Solano Emergency Medical Services Cooperative (SEMSC)
Meeting Minutes
April 11, 2019; 9:00AM – 10:30AM
Suisun City Hall

BOARD MEMBERS

- Birgitta Corsello, Chair, SEMSC Board
- Joshua Chadwick, Fire Chiefs Representative
- Thea Giboney, Medical Professional Representative
- John Jansen, Healthcare Consumer Representative (newly elected)
- Lillian Pan, Medical Professional Representative
- Caesar Djavaherian, Physicians' Forum Representative
- David White, City Manager Representative

STAFF

- Bryn Mumma, EMS Medical Director
- Ted Selby, EMS Administrator
- Bela Matyas, Public Health Officer
- Rachelle Canones, Administrative Secretary
- Keith Erickson, EMS Coordinator
- Colleen Hogan, Health Education Specialist

AGENDA ITEMS	DISCUSSION	ACTION	RESPONSIBLE
Call to Order/Roll Call	Meeting called to order with a quorum present. **Board Member Pan was late. Healthcare Consumer Representative was vacant.**	(none)	
Approval of Agenda	**Board Member Chadwick moved to approve the agenda. Board Member White seconded. AYES: 5; NAYS: 0; ABSENT: 1; ABSTAIN: 0; VACANT: 1.**		
Approval of Minutes **October 11, 2018** **January 10, 2019**	**Board Member Djavaherian moved to approve the minutes of the meeting; Board Member Giboney seconded. AYES: 5; NAYS: 0; ABSENT: 1; ABSTAIN: 0; VACANT: 1.**		
Public Comments	(None)		
Reports a. Medical Director's Report	a. Dr. Bryn Mumma, EMS Medical Director provided various reports: 1. Discipline Actions – Dr. Mumma stated that there are two pending discipline cases. a. Policy and Protocol Changes – Dr. Mumma stated that there are updated policies and protocols effective April 15, 2019.		

b. EMS Administrator's Report	There were minor updates that were made to the following policies as these have not been reviewed and revised for quite a while: • Policy 1100 – EMS Agency Mission Statement • Policy 1300 – California State EMS Framework • Policy 1400 – Pertinent EMS Legislation • Policy 1600 – Roles and Responsibilities of the Solano EMS Agency • Policy 1705 – Provider Agency Medical Director Requirements and Responsibilities • Policy 1755 – EMS Advisory Committees • Policy 6190 – Duty to Report Child, Elder and Dependent Adult Abuse The following obsolete policies have been deleted as they pre-date the current SEMSC structure and are largely outdated: • Policy 1410 – System Ordinance for Incorporated and Unincorporated Areas of Solano County • Policy 1500 – The Organization • Policy 1760 – Organizational Structure and Functional Structure • Policy 1776 – Emergency Medical Care Committee Bylaws The EMS Medical Director added that there will be more policy and protocol updates for the next meeting. Some of these will be discussed at the EMS Quarterly Meetings in the afternoon. b. Emergency Medical Technician (EMT) Discipline – Dr. Mumma announced that there are no new probations, suspensions, denials or revocations. There are currently six (6) EMTs on probation. b. Ted Selby, EMS Administrator, provided an update on the following: 1. General Update –Mr. Selby made the following announcements a. Mr. Selby began his report with a recognition, and stated that most are aware that Board Member White has accepted an invitation from the City of Berkeley to join their city management team.		

Mr. Selby added that although Board Member White's tenure was limited, he was very actively involved, engaged and has made great contributions while serving in this capacity, and was even elected as Vice-Chair at the January SEMSC Board Meeting. Mr. Selby presented Board Member White with a certificate of recognition for his dedication, contributions and efforts as City Managers' Representative to the SEMSC Board.

b. Mr. Rudy Manfredi's retirement as Chief Executive Officer (CEO) of Medic Ambulance was announced. The EMS Agency received correspondence from Medic Ambulance announcing that their founder, Rudy Manfredi retired the previous month, and the subsequent change in their executive management team. It was added that Helen Pierson has taken on the responsibility of CEO, while James Pierson has taken on the role as President and Chief Operating Officer (COO). Mr. Manfredi started the company in 1979 and spent forty (40) years overseeing the business.

2. System Update – Mr. Selby stated that the prehospital EMS partners – Medic Ambulance and the Public Private Partnership (PPP) Fire Departments – have continued providing exceptional service to the citizens and residents of Solano County. Response time statistics for the second quarter of Fiscal Year 2018/2019 for Medic Ambulance are at an average of 99%. The Public Private Partnership (PPP) Fire Departments, have also continued their consummate support to the residents of Solano County as evidenced by the following response time averages:

	2nd quarter FY 18/19
• Benicia –	96%
• Dixon –	96%
• Fairfield –	92%
• Vallejo –	92%

	3. Announcements • Mr. Selby stated that May 19-25, 2019 has been declared as National EMS Week. The EMS Agency will host the Annual Emergency Medical and Health Summit on May 21, 2019 at the Sunrise Event Center in Vacaville. The focus this year will be active shooter, which is a topic frequently requested by our EMS and hospital first responders and first receivers. Keynote speakers include an Emergency Room (ER) physician and Special Weapons and Tactics (SWAT) team supervisor from the Las Vegas, Mandalay Bay, Jason Aldean concert shooting, as well as a team of EMS first responders from the Pulse Nightclub shooting in Orlando. In addition, the local trauma centers will provide an actual "Stop the Bleed" training session. Mr. Selby added that the Annual EMS Week Recognition and Awards Banquet will also be held later that evening at the same venue where this year's Jason Comer Award winner will be announced. Everyone is encouraged to send in their nominations. Nominations can be submitted using the link found on the Solano EMS website, at the bottom of the page. The following day, May 22, 2019 will be the public outreach, where the EMS Agency and its partners will conduct free cardiopulmonary (CPR) and "Stop the Bleed" training at the Solano Town Center Mall. • Mr. Selby concluded the report by informing the SEMSC Board that there are two letters on the front of the binders that were received by the EMS Agency very recently. The first is a letter from the California Emergency Medical Services Authority (EMSA) to the State Office of Administrative Law, which was furnished by the California Fire Chiefs Association (CalChiefs). The second letter was received the previous night from Medic Ambulance.		

c. Contractor's Report	c. Helen Pierson, CEO of Medic Ambulance, provided some highlights around what is happening in the company. 1. Ms. Pierson began by announcing that after forty years at the helm of Medic Ambulance, and accomplishing all that he has accomplished beginning in 1979, with only twelve (12) employees and three (3) ambulances, Rudy Manfredi has retired. Medic will be celebrating their 40Th Anniversary on June 1, 2019, with three hundred five (305) employees and seventy (70) ambulances in their fleet. Ms. Pierson added that it has been their honor to serve in Solano County, and have also expanded operations into Sacramento. Medic added that their new owners, which include Ms. Pierson, the CEO, James Pierson, the President and COO, as well as Cindy McBride, Sandra Whaley and Kristi Kendall, reaffirmed their commitment to Solano County, and felt privileged to be able to continue working for the citizens of this County. 2. Ms. Pierson announced that 13 of their employees will be recognized at the California Ambulance Association's Stars of Life on April 22, 2019 at the State Capitol, where they will be honored with a dinner, as well as meet with legislators to talk about issues that pertain to the ambulance industry. 3. Medic Ambulance Dispatch was recently re-accredited by the Accredited Center of Excellence through the efforts of their team headed by Sandra Whaley. The accreditation is done through the International Academy of Emergency Dispatch (IAED). This re-accreditation means that Medic is one of only 215 ACE accredited dispatch centers in the world, and one of 15 in the State of California.		

Regular Calendar Items:			
a. Review Ad-Hoc Committee Recommendation and Consider Appointment of Healthcare Consumer Representative (HCCR)	a. The EMS Administrator stated that interviews for the vacant position of HCCR were conducted on March 14, 2019 by the Ad-Hoc Committee that was formed by the SEMSC Board. Four candidates were interviewed, and the Ad-Hoc Committee unanimously agreed upon their selection and recommendation. The required reference checks were completed following that interview. Mr. John Jansen was the applicant selected, and his resume and application are included in the meeting packet and were provided in advance to the Board for review. The Board is asked to approve the recommendation of the Ad-Hoc Committee and appoint the selected applicant as HCCR. **Board Member Chadwick moved to approve the recommendation of the Ad-Hoc Committee and appoint John Jansen as Healthcare Consumer Representative. Board Member White seconded. AYES: 6; NAYS: 0; ABSENT: 0; ABSTAIN: 0; VACANT: 1;** Newly appointed Board Member John Jansen was invited to join the rest of the SEMSC Board on the dais.		
b. Receive Presentation on Emergency Medical Dispatch (EMD) and Pre-Arrival Instructions Associated with Emergency Ambulance Services	b. Mr. Selby introduced Mr. Brian Dale, Associate Director of Medical and Quality Control at the International Academy of Emergency Dispatch (IAED), who was invited to return to this Board Meeting to present a more detailed overview of how emergency medical dispatch and pre-arrival instructions would best be implemented in Solano County, as well as provide guidance as to next steps associated with an implementation plan. Mr. Dale began by clarifying if there were changes to the plan as far as the Request for Proposal (RFP) and implementing EMD at each center. It was noted that their organization does not believe in simply providing software to clients looking at implementing at EMD plan, explaining further that IAED conducts a thorough implementation process including a site review.	(No Action)	

	In the case of Solano County, there may be as many as nine sites that would need to implement this process, where it will be determined how many EMD "seats" would be needed at each site, and consequently how many EMD's need to be trained, etc. It was added that the EMS Medical Director would have considerable involvement in this process. Should the Board decide to move forward with this design, what this would look like in Solano County would be presented in more detail. Mr. Dale added that in the last three weeks IAED has been involved with the California State Assembly on Assembly Bill (AB) 1231, talking about response times. It was noted that this was an interesting development since IAED has never published or been asked to review response times, adding that the organization has mostly stayed away from response times or dispatch times. Although there are National Fire Protection Association (NFPA) and International Standardization organization (ISO) standards for these, it is not something the IAED has been asked to do. It was further noted that there is currently a movement in California to look at different pieces of this puzzle. Mr. Dale emphasized that when looking at dispatch times, response times or treatment, EMD is a very "non-visual" environment. The EMD literally has to give a CPR class, deliver a child, instruct someone how to use an Artificial External Defibrillator (AED), or use an auto-injector for instance, etc. without ever being able to actually see the patient. Therefore, the instructions and sets of things they use are designed for that very specific environment and purpose in which the EMD works. For example, in opening up an airway, every EMT and Paramedic can do it easily, but for the average person who has never done this before, the EMDs may give instructions that do not follow the American Heart Association (AHA) established standard for opening up an airway, although they have AHA approval for their specific method. The reason being that it is designed to be easier to describe and understand in a non-visual environment. The specific trainings, specifications, accreditation, communications, etc. come from that unique non-visual environment in which the EMD works.		

	Mr. Dale described the two parties to this implementation process. Priority Dispatch Corp. (PDC) is the company that does the EMD implementation, training, and produces the software and back-up card sets. IAED, for which he works with, is the non-profit that brings various ideas, expertise, including research, clinicians and processes to the table. It was noted that for the first time in the history of IAED, they are about to release a new protocol designed purely by their research group. With the new reality of dealing with active shooter, there are now specific protocols to deal with tourniquet use. IAED has produced videos and instruction manuals regarding tourniquet use in this scenario, and it is slated for release later in the summer. Additionally, due to the increase in opioid overdose, IAED is about to release version 13.2 of their narcotic overdose protocol, which includes a fast track for opiate overdose, and a faster way to get to Naloxone (Narcan) instructions if the person has Narcan a their disposal, along with very specific instructions on how to use a newer version of over-the-counter Narcan nasal sprays that are now available. In other words, IAED brings together protocol standard-setting groups, experts that help them develop protocols in the non-visual environment, such as those that were just mentioned, and PDC produces these. IAED is responsible for the content, PDC then produces it. Mr. Dale highlighted that they are the only vendor that has a research group that conducts the science in all that they do. As such, their protocols are produced and backed by science, research, and data. PDC is responsible for the other side of that coin, and does the implementation, follow up, and helps organizations move forward, including a plan to get to accreditation, as Medic Ambulance has already done. Mr. Dale went into detail about the software they employ, such as ProQA, which is what call-takers use when they are taking a call. It interfaces with Computer Aided Dispatch (CAD), as they have established interfaces and arrangements with over 360 CAD vendors worldwide. For instance, when a call is received, CAD initiates it, which then kicks it out to ProQA. It was emphasized that there is constant communication and interface between CAD and ProQA for each call. These includes code, patient description		

	such as age, chief complaint, status of consciousness, and status of breathing, etc. which first responders can access enroute to the call, for example. AQUA is their quality assurance (QA) and quality improvement (QI) software that integrates seamlessly with ProQA, working with one another when they do case reviews. It was stated that agencies use this tool to determine what goes, when they go, how it goes, and how many of them go. Mr. Dale emphasized that if an agency is going to do that, it would be prudent that these agencies ensure that the EMDs answering the phones are doing things correctly. For example, when he was Chief in Salt Lake City, they reduced their lights and sirens use by over (48%), adding that his fire department will not send an engine "cold" when a patient is critical, and to do this, they have to be fairly confident that their EMDs are doing it correctly. Again, AQUA is what they use for QA/QI. An important piece of all this is to realize that IAED has a research arm, called ARC. It was added that for instance, when this project moves forward and Solano County could partner with this research arm, at no cost to study something. For example, if the EMS Medical Director wants to look at CPR, Stroke or Trauma outcomes, ARC will take existing data and produce dashboards so that the group can review and look at what the local EMS system is doing using their system. Their EMD implementation process was discussed, including the various phases of the onboarding experience, which includes Phase 1 (Pre-Live), Phase 2 (Go Live), and Phase 3 (Post-Live), and what each phase or section involves. • Phase 1: Pre-Live 1. Site Evaluation and Plan PDC will send out an implementation expert to gather information such as determining how many seats are needed, what is the CAD, connection between CAD and ProQA, how many people need to be trained, and then devise an implementation plan.		

	2. Stakeholder Orientation The stakeholder orientation deals with the “owners,” which could include the SEMSC Board, Fire Chiefs, various EMS stakeholder groups, etc. to ensure that these groups understand what the system entails. For instance, their coding matrix is composed of 468 individual codes in medical, which is one of the cleanest and most objective, and never changes. These allow entities to look at various data, such as chest pain, stroke or asthma attack outcomes, etc., over an extended period of time. This information will be readily available as long as CAD is interfaced with ProQA and the Records Management System (RMS). The Medical Director for instance, can look at the patient care record (PCR), and connect prehospital, from dispatch, field, and post-hospital. 3. Kick-Off Activities 4. Administrative Preparation This deals with what the implementation plan will be, when it will go live, and what this all means, especially to the field crews. All information should be consistent, remaining the same regardless of what call center it comes through. Compliance should be monitored, in a similar way that response times are scrutinized. It was noted that while the type and level of response for each call is set by the fire chiefs and EMS stakeholders prior to going live, they do not recommend changing response type/levels at this point. 5. Training and Certification EMD, Pro-QA, QI, and other trainings are conducted. Again, it was reiterated that since the PSAPs have not been EMD certified, that no changes to the type and level of response be made within 90 days and give crews time to adjust to all the other changes first.		

It was noted that most PSAPs are primarily run by police, where only about 20% of the volume are EMS, and the majority will be police matters. It might be a challenge to convince dispatchers to put 80% of their effort into only 20% of their load, in a police-driven call center.

6. Installation and Configuration

- Phase 2: Go Live
  1. Go-Live Support
     PDC staff will be present at each other to provide support and answer questions, whether it be on the software, trouble shooting, etc. and this can help build confidence

  2. Instant QA
     Once the call centers go live, QA also begins, which will also involve first responders, to see if the information they receive from the EMDs match patient condition on scene.

  3. Outreach and Communications
     Simply means letting everyone know what is going to change, and what is going to happen. IAED assists agencies in this process and has a packet of information they use to help the public understand what is going on.

- Phase 3: Post Live
  1. Follow-up Checkpoints
  2. QA/QI and Performance Review
  3. Continuing Dispatcher Education
  4. Ongoing Support/Feedback
  5. Agency Accreditation

	It was noted that while QA and training are usually the first ones cut when finances get tight, the EMS system could not afford to skip QA and ongoing training. In the post-live stage, the importance of doing a case review and feedback from the first call was emphasized, to avoid issues and possible lawsuits. In the average 9-1-1 center, the call takers have no EMS background. The dispatchers' role is to determine patient signs and symptoms, and dispatch resources based on those signs and symptoms, and to try and stabilize the patient until those resources arrive on scene. Again, it was reiterated that case review, feedback, and ongoing education are integral to their program, and will not sell the program without these. Once things are in place, where EMS can look at the data and make adjustments on type and level of response for various medical calls. It was highlighted that initial resistance can be overcome if the dispatchers do what their supposed to do, as evidenced by improved outcomes, etc. This process can ultimately lessen the load on fire engines and ambulances, as the process gets refined and adjusted, with the data available to support the changes. Mr. Dale also mentioned the importance of working with the media in the post-go live to highlight that this process is to improve outcomes; and mentioned that they have a public relations firm that can help manage media relations. There was also a discussion about the various oversight groups involved in this process. There is the Quality Assurance Unit (QAU), which conducts random audits and case reviews monthly. In addition to the QAU, PDC also offers NationalQ, which is a pay-for-service case review, which can be utilized as needed. The Dispatch Review Committee (DRC) is composed of QA staff, communication center staff including EMDs, trainors, and even information technology (IT), as well as field providers, ideally no higher than the fire captain, who meet monthly to discuss any concerns, questions, and problem-solve to improve the system.		

	It was emphasized that the EMDs working in the call centers do not generally see the patient or outcome of the call, unlike the paramedics and EMTs. This is the connection between dispatch, field, training and QA. The DRC gets together, reviews data, and drafts policy for Dispatch. The Steering Committee, which meets quarterly, and is composed of fire chiefs, communication directors, operations managers, medical director(s), and even legal counsel, reviews and approves these policies. It was noted that they can give the DRC desired outcomes but should ideally allow the DRC to write specific policies to achieve those outcomes. Mr. Dale observed that without an engaged DRC drafting policy, reviewing protocols, et., over time, the system will likely fail. It was added that this design has worked well all over the world, although each system may not look the same. Mr. Dale cautioned that it would not be ideal to have all the fire departments represented all at once in the DRC, or it will be harder to get anything accomplished due to its size. It was suggested that fire department representatives to the DRC could perhaps rotate between the various fire agencies, so everyone still has a voice in the system. In the post-live phase, the importance of regular QA case reviews, feedback, call-taker certification, ongoing training, and subsequent agency accreditation, for the success of the system was also emphasized. It was added that the College of Emergency Dispatch (College) now has over one hundred twenty hours of education available online to their clients, where EMDs can go through the required certification courses for medical, fire, and police anytime. This simplifies the certification process. EMDs are tested at the end of each module, which means no additional testing is required after completing all the courses in three disciplines. Furthermore, as mentioned by Medic, IAED offers an accreditation process, which looks at policy, procedure, ongoing certification, number of critical and major deviations, non-compliant and high compliance cases, etc. IAED already reviews their client's call centers monthly to look at compliance, which gives the client confidence to make changes, not only at the call center, but also with the types of response, etc. that they find necessary for system improvement and risk reduction.		

	There was discussion risks and benefits, and one risk is the number of call centers for Solano County, of which there are eight, including Medic and the California Highway Patrol (CHP) according to Mr. Selby; the Board Chair stated that there seven city fire departments, and four unincorporated, bringing the total to eleven. Mr. Dale added that there is some risk if there will be 7-8 call centers where EMD will have to be implemented, as this will dilute the call volume for each center. The smaller the center or lower the call volume in a call center, the harder it is for EMDs to stay compliant or competent in their skills because they do not take those critical skills calls often, especially if the primary task is police call taking. In this case, additional focus on more ongoing training and certification for EMDs will be important to minimize this risk. QI process can sometimes also be challenging in smaller centers, including having to find staff to do the case reviews. The benefits of this program were also discussed. One is that no matter what call center they call, the person will reach a trained EMD, noting that the best possible way is when the first person a caller talks to when they call 9-1-1 would take the call, keep the call, and walk the caller through the interrogation instruction sequence. Another benefit is local control, where different chiefs may want different things, and local systems may be set up a different way. However, the same coding matrix can be used and tailored to the unique environment of your local system. Furthermore, each city or district can function as each other's back-up, in case of a large incident, as their standards of care would be the same, with personnel having had the same training and certification. Another advantage would be the potential for research and benchmark against other agencies. In summary, Mr. Dale repeated that should Solano EMS decide to move forward, PDC would send out an implementation expert to complete an assessment of the system, which includes looking at how many actual call centers will be opened, how many EMD seats need training, which helps determine cost for each EMD seat, for each center, and total cost for the County for AQUA, ProQA and for certification, etc.		

	Implementation timelines will then be established, including scheduling EMD classes, which are normally three days each, which could be done through regional courses, which can help economize on this aspect. Other steps would include getting all EMDs certified, deploying the software, testing that the software and CAD are functioning together as they should, develop the interface between CAD and the mobile data terminals or computers (MDT/MDC) and ensure that they are working, get the various committees set-up, and then plan for Go Live. Board Member Pan wanted to understand how the calls are routed and who receives the calls when someone calls 9-1-1, given that there are currently multiple call centers. Board Chair Corsello replied that each phone number is programmed to reach one of the eight call centers, when a person calls 9-1-1, depending on the caller's location. Calls from cellular phones go to the CHP. Currently, most of these dispatch centers are run by law enforcement, with a couple of jurisdictions that are overlapping, such as where an area is covered by the County, and a fire district, or two cities are working together, or sometimes, like in the case of Benicia, where they are buying their services from another County. Board Member Pan wanted to clarify that if the County moves forward with this EMD process with Priority Dispatch, that this system will be more cohesive. Mr. Dale responded that one of the benefits is that no matter where the call goes to in Solano County, the caller knows that the person receiving the call is trained and certified to be an EMD to manage that call. Board Member Pan further inquired as to whether PDC offers a simulation or some similar program to experience that would allow prospective buyers to "experience" the EMD system. It was explained that on the PDC website (www.prioritydispatch.net) there is a video available where viewers can see a person working with ProQA. Mr. Dale added that when PDC comes in to do the ProQA training, they set up all the dispatchers through that software training. However, if the Board would like to request a 15-minute demo, this can be arranged through a conference call or a webinar, but this would not include the different CAD interfaces. Board Member Pan stated that she would be interested in a demo with the other Board Members.		

	Mr. Dale stated that it could be arranged by email, even if there was only one person who would like to see the demo. Board Member Chadwick declared that he believes CHP does not dispatch for medical, so EMD would not be needed there, and was also unsure as to whether Medic receives 9-1-1 calls in dispatches. It was pointed out that Medic is already using EMD. Board Member Chadwick opined that based on Mr. Dale's detailed presentation, the two biggest benefits are pre-arrival instructions and the coding matrix, and asked if the latter has to be dealt with at the County level. Citing Benicia as an example, if they wanted to implement this, Board Member Chadwick wanted clarification on whether the city can decide whether to respond to a call, or respond Code 1 or Code 2 to a call, without the County having a policy for it. The EMS Administrator, Mr. Selby, replied that the EMS Agency cannot not dictate whether to respond Code 1 or Code 2, as this is a non-medical decision. The medical aspect would be getting pre-arrival instructions. Dr. Mumma, the EMS Agency Medical Director, concurred, adding that this was what was previously discussed. The code remains the same, but the responding agency decides the response to that code, who goes, etc., similar the earlier discussion on how a response to the same code may look different in Salt Lake City versus Los Angeles, the response between cities may differ, within the same code. Board Member Chadwick stated that this makes sense for the (fire) first responder unit, but wondered if the same applied to the ambulance providers such as getting to a call in a certain amount of time. Mr. Dale explained that the fire chief generally makes the decision on who, what, when, where, and how within reasonable standards. As far as the ambulance provider, this becomes a contractual agreement, and even when a fire agency is using their own resources, which usually requires a modification of the contract, and typically is not done in the first year. For this group, for instance looking at all nine centers becoming compliant, is more important. Mr. Dale gave an example of what was done in his area, where they had an ambulance contract, and how they categorized the calls into life threatening and non-life threatening.		

	For the highest acuity patients, they wanted the ambulance to arrive within 7 minutes 59 seconds, 95% of the time. For the non-emergency or non-life-threatening cases, their standard was 15 minutes 59 seconds. This change was done by determining codes. Board Member White inquired if PDC had any competitors, who are those competitors, wanting to know how broad and deep the market is for this type of service. Mr. Dale explained that his company is in the top 85% of the top two hundred largest cities in the country, and in the top 75% of the top 25 cities in the country. Their competitors are Powerphone, Association of Public-Safety Communications Officials (APCO), and LTI. King County in Washington State produced their own product, but has since stopped providing support for their software. It was added that there are also a number of homegrown EMD products. For instance, the San Jose Fire Department (SJFD) produced their own EMD version, but was unable to keep up with the standards of care and practice, that they switched over to PDC. When SJFD switched over to their system, they had a unique ability to do CPR and mouth stoma for a patient who has a tracheotomy. PDC produced a software version of this, and implemented it into their system. It was stated that there are also other state programs, such as in the State New Jersey, who have their own system, and they offer it for “free”, but the organizations who use them have to input all of their own questions and instructions. In other words, they provide a template for EMD. Mr. Dale summarized that while they do have competitors, but none of them are worldwide, and his company is the only worldwide competitor in this market. They are also the only ones that have research and accreditation available. Board Member White noted that Mr. Dale talked about the impact on dispatchers from the perspective of training, spending eighty percent of their time learning, implementing and getting up to speed on EMD; Board Member While wanted to know the impact on call times, specifically, if the calls times will be longer because of using this system,		

	does this change dramatically, and what is the work load impact, if any. Mr. Dale responded initially, the call processing time will go up, then they will flatten out and be similar to previous levels, perhaps slightly higher than they were before because they are doing more. It was emphasized that the majority of time is spent verifying address and phone number, which takes about 45 seconds per call because so many calls are now coming from cell phones. In California, it is more prolonged because cell phone calls are routed to CHP first, before being transferred to the appropriate PSAP. Therefore, it is unfair to begin computing call processing time from this point. Mr. Dale pointed out that IAED computes the call processing time starts when the EMD asks what happened to the patient, which generally happens after telephone and address verification. Furthermore, the average call processing time for medical, fire and police for critical emergencies is less than 40 seconds to get a code and get resources out the door. However, if the call is for a non-emergent issue such as gout, joint pain, sleeplessness, etc. the call is going to be closer to between 1 minute to 1 minute 20 seconds, because the EMD is going to try to make sure that nothing else is going on. It was also added that if one looks at the aggregate call times, about 60% are non-emergent, and higher at urban communities. Therefore, when they look at average call times, they break it down based determinant type, classifying them as Echo, Delta, Charlie, Bravo or Alpha. The Echos and Deltas need to be dispatched fairly quickly, while the Charlies, Bravos and Alphas might not be dispatched quite as fast. They look at whether the call is life threatening, or non-life threatening, or emergent or non-emergent and that is where they begin looking at times on task. Mr. Dale noted that their times on task are in parameter with the NFPA 1221 call processing standard, which states that 90% of emergency calls are dispatched in 60 seconds or less. It was noted however, that this is changing again in August 2019. Furthermore, that the NFPA is very vague, saying things such as cardiac emergencies, neurological emergencies, severe trauma.		

	It is not clinically specific or clinically relevant in as far as identifying what constitutes a cardiac emergency – does it include panic attacks with chest pain, or is it strictly severe chest pain or only cardiac arrest? Mr. Dale further explained that there is a specific report in ProQA called NFPA 1221. This allows agencies to look at specific codes and determine if they are within NFPA 1221 standards. Board Member White also wanted to know if PDC and IAED have had experience in working with Joint Powers Authority (JPA), which is how the local system is set up, noting that this is part of how the member cities insure themselves, in addition to securing insurance up to a certain limit for each city. If so, what kinds of issues or questions those JPAs might have had with regards to implementation if SEMSC would like to move forward with this project. Mr. Dale explained that in 38 years, his organization has never been sued, so they have not had any experience with litigation. They do provide professional witness protection, if something does occur. It was added that they have had perhaps three to four cases filed in some way but has never gone past the initial investigation phase. Mr. Dale added that they have had experience working with JPAs. In the past, there was an insurance agency that said using the Medical Priority Dispatch System (MPDS) was a de facto insurance against litigation as they have never had to deal with it since 1979. If an agency using their system is compliant to the protocol process, they simply have never had anyone have a bad outcome. Not to say that they have not had patients who died, but their system meets or exceeds the standard of practice and they ensure it is upgraded all the time. Board Member White noted that Mr. Dale made a good point about the number of calls in a call center impacting an EMDs ability to stay sharp on the protocols; The question was, given the number of centers PDC is in, has PDC done any statistical or data analysis on quality as it relates to the number of calls, and if there is any useful benchmark that they have produced that could be meaningful to SEMSC during this process.		

	For instance, to consider what is the right size call center, is there some sort of diminishing quality, what does that call volume look like on the upside where you know that everyone will be sharp on their skills, etc. Also, if they have had a chance to look at their centers and analyze that data for SEMSC to consider that information. Mr. Dale explained that many agencies have asked this question, and there are a lot of variables that kick in, but the simple answer is that they have never come up with a specific numeric value of how many cases need to come through to each call taker to be able to stay competent. It was added that he is unsure that they have looked at competency versus the number of calls that are taken. It would be a challenging but interesting research study if it was done. The more important issue is the number of training hours and education that that the EMDs get. It was pointed out that the struggle is that call takers almost never see training on what they do; which is not tangible or touching the patient. The EMDs have to give instructions such as CPR to the caller "blind" and have to control the caller, the scene, and provide care to the patient from a distance. The training that IAED provides through the College is very specific to this environment. Board Member White also wanted to know the estimated cost of something like this project. For instance, using an agency that has an average of 100,00 calls, with 15,000 of them on the medical or fire department side. Mr. Dale explained that it is better to look at what it costs per seat in the communications center. An average call center would have three or four call-taking seats. It was noted. that 50% of their US clients have four seats or less. Granted that they have clients with larger centers that may have more, but the majority of their clients have four seats or less. Here the average cost per seat for ProQA Medical is about $3,800 per seat, including everything that was discussed. They also offer an extended service plan so that agencies do not pay that fee every year, and instead pay based on the number of seats the agency has certified in the center.		

	Training seats are a different cost, usually minimal, because while these may get turned on during a large emergency, these are typically only used for training. Mr. Dale emphasized that these are estimates as he does not work in sales, and Cheryl Collins, Client Services Representative for California, will be better equipped to provide specific figures. Board Member Giboney inquired further about the range from pre-to-post that was described during the presentation, for a typical communications center. Mr. Dale explained that there is a breakdown of costs that PDC typically provides, but he is unable to provide specifics as he does not do sales, and the figures have changed so much, and he does not want to provide inaccurate figures. It was however, estimated that the price to cover most of the cost is between $3,000-$5,000, and this is probably going to be true here. Board Member Giboney also asked about the implementation time frame. Mr. Dale explained that this is dependent on the local groups. Noting that SEMSC will likely put together a project group, similar to how most county systems operate. There would be representatives from the various centers, and stakeholders who would sit down with PDC's implementation staff to work something out. It was emphasized that they do not set the schedule. Instead, they lay out the things that need to be done and the SEMSC will come up with the timeline. Perhaps three centers can be rolled out initially, and then the next three, or the next two, or whatever it is decided upon based on the timeline SEMSC sets with the project team. PDC is quite flexible on this matter, especially since these will not be very large call centers with hundreds of people inside of them. Larger communication centers are a different implementation, such as their recent roll out in Brower County involving 400 employees. For smaller counties such as in Solano, they are more at the leisure of the client.		

c. Discuss and Consider Approval of Annual SEMSC Budget/Revenue Allocation Plan for FY 2019/2020 and Adoption of Resolution 19-001	c. Mr. Selby explained that the bylaws of the JPA require the Board to annually adopt a Revenue Allocation Plan for the Agency. Included in the packet is the recommended budget, or Revenue Allocation Plan as the Auditor Controller refers to it. This Revenue Allocation Plan is essentially a zero-based budget. The most noticeable difference from last year's budget is the Public Private Partnership (PPP) pass through allocation increased by about $230,000. This is greater than half of the total budget increase from the previous fiscal year. PPP funds are passed through SEMSC, from the Exclusive Operating Area (EOA) provider, Medic Ambulance, to the participating PPP fire agencies. The additional increase in projected expenses is a result of the hiring of an additional EMS Coordinator, a position that has been difficult to fill and was vacant for some time, as well as the unanticipated cost of the EOA Request for Proposal (RFP) project which has been built into the budget. Revenue is projected to increase through increases in fees, fines, assessments, proceeds and pass-through revenue. It is estimated that slightly less than $10,000 of SEMSC's reserves may be utilized during this budget cycle Board Member White inquired as to how much are the total reserves for SEMSC and what are they projected to be in the next few years based on budget forecasts. Mr. Selby replied that there are approximately $500,000 in total reserves. This number is calculated on an annual basis at the end of each fiscal year, and this figure has been very consistent over the years. Board Member White further inquired as to whether SEMSC has a reserve policy, to which Mr. Selby replied that there is no such policy to his knowledge, and the reserves are calculated annually under a special fund. Board Member Jansen wanted to know if it was possible to get more details on the budget, including a comparison from last year's budget, this fiscal period's budget, and the forecast for the next year. The EMS Administrator explained that this information can be sent to the Board Members via email for informational purposes. However, the JPA requires that the Board approve an annual budget and pass a budget resolution annually.	Provide additional background information on budget for FY 2019/2020	EMS Administrator

	Board Chair Corsello inquired if the Board was required to act on this matter today; and queried fellow Board Members if they were amenable to doing so, or if they would first like to receive the additional information requested. Mr. Selby recommended that the Board act on this matter today, otherwise, this will have to be taken up and approved at a Special Meeting prior to the start of the next fiscal period. Board Member Jansen stated that seeing the additional details afterwards is acceptable as well, explaining that as a new Board Member, it would be ideal to obtain more information on this matter. Board Chair Corsello inquired if there are any other questions for Staff on this item, and if there are no other discussions, a motion and a second is required, as this is an action item. **Board Member Jansen moved to approve the Budget & Revenue Allocation Plan for FY 2019/2020 and the adoption of Resolution 19-001. Board Member Djavaherian seconded. AYES: 7; NAYS: 0; ABSENT: 0; ABSTAIN: 0**		
d. Review and Consider Comments on Draft Request for Qualifications (RFQ) for Consultant Services for Emergency Ambulance Services System Reviews and RFP Development	d. The EMS Administrator explained that at the January SEMSC Meeting, staff was requested to identify a consulting firm using the RFQ process to facilitate the RFP project associated with the emergency ambulance advanced life support within the EOA in Solano County. The draft document for the RFQ was posted a week ago, and if approved by the Board, written comments will be accepted for a period of two weeks from today, through April 25, 2019. It is anticipated that a special meeting of the Board will be called to approve the RFQ and affirm the selection process for the consultant. The approved RFQ will be managed by Solano County's Purchasing Division, which would be supported by EMS Agency Staff.		

	Board Member Giboney suggested a wording change on Page 3, Section 3 Scope of Service or Project, under the first bullet, reiterating that in previous meetings, several Board Members have commented about not being presented with impacts and implications of the alternatives being suggested. Considering this, Board Member Giboney asked that language be added to suggest viable alternatives and include impacts and implications of various components of those models to our current system. Board Member White add that the RFQ seems to be asking for two main pieces of work, and wanted to ensure clarity on what specifically the EMS Agency is trying to accomplish. These are reflected on the first paragraph on Page 2, and the first bullet point. The two main elements that are being asked of the contractor are (1) design a system, and (2) design an RFP to solicit proposals to bring this system to life. Board Member White stated that it would be helpful to be clear that if the contractor is asked to facilitate a discussion with the Board and stakeholders to design the system, this is one process and one set of buy-in that the Board needs to achieve; and then to go ahead and work on the RFP. It was added that the previous process became very confusing as these two elements were conflated. The Board was being presented with the system design and the RFP at the same time, which did not give a chance to separate those two discussions, and get better clarity, direction and consensus on what that system is, before doing the RFP. Board Member White urged that as this RFP is structured and a new contractor is selected, that the EMS Agency be quite clear on how this process is going to unfold with the SEMSC Board, and expressed concern that in the current draft of the RFQ, those two major elements seem to be coming together again. When soliciting those scopes of work, Board Member White asked that it should be quite transparent to the Board on how this process is going to work to move forward, and avoid the confusion that resulted the last time. Mr. Selby clarified if Board Member White is asking that the EMS Agency be clear that discussions on system development, how the Board and stakeholders would like that system to work, be completed first, and then look at the actual development of the RFP. Board Member White concurred.	Clarify the steps in the process under Scope of Work in the RFQ	EMS Staff

	Board Member Giboney asked that the EMS Administrator elaborate on who the other parties mentioned on Page 10, Section 7, Evaluation of the Proposal which states that the Evaluation Committee would be composed of EMS staff and other parties that may have relevant experience. Mr. Selby responded that the expectation was that the EMS Agency would work with the SEMSC Board on who would be on the Evaluation Committee. Board Chair Corsello asked that a clarifying statement be added to indicate that the composition of the Evaluation Committee will be done in consultation with the SEMSC Board. Board Chair Corsello inquired if there were members of the public wishes to address the Board at this time. There were none. Board Chair Corsello asked what action Staff is asking of the Board on this agenda item. Mr. Selby asked that the Board approve the two-week posting of the RFQ to receive comments, with the changes recommended by the Board today incorporated into the RFQ. Board Chair Corsello inquired how EMS Staff will show that the document that will be posted is a revised document, whether it will be red-lined. Mr. Selby explained that it will be posted in "track changes" to red-line the changes that are made. The Board, however, would like to review the revised RFQ before it is posted. Mr. Selby requested that a Special Meeting be scheduled to approve the RFQ that will be used to select the vendor for the RFP process, in order to adhere to the timeline.	Include clarifying statement on composition of Evaluation Committee	EMS Staff
e. Receive from EMS Staff Map Clarifying Operational Zones for Emergency Ambulance Services	e. Mr. Selby stated that there are two maps included in the meeting packet, one includes the entire County, with the areas where the City of Vacaville provides ambulance services highlighted. It was noted that a small area that was recently annexed by the City of Fairfield is also highlighted, as there was a slight change there. The non-highlighted areas of the County on this map are the EOA that was established by the Board. The second map in the meeting packet enlarges the area served by the City of Vacaville.		

	It was added that these maps were created using advanced Geographic Information System (GIS) software to better pinpoint the actual geographic areas contained in Zones C and V. Mr. Selby thanked Deputy Chief Alan Hartford of Vacaville Fire for his assistance in this mapping project. These maps are being provided to the Board for informational purposes at this time, to clarify the areas. Board Member Chadwick inquired as to whether the EMS Agency has received feedback from the providers on these maps, considering the concerns that were previously raised. Mr. Selby replied that the City of Vacaville and Medic Ambulance are both in agreement with these maps. Board Chair Corsello clarified that going forward, when the plan is updated, these will be the maps used to clarify what areas are covered by the EOA. Mr. Selby concurred.		
Board Comments: a. Chairperson	a. Board Chair Corsello thanked Board Member White for his presence, contributions, and involvement in this EOA RFP process, which is not something that is frequently done, noting that his predecessor was also on the Board during a highly visible period for SEMSC. It was added that the City Managers are already discussing a plan for his replacement before the next meeting. Board Chair Corsello also welcomed the new Healthcare Consumer Representative, John Jansen to the Board. The Chair also opened discussion for a possible Special Meeting to be held in May or June. Board Member Chadwick expressed concern about the sense of urgency, and inquired as to whether the EMS Agency has received a response from EMSA on the request for extension, to which Mr. Selby responded that no response has been received yet. It was further explained that in view of this, the existing two-year timeline remains, and a special meeting would be necessary before the next regular meeting on July 11, 2019.		

	Board Member Chadwick cautioned again about rushing the process, but was amenable to scheduling a Special Meeting. Board Member Giboney can be available most Thursdays in June, if needed. It was proposed that the Special Meeting be held on June 13, 2019, to which the Board Members agreed. Upon the inquiry of the Board Chair, it was clarified by County Counsel that the RFQ and other items may be discussed at the Special Meeting since it is not an Emergency Meeting.	Schedule Special Meeting on June 13 th	EMS Staff
b. Directors	b. Board Member Chadwick asked about the letter received from Medic Ambulance, which was not on today's Agenda, and wondered if this will be discussed in a future meeting. County Counsel explained that this matter will have discussed, and the Board Chair can have it Agendized for the next meeting, if the Board so chooses. Board Chair asked the members of the Board if they were amenable to discussing this matter at the next meeting, and there was concurrence. Newly elected Board Member John Jansen thanked the Ad-Hoc Committee and EMS Staff, and praised the selection process used in choosing the new Healthcare Consumer Representative.	Agendize Medic Letter for next meeting	EMS Staff
Adjournment	Meeting adjourned to the Special Meeting on June 13, 2019.	(none)	