ADDENDUM 1, QUESTIONS and ANSWERS

Date: February 27, 2023

To: All Bidders

From: Dana Crawford-Smith, Procurement Contracts Officer
DHHS

RE: Addendum for Request for Proposal Number 114658 O3
to be opened March 13, 2023, at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered as part of the Request for Proposal. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
1.			The state indicates that, for this RFP process, "each option can be provided by an independent vendor; however, the EMS PCR System and the Trauma Registry must be able to exchange compliant data." We would like to ask whether the state has a preference for one or two vendors? That is, would the state prefer a unified solution, we can be convenient; or two solutions, which adds resiliency (i.e., less likely that if something goes wrong with one, it goes wrong with both…); or is the state truly neutral about whether it contracts with one or two companies as long as the end result is interoperable? Will there be any aspect of the scoring factors in a unified vs. split solution?	If more than one company is awarded, the systems must be interoperable. The State does not have a preference for one or two vendors.
2.			The RFP indicates that the state has a preference for cloud-based solutions. However, Nebraska has significant wide-open spaces where network connectivity will be a persistent challenge. Additionally, cloud-based solutions can be very problematic	Attachment A line 50 does state that the proposed solution will provide for live (real-time) data entry, or the collection of data offline being cached until it can be connection to the Internet.

			during weather emergencies such as tornadoes, when the network becomes inaccessible due to outages. Please explain why the state prefers cloud-based solutions as opposed to locally deployable and/or cloud-and-client (i.e., cloud-based but also locally installed with secure databases and "store and forward" capabilities)?	
3.			Would the state be willing to consider a cloud-and-client (i.e., locally installed with secure databases and "store and forward" capabilities) solution instead of a cloud-based solution, in light of the resiliency that the former provides?	The State would consider a solution that is installed on premise.
4.			Please elaborate regarding the expected data values and functional capabilities of the Community Paramedicine module ("Community paramedicine functionality to include but not be limited to development of medical charts, outcome measure, patient visit document, etc."). Does this include longitudinal ("over time") data visibility?	DHHS is currently in the process of approving the practice of Community Paramedicine within the State of Nebraska. Currently there are no defined data values. Anticipated use will be to collect, and report on activities and outcomes, data use for quality improvement, billing and/or financial data, and collaborate and/or integrate with other healthcare EHR systems locally. There should be the ability to have longitudinal data over time. DHHS should be able to set minimum requirements with individual agencies being able to further customize.
5.			Does the state have specific Community Paramedicine program types in mind (e.g., substance use disorder intervention, children and adults with special health needs, mental and/or behavioral health, etc.)?	DHHS does not have specific paramedic programs in mind. Currently, they're our pilot programs for post discharge follow up and chronic disease management. As Community Paramedicine grows in the state, we would anticipate we will see a variety of different programs.
6.			The "Hospital Data Interface" section of the requirements grid does not provide any data standards, formatting requirements, or data exchange methodology details. Please specify the nature of the "data upload (preferred)" and what is meant by "linkage"? Without specific detail, a company may be able to satisfy these requirements by providing a PDF, eFax, or other non-discrete, non-EHR consumable data. If the intention is to require some type of HL7-formatted output, please specify	Data should be able to be used in a consumable data format. Some projects that DHHS has participated in have used HL7, CCD, and C-CDA. It is anticipated that some future projects may include FHIR. Data projects have included the Health Information Exchange with CyncHealth. Please review line 107 in Attachment A for specifics.

			the nature of the data file(s) that are desired (e.g., CCD / C-CDA), and if there are any specific requirements for transport of the data (e.g., SFTP, Direct Messaging, routing via the Health Information Exchange (CyncHealth), etc.)?	
7.			Have hospitals across the state already agreed to receive EMS data, and if so, using what formats and mechanisms? Have they agreed to utilize a third-party portal (e.g., MEDIVIEW BEACON Prehospital Health Information Exchange, ESO Health Data Exchange, ImageTrend Health Information Hub, or Zoll Care Exchange)? Or do they prefer to receive data internally to their EHRs (e.g., Epic, Cerner, etc.) as discrete data?	DHHS has coordinated in previous projects with the State Health Information Exchange, CyncHealth. This project is on hold; however, hospitals and providers had the ability to look patients up and view EMS runs with the future end product to be able to use the HIE to import data to their respective EHRs with patient outcome data coming back to the EMS patient care report.
8.			No mention is made as to whether the hospital data interface should be standard-off-the-shelf, or whether custom engineering is required. Some vendors' solutions REQUIRE custom development. Others are "commercial off the shelf" and use federal standards to eliminate the need for custom development, because the data exported can be received by the hospitals "out of the box" and in real time. Please indicate the state's preferences, as there is insufficient detail provided in this section ("Hospital Data Interface") to enable the State to make an apples-to-apples comparison of the various available options.	Due to the wide variety in systems and requirements it is anticipated that software may be off the shelf and/or have a custom development component.
9.			No mention is made in the RFP about CyncHealth, the state of Nebraska's official Health Information Exchange. Please indicate whether interfacing with CyncHealth – using discrete data values that it can consume, clean, aggregate, and share – is within the scope of this RFP. Specifically, the "Hospital Data Interface" may be redundant and/or interfere with Nebraska's use of a statewide health information exchange, because it suggests that hospitals and EMS agencies should utilize a connection method separate from each hospital's connection to CyncHealth. Have the State's hospitals agreed to use a dual /	DHHS has previously worked with CyncHealth for HIE exchange with EMS data. Projects are on hold with no specific timeframe to reengage this work; however, solutions should be able to handle this type of exchange with bidirectional data interfacing (PCR data to the hospitals and patient outcome data back to the PCR). Currently hospitals are using a system they log into to get EMS run reports separately from the Nebraska HIE.

			separate, EMS-specific "interface" even after they have already invested in working with the state's health information exchange?	
10.			Finally, with respect to the "hospital data interface" – no indication of TIME FRAME is provided. What is the state's expectation for the duration of time that is allowed to pass before the EMS data should be accessible to and/or "linked with" the hospital's health record system? Is the expectation real-time, or end of shift, or a specific amount of time elapsed? What is the state's preferred method for ensuring patient matching across the range of electronic health record systems that are deployed across the state of Nebraska – or does the state expect that the ePCR will have access to those hospitals' EHRs so that they can each facility's EHR for site-specific patient ID matching? (If this is the expectation, have the hospitals agreed to use such an approach, and how will the EMS agencies ascertain match quality?)	Currently EMS records are sent to a respective hospital to review, print a PDF, or be imported into the trauma registry as soon as it is completed. DHHS feels that the near real-time expectation from hospitals and services are what they would want maintained. Currently the ePCR is not directly connected to hospitals EHRs.
11.			We would like to formally request that the first three lines of the EMS technology grid be amended to read ***"number of years providing state-level EMS-facing technology, including (but not limited to) ePCR" -- and for the other lines in that section, to indicate "state-level EMS-facing data systems," instead of listing "state-run EMS PCR" specifically***. Very few companies provide state-level ePCR systems. The vast majority of them are provided by ImageTrend today -- this is Nebraska incumbent system. ESO Solutions provides some, but it does not provide Community Paramedicine and its hospital interfaces are custom-built. Biospatial provides some state systems, but it also does not participate in Community Paramedicine. Our company -- Beyond Lucid Technologies -- meets all of the technical requirements of the RFP, including hospital interoperability, health information exchange at the state level, and community	The Department must be responsible for the overall administration statewide of the system with some control given to the local level at the discretion of the Department. Bidders should answer the question in terms of how their solutions meet the requirements of a state administered system, regardless of how the system looks today. It should be noted that items such as Community Paramedicine or Critical Care Paramedicine are listed in the optional sections of the Attachment A.

			paramedicine (longitudinal care). However, we have not provided ePCR services at the state level due to the aforementioned incumbents, which have historically enjoyed long-term contracts. We provide other state-level EMS-facing technology systems, including two statewide contracts across Oregon pertaining to end-of-life medical orders (POLST) and pediatric medical complexity / special health needs. We have provided ePCR services in and around cities with populations larger than any in Nebraska (Omaha: Population ~488,000), including Philadelphia (~1.57 million) and greater Boston (~4.9 million), and a large number of rural services from Kansas to the Carolinas. The first three questions in the EMS data grid appear to bias in favor of certain vendors (e.g., ImageTrend, ESO, and Biospatial), because it only indicates "state-run ePCR" systems. After more than 10 years of service to the EMS industry, with numerous accolades and recognition at both the state and federal level for our technical capabilities and industry contributions (including working with the State of Nebraska on the NEMSIS v3.5 standard, as well as the federally directed Compass Initiative), we would be surprised to learn of any lingering concerns about our capabilities or credentials. Nevertheless, our work to date has been at the local and county level for ePCR, and at the state level for relevant adjacent technologies. We are concerned that if we indicate "0" in the box related to "number of years providing a state-run ePCR," our submission will be considered nonresponsive, unqualified, or otherwise eliminated from consideration -- this is not an accurate reflection of our experience, and it would leave the state unable to meet some of its stated requirements per this RFP. Changing the language to reflect "***state-level EMS-facing data systems***" would let us bring our experience to the table. Thank you so much!	

12.	5, B	28	Please provide the total/combined call volume for the 429 EMS units/agencies.	The current combined call volume for 2022 was approximately 264,000. Call volume has been over 300,000 per year in the past.
13.	I.A.	1	Can more than one vendor submit separate proposals to cover all requirements of RFP Attachment A EMS?	Yes
14.	I.A.	1	Can a bidder submit more than one proposal to EMS PCR System?	Yes
15.	Attch A	Row 107	What are the "state's existing data interface standard(s) for automated electronic intrastate interchanges and interoperability"?	DHHS currently has no existing automated electronic intrastate interchanges.
16.	Attch A	Rows 109, 133	What are the "existing and planned Nebraska DHHS systems" for integration?	No existing interfaces and none are planned yet. DHHS is working on an enterprise data warehouse where this data may need to be consumed.
17.	Attch A	Row 136	Can you provide more information or references on the "State API Gateway"?	The gateway provides features such as authentication, authorization, request, response transformation, and API version management. The API Gateway also provides the ability to integrate with the State legacy applications and systems via APIs. DHHS is promoting REST as the standard and prefer to use OAUTH security standard for ssecuri8ng the APIs.
18.	Attch B	Row 103	What are the "existing and planned Nebraska DHHS systems" for integration?	No existing interfaces and none are planned yet. DHHS is working on an enterprise data warehouse where this data may need to be consumed.
19.	Attch B	Row 106	Can you provide more information or references on the "State API Gateway"?	The gateway provides features such as authentication, authorization, request, response transformation, and API version management. The API Gateway also provides the ability to integrate with the State legacy applications and systems via APIs. DHHS is promoting REST as the standard and prefer to use OAUTH security standard for ssecuri8ng the APIs.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.