of pillows you sleep on _____
8.	Central Line	☐	☐	If **YES**, not a candidate for the MSNS Type: _____ Location: _____
9.	Memory/Behavioral Health	☐	☐	If **YES** and has **hx of exhibiting violent behavior: not a candidate for the MSNS**
10.	If terminally ill and/or hospice, are you aware of any direct medical care required within the next 72 hours?	☐	☐	If in Hospice Care, **bring "Do Not Resuscitate"** forms!
11.	Dialysis patient? Peritoneal ☐ Venous ☐	☐	☐	Date/time of most recent dialysis: _____ Next due date? _____
12.	Oxygen dependent	☐	☐	a) Have own O_2 concentrator: ☐ Yes or ☐ No b) Nebulizer Rx: ☐ **Yes** ☐ No If **YES** to Neb Rx, how often? _____
13.	Seizure disorder	☐	☐	Type: _____ Last seizure: _____
14.	Recent surgery	☐	☐	When? _____ What kind? _____
15.	Insulin dependent diabetes	☐	☐	Can you or your caregiver inject and check your blood sugars? _____

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Name of Shelteree: _____

Answer the following with a check mark and give comments as needed

	Condition	Yes	No	Comments (examples of additional probing questions)
16.	Daily wound care MRSA ❑ Yes ❑ No Drainage ❑ Yes ❑ No Referral to Physician ❑ Yes ❑ No	☐	☐	Can you/caregiver take care of dressing changes? _____ Do you have supplies? _____ Type: _____ Location: _____
17.	Daily tube feedings	☐	☐	**Bring pump and formula for five days**
18.	Daily Foley catheterizations	☐	☐	Can you or your caregiver perform?_____
19.	Visual, hearing, or speech deficit	☐	☐	If visually or hearing impaired, **do you have a service animal?** ☐ Yes ☐ No What service does this animal provide? _____ Who will care for animal in shelter? _____ Will you bring supplies? ☐ Yes ☐ No
20.	Mobility deficit	☐	☐	Type (bed-bound, wheelchair, etc): _____
21.	**Other conditions or additional comments**	☐	☐	

DISPOSITION ☐ OKAY TO REPORT TO MEDICAL SPECIAL NEEDS SHELTER **FOR FURTHER TRIAGE**
(Please review Triage Telephone Checklist when person calls in)

☐ REFERRED TO GENERAL SHELTER

☐ REFER TO HRSA COORDINATOR (Hospital Designated Regional Coordinator)

Triage done by: _____