TRANSCRIPT OF TAPE-RECORDED
PUBLIC HEARING OF THE
SOLANO COUNTY EMS AGENCY BOARD
DECEMEBER 13, 2018

MR. CHADWICK: I've prepared a written statement to set the record straight, which I have attached to Mr. Segal's letter. As I explained in my written statement, the city of Benicia is not planning to respond to the RFP. As explained in Mr. Segal's letter there is no conflict with respect to the awarding of the contract by the SEMSC to an ambulance company.

Yesterday morning, Mr. -- Mr. Segal and I called Ms. Darbinian. She then raised the question for the first time to me about whether the RFP discussion regarding the scope of the PDP contract that the city of Benicia and other jurisdictions subsequently enter with an ambulance company might create a conflict if I participate today in the RFP discussion.

I've asked Ms. Darbinian to work with me to seek a FPPC opinion about this purported conflict and that she raised for the first time yesterday morning, and for the chair to continue this item so that we can better be informed about this issue.

If Ms. Darbinian and the chair refuse to in- -- to insist that -- and -- uh, I'm sorry, if Ms. Darbinian and the chair refuse and insist on pressing ahead, here's what I'm prepared to do.

While I do not believe I have a conflict including with respect to whether the city of Benicia may subsequently enter a PDP contract in the abundance of caution, I will recuse myself from today's discussion on the RPF.

Let me be clear; I want to fulfill my role as a member of this board by participating in this important discussion about the RFP.

I and the board and our constituents all deserve to be better informed about whether the participation would create conflict of interest issues. So this matter should be continued to -- and -- and so that would be allowed. Um, but if this is not the case, I will recuse myself in an abundance of caution.

MR. WHITE: If I may just read the following. Uh, pursuant to government code Section 1091.589, I'm disclosing that I receive a salary from the city of Fairfield as an employee and I request that this disclosure be reflected in the minutes of the meeting.

MS. DARBINIAN: Thank you. As the -- as the attorney for the SEMSC board, my responsibility is to represent this board and to ensure that the process for the RFP is followed and withstands any

challenge.

Part of that -- as part of that, I have advised that there is a conflict. The decision is up to you whether or not you want to recuse yourself. If you disagree that there is a conflict you can certainly make that decision and proceed [inaudible].

MR. WHITE: I think the ask is that we continue to get a FPCD can- -- uh, opinion on it.

MS. CORSELLO: Okay. I'd like to proceed with the presentations, the public comment, feedback to the consultant, um, and see how far we get today.

Uh, I do have my concerns about whether or not we as a board collectively can put together a -- a sustainable plan, uh, that serves all of Solano County, uh, that -- that, uh, we can get through a process without litigation, but then this group has been sued before on the previous RFP, um, and I would hope that as we work through this process each of the jurisdictions has an opportunity to go back and look at this more accurately and more completely.

I don't anticipate -- we're actually going to be able to make a decision based on the volume of comments that we received going into this.

I do hope we can provide direction to our consultant, uh, on the various components that are included so that we can get to an RFP that all of us will be comfortable with, including all of those who are present in the room today.

So with that said, you're welcome to stay, as far as I'm concerned. At this point I would ask that legal counsel work with the city on the FPP, a decision; it is up to the city of Fairfield's representative --

MS. DARBINIA: Chairwoman, I'm sorry. So the FPPC issue would be the individual thing --

MS. CORSELLO: Yes.

MS. DARBINIA: -- that they send out. It wouldn't be my [inaudible].

MS. CORSELLO: Right. That's fine. So I'm going to leave that up to the chief's representative. Um, and I'm going to leave it up to the City of Fairfield and I'd like to really proceed if we can.

MR. WHITE: Just one quick question. Is there a legal reason why county coun- --uh, counsel for the R- -- for this board cannot, uh, reach out to the FPPC on your own just so we understand?

MS. DARBINIA: It would -- when you reach out

to the FPC it would be --

[talking in background, inaudible]

MS. DARBINIA: Sorry. Can you hear me now? Okay. Uh, when you reach out to the FPPC it's your request. So I would be happy to work with you, but each of you have representatives that I received letters from, so I suspect you want to work with them.

I would be happy to work with your res- -- representatives to send out letters to the FPPC, but in order to get the opinion, I suspect you want your explanation and your, um, your insight to the FPPC.

MS. CORSELLO: So [inaudible]. So I'm going to offer -- can we just proceed at this point? I'm going to let you guys stay up here. We're going to go through this process.

I went back and looked at what happened in 2008, uh, the last time that we did an RPF, um, by my predecessor and none of us up here were involved in that, not a one of us was involved in that, uh, including legal staff, including the -- the staff, uh, in the EMS authority.

What I can tell from the records is that in January of 2008 when this process started once

before, with a long lead time, uh, the representatives from fire chiefs and the city managers included Rick Doors [ph], who ultimately, uh, was the city of Dixon and has a PPP today; Kevin O'Rourke, who was the city manager at that time from the city of Fairfield who ultimately also today has a PPP.

And somewhere between January of 2008 and -- and 2009 the summer of, when the contract RFP was issued and then the actual decisions were made and the award, it changed to Michael O'Brien from the city of Suisun and Hector Delarosa from the city of Rio Vista. We have time, as far as I'm concerned, to work through this. I don't want to delay the conversation about the RFP further. I'd like to just proceed if we can.

MR. CHADWICK: So a couple things, first of all, you're the one, um, who recommended that I recuse myself, correct?

MS. DARBINIAN: Correct.

MR. CHADWICK: But you cannot ask for an RF- -- uh, a PPC ruling on it?

MS. DARBINIAN: I will be happy to work with you and your attorney to request an FPPC ruling. As I -- as I said, if they get the FPPC request from

me, you may not be content with the version I put forth. So I would like to work with you and Kevin so that you can also put in your view of what the situation is.

MS. CORSELLO: So can we get the first presentation, please. I'm not sure who that is. And so we're -- we're going to take Item B at least one presentation out of order and then go back to -- to Item A on the regular calendar. Um, or are we going to go back and do the reports from the EMS Administrator? I -- I'm -- can I get direction from staff here.

MALE 1: So, um, Mr. Wolfberg has -- has worked with, uh, our first presenter Brian Dale from the National, uh -- uh, A- -- Academy of Emergency Dispatch to come and provide a presentation today and he is on a -- a time restricted, uh, visit, So, uh, Mr. Dale.

MR. DALE: [inaudible]. Um, a very quick about myself, um, I spent 30 years in the fire service, retired as Salt Lake City's fire chief. Uh, I now work for the International Academy of Emergency Dispatch as the associate director of medical quality control. Um, I've been asked to come to just talk about the EMD, um, aspect of this RFP

that has been recommended.

So very quick, just for the audience, um, International Academy of Emergency Dispatch and Priority Dispatch Corporation, which is our partner, Priority Dispatch is a for-profit, the International Academy's not-for-profit.

Uh, we were the ones that owned the protocol and developed the protocol and moving forward through all the renditions for medical, fire, police and now emergency nurse as well. Um, it's used, um, in some 45 countries, translated in 23 languages.

Every year it's responsible for managing over 90 million EMS calls world-wide. And the only reason I bring that up is that we have the only product on the market that has one version. Everybody in every country and every language uses the same one.

So when someone -- like London Ambulance Services goes through 1.5 million calls per year. Sao Paulo, Brazil, 2.6 million calls per year. They go through the iterations of the questions and instructions and answers fast enough to find problems, flaws or enhancements.

So when they find those things, every one of

our centers benefits from that finding, that clinical output. Uh, we're the only ones that -- on the market worldwide that have instructions for giving Narcan, Epinephrine. Now we have tourniquet instructions.

We actually have an AED locator, so if someone calls from a -- from a commercial residence it pings to the actual -- if there's an AED service it will tell us where the closest one is for people within the building. Those are the kinds of things that the -- that the International Academy does with its protocol.

Um, it's used all around you and the intent with the RFP would be this would be the tool that we recommended for development in this area as well.

Um, some of -- we ha- -- we are maintained as -- in the largest populations in the world. Uh, in the U.S. obviously is where it started.

Uh, Dr. Jeff Clauson [ph], who is my direct supervisor, was a medical director from Salt Lake City fire department and we sent everything on everything including a police ambulance back in the '70s, and he felt that there was a way to do this better.

By asking a few questions we could decide what needed to go hot, what could not, what needed ALS, what needed BLS and by doing that at the same time the paramedic firefighter -- paramedic in, uh, Phoenix, Bill Tune, actually talked to a mother, uh, the fire chief in Phoenix was trying to -- if you will, do a public marketing for their new paramedic system, this is back in '77.

And a woman calls up who's baby had drowned in a pool and Bill Tune steps her through CPR, the baby's heard crying in the background and then Dr. Clauson started developing the instructional sequence of our protocol as well.

Our protocol for medical has a response matrix from protocol 1 through protocol 37 now, and the determinants at the end, based on the four or five questions the call taker will ask, will come up with a chief complaint number like abdominal pain is number one, protocol 10 is chest pain, 29 for motor vehicle accident and then there was a determining code that goes with that.

So a 1 Charlie 1 is an example is a patient with -- over 45 years of age having ches- -- having abdominal pain. This matrix, if you will, goes from Omega, which is a nonresponse by EMS.

Probably the best example of that would be a child who has ingested one Geritol tablet at grandma's house. That -- we have plenty of information to suggest poison control centers can handle more than 85 percent of those accidental ingestions without any type of EMS response at all.

Um, the other piece of this is becoming more popular in the urban environment is we are becoming more episodic treatment than we are critical care treatment.

The number of true ALS cardiac arrests critical patients is dropping. The number of episodic abdominal pain simple medical problems are going up.

We have developed what we call ECNS, Emergency Communication Nurse System and for my department, when we implemented ECNS in Salt Lake, we had about 8 percent of our 911 call line would be [inaudible] to the nurse to do an interrogation.

International studies or information that we have right now suggests that about 67 percent of the time when it's pushed to the nurse these patients are treated in home health care without going to the hospital or a clinic or without having the EMS response. That is an option for

communities, uh, if they implement our system to move to the ECNS model as well.

If you look at the alpha bravo tier, those are clinically speaking, basic life support needed. People say, well, we have an all ALS system. That's fine.

In the alpha and bravo tier, whoever goes is either functioning as a cold first responder or if the transport unit is responding cold to manage that. An alpha call would be something as simple as, um, I'm playing racquetball and I sprained my ankle. Some of those are non-clinically, these patients are just fine.

Bravo tier simple -- the average motor vehicle accident, no rollover, no ejection, we're just talking two [inaudible] in the car -- and at the corner, and this data suggests that less than half of those accidents have any injuries at all, less than 10 percent are critical, less than 1 percent are dead.

So the average unknown that just drove by an accident, saw it, calling 911 it's the number one reason people call 911, by the way, because everybody's got a cell phone. When we're looking at those, you can either send cold or hot, this is --

but still the need is BLS.

So in my city we used to respond an engine, hot, transport, cold. We actually did a study and I'll show you which changed our methodology and our approach to go away from lights and sirens for bravo calls as well.

When you move into the ALS category Charlie, deltas and echoes, a Charlie would be a non-alert diabetic; 48-year-old male with chest pains. These calls need to have ALS assessment at least, perhaps ALS transport.

The delta call or those we -- we consider to be life question- -- or life crisis, an unconscious overdose, cardiac arrest, um, motor vehicle accident with injection, auto pedestrian, gunshot wound to the core part of the body, these are all calls where we need to get as whoever's closest plus ALS transport on scene as fast as possible.

The echo determinant on the right far corner are those calls that are eminent life threat right out of case [inaudible] of the initial assessment.

Since many people in the room have an EMS background, it's no different than a paramedic or an EMT in a rapid assessment initially and a secondary assessment later on. Case entries, that

first 30 seconds where I'm telling you my son took too much drugs, he's unconscious; he's turning blue.

These are imminent life threat and if you're used to a system uses pre-alerts our system has built-in pre-alerts for those cases where the patient is known to be in life status questionable at the beginning of the incident.

There are very few questions that are asked, immediate response is set, it happens to be the same clinical need as delta except it happens sooner. In medical alone, there's over 460-some-odd determinant codes if you look at our system.

Not just a chief complaint number or not just this al- -- omega through echo, but also what we call descriptors. Like a non-alert chest pain patient is a 10 delta 2.

What that allows the county or the agency, the entity to do, is go back and do outcome studies right from the amount of dispatch point, what was the acuity when the patient hit the dispatch point, what was the acuity of the patient when the EMS arrives, and what is the acuity of the patient when they arrive at the hospital.

We have millions and millions of cases where

we know what the outcomes will be. We have agencies that use our system that can tell you every single patient is a bravo or alpha, charlie, delta, echo and what their outcome actually was. How many of these patients had cardiac indicators?

How many of these patients had abnormal vital signs? There have been peer review studies of our system, it's the most studied EMS protocol on the planet in all of these countries. We know what is working, we make adaptations as we get more information.

Now with all the stuff about the use for tourniquets in mass casualty it's easy to say put a tourniquet on your -- in your protocol for people to use. The problem is, if you know how many clinic -- or many products are available on the market for tourniquets, you've got at least six or seven.

So when we developed our tourniquet protocol, we had to get a number of these and try them out with people that have no EMS background and find out how many of those devices will work. And if somebody just grabs a belt, we have to be able to work through that system as well.

Our tourniquet protocol -- protocol team will be coming out in April of 2019. We did the same

thing for NARCAN. NARCAN, you've got Imagex [ph], you've got mist inhalers, you've got any type of injector out there that's available.

Our engine companies in Salt Lake City carry them and if somebody has a male [ph] relative that's had a problem with it, we'll actually give it to them when we walk out the door, so they have that available for the next time this thing happens.

Oh, our -- our NARCAN protocol has to adopt or adapt to any number of types of implementations or uses that people have from home-grown kits to kits they can buy that are massed produced.

Our system also knows the outcome -- we're able to change this based on what we see. As an example, right now in the United States and in Europe, the number of ventricular fibrillation cardiac arrests are going down. The number of overdose cardiac arrests are going up.

So even the use of AEDs that need is not as prevalent today as it was 10 years ago. Clinical medicine continues to change in relationship to what we're seeing in every hospital setting. Our protocols have the ability to adapt to that.

Some of the stuff I can show you people talk

about is this protocol sensitive enough to identify which patients are critical and which patients can go without lights and sirens or do not need paramedics.

In one slide, this one right here, they found that less than 1 percent, .99 percent of patients that were identified as low acuity by the dispatcher using our system had any type of abnormal vital sign or needed any type of ALS treatment once they got to the hospital.

On the other side of the coin, when you're talking about not sending lights and sirens, you're not sending a maximum response, you've got to have a level of comfort that the system's going to do the right thing, the interrogation, coding sequence so that mistakes are not going to be made and you find out you respond no lights, no sirens, no paramedics and you got a critical patient.

The risk there is high. Again, 98 percent or higher of these patients are found to be just what the dispatcher said they were.

In one study that was done two years ago the dispatcher's using EMD from an accredited center using -- or with the stroke diagnostic tool actually found more strokes than the paramedics on

scene. It irritates me because this is my county that they did this in and I'm a very old paramedic.

But again, if the pro- -- if the dispatcher's compliant they have QA, they're doing the right thing, the system can be trusted. It does very, very well.

So when you're talking about low acuity or high acuity, the party dispatch has been found in multiple, multiple studies to hit that mark as long as the dispatcher is compliant the system works.

When you start looking at some of this stuff and you're looking at the inappropriate responses made by LS crews the MS crews are responding on scene if they're -- if we tell them it's a delta or an echo, it's a critical patient, they arrive, the person's got a, you know, a buttle [ph] -- a boil on their butt, that's irritating the paramedic. You're not trusting the information's coming from the com center. Again, when they're looking at these things, the protocol is designed to over triage when there's any doubt.

Those [inaudible] people in the EMS and groom that have the EMS background you talk about rollover accidents. Happens all the time. Patients in rollovers are one of two categories, dead or

upset. When they're ejected, they're dead.

When they're inside the car they're upset because now their car is trashed. But because the [inaudible] data set that we look at that we look to define some of the clinical acuities for this stuff doesn't say what killed the patient. There are some rollovers that have death, it doesn't tie the rollover to ejection in their data set.

So for us, the rollover is still a maximum response.

In my own city, we send one engine company, no lights, no siren. So when you're looking at this, the agencies have the ability to adapt the coding matrix to what they want to send.

One of the biggest myths that I deal with as I travel around talk to people about our system is that we mandate to you or to the fire chief or EMS director what you will send.

If you want to send a Dolly Madison wagon to an unconscious diabetic, know yourself out. All we're doing is providing you a code, a clinical reference code that you apply whatever resources are appropriate for your city.

So there's nothing from the Academy, nothing from Priority Dispatch that says you have to send

this, or you can't send that. We're applying you a bunch of codes, 400. You send what you want to send.

In Southern California, as an example, there's a thing on kids with seizures. All the medical directors want to have a lights and sirens ALS response. Okay, seems weird to me clinically.

Uh, in our city we don't see that. We see very few children who are critical after having a seizure. But again, what I send in Salt Lake and what they send in LA, two different things. That's the local control when using our system.

I know one of the things in the RFP was about lights and siren. Um, when you're looking at the use of lights and sirens in EMS and in the fire service, many, many departments are trying to look at a risk benefit ratio and reduce the risk, not just to the citizens but to the firefighters as well.

Prior to retiring two and a half years ago we had dropped the use of lights and sirens across the board, fire and medical, by 48 percent.

That includes not just how we respond, but how many of us go. On the medical side we don't respond at all on alpha calls. On bravo calls we respond

but respond cold. Closest vehicle cold, ambulance code.

On Charlie calls our ALS engine responds hot, the ambulance responds cold. On deltas, the closest engine, the closest ALS, closest ambulance all responding hot, same as echo. That's our decision. When you start looking at this the blind use of lights and sirens is just not safe.

As a chief officer I'm telling you you can reduce that risk, it's better for everybody. If you ever get hit by a big red truck with 500 gallons of water, the engine's not going to lose that battle. And there's just not enough evidence to support the use of lights and sirens especially in lower level calls as necessary.

That's like you can't go but responding no lights and no siren is one of those things that makes sense when you start getting better information, but again that goes back to the dispatch point.

If your dispatchers are compliant following a national instructed protocol, then that risk to the city and the department drops. If you're letting people do whatever they want based on their gut, you're putting people at risk for no objective

reason.

Our department in 1996, we had a total of 19,000 EMS runs, 9,000 of those were that bravo level response. Uh, a kid today's a coffee taste test has got two similar lacerations over his eye, he's bleeding, he's awake, he's breathing, he's fine. That would be lights and siren response.

The average motor vehicle accident's lights and siren. Dislocated knee, elbow, lights and siren response. We then looked at how many times those patients are transported back to the hospital, lights and sirens.

Seventy-two times out of 9,000 that's less than 1 percent. Of those 72, 14 received ALS care. And all 14 got the same thing, IV therapy, nothing else. No airway, no drugs, no [inaudible] monitor, just an IV.

We broke that down and we stopped sending lights and sirens on bravos across the board. Fire chief in 1990 -- or late 1999 decided we would send no lights no sirens on alphas or on all bravo calls, we don't respond in alphas, and it was a -- it was a fearful thing because now we're not responding lights and sirens.

And I was the brand new fire captain who was

dedicated in the EMS division to go tell the fire captains we were stop using them. I thought I was a dead man.

What I found from some of the crustiest fire captains in our department was that they already knew it. One of them, and I quote said, it's about damn time.

They know these calls are emergencies, they get there it's nothing. They felt it was a good thing and bar- -- prior to I'm -- prior to my retirement people started coming to us, our union, our EMS service would say why we going lights and sirens on man down calls.

These people are sleeping and they're drunk. We looked at it, we started changing it for the -- for the code 32 delta 1 which is man down unknown life status. No lights, no sirens, no problems.

In San Jose the number one man-down life [inaudible] call is a person in a sleeping bag under the freeway sleeping. I don't think he got shot and fell into that sleeping bag. This is one of those calls we have to manage, but we can manage it better by reducing that risk.

So when we did this, the first year the top line in black every apparatuses [sic] are all BLS

companies, they're all responding lights and sirens. Those same companies after we started this are across the blue line. The bottom line is interesting.

The most amount of time for truck 5, which is around University of Utah district 30 second -- 36 seconds on average, that's an entire year worth of data. Engine 13, which is in a more rural, affluent area they are actually faster no lights and sirens than they were with lights and sirens.

There is a feeling that lights and sirens save a dramatic amount of time. Categorically I can tell you it's not true. Lights and sirens will save you time in a downtown district with lots of stop signs because hot or cold you got to stop.

When you're on the open highway in the rural communities, you're actually not going to save any times because you can drive a heavy 75, 80 miles an hour, not safe, but you could do it.

The longer you travel actually the less time you save using lights and sirens. So we look at this. We made our decision and in the first two years after we did that, we had one citizen complaint on alpha call in a very fluent part of our city, [inaudible] Cross our transport provider

by themselves and they got lost; 19-minute response time for a dislocated ankle. Okay.

But we -- we -- we're fearful it was going to be this great out-crying from our community when they didn't see the big red truck lights and sirens in front of their house.

If anybody in here has worked in the com center, you'll hear just the opposite. Many, many times people will call and say do you have to send everybody with the lights going?

They fear -- they don't want to have the neighbors upset because grandma fell and broke her hip. So when you're looking at this system, um, we have never had an EMS litigation involving our product 19- -- since 1979, not one ever.

Um, when you start looking at what this can do, again some people may sh- -- uh, refer to this thing we make you send something, it's a -- completely up to the agency to decide what they send when they send how they send.

But the other side of that coin is we know the risk for responding in a hot fashion versus cold fashion, it's got to be higher. We know that there is the way to reduce that risk significantly by using a product such as this.

Obviously, I'm biased but I think this product is bar none the best in the industry. And we are the large- -- we are the market leader when it comes to EMD, EFT and EPD protocols and design systems.

So my place in this is to provide you with information relating to our product, um, which was -- I -- I mentioned in the RFP. Um, I -- I can't imagine I'll be asked to come back on the 10th, I'd be more than happy to do that if -- if required. And since I am -- I'm well ahead of my schedule, um, I'd be more than happy to answer any questions if there are any for me at this time.

MALE 2: So procedural on this, I -- I was under the impression that we were changing the -- the agenda as far as the order of the speakers, that we weren't moving this item all the way up. I thought we were going to talk about the healthcare representative first.

MS. DARBINIAN: That was -- that was originally the plan but this gentleman needed to leave by 11:00 o'clock and you can amend the agenda as you sit here.

MALE 2: So -- so then it's going to go back to the --

MS. DARBINIAN: Correct.

MALE 2: -- and then we're going to --

MS. DARBINIAN: Correct.

MALE 3: I'm curious about, um, from the implicating agency perspective, I'm just curious about from a liability perspective, um, what types of procedures, you know, you have to put in place in terms of is there additional liability or is the training sort of inoculate or keep a city or a county or an agency immune from liability under this protocol?

I just don't have a lot of education on that and I appreciate if you could share some of that experience.

MR. DALE: Sure. So for years and years people would tell us -- actually, there was a -- a county around Sacramento that one of the more infamous cases where a woman had called up for 18 -- an 18-month-old child who had fallen face first into a 5-gallon bucket of water while she's washing her car, and the EMD -- the person taking -- the call taker was not allowed to give her CPR instructions.

Her city manager had said there was too much risk because when you do something, you're more liable then you are if you do nothing.

And so when you start looking at that we have never seen that to a -- we've never seen -- all the litigations we have seen in emergency dispatching going back to the early '70s, we've never seen an agency sued for doing something. There are at least 14 multi-million dollar lawsuits associated with those agencies who have chose to do nothing.

As far as protection from litigation, one of the insurance companies, um, in one of their documentation had said that the EMPDS provides de facto immunity to litigation because we just haven't had any with agencies using our product.

Um, if someone is, uh, brought under litigation, uh, Dr. Clausen himself is one of the license agreements that they sign with us is that if you are compliant to the protocol and you are sued Dr. Clausen would provide professional witness protection to that entity or agency in that event.

We have had several things happen, but we've never gone past a discovery phase or inter- -- interviews by the attorneys has never gone past that point.

The opposite side of this, which may affect, um, any agency implements is we have agencies that will use our product but they're not ensuring the

call takers are using it correctly.

It would be like, I went through paramedic school in '82 and if I have gotten none -- no training, I haven't had any e- -- updated, no one's been watching me run a code, I haven't had any type of -- of case review or anything associated with me, I don't think you'd want me touching your family member. So the same goes for the dispatch system.

When they implement -- our implementation process is not just selling your software. The implementation process you buy a packet which includes certification for some of your staff in that center for quality management.

The aqua, which is our software that we do case review with which talks to our primary product [inaudible], um, the education for medical director is education for staff and there's also pieces which, since I know I have, uh, EMS [inaudible] people behind me, there's what we call the dispatcher review committee.

The dispatcher review committee meets monthly and the intent is to bring someone from the field and dispatch and administration into a room to have this discussion.

That's where you start finding where, I don't know if it's the same thing here, but for us we had a -- always had an issue the fire service and our police department for psyche patients. The patient, he -- he's crazy, come look at him.

Well, in my training for para- -- as a paramedic for psyche patient is you have a cardiac problem, is your blood sugar good, do you have chest pain, you're breathing okay, okay, have a nice day.

So this -- this contentious relationship between police and EMS on psyche patients, um, that -- rather than having that -- that contest on scene, you have that in the dispatch review committee meeting where you identify a policy and procedure what that looks like.

The end result for us was the police department chained -- trained several officers in CIT, critical incident team, and then once they got on scene, they're actually writing a safety plan for this people.

And EMS is like, blood sugar is good, vital signs -- the vital signs are fine, we can just -- well, I know obvious clinical reasons to have this behavior and we back out and they take care of it.

So the dispatch review committee is that middle management. Anyone in the room that has gold bars across each other, out of the room because that position changes the dynamic in the room.

So from the fire -- from the EMS or fire service you would be like a captain, no higher than a captain or lieutenant and you have supervisors, trainers, and they meet monthly and they work out these things that they find. Um, an agency doesn't like this, or they want this.

That becomes a proposal for change to the academy to adapt that to our next version of our protocol. We implemented a version, 13.1 for medical last year. We're half way through version 13.2, over 400 proposals for changes and 80 percent of those come from our users.

So when you start looking at this, that's how the system works. At this level, fire chiefs, administrators, medical directors, that would be the dispatch hearing committee.

Those people meet quarterly and they're approving or modifying ideas, protocol, procedural documents that the DRC identifies. So that way everybody in the system has a say at the right level.

If you put a fire chief or battalion chief or deputy or assistant chief in the dispatch review committee, those individuals are used to hearing what? Chief -- what you -- will you -- if you ask me something what's the answer you're looking for? Yes.

He's got five [inaudible]. I know the answer. If he's talking to the police chief, that answer's not always yes. So you want to put the right people from the right entities in the room at the same time. It's true, right?

So when you're doing that, the intent is to set up those structures, that's why we don't just sell you software. We -- actually, you cannot just buy our software, we won't sell it to you.

It's got to come with the system because we are putting ourselves out there. If you adopt something like this for responses with your ambulances, your engine companies, ALS, BLS, whatever you're doing, there's risk. T

here's risk to us. So we want to make sure that a system is designed correctly. We used to just sell card sets and software, no more. We're beyond that. In a very long answer, but there -- there it is, to answer your questions.

MS. CORSELLO: Are there any other questions? So I have two --

MR. DALE: Okay.

MS. CORSELLO: -- questions for you. Um, when you flashed up on the screen 3600 locations --

MR. DALE: Mm-hmm.

MS. CORSELLO: -- uh, there were 4 listed in California; San Diego, San Francisco, San Jose and Sacramento --

MR. DALE: Mm-hmm. There are many more --

MS. CORSELLO: -- are those cities --

MR. DALE: -- those are larger.

MS. CORSELLO: Okay. Are those city --

MR. DALE: Yes.

MS. CORSELLO: -- or county wide?

MR. DALE: Depends on where it is. Um --

MS. CORSELLO: I mean I know --

MR. DALE: -- Sacrament is city, San Jose is city, but Santa Clara county also, use it, they're also a center -- they're also a credited center. Uh, LA had us, the fire department went away from us in LA City. Uh, San Diego, it's the city itself. San Francisco it's the city.

MS. CORSELLO: Well, it’s a city and county in San Francisco. Okay. So I get a general idea. Uh,

second question I have for you, um -- uh, departments with ambulance or with private provider?

MR. DALE: I'm sorry, I'm not --

MS. CORSELLO: Are they -- So your protocol is set up -- your emphasis is on fire response --

MR. DALE: Well --

MS. CORSELLO: -- kind of in terms of the level of response in conjunction with an ambulance.

MR. DALE: Mm-hmm.

MS. CORSELLO: Do -- do the majority of your clients today use that in conjunction with an embedded EMS ambulance provider or a private provider?

MR. DALE: I -- I couldn't give you the number of -- of what that looks like as far as a breakdown, but there may be some misunderstanding. I'm just giving you my experience for Salt Lake City fire. Salt Lake City fire department, we have the EL- -- ALS license, we're the ALS provider.

We do not transport. So Go Across, which is a local provider has been for 40 years pays the fire department for every time my paramedic gets in their ambulance to go to the hospital, they pay us a fee.

They don't pay us for response, but they pay us for para- -- what we call PA, paramedic aboard. Um, that's -- that's how they re- -- because they're able to bill at a higher level if my paramedic is in the back of their engine -- back of their ambulance.

As far as the systems in the U.S., most of the systems we deal with are fire based. In Europe, not many systems have, if any, are fire based, they're all third service or through the health departments.

MS. CORSELLO: So my final question for you then is, um, is there a situation where today that your license is being used by a private sector, where calls are being transferred?

MR. DALE: For transfer calls -- in -- interfacility transfers?

MS. CORSELLO: No. Your product --

MR. DALE: Uh-huh.

MS. CORSELLO: -- is residing in a private sector dispatch --

MR. DALE: Mm-hmm.

MS. CORSELLO: -- and calls are being transferred from a public sector piece app to a private sector piece app for purposes of

coordination.

MR. DALE: Yes. There are -- there are -- there are several of those models that apply, a secondary [inaudible] app, primary piece app in this country is usually owned by the police department.

And then if it's a medical or a fire call they'll broadcast that over to a secondary piece app for medical or fire dispatch.

MS. CORSELLO: Privately operated and owned --

MR. DALE: There are --

MS. CORSELLO: -- as well as --

MR. DALE: Yeah.

MS. CORSELLO: -- publicly operated --

MR. DALE: Mm-hmm.

MS. CORSELLO: -- and owned?

MR. DALE: I -- I couldn't give you the actual breakdown. And there's another part in there. Like in Salt Lake County, Salt Lake City does dispatching for Salt Lake City fire, Salt Lake City police and then the other -- the county dispatch center is not owned by the county. It's a private partner -- private -- public private partnership and they dispatch for fees.

MS. CORSELLO: Okay. Thank you.

MR. DALE: So I will leave my information with, uh, Mr. Wolfberg or you? Okay?

MS. CORSELLO: I'd appreciate it if you'd leave it with staff, I --

MR. DALE: Okay.

MS. CORSELLO: -- and if your PowerPoint is available, um, we'd -- we try and make sure that the members here actually have a copy of --

MR. DALE: Sure.

MS. CORSELLO: -- the documents that are being shared.

MR. DALE: I believe they have it already, is that right?

MALE 2: Yeah.

MS. CORSELLO: Okay. And, um, no other questions at this point. Thank you for your time this morning.

MR. DALE: Okay. Thank you.

MS. CORSELLO: Okay. I'd like to return to the normal order of the agenda. Uh, so that means the first is the approval of the agenda. So I need a motion on the approval of the agenda. I -- I recognize that we may not get through everything.

MALE 3: I'll move to -- I'll make a motion to approve.

MS. CORSELLO: Have a motion, do I get a second --

MALE 4: Yeah.

MS. CORSELLO: -- for the approval of the agenda?

MALE: I'll second.

MS. CORSELLO: Okay. All in favor of the approval of the agenda at this point.

GROUP: Aye.

MS. CORSELLO: Aye. Any opposed? Any abstentions?

MALE: [inaudible]

MS. CORSELLO: So noting one abstention. Okay. All right. So let's go on to, uh, reports from, uh, the EMS administrator.

MR. SELBY: Thank you. Um, if you've had a chance to review the meeting packet, you are undoubtedly aware that we have recently lost, uh, two pillars of the local EMS community. Richard Watson, who served on this board as the healthcare consumer representative was retired from the State of California where he served as the director of the Emergency Medical Services Authority, and of course, had worked in various locations throughout the state, including his appointment as the CAO,

the County Administrative Officer right here in Solano County back in the 1980s. He passed away on November 6th, just a few days after turning 87.

About a week later Aaron Bair, who sat up here, uh, as the EMS medical director throughout the lengthy trauma center competition, who also served as, uh, UC Davis' director of the center for virtual care and the medical director for the center for health and technology passed away on November 13th at the age of 52.

Uh, both Aaron and Richard will be sorely missed. Uh, they both made incredible contributions to the EMS system that we are very lucky to have in this county with a trauma system and the changes that were made.

So before we get started, uh, with the regular calendar, I thought it would be prudent to highlight a couple of things. First, is the projected RFP timeline that was originally presented to this board back in April of this year.

Um, I just thought a memory jogger, if you will, might be useful and I have a slide up on the, uh, screen for you.

Um, we had identified that we would attempt to post the RFP in January. Letters of intent would

then be due in January or February with a bidders' conference being conducted in February.

Uh, bid submissions would be due in May, um, fol- -- followed by an evaluation period which would end in July.

Once those, uh, evaluation -- that evaluation period concluded, uh, the selected bidders would be interviewed in July and in August, uh, the award would be announced with implementation in May. Again, this -- this was presented as kind of a fluid projected timeline.

And the board accepted that at that April meeting as just that, a projected timeline. Uh, and this was done with the caveat that the State, uh, Emergency Medical Services Authority must receive, review, and approve the request for proposal before we can post it. So it hinges upon their length of time reviewing and approving as well.

Secondly, you may recall in October of this year I was asked to correspond with the State Emergency Medical Services Authority to ascertain if the Authority would have concerns with this board extending the terms of the current master services agreement for life -- for advanced life support ambulance services in Solano County in the

event our timeline couldn't be adhered to.

While I did not receive a written response from the State, I did receive a phone call and the EMS Authority made it clear that their expectation is that the local EMS agencies not exceed the 10-year periodic intervals between RFPs.

As further conveyed, that it is not likely that an extension would be granted although requests can be submitted and they are reviewed and considered on a case-by-case basis.

So I realize this is not black and white, it's very gray. Um, it's the information that I received in -- in response to the inquiry and I just wanted to remind you all of that information, uh, so that we would all be on the same page.

I just thought it might be helpful as kind of a reminder where -- what our goals were. And with that, I will conclude my administration report.

MS. CORSELLO: Are there any questions of the administrative report? Seeing none, Madam Clerk can you read item 2A, please?

MS. CLERK: [inaudible]

MS. CORSELLO: Um, do we have a report from staff on this?

MR. SELBY: So in your packet in -- under

regular calendar, you'll see some background information with, uh, the staff recommendation that recruitment for the vacant SEMSC health care consumer representative be opened on December 17th of this year, uh, with a closing date of January 18th, uh, allowing for just over a month of recruitment time since we do have holidays that fall within there -- it seemed that we needed to have an adequate amount of time for people to see this.

Uh, reflecting the process that was used in 2010, the last time that we did this, um, we would recommend that we adhere to basically the same process which would initially, um, require us advertising the position in the local news media. I've listed out the local news media in your packet.

And, also professional organizations that would likely be able to get the word out. We would create -- or, excuse me, the board would create an ad hoc committee as, uh, read in the item.

Uh, in 2010 that was a -- the chair and two members of this board that comprise that ad hoc committee, uh, because it was effective staff would recommend that we retain that same composition.

EMS staff, together with the ad hoc interview committee, would prepare a list of qualified candidates for ad hoc committee interviews at the end of the advertisement period.

The ad hoc interview committee would then interview the candidates and make a recommendation for selection of the consumer representative to be affirmed by the board at the next available board meeting following completion of the process and then this board would affirm the health care consumer representative.

MS. CORSELLO: So I am -- I'll take comment and/or volunteers.

MR. WHITE: So I -- I do have one comment. Um, I appreciate the preparation of this item. Um, I was particularly interested in the experience, um, that you're looking for.

And I noticed a different between the bylaws and how it describes, uh, the requirements for the health care consumer and the more restrictions that you're placing on that position in this, um, agenda item.

And so I was just wondering if you could help bridge for me the difference between what the bylaws call for in this position and the

description that you have here, um, in this agenda item, please.

Because I appreciate that there could be history and policy that may have amended the requirements over time.

MR. SELBY: Thank you. Uh, so this background is based upon the direction that we received at the -- the last period that we -- that we sought out a consumer representative and that was well after the JPA had been established as you -- as you indicate.

Um, and what it -- it has served us well with Mr. Watson, uh, having a candidate with knowledge and familiarity in all of these areas; health care systems, ambulance services, emergency medicine, and, um, what we did indicate here, I believe, and -- and I'm working from memory with regard to the -- to the bylaws, but I believe it did indicate that we were looking for somebody with, uh, some familiarity of emergency medical services. Is that -- does that sound correct?

MR. WHITE: It does but maybe I'll -- I'll read it, uh, for the board because I think there's some important differences that I think are certainly germane to the purview of this board.

So the bylaws read for the health care

consumer that they must be knowledge in pre-hospital emergency medical care issues, which I think is very important. I've demonstrated a commitment to achieving the goals of the SEMSC, which, again, I strongly concur with.

And this is one of the more important parts that I think is missing, uh, from the description here, which I think we should consider, which is and be willing to represent the interests of Solano County consumers in achieving high quality, efficient pre-hospital emergency medical care.

So from my perspective as I'm reading it, I think the bylaws well represent what we're looking for and my, uh, feedback to this board would be that we consider, uh, that whatever is described as consistent with those bylaws as opposed to what's here, which I do find to be overly restrictive and I think we should consider those who do care about Solano County and the consumers in Solano County.

MR. SELBY: Absolutely. And that -- that was an oversight, uh, to not include that language in this item. And that -- abso- -- I concur should be included.

MS. CORSELLO: So clarification, David, are you suggesting we substitute what's in the bylaws

or augment with staff is -- add staff -- when staff is added or make a change? I'm -- I'm trying to clarify before I ask for a -- before I call for an action on this one?

MR. WHITE: I appreciate that. I -- I would -- given that these are the bylaws of the board itself, I would recommend that we substitute [inaudible].

MS. CORSELLO: Okay. I -- I don't see any one raising a question or a concern. We can certainly do that, it would make more sense that we stay with what we already have.

So, um, at this point, um, then it is a substitution in terms of the description and still a recommendation that there be two members in the ad hoc committee.

So I'm looking for one affirmation that that's we're going to do and then next I'm going to be asking for volunteers. So are we okay with the recommended outline with the change in the description? If so can I get a -- a -- a -- a motion to approve that?

MR. WHITE: I'll make the motion with the substitution and the description for the position.

MS. CORSELLO: Okay. And a second.

FEMALE 1: I'll second the motion.
MS. CORSELLO: Thank you. All in favor.
GROUP: Aye.
MS. CORSELLO: Opposed? Abstention? Hearing none, that carriers. All right. So now -- now I'm looking for two volunteers.
MALE 5: I'll volunteer.
MS. CORSELLO: So we have a fire representative. Can I get one more volunteer?
MALE 6: I'll volunteer.
MS. CORSELLO: And a hospital representative. Thank you. So the rest of the committee -- oh, is the rest of the group okay with that? We have two individuals that -- whatever recommendation is going to come to the full board anyway; okay?
Do I need to have a vote on that? Okay. Seeing -- all right. Yes. On to the second item on the regular calendar. Madam Clerk can you read the item, please?
MS. CLERK: [inaudible]
MALE 7: [inaudible] yes.
MS. CLERK: [inaudible] services. [inaudible] services [inaudible].
MR. WOLFBERG: Good morning. Uh, it's a pleasure to be back and to see all of you again in

what must be the safest room in California. So, uh, and, uh, I --I -- again, I am Doug Wolfberg.

For those who don't know, uh, I am with the firm of Page, Wolfberg and Wirth. We are the consultants that, uh, wrote the, uh, draft RFP as well as the blueprint that we presented at the last meeting.

Today our function is to present the provisions of the draft, uh, RFP. And I believe the -- this slide deck was part of the public materials, if I'm not mistaken, so everyone I think has this or will be on the website.

MALE 8: I don't think this -- it will be on the website.

MR. WOLFBERG: Okay. So you'll all have access, uh, to this. Uh, I would, uh, like to just point out the -- at the outset that based on the public comments that have already been submitted, uh, fire chiefs, firefighters, private ambulance providers, city managers, uh, are all mad at us, so we must have done a pretty good job, uh, writing the RFP.

Uh, so I -- I also like to point out that, uh -- that when Brian Dale gave his presentation, uh, he was here voluntarily. Actually, nobody paid him

to be here.

Uh, but because of the, uh, debate and questions that were raised about EMD and its place in this proposal, uh, he sort of volunteered to come out here from Salt Lake, uh, to do that representation, so I just wanted to make sure the board, uh, was aware of that, uh, on why EMD is so critical.

I'd also like to introduce and I'll do that, uh, more formally here with -- with some slides in a second, but joining me today is my partner Steve Wirth and, uh, my colleague Ken Brody.

Uh, Steve will be tag teaming this presentation because we do have a lot of slides to go through the whole RFP, and you will get sick of hearing my voice, uh, so we're just going to break that up a little bit and Steve was involved, and Ken were both involved with this as well.

Uh, one of the things that came up in the, uh, public comments and that I was asked to comment on in our presentation was a little bit about our experience. We do this not to just say, hey, we're great, but because there were questions raised about, well, what do these guys know about California and they're either a bunch of lawyers.

So, uh, we were asked to sort of speak to that. It's true we are lawyers but we -- we also have, uh, collectively quite a few decades of experience in EMS, fire, and, uh, public safety.

Uh, our firm again is called Page, Wolfberg and Wirth and I know many of the fire, uh, personnel in the room, uh, know the name Jim -- Jim -- James O. Page or Jim Page. He was one of our founding partners.

He was a long-time fire chief in several departments here in California, uh, and also worked for -- for many years at the Los Angeles County fire department. Uh, he -- among other things, he was the founder of Jim's Magazine, uh, and, uh, was the technical adviser to the television show Emergency, which those of us over a certain age remember.

Maybe some of us in reruns but, uh, it's a -- Jim was actually the real John Gage, uh, is where that character, uh, was named from actually. So, uh, Jim cast a -- a pretty long shadow in EMS and in fire service.

As for myself, I started out in EMS and rescue as a provider, uh, about 112 years ago and, uh, also worked as a -- myself as a county EMS director

and, uh, worked at the state level and for the U.S. Department of Health and Human Services, all of that prior to law school, so this is sort of second career with EMS and -- and public safety having been my -- my first one.

My partner Steve Wirth, who you'll hear from here in a few minutes, uh, was one of the first paramedics in central Pennsylvania, also an active firefighter, uh, as well as being an attorney and has served in multiple capacities within the fire service, uh, and EMS as well.

And although he has a non-speaking role today, my colleague Ken Brody that is here with us is an attorney and, uh, for over 20 years was chief counsel to a state-wide EMS agency, uh, and has been involved in, uh, much of the work that our firm has done throughout California and, uh -- and nationally.

One of the other things that was mentioned in the comments was we're from Pennsylvania what could we possibly know about, uh, California. Uh, when our firm began, we actually had an office here and -- and had one until Jim Page died in, uh, in 2004.

So, uh, we were sort of born here in California as well as in Pennsylvania. And our work

here in the state has been, uh, about 20 years the whole time we've been inexistence. And our clients across California, I think this is important to mention, have literally run the gamut of -- of public safety agencies, both public and private.

Uh, Steve can tell you our -- our firm motto is we like everybody, we get along with everybody. We -- we're not just public, private, fire, EMS, we've represented all manner of agencies that -- that do or oversee or provide EMS in California. We have represented cities.

We've represented fire districts; local EMS agencies, uh, obviously, as we're doing here today; ground and air ambulance companies. Uh, hospitals and act- -- and also firefighter unions have engaged our firm services over the years.

And most of the -- the main statewide organizations in California have also, uh, utilized our services to come speak at their statewide conferences including Cal Chiefs, California Ambulance Association and, uh, EMSAAC, the EMS Administrators Association of California.

Uh, and another question was, well, there's case law that you guys can't possibly be familiar with. Well, we are actually familiar with it and we

participated in making some of that case law.

We've represented parties in cases that have gone up through the appellant courts on EMS issues here in California. I personally have appeared in appellant courts on EMS cases here in California.

And we have done other procurement processes in California and system-wide assessments in other counties, uh, throughout the years including [inaudible], Merced, and -- and several others.

Now, as Ted talked about the timeline, I won't repeat what he said about the timeline, but I will just add the big maybe to that because, of course, it is your discretion.

Uh, and, uh, the timeline is ultimately going to depend upon what revisions the board requests of us, uh, what timing the board utilizes in making final decisions to approve the RFP, and then, of course, what is beyond any of our control, uh, is how long the state EMS authority takes to review, uh, the draft RFP.

I will just reiterate one thing Ted said and that is that the biggest deadline is the expiration of the current contract in May of 2020 and, uh, you heard Ted's update on what the EMS Authority has said about going, uh, beyond that period and I will

let that speak for itself.

Now, a couple of things before we go through the provisions of the draft RFP, uh, one is that I think it's very important to remember, both for the board and for the audience, that this is a draft document.

And what the public may not be aware of is that there was extensive discussion about the decision to release a draft, which is usually not done actually in these procurements.

Um, in fact, it very rarely is it done, uh, but the fact, uh, remains that it was part of our original recommendations and our work plan from the beginning to release a draft, to allow for public comment.

And we received a lot of public comment. And I -- I just want to thank everybody who submitted public comment and who came out, uh, today to support whatever position it is they want to support.

These are important issues and the bottom line is I think everybody's input should be listened to respectfully, uh, and responded to respectfully and that's what we've tried to do.

Uh, so no matter what position people take, I

think it's important to remember, this is a draft. We've brought a set of recommendations to you as the board, but this is ultimately your decision.

Uh, what provisions of the draft RFP you direct us to change, we will change. Uh, what provisions you ask us to keep, we will keep and those you ask us to delete we'll delete Uh, you are the board that is, of course, charged with the authority to put out this procurement and to design it the way you want.

Uh, as your consultant, uh, we are bringing to you our recommendations not pretending that they are perfect, but what we believe are the best practices that are supported by the evidence and the data, and we tried to extensively cite and, uh, publish data to support every one of the critical recommendations, uh, that we have made.

So it is a set -- what this draft RFP is is a set of recommendations by us as your consultants. It is patient centered.

Uh, it reflects published peer reviewed data, literature, national consensus best practices, uh, from around and throughout the United States and in some cases internationally. What the draft RFP that we've presented to you is not, is it's not your

official policy.

And as some of the comments, you know, the -- the, you know, SEMSC shouldn't be doing this. Well, you haven't done anything yet. We -- we'll take all the blame and/or credit so far because all we -- all you guys have done is receive recommendations from us.

So nothing that has been stated or put out there is your official policy because that is yet to be decided by you.

The other thing that I think many commenters would agree with is that our, uh, recommendations were not primarily political in nature and the number of comments received in opposition to some of our recommendations makes it clear that politics was not our first consideration, it was trying to incorporate evidence and data and clinical best practices and, of course, uh, you folks will have to reconcile the competing interests.

One of the comments that was made, in fact repeatedly, was that, gee, there was all this stakeholder input and none of it was -- none of it was considered. Actually, a great deal of stakeholder input was considered.

All I would remind the board is that many of

the, uh, pieces of input that we received in those multiple stakeholder meetings are directly opposite of each other. Some -- somebody wants A and somebody wants Z, and you can't have both things.

So what our job was was to try to reconcile that stakeholder input to, uh, reflect the best practices for patients here in the county. Um, I mean in one case we were criticized for certain standards that we recommended that we'll talk about in terms of what the experience should be for the bidders.

On the other hand, somebody had suggested, well, the private ambulance contractor shouldn't have to pay any first response costs because that's the job of the cities to support fire con- -- fire departments.

Obviously, we can't -- we can't do both things, right? So if -- if the simple answer was anytime a stakeholder gives input, you have to incorporate it in the RFP.

Number one, that's not how it works, and we said that at the beginning; that we'll hear all the input, it'll be listened to, it'll be considered, but not everybody's comments are going to be incorporated into the draft RFP.

They all cannot be because some of them are diametrically opposed and some of them simply are not good recommendations for patient care. Uh, and the number of people who repeat a bad idea doesn't make it a good idea. And I think that's something else that's important to remember.

Um, so we have presented a proposal for an EMS system model that is number one, first and foremost, patient centered, evidenced based, clinically justified, cost effective, uh, and finally economically sustainable.

Uh, and, uh, you know, some comments revolved around the fact that, oh, we're concerned about, you know, private companies making profit. And in the next breath they say you're not paying cities enough money. So you can't say it's about money and then say, well, you're not giving us enough of it.

So again, these are just -- in some cases diametrically opposite positions that the board is going to ultimately have to balance in deciding what its final RFP is going to look like.

But we're going to come back to that theme a couple of times of economic sustainability, and this board has heard me say it before, that in very recent past in two other counties the contractors

in what were supposed to be zero subsidy systems have come to the county, knocked on the door, and said give us $4 million in one case or $7 million in the other, or here are the keys. We're out.

And when you put too many costs on an ambulance provider, that system can become unsustainable. That is not theoretical. That is not hypothetical. It has happened in two other counties in very recent years. So all of these were the driving considerations --

MS. CORSELLO: I want to stop.

MR. WOLFBERG: Yes.

MS. CORSELLO: Uh, I want you to clarify --

MR. WOLFBERG: Yeah.

MS. CORSELLO: -- those were county-issued, not this cooperative? This --

MR. WOLFBERG: They weren't here in Solano County.

MS. CORSELLO: Well, you continued to indicate the county bailed them out. Those were also county-authorized projects. This is a joint powers authority. Th- -- and a quasi-judicial decision. So the -- the responsibility resides with the members sitting here, not the county; correct?

MR. WOLFBERG: I understand. But do you guys

have $7 million? I mean, as a -- as a cooperative?

MS. CORSELLO: Uh, as a cooperative, uh, I don't think so. But --

MR. WOLFBERG: So --

MS. CORSELLO: -- I mean, uh, I want to make sure that there's a distinction and not -- not confusion about that piece. Because I, uh, uh, it has been raised and I don't want that confusion cr-- -- continued.

MR. WOLFBERG: Yeah.

MS. CORSELLO: We're a unique model and this is where that decision is residing, not with the county.

MR. WOLFBERG: I understand that. But --

MS. CORSELLO: Okay.

MR. WOLFBERG: -- the reason I said county, Birgitta, is because those two other systems were county systems.

But my point is that I think if the system is pushed to the brink of economic collapse, a provider is going to have no choice but to knock on either the county's door or they can come knock on the cooperative's, door, but I don't think the cooperative is going to be able to write the check.

So my point is -- is that economic

sustainability of the system is one of the key issues, regardless of who ends up having to step up to pay the bill. But your point about this model being unique is -- is definitely well taken.

I'm going to give you an overview of the, uh, just general structure of the RFP, and I'm going to turn it over to my, uh, my partner, Steve Wirth [ph], who's going to, uh, talk about, uh, some of these sections.

And then, I'll jump back up, again, just to, uh, reflect that, uh, more than just me has worked on this proposal in our firm, uh, and also, to give you a break from my ears.

But, uh, the draft RFP, which I believe everybody has; is that correct? Yes? The board does. Okay. Um, has these six sections in it. Uh, introduction, uh, information about the procurement. We're going to go through these one at a time. Uh, just a description of the current system, which is Section 3.

Uh, where all the fun begins is Section 4, which is the minimum requirements for proposers. Uh, lots of fun in Section 5, which are the competitive criteria. And then, Section 6 is all the legal and contractual stuff. So we'll go over

that.

I'll just briefly do the introduction. Then, I'm going to turn it over to Steve to talk about, uh, Sections 2 and 3. But Section 1 just contains an overview of the RFP. Uh, it defines the scope of the services.

Now, we're going to get into these three levels of service a little bit later. But the first one is that, of course, it covers emergency ambulance services, which it covers now. Uh, it covers ALS interfacility ambulance services, which it covers now.

And the third, which is a new recommendation, is that it include CCT, or critical care transports. Uh, we have reasons for that recommendation, which I will get into a little bit more when we get into that section.

Now, the second piece that's significant in the introduction is it sets forth the geographic scope of the exclusive operating area, or EOA. So I'll use that acronym EOA, and I mean exclusive operating area when I use that. It's the contract.

It -- the -- the geographic scope of the EOA includes all of Solano County, except for the city of Vacaville, because of the city's 201 rights, uh,

and it -- it excludes from the contract the area that has formerly been described as Zone C, as approved in the, uh, uh, current EMS plan.

Now, the blueprint report has recommended including Zone C in the contractor's EOA. This is a change from the blueprint that we are pointing out to you in the f- -- in the, uh, draft of the RFP.

So in other words, that zone would be continued to be served by the city of Vacaville. That's also going to have some changes on dispatch, which we'll highlight when we get into that section.

I do want to point out, though, and I think it is important for the board and for Council, to point out that -- that Vacaville's exclusivity in this zone arises not under Section 201, as has been claimed.

That is legally incorrect. There are no 201 rights outside of the city limits. Any exclusivity rights that they may have arise, instead, under Section 224 of the EMS Act.

That is an important distinction because a local EMS agency is bound to respect 201 rights. 224 is a voluntary section. It gives the EMS agency an option of either putting it in a bid or using an

-- an -- an existing provider.

Our recommendation is that that area continue to be served by the city of Vacaville. The only thing I will point out is that there has been some correspondence exchanged questioning the exact, uh, delineation of the boundaries of that historical zone. That is being worked out.

So in the RFP, we simply let bidders know that the -- the exact geographical lines of that, uh, boundary area are still being discussed.

But the intent is that the city of Vacaville would continue to serve those areas that they have historically served, both in the city and in the surrounding, uh, areas.

And Travis Air Force Base also is excluded, uh, from the geographic scope of the EOA. I will also note that, uh, this has just been historically done.

I -- I don't have any answer to why, but, uh, certain areas of Sacramento County are also within the scope of the EOA, I assume without objection by Sacramento County. Um, I, uh, I don't know. Your -- your look said -- said a lot, Ted.

MR. SELBY: Well, I -- I, uh, [inaudible]. Oh, sorry. The city of Isleton, uh, was involved in

discussions from my historic reading of it. And there have been discussions with the county of Sacramento in the past, and they have not, uh, taken issue.

MR. WOLFBERG: So they've said here, Solano, it's all yours. So -- all right. So that's the other area that is in the EOA and highlighted also with the areas that would be excluded from the EOA.

Last things in terms of introduction before I hand it over to -- to Steve, uh, is that, uh, you heard Ted talk about sort of 10 years being the state EMS authorities, uh, tolerated or permitted maximum for an existing EOA contract.

Uh, and what we are recommending is that the term of this agreement be five years with a renewal period of five years. So at that five-year mark, the board would have the ability to either extend the contract or, if they chose to, to rebid, uh, a new procurement at that five-year mark.

Uh, but if the board is satisfied with the provider, then it would have the option to extend up to a second five-year period.

Um, the RFP sets forth in Section 1 just the policy goals of the procurement, that, you know, we save lives and reduce pain and suffering and all

that kind of stuff. And then, fees are set forth in the -- in Section 1 as well.

Uh, there's a contract award fee of $100,000, which is intended to help, uh, offset some of the EMS, uh, local EMS agencies' costs in doing the procurement process. And then, an annual franchise fee of $600,000, which is a $100,000 increase over the current $500,000 amount.

And then, of course, there's legal disclaimers and releases to protect the cooperative from liability in the procurement process. Uh, and -- or at least to attempt to protect the, uh, cooperative from liability in the procurement process.

And that's included in there as well. So I'm going to ask Steve to jump in for Sections 2 and 3. And then, I'll be back to talk about 4 and 5.

MR. WIRTH: Okay. Very good. Good morning, everybody. Great to be here. Um, I'm going to talk about the procurement information and the procurement aspects of -- of the RFP. These are probably the more straightforward, uh, areas of the RFP.

So we can probably move through these fairly quickly. But it is a performance-based contract, and Doug outlined some of the key areas on the

clinical, operational, and financial side we're focusing on, based on what's happening out there and -- and the future trends we're seeing with healthcare and based on the evidence.

There's a notice provision, of course, that, uh, and -- and you, as the board, certainly reserve the right to cancel the RFP. And -- and there's lots of -- of -- of procedures in there to allow for due process throughout this whole, uh, procurement cycle.

Um, non-collusion. Uh, certainly, you have to have non-collusion to make it a fair and equitable process for everybody who wishes to, uh, submit.

But, uh, that -- significantly, that does not include, the legitimate activities of two of more, uh, entities who want to work together as a bona fide joint venture. So that's important to, uh, to point out.

Um, the time limit, we've -- time line, we've already talked about that a little bit. Ted outlined it. Uh, that's certainly subject to some change, uh, that the, uh, realization that you have to move, uh, you know, you have that 10-year window coming up.

And, uh, there'll be a mandatory pre-bid

conference and all the, uh, proposals would be submitted electronically through the public purchase, uh, website that is already in existence. It's worked very well. So that would ensure that everything is properly, uh, submitted and timed.

There will be an independent review panel proposed in this RFP. Seven disinterested individuals from outside and/or inside, uh, of Solano County, and this, uh, independent review panel, uh, these meetings would be, uh, closed to the public. And of course, any improper contact, uh, with review panel members would be, uh, prohibited, certainly.

Um, the initial review would be done, uh, by Staff to determine if all the minimum requirements are met to make sure that, uh, you know, all the Is are dotted and the Ts crossed, and we have a -- a legitimate, uh, proposal in front of you before it goes to that, uh, review panel.

So that that way, the review panel is just looking at responsive proposals. That's important, to have some screening there.

And then, there'll be a scoring process. There's a price scoring, uh, process that's defined in the, uh, RF- -- draft RFP that you could look

at.

Uh, and there's a scoring matrix based on the various aspects of, uh, of the RFP, dealing with core requirements, as well as the competitive criteria.

And it basically is a one-to-five Likert-type scale for each of these categories. And then, each of them are assigned a percentage of the total points for each of these categories. And then, it adds up to a total possible points of 2250. That just is the way it came out in the math.

Um, the process, there'll be a post-submission presentation of the top three, uh, proposals. Then, of course, investigation and background checks to -- to make sure, uh, these are legitimate and we don't have any issues there.

And then, notification. And then, there's protest and appeal procedures. The first appeal would be an informal meeting to discuss it. Second level would be an independent review with an independent reviewer.

And then, the third level would be to the Solano County, uh, public health officer in terms of the appeal process. And during that process, of course, the -- the -- the -- the, uh, board would

continue to negotiate implementation of the, uh, of the procurement.

Um, the system itself, as we know, uh, we've already had a bit of an overview on that. Notably, there's seven, uh, PSAPs already operating in Solano County. That would include the incumbent, uh, contractor. Only two of them, uh, currently furnish EMD services, which we heard about, uh, this morning, from -- from Mr. Dale.

Payer mixed data. It's always hard to get this information. Uh, it's -- it's, uh, variable. And, uh, we looked at -- we didn't have real good payer mixed data initially from the incumbent to include in the initial blueprint report that was developed, uh, which this, uh, RFP is based on to a great extent.

But we did obtain payer mixed data from the emergency departments, which is pretty reflective of what ambulances are going to see, uh, because they're taking them to emergency departments.

So those payer mix, uh, in terms of percentage of patients who are Medicare-Medicaid, commercial insurance, self-pay, that sort of thing. That's what we're talking about with payer mix.

And we did just receive, uh, recently some

unaudited, uh, payer mix data from the, uh, contractor. And that's, uh, in the public comments that were received. And both of those have been incorporated into the draft RFP.

Of course, there's minimum requirements. There's minimum disclosure requirements in terms of legal name, corporate ownership. It's important that that be, uh, uh, very transparent. The experience, uh, this has been an area of some discussion and some commentary.

Uh, recommendation is to have at least five years' experience, uh, in providing ALS-level, emergency ambulance level, uh, services, in an EOA with a population -- minimum population of 300,000.

Uh, that's the approximate population of Solano -- of the Solano EOA that we're talking about here. It's not an arbitrary figure. I think it was mentioned that the number was -- was even higher in the last RFP.

Uh, so that was with the recommendation, is to have, uh, you know, uh, an entity that has experience with dealing with this size of an operation, we felt was important.

And that's consistent with what other areas have done in California in having a -- a experience

requirement like this. And here's just some examples there of -- of those other areas that have that type of thing.

As we mentioned, we also have a CCT, uh, experience requirement that is included in this. And, uh, it -- it, um, need not be an ex- -- from an existing EOA experience, but it's preferred if it was experienced with CT- -- CCT in an EOA environment. But, uh, it is -- is part of the RFP.

Uh, minimum proposal requirements, there was some public comments addressing the experience requirement, as we mentioned. Uh, some supported outright elimination of that experience requirement altogether.

In our opinion, as we said, given the magnitude of this project, uh, in this area and the impact on the citizens here, we certainly believe you want to make sure that you have a -- a good, uh, solid, uh, provider with good, solid experience, uh, in this type of environment.

We also have requirements proposed in here for experience levels for the people in charge, the CEO, chief operating officer, and so forth. Various requirements are in there. Uh, also, we have an incumbent workforce provi- -- protection in here.

That's fairly standard in these RFPs so that if, uh, uh, another contractor comes in that -- that they would have preferential hiring of the employees from the previous contractor. So that's a -- a, uh, pr- -- employee protection program.

Uh, with respect to certifications, there's a lot of, uh, things happening out there in the world of healthcare, particularly in the area of healthcare fraud, billing, and reimbursement. It's gotten very complex these days.

Uh, you just have to see the news and see the number of healthcare entities that had -- have had issues. And we want to make sure that the people involved have proper certifications.

Uh, some of those being the, uh, uh, certification at the national level for healthcare, uh, for EMS executives, as well as certification.

We have the National Academy of Ambulance Compliance, uh, certified ambulance coders, so that the, uh, bills are processed correctly so that, uh, money is not left on the table, but it is done in a proper way, a compliant way. And that protects everybody in the system.

And one thing we do want to mention as a disclosure on our part, uh, the National Academy of

Ambulance Compliance is under common ownership with our firm. Uh, it just happens to be it's the only entity in the nation that actually provides this level of certification.

And it is the, uh, certification that is often included in RFPs and other, uh, requests, uh, around the country. So we d- -- we just have to disclose that up front, of course. But, uh, it is the standard in the industry for certification in the area of compliance in the ambulance industry.

Um, legal actions, of course, they -- we have to have the, uh, proposers disclosing any potential legal action, including potential False Claims Act actions involving improper billing practices and things of that sort.

Uh, very important to have in here in this day and age. Uh, and we want to make sure that the proposers demonstrate adequate financial stability, a very key thing so that you're all not left holding the bag after a few years, uh, with a proposer, uh, who does not have the financial wherewithal and capability to, uh, continue throughout the contract period. So that's very important as well.

And multiple types of insurance requirements,

which were similar to what w- -- was in the past RFP under the current contract with some of those coverage limits adjusted, uh, slightly to be consistent with -- with current practices. Uh, dispatch, uh, EMS dispatch and communications.

Uh, so I think this is Doug's part, actually.

MR. WOLFBERG: I'm back.

MR. WIRTH: You're back. There you go. So as soon as I saw dispatch, I --

MR. WOLFBERG: Yeah. You knew.

MR. WIRTH: I knew it was all you; okay? All right.

MR. WOLFBERG: Thanks. You could stay up here. I mean --

MR. WIRTH: It's okay. I'll --

MR. WOLFBERG: Okay. I'm back. So now, I want to move on to Section 5. And of course, this is really where the meat and potatoes of the system design that we're proposing for the next 10-year cycle, uh, for your consideration.

And we tried to sort of just make this a linear process going through the, you know, EMS operations process of dispatch response, uh, patient care, transport, the whole bit.

So we start, of course, with dispatch and the

draft RFP proposes a centralized, uh, secondary PSAP, Public Safety Answering Point, uh, with full EMD, Emergency Medical Dispatch, and Pre-Arrival Instructions, PAI.

That's what the dispatchers, the instructions that, uh, uh, Mr. Dale referred to, uh, when he answered your question, Mr. White, about, uh, dispatchers being able to provide instructions to callers prior to the arrival of EMS.

What's important about pre-arrival instructions is it really starts -- it's a sort of a zero-second response time clock. I mean, it enlists the caller and the people and the bystanders who are around to start providing care immediately.

So pre-arrival instructions are a critical piece of what we are recommending, uh, as well as EMD. Now, our suggestion would be that full EMD be required by the contractor at the start of the contract.

So the bidders are going to have to propose in their, uh, in their proposals to be able to tell you, uh, that they've got the capabilities to do full EMD on day one.

Uh, and we put a one-year grace period in for

the -- we -- we are recommending a one-year grace period for the implementation of pre-arrival instructions. I mean, honestly, I think the sooner, the better, that that can be done.

Uh, but, uh, recognizing the complexity of implementing it, that is what is in our recommendations. Um, now, this is a bit of a change from the blue- -- blueprint. I want to point this out as well.

In the RFP, we essentially put forward two options that the proposal -- proposers will have. One is that the contractor operate the secondary PSAP and do the EMD. Or the second is that they staff EMD positions within the county's, uh, the county sheriff's office dispatch center.

So, uh, I know that many of the co- -- commenters have sincerely held beliefs, uh, which I appreciate, that dispatch should -- should remain a public function.

Uh, I will talk about, uh, some protections that were put into the dispatch oversight, but that is a policy question that the board is going to have to decide.

But as we recommend it, we put two options in, and -- and the reality, folks, is that EMD is -- is

central to really every clinically based recommendation that we've made. It needs to be done and it needs to be county-wide.

And I -- I -- I'm not trying to disparage any municipality, but most of the local centers in here, in this county, do not do it. Despite prior recommendations to do it, they haven't done it. And the -- the most direct way that this board can obtain county-wide EMD is to make the contractor do it.

Put it in a contractor -- in a contract, get oversight, and say you've got a contractual responsibility to get it done. You don't have that same control over telling the municipalities what to do.

So putting it in the contract and making it a requirement of the contractor gets it done. It does that which the county has not -- the municipalities in the county have not yet done, uh, county-wide. So those are the options that are presented.

MR. WHITE: Excuse me, Mr. Wolfberg.

MR. WOLFBERG: Yeah.

MR. WHITE: Chair. I just have one comment, um, protocol and decorum. I feel like I'm being lectured to up here for the duration of this

presentation. I would prefer that Staff just deliver us the contents of the RFP in a neutral fashion.

It's the purview of this board to opine on the matters in the RFP. I really just don't enjoy being lectured to by you during -- for -- over and over again. I get it; okay? Just go through the contents. We will discuss it and we can move forward. But, please, stop the lecturing.

MR. WOLFBERG: I'm sorry, these are facts. And if the -- many of the people who have commented have misstated those facts. And there are many people who need to hear that.

And I know you're well aware of that, Mr. White, but obviously, many people in this room are not. And our job is not to put a new cover on your 2008 RFP. Our job is to make sure that this board knows what these issues are.

I know you do, but there are new members on this board who do not have this history, and it's important that they hear it. That's my opinion. You want me to shut up? I'll shut up. But these are important facts.

MS. CORSELLO: I would ask that you stop arguing and be brief in your general comments.

MR. WOLFBERG: I will. Thank you. So, um, these, uh, draft RFP contains a change from the blueprint report, as we mentioned, regarding calls originating in the city of Vacaville.

Uh, because the city has, uh, provided ALS transport, uh, there did not seem to be a need for those calls to be transferred to, um, the secondary PSAP, uh, and that those calls would remain within the, uh, city, uh, for EMD and for dispatch within the city's, uh, service area.

The dispatch is based on, uh, as you heard from, uh, Mr. Dale, standard response determinants established by the National Academies of Emergency Dispatch. Uh, those response determinants are fairly standard in the industry.

Those include Alpha, Bravo, Charlie, Delta, and Echo response levels based on patient acuity. Uh, those final response determinants and dispatch levels, uh, even though there are standards, there would be local medical control over those specific response determinants.

Because physicians can look at those standards and say, well, I think this condition should have a lights and sirens response, whereas another condition shouldn't. Uh, so that provides local

control, and you heard Mr. Dale talk about that as well.

Uh, that the local, uh, medical director and the physicians' forum can weigh in on those individual conditions, uh, to, uh, be able to decide on the final response determinants.

Uh, another thing that the R- -- draft RFP includes that has not been part of your system in the past is a requirement to measure, uh, call -- what we call call processing time, which -- it's -- it's one thing to look at the response time clock and how fast does the ambulance have to get there when they're dispatch. But how long it takes dispatchers to handle the call is important to the patient who may be laying on the sidewalk, you know, bleeding or not breathing.

So that time has to really be factored in. Response time isn't really how long it takes the vehicle to get there. It's how long has that patient been without oxygen or how long have they been, uh, bleeding or whatever the case is?

So including call processing time in the, uh, performance standards that the contractor would be required to measure and report to SEMSC would, uh, add a m- -- an element of oversight that SEMSC does

not currently have.

You als- -- already heard discussions about the red light and siren responses. Uh, we have incorporated, as I said, national benchmarks and best practices wherever they exist.

And one of those is a f- -- a federal report that recommends a benchmark of no more than 50 percent lights and siren responses when -- when units are responding to the scene. In a few minutes, I'll talk about the benchmark for when we're actually transporting the patient, which is a much lower benchmark.

But for responses, the national, uh, benchmark is 50 percent red light and siren use, which is why we recommend that only those Delta and Echo, the high-acuity emergency calls, have lights and siren responses.

You saw the data that Mr. Dale presented that -- that the use of the lights and sirens has not made much of a difference time-wise, uh, and certainly does not have a relationship to patient outcome.

Uh, now, we have received extensive public comments on the issue. Uh, most of the comments, I think, do support EMD.

But as I said, I think those comments can fairly be read to say they do not support, uh, at least of the ones that were submitted, they do not support the contractor doing that EMD. Uh, and most of those comments, I think, revolved around just -- rather -- you know, not wanting a private entity to do that.

And secondly, uh, perception that that would have built-in conflict of interest for a contractor, perhaps to downgrade a call; right? So they could have longer response time if they have control over the EMD.

I would just point out that, of course, this -- that is a policy question for the board to decide. But we did, uh, incorporate numerous safeguards over dispatch, uh, in the report.

And I would urge that because dispatch is a medical oversight issue, regardless of who does your dispatch, there are certain metrics that you want reported that you are going to want to keep an eye on.

And those include, you know, extensive data reporting, uh, all y- -- the dispatch protocols would be subject to approval of the, uh, SEMSC medical director.

Uh, the contractor would be required to implement quality improvement programs for their dispatch. And, uh, we have specifically written into the breach conditions that any manipulation of EMD responses by the contractor would be a cause for breach of the contract, which is a pretty significant, uh, oversight, uh, mechanism that the board would have.

Uh, again, the reality is, uh, that E- -- that dispatch is not centralized, as currently, uh, set up. Uh, in many areas of the country, callers are not receiving the benefit of EMD or pre-arrival instructions.

Uh, and we think this is important. And again, if that is a contractual obligation, then this board has the ability to make sure it gets done, uh, and to make sure it gets done according to the standards that you set.

Uh, this is a national standard of care, uh, and this is an area where the county has, uh, lagged behind some other systems. And it is something that directly benefits the public, particularly the pre-arrival instruction, uh, piece. Um, and, uh, some of the blueprint comments also objected to the recommendation in the

blueprint that that secondary PSAP then also handled the dispatch of all the resources.

Another area that I would point out a difference between the draft RFP and the -- what was in the blueprint is that we are, uh, recommending in the RFP that the dispatch still be done by the existing local PSAP. So whoever dispatches the fire departments now would continue to dispatch them.

And this is an important distinction between doing the EMD on the calls, so when the caller says my mother can't breathe or whatever, the EMD would handle the medical interrogation of that caller and would give the pre-arrival instructions.

Who actually dispatches the units is a separate issue. So some of the commenters have said, well, we think this infringes on municipal rights if they don't get to do, you know, their own dispatch.

In the RFP, we are recommending that those agencies continue to do their own dispatch, but that the EMD, which is a medical issue, be done in a centralized PSAP. So it's a distinction that is in the RFP that was different than what was in the blueprint. And I think it's important to point that

out.

Uh, Mr. Dale sort of alluded to this, but there are also some optional criteria, which, frankly, I hope your -- your bidders do propose. And he referred to this briefly, but, uh, one is that they be an accredited dispatch center of excellence.

Another is autom- -- automated, uh, geolocation. So, oh, there's an AED in this building and there was a cardiac arrest right nearby. So they could alert people to do the fact that there's an AED nearby.

And then, lastly, is what -- what's called the, uh, Emergency Nurse Commu- -- Emergency Communication Nurse System and the Omega Protocol. Mr. Dale alluded to this, but what this means is that there are many calls that not only are low-acuity, but really don't even require an EMS response.

We all know people use 911 for things that 911 was not meant for. So what this protocol does is it allows the call-taker to refer that caller to alternate kinds of services, whether it's social services, addiction counseling, uh, other kinds of services that simply do not require, uh, a 911 EMS

response, which can take burdens and pressures off of your EMS system, uh, for things that it currently has to respond to.

Um, so all -- and I think it's also important to point out -- because, again, I have been asked to respond to some of these comments. Uh, and all high-acuity emergency calls, true emergency calls, would get the exact same response as what your system currently has.

That means ALS ambulance, ALS first response, in the same response times that they have now. And actually, I would point out that the 2008 RFP had a 90-minute response time for the remote areas. Ours has a 60-minute response time.

So for true emergencies, not only would the public get the exact same response that was in the 2008 system, but it would improve in outlying areas of the county.

So many of the comments said people will wait longer in emergencies. That's not accurate because the emergency calls would get the same, in fact, even an improved, response over what was in the system design in 2008.

Uh, so -- and what would -- would change, what our -- our recommendation would be, is the low-

acuity calls, which in the EMD system, are called Alpha and Bravo, that are really non-emergency-type calls, would get a, uh, response that the contractor at their option would either be free to send an ALS ambulance if they want, but would have the option of doing BLS or what we call tiered deployment.

What is also important to point out is that under that proposal, the fire departments would still get 100 percent notification. That would be a contractor obligation to make sure that the city fire departments are notified of 100 percent of the calls, whether they're serious or non-serious, and would always have the option, if they chose, to respond to any calls within their jurisdiction. And that's important to point out.

Here are the response times. This is what was in the blueprint. So this is not the first time you're seeing that. But you can see the top line is the critical emergencies, the Delta and Echoes, which are the exact same response, uh, uh, response time standards as you have now and the same response configuration; ALS ambulance, ALS first response.

Then, you do see the response time standards

change for calls that get less serious. Um, and the data are extremely clear that people will not suffer any negative outcomes by waiting longer for, uh, EMS resources for low acuity calls like sprained ankles and my back hurts and those kinds of complaints.

Again, I point out that a -- a board with public accountability, you may well say, well, thank you, Mr. Wolfberg. We understand that the data will show there's no h- -- risk to the public.

But from a public service and customer service and whatever other standpoint, we want to make these response times shorter. And that is, again, your, uh, your prerogative. Um, this section also includes, uh, vehicle maintenance, minimum fleet size.

You want your contractor to have minimum number of ambulances. Replacements, spares, surge capacity for disasters, and that is written into the proposed RFP as well.

Uh, the next section, Section C, is the first response in public-private partnership. Uh, part of the RFP, uh, the, uh, final -- first thing that the RFP says is that the PPP agreement would be negotiated between the contractor, which we don't

know who it is yet, and the participating cities, but with SEMSC as the sort of party overseeing and then drafting that agreement.

Uh, proposers, as is currently the system now, would be required to, in their proposals, include what they project as their estimated cost-savings, uh, by having the fire departments meet those response time obligations and giving the contractor extra minutes. That's what you do now. That would continue, but for the Charlie, Delta, and Echo, or the ALS-level calls.

Uh, the contractor would also be restock supplies and medications, uh, and to cooperate with the PPP cities on training.

Uh, now, what is a di- -- a change from the current system, but this was in our blueprint, is the recommendation that the contractor not be required to, uh, include in their compensation, under the PPP arrangement, those optional responses that I referred to earlier. The low acuity, Alpha, Bravo, where the data show that a first response does not impact patient outcomes.

The first departments would, of course, be free to deploy their units on those calls at their -- at their, uh, uh, their -- their discretion. Uh,

but our suggestion when it comes to, again, financial sustainability of the system is that the contractor not be obligated to reimburse first response costs for those responses that do not benefit either the patient or the contractor.

We have also added, uh, a mechanism to require the contractor to pay. And you heard, uh, Mr. Dale refer to this as well. That if the medic from the fire department is needed to come along in the ambulance for an extra set of hands or for an ALS-level provider, that there would be a separate compensation mechanism to compensate the cities for the medic actually then accompanying the patient during transport.

Uh, again, there were numerous public comments submitted regarding the funding of the fire departments, uh, through the PPP. Um, and all I would point out is that this is to be determined based on the proposals that the bidders submit.

They will have to come to you with their proposed unit hour costs and how many hours of -- unit hours they would save. And it's not until those calculations are done that this board will really be in a position to know what the impact is on the PPP, uh, funding, compared to what it is

now.

But I would point out there are three very important issues that the board, I believe, should pay attention to when it reviews these proposals. Uh, first is when the co- -- when the bidders propose what they're going to pay for those costs, uh, for the PPP first response.

Uh, one of the things the c- -- the RFP requests that they do is submit a calculation of their costs. Because those costs, that payment, needs to be based on cost.

If a bidder comes in and says, well, it only costs us $125 a unit hour, whatever it ends up being, but we're going to give them $250 a unit hour, that can raise federal legal implications, uh, under the federal anti-kickback statute, which we think the board should be, uh, mindful of as it reviews those proposals.

So the -- the -- the PPP first response reimbursement needs to be based on the cost, uh, of what the, uh, contractor receives in the, uh, additional minutes for response.

Uh, second, and we stated this in our comments, but I'll let the slide speak for itself about, uh, whether or not that is something that

should be funded through the contractor or something that should be funded through, uh, city, uh, subsidies of their fire departments.

And then, the third point that I'll make is that, uh, we have been extensively involved in ambulance reimbursement issues at the national level. And it's sad but true that the reimbursement paid by Medicare or certainly by Medi-Cal and most other government payers, uh, does not really even compensate for the cost of doing the transport, let alone the cost of, uh, of fire department first response.

The simple reality is there's just not enough money built into government reimbursement to really even cover transport, let alone cover first response. That's just important, again, from a -- a sustainability aspect that we talked about, uh, earlier.

Um, I have noted this, so I won't repeat it, about the, uh, issues with the other counties. Um, and I've -- I've talked about all this stuff too. So I -- I will move on. Um, the job, aga- -- well, that sounds lecturing, so I -- I will skip that.

Uh, Section D deals with clinical care and patient transport. Uh, this is the section that

deals with the clinical care that the EMTs and medics provide on scene. Uh, and then, protocols and policies that they deal with medically.

So this section has -- deals with things like medical protocols being reviewed and approved by medical director and physician forum. But I will point out that where the RFP really focuses now, where it hasn't in the past, is very high-acuity clinical conditions that -- where -- where certain factors make a big difference in patient outcome.

STEMI, which is a kind of heart attack, ST-elevated myocardial infarction; trauma patients, stroke patients, and mass casualty. Data show that the sooner the pre-hospital providers alert the STEMI center or the stroke center that they're coming in and let the stroke teams or the STEMI teams be prepared to take the patient, the better the outcome.

So we spend, uh, time in the RFP talking about making sure the medics know how to, you know, apply 12-lead EKG, that they know how to interpret the 12-lead EKG, that they remember to promptly notify the STEMI, uh, centers and stroke centers of these patients coming in so the teams can be on the alert. Um, and, uh, incorporates those clinical

best practices in the RFP.

Uh, we also have a -- a recommendation, this was also a stakeholder input, uh, request, that the contractor have to specifically focus on training their providers on skills they don't get to use very much.

There are certain things that medics don't get to do often, and those skills can degrade over time. And, uh, it was asked that the contractor have to monitor the data of what skills they do and don't do and provide extra training on those things that they don't get to do very often.

Uh, one thing that is not in the RFP that usually you do see in RFPs is on a monthly basis, the contractor must submit 10 reams of data to the EMS agency on response times and oversight and all of that.

Instead of doing that, SEMSC staff would have real-time 24/7 access to the contractor system, and they can pull reports anytime they want in real time and monitor that, instead of waiting for those monthly reports.

I mentioned earlier that we also included a benchmark for red light and siren use during transport, uh, which would be less than 5 percent.

And that, again, is a standard that comes out of NHTSA, the National Highway Traffic Safety Administration.

And then, lastly, we had a recommendation that the contractor have to integrate their records with, uh, health information exchanges, which give better access to patients of their own medical information, and which is, of course, becoming a new, uh, a national, uh, trend.

Um, okay. Next is interfacility transport. So the EOA contract would include ALS interfacility transports, as it does now. Uh, the contractor would be required to maintain the existing ALS RN program, as it does now.

Uh, and -- so neither of those would change. We do also recommend that CCTs, critical care transports, be included in the EOA, which is not currently the case.

Currently, uh, SEMSC has a open market for CCTs. There is, uh, a resolution that this board adopted a few years ago regulating CCTs and establishing standards.

Um, we believe that because of the implementation of the ALS RN program, the data show that the volume has gone from about 4,000 down to

about 400 CCTs a year. Our concern, and if the board does not share this concern, it is free to direct us to exclude this from the RFP.

Uh, but our concern is that with so few calls, that is not a robust enough market incentive to keep outside CCT providers wanting to come into your market and that facilities would not be able to get CCTs in the time that their patients need them.

So our proposal is to include those int- -- into the EOA so that the contractor would have the obligation to perform them. As I've been pointing out throughout the presentation, areas where there has been opposition and the contractor that's currently in place supposes that, uh, r- -- that, uh, recommendation.

Now, it is no doubt that CCTs are a high-cost, low-volume service. Uh, but we believe that the inclusion of ALS interfacility and 911 exclusivity allows the contractor to sort of use those revenues to subsidize what we think is a needed but infrequently used, uh, service. So that is the rationale for including CCTs, uh, into the interfacility transport part of the EOA.

The next thing that is new is based also on

stakeholder input, we have recommended the inclusion -- or the implementation of what's called a re-triage transport program.

And very briefly, this means that if a patient is brought into an emergency department by another provider, let's say, uh, whether it's Vacaville Fire, whether it's an out-of-county provider who brings a patient into an ER here in the county.

That if the physician believes that that patient very quickly needs to be turned around and sent out to an appropriate center, stroke center, trauma center, you know, whatever it is, that they would be able to ask that ambulance who brought the patient to stay and rapidly take that patient to the next facility.

Of course, it's up to that ambulance whether they choose to do it, and they would have to be permitted and enter into a sub-contract with the provider to do it. Uh, but that that program gives the facilities the option to use the incoming provider, whoever it is, to rapidly transfer those patients on to another facility.

And the benchmark that has been recommended is if the physician believes that that patient is going to require transport out within 15 minutes,

that the ambulance that originally brought the patient in would be allowed to do that, uh, if the contractor could not place an ambulance there within that 15-minute, uh, timeframe. That also is opposed, uh, by the -- by the current contractor.

Okay. I'm going to ask Steve to talk about personnel issues and take us through to the conclusion. And then, I'll be back up to answer whatever questions you may have. Okay. Thank you.

MR. WIRTH: I read a report recently, uh, that said that people would rather go to the dentist and have a root canal than endure a PowerPoint presentation. But we are on the home stretch.

Uh, just a few minutes left. I'm going to talk a little bit about the personnel issues, and one of the concerns here was to make sure that the contractor, uh, takes care of its people.

Uh, fatigue is a big issue in EMS and the fire service, as we all know in this room. That we don't want the pe- -- have people who are overworked serving your citizens. So there's anti-fatigue policy recommended.

There has to be eight hours between shifts, whether that's, uh, with the contractor or anyone else ou- -- uh, inside or outside employment.

Sixteen-hour maximum shifts, with some exception to that in certain cases, like in some of the less-busy stations, that sort of thing.

And they have to submit a proposal to, uh, achieve a culturally diverse workplace that represents the community. I think that's very important to have in this RFP.

Numerous training requirements. Uh, the standards in the industry that we see, uh, and, uh, A- -- for ALS and BLS staff. And, important, stress management. Suicide, uh, prevention.

We all know in public safety, fire, police, and EMS, suicide rates, depending on what study you read, is at least four times that of the -- of the general population. So we want to have resources available for those personnel as well.

And to make sure that, uh, there's adequate comfort facilities, especially if they're out posted somewhere, uh, where they -- they don't have, uh, a nice, uh, uh, work, uh, nice lounge to sit in all day or whatever.

Uh, revenue cycle management, compliance, and financial practices. There are a lot of consumer protections built into the, uh, recommendations that we make in this RFP. Uh, making sure that

there is an objective hardship, uh, financial hardship criteria in place.

So that is not just an ad hoc arbitrary decision, so that there are, uh, qualifications and that people will not be pursued if they're in financial hardship. Uh, protection for qualified Medicare, uh, beneficiaries. Those are low-income Medicare beneficiaries, where, uh, some of their out-of-pocket expenses are paid by the Medicaid program.

Uh, billers and coders must be certified, as we mentioned earlier, to make sure that p- -- bills are done properly, uh, and only for the proper level of service.

And they have to have a compliance program in place, because you don't want to have headlines here about, you know, uh, Medicare fraud and things like that that we're seeing all around the country. And it doesn't matter, you know, who you are in healthcare today, or the size of the organization.

Uh, we're seeing a significant increase in government enforcement activity at the federal level in the area of compliance. So we have to have a compliance program in place.

Uh, we talk about increases. There's, uh,

automatic increase is built into it based on the CPI. Uh, and this, uh, one aspect that we had recommended was there be no automatic increase if the CPI is zero or a negative number.

The current, uh, contractor opposes that. But we do note that at any time under this proposed RFP, the contractor would be permitted to request some additional increase in its fees, uh, its rates, uh, based on extenuating circumstances or whatever, a variety of reasons.

Um, i- -- they have to have accountability, uh, to the board, to the community. Uh, submitting annual independent financial audits. Uh, undergoing an annual billing and coding audit, which is very important to make sure their billing practices are proper and compliant with the law.

And to report, uh, financial and revenue data so that we can measure -- so you all can measure some of these benchmarks and to have proper oversight and to spot problems before they get big. That's the big thing. You want to make sure you identify issues when they're small so that they can be addressed.

Disaster, a mass casualty incident response, certainly, uh, things like the ambulance strike

team, uh, we have to have -- they have to have a contractor that has a -- an adequate -- very good -- not just adequate, a good, uh, disaster and mass, uh, and multiple-casualty incident response program as well.

Provider public education, there is provisions in this RFP that the contractor would have to provide. Good, solid, public education addressing CPR, AED training, all of those things that we know that the research shows saves lives and involves the community in the system, which is very important to make them a part of -- of the EMS system. So those things are built-in as well.

And there are, uh, a series of liquidated damages, uh, for failing to meet some of the performance standards.

Uh, we're not going to go through all of those now. You can read those on your own and see what they area. Uh, certainly, there's an aspect related to response, but also, deficiencies related to clinical deficiencies.

Because the focus is on patient care here, making sure your patients are getting the best possible, uh, emergency care possible. So a lot of these benchmarks related to, uh, those. And some of

those damages are relating to things other than response time.

And this is really ground-breaking and innovative. Because we're focusing on the things that matter here, the things that affect people's lives and make their health better. Uh, rather than just who can get to the scene the quickest. Because, as we know the research doesn't really show that that's very, uh, very effective. So those provisions are in there as well.

Uh, CAAS certification, Commission on Accreditation of Ambulance Services, is a requirement. Uh, clinical performance deficiencies are outlined here as well related to, uh, accreditation and the -- the -- the standards that are established through the accreditation, uh, program.

Uh, red lights and siren uses, employee turnover, uh, and other deficiencies that you may determine. These are other liquidated damage provisions that are -- that are suggested or recommended in the RFP.

Again, we're trying to keep people, uh, happy in the workplace. And certainly, we want to see, uh, a contractor that -- that treats people well

and -- and want -- we want to have people who want to stay and contribute to the -- to the community. And we already touched upon the -- the RLS, uh, aspect as well.

Uh, any violation of material terms would constitute a breach. There's a listen of 17 different specific breach conditions outlined in this, uh, proposed RFP that would constitute a breach of the contract.

And a provision for emergency takeover, where the contractor would have to turn over vehicles and equipment to -- so that you can under an emergency situation, if they were not able to do it or you had to, uh, take back, you know, uh, takeover, so to speak, on a temporary basis, uh, the emergency ambulance system, uh, that provision is in here as well to protect, uh, the community.

Uh, contractual provisions dealing with what controls. Of course, it starts with the contract. Uh, then the RFP and then the contractor's proposals.

Especially when it comes to the defining terms, uh, that are outlined in the contract and other issues that may come up re- -- relating to anything that might be a little ambiguous or

unclear. That's the order of precedence in terms of those interpretations.

Uh, we have a provision in here to, uh, allow for waiver of the franchise fee or the liquidated damages provisions if there is, uh, a designated financially distressed, uh, contractor here.

And there are procedures outlined in there to protect you all to make sure that that is done appropriately. But we want to, again, make sure you don't have a collapse of your contractor and leaving your -- your citizenry in a lurch and not having adequate response. So that -- there -- that provisions is -- is in there as well.

And other provisions in the contract dealing with modifications, if necessary, gives you really broad discretion in terms of modifying the contract, even outside of what was defined in the RFP.

Uh, so those provisions are in there, uh, dealing with an initial 60-day period. So you can see if things are going okay to make sure that, uh, this is a, uh, situation where you're going to have a long-term relationship with that contractor.

And, of course, provisions that prevent the contractor from winding down prematurely, uh, at

the end of the contract award if -- if they don't -- or if they feel like pulling out, uh, at the end of that 10-year period, to make sure they have to maintain that same level of service throughout the entire, uh, 10-year period.

Again, transparency and access, uh, for you all. Right to enter and inspect. It's an independent contractor relationship. That's going to be clearly defined in the contract. And of course, indemnification and you consent to jurisdiction provisions that protect the board, uh, and the agency here.

And of course, the typical non-discrimination, uh, provisions as well. So with that, I'm going to turn it back to Doug for the -- for the wrap-up for our presentation. Doug?

MR. WOLFBERG: So in conclusion, we conclude. Uh, I'm happy to take questions.

MS. CORSELLO: So it's in our hands. Do you want to take questions or comments at this point? Or would you like to hear the other two presentations and the public comment first?

I'm assuming we'll have all of those. Uh, I'm looking. Any questions at this point? Okay. Thank you. We'll move on to the next presentation.

DR. MUMMA: All right. For those of you who don't know me, my name is Bryn Mumma. I'm the EMS medical director.

We had meeting of Physicians' Forum a weeks ago to discuss the -- the blueprint. We didn't have the draft RFP at that point. Uh, specifically the medical aspects of it. I just want to present the results, um, and conclusions from that meeting today.

So as I mentioned, our goals are really to discuss the RFP recommendations contained in the blueprint. Really taking a medical patient-centered perspective.

So there are several aspects of the blueprint that we didn't discuss because they were non-medical. We did a -- a brief literature review. We looked up, you know, the facts around these.

Uh, we used what the firm had prepared, but we also did our own independent literature review to make sure there was nothing that was missed and to make sure that we were really getting, uh, an unbiased view of the literature. Um, and then, finally, where we could, we provided recommendations to the board.

Sure. Let me get the microphone closer. Is

that better? Okay. Thanks. Thanks for letting me know. If I tend to fade, just let me know. So there were 13 key points in the blueprint RFP.

Uh, there were -- the ones that we felt were medical and that we discussed were tiered EMS response, central EMD, red lights and sirens, the response time standards, interfacility transports, and finally, the experience requirement.

So tiered EMS response, uh, I think we've already heard what this is. Currently, all the calls receive an ALS response. The proposed -- the blueprint, uh, proposed matching the level of service, either ALS or BLS, to patient need for 911 calls.

Currently, we have no triage or county-wide dispatch protocols. This proposes using EMD. And then, currently, all calls -- or most 911 calls, I should say, receive two ALS units, one fire and one ELA provider.

That obviously, uh, excludes the city of Vacaville and most of the county, receives two ALS units. In the proposal, low-acuity -- again, low-acuity, only 911 calls may receive one ALS or BLS response unit.

We already heard a lot about EMD and MPTS, so

I'm not going to go into this. Uh, I did -- was able to get some data from Fresno, Kings, and Madera counties, who use EMD.

This is their 2008 year-to-date dispatch data, just to give us just a -- a rough sense of what -- what it looks like EMD in-use in a county somewhat similar to ours.

So 27 percent of their calls were going out priority one, 23.5 percent were priority two, and 49.5 percent were priority three. In terms of the response level, uh, and this is based just on local practices, they were having 94.5 percent receiving an ALS response.

Uh, they do have a BLS option. It's not widely used, but they did respond to about 5.5 percent of their calls using BLS only.

I do also want to mention, uh, that a 2010-2011 Santa Clara, uh, County civil grand jury report. Again, a county in California somewhat similar to ours. Um, they looked at sort of the sustainability of the fire system, uh, with a -- with a, uh, bend toward tiered response.

Their conclusions were that the firefighter paramedic versus EMS paramedic does not matter to the citizen. Uh, using firefighter paramedics and

firefighting equipment as first responders is unnecessarily costly.

And their recommendation, again, to Santa Clara County, uh, was that the county should modify its approach to mandating the fire department's service first responder. Reserve the use of firefighting vehicles for fire events and enable the EMS contractor to be the first responder.

There's also a recent report published, uh, by New York City looking at restructuring their EMS services. Um, there are major inefficiencies and reforms that could enhance the performance of New York City.

They're listed here, and I just want to highlight two of those. Um, and again, they said the use of fire engines, in addition to ambulances, as a response to medical incidents is wasteful. The heavily staffed fire engines are more expensive than ambulances as a response.

And many of the incidents to which they respond are not fire-related. And their recommendation was to dramatically reduce the role of fire engines in responding to medical incidents. And they went on to talk about the cost and the staffing required, uh, for fire engines versus

ambulances.

We heard briefly earlier from Brian Dale about how MPDS or EMD performs in terms of triage. Two studies -- this one is from Australia, so not quite our population, but I think cr- -- relatable.

Um, it looked at over 200,000 calls in Western Australia. Of those, about half, 52.7 percent, were priority one dispatch, and 3.3 percent were time- -- were time-critical cases, as defined by the paramedics on scene. So the paramedics on scene felt that that was a time-critical condition.

When they looked at the sensitivity and specificity of priority one dispatch for all chief complaints, they found they had a sensitive of about 94 percent, 93 percent, and a specificity of just under 50 percent. Of those that were dispatched priority one, 5.8 percent were time critical.

And then, of those that were dispatched priority two or priority three, only 0.5 percent were deemed to be time-critical. So we see a very, very low rate of under-triage.

If anything, it seems like the problem is potentially with -- with over-triage, and that's really what EMD has been criticized for in the

literature, is over-triage rather than under-triage.

Closer to home, another study, looking in San Mateo County, all calls received in ALS response in a tiered system with fi- -- with fire and a private transport agency. So very similar to ours.

They defined Echo, Delta, and Charlie as ALS, and Alpha, Bravo as BLS. And they defined ALS procedures specifically as intubation, defibrillation, pacing, cardioversion, or needle thoracostomy.

Only one patient who would have been coded -- who would have been coded to receive a ba- -- BLS response based on their system, uh, received an ALS procedure.

They found that MPDS coding for all medical calls had high sensitivity and low specificity for the prediction of calls that required ALS intervention. So again, similar to what we saw in Australia.

When we look not only at ALS interventions, but at any -- or not only ALS procedures, but at any ALS intervention, which includes medications, we, again -- I know the figures are small, but we see a very low rate of BLS coded calls receiving an

ALS intervention.

And a lot of this was because they were all receiving an ALS response. It's not that they received a BLS response and BLS had to call in an ALS unit to provide this.

And then, when we look over at the over-triage, on the right side, we see very high rates of over-triage. Uh, where -- meaning an ALS call recei- -- an ALS-coded call received a BLS intervention only.

I do want to point out -- just highlight we've talked a little bit about ALS versus BLS. And I do want to point out, uh, this isn't -- this -- this is for cardiac arrest.

These are what we call Kaplan–Meier survival curve, which basically looks at survival over time following an event. Um, the large figure shows survival out to 90 days. And then, the smaller inset figure shows survival out to about three years.

And when we look at this, we see that patients who are treated -- who receive BLS care for an out-of-hospital cardiac arrest have better survival than patients who receive ALS care.

There- -- this is probably multifactorial,

probably involves airway management. There's been a lot of literature coming out on this recently. But I do want to use this slide to highlight that BLS care is not no care.

These are still trained professional providers who are -- are clearly providing high quality care. So it's not like a patient is getting nothing is getting a bystander only. They're still getting a trained professional responding to them.

I also want to highlight just the importance of pre-arrival instructions, looking locally at our data. We saw some data earlier from national. Um, we were able to get ourselves into the Cardiac Arrest Registry to Enhance Survival, or the CARES registry.

This is -- these are very preliminary data from the CARES registry, looking at rates of bystander CPR and bystander AED use, which is the one area where we were, uh, below the national -- below the national average.

County-wide, our bystander CPR rate was 22 percent. Um, and our bystander AED use rate was 21 percent. When we look at the city of Vacaville, which is all EMD, we saw bystander CPR rate of 30 percent and a bystander AED rate of 50 percent.

Now, again, the numbers are small, but I think we do see a difference when we look -- when we compare the city of Vacaville to everywhere outside Vacaville, most of -- most cases of which did not receive EMD. And we saw a bystander CPR rate of 20 percent and AED application rate of 10 percent.

So I think this really begs the question, knowing that bystander CPR and bystander AED use increased probably a least double if not triple or quadruple, depending on which study you look at, uh, the odds of survival -- good neurologic recovery and survival after cardiac arrest, our residents of Solano County being harmed in some parts of the county by not having, uh, pre-arrival instructions and not receiving bystander CPR.

So I think this really highlights the difference in cardiac arrest in areas with EMD versus non-EMD. The drawbacks of EMD, I think we heard already there's training certification, there's ongoing Q- -- QA.

It's very -- it's expensive and time-consuming. Um, and it may even be unaffordable for some of the local PSAPs.

So our recommendations from Physicians' Forum were that we support EMD using MPDS for Solano

County, we support a tiered EMS response with some low acuity patients receiving a BLS-only response, and we believe Physicians' Forum should review and approve the response for each determinant code and have an ongoing QI process that tailors our responses, uh, to our county's needs.

The second issue we addressed was central EMD. Uh, we heard earlier about the current state and the proposed state.

Currently, uh, just to put it out, uh, lay it out graphically, a call comes in. It's to a local PSAP. Local PSAP dispatches first response and the EOA provider who reached the patient.

In the proposed system, the local PSAP, once the call is identified as being medical in natural, be transferred to that central secondary PSAP, who would discharge -- or who would dispatch or transfer the call for dispatch of, uh, the EOA provider and the first responder. And then, would also provide pre-arrival instructions to anyone who may be on scene. The points to consider some of these were raised in the public comments.

Uh, there may be time required to transfer calls from the primary PSAP to the secondary PSAP. And there is a potential conflict of interest with

the EO provider, uh, operating the secondary PSAP and determining the level of response.

Uh, we heard earlier that implementing a centralized EMD requires very large, uh, upfront investment.

And several local PSAPs have stated that they're unable to afford the training and the certification. Uh, we talked earlier about the timeline and the difficulties, uh, that have -- we've already experienced in implementing EMD.

This questio- -- I think this question came up earlier, whether there are contracted medical PSAPs in California.

Um, in our research, we were able to find at least -- there may be more, but I found five that required, uh, the contractor to provide a secondary medical PSAP, uh, San Joaquin, Imperial, Butte, Merced, and Fresno.

And then, similar to what's in the RFP that we looked at today, um, an optional secondary PSAP. That's what Inyo did in 2016.

So Physicians' Forum conclusions were that we support a centralized EMD for Solano County's EOA area. We did have concerns that a contractor operator dispatch center may have a conflict of

interest in assigning their determinant code and response level. And we support the centralized EMD being operated by a public entity.

Moving on to red lights and sirens, this has been previously discussed. Um, currently, we have no standards for red lights and sirens use. Uh, proposed is less than 50 percent of responses and less than 5 percent of transports.

This -- this largely comes from this U- -- uh, U.S. Department of Transportation NHTSA Office of Emergency Services, uh, report. This is -- these are the national benchmarks that they set. And other areas have shown us that these are largely achievable.

I have several, several sources of supporting evidence here. Uh, most states have shown that lights and sirens use reduces response intervals by about 1.5 to 3.5 minutes. And they found that shorter response times are not associated with improved patient outcomes.

However, unfortunately, lights and sirens use has been associated with traffic collisions, which poses a risk both to the -- to personnel and to the public. Uh, Salt Lake City, where Brian Dale works, um, implemented, um, restrictions on their red

lights and sirens use, make -- made an effort, uh, I'm sorry.

They implemented EMD and did the same with a -- with a goal towards reducing their lights and sirens use. Uh, when they implemented EMD, they found a 50 percent decrease in lights and sirens use and a 78 percent decrease in emergency vehicle collisions.

Physicians' Forum considering those, uh, that evidence, uh, felt that we would support performance standards around lights and sirens use. We -- in addition, we propo- -- we support the proposed standards, 50 percent for responses and 5 percent for transports.

And we also discussed some other s- -- public safety, uh, po- -- features and possibilities. And we recommend that the RFP suggest but not require, uh, the bidders additionally implement a driver safety and monitoring program.

Looking at response time performance standards, currently, we have the same response time standards for all acuity levels. In the proposed RFP, we would have response time standards based on the acuity of their call.

Just to show you, this is -- these are the

response time standards, uh, that the current contractor is held to. So nine minutes for an urban area, 15 minutes for a rural area, and 90 minutes for a remote area.

In the proposal, uh, the Delta and Echo calls are held to the same standards, with the exception that the remote areas actually shortened from 90 minutes down to 60 minutes.

And then, I'm not going to spend too much time on the remainder, but they are shorter. Charlie, 12. Bravo, 18.

And Alpha, 40 for urban areas, which is the majority of the county. And then, the longest possible time would be an Alpha call in a remote area, which is 90 minutes. And that's currently our standard for all calls, regardless of acuity, for remote areas.

In looking at medic ambulance, the current contractor's response times, in an urban area, we see they're somewhere in the 7.5 to 10.5-minute range. In rural areas, they're, uh, just under 13 minutes.

And then, in remote areas, they're, uh, they're 90th percentile -- sorry, not their median. Their 90th percental response time was about 15.5

minutes. So well under the 90 minutes that is allowed in the contract.

In terms of the evidence that -- that we found for supporting longer response times, we found response times not associated with a -- patient outcomes. And in the vast majority of conditions, out of hospital time is not associated with patient outcomes.

Um, this eight-minute response time has sort of been historically used as the standard, but there's really no evidence to support and 8-minute response time. And that's, um, there's several opinion articles that have come out in the literature saying that. Uh, and lights and sirens that are often used to achieve that 8-minute response time standards carry risks.

Uh, in the same report I mentioned earlier, the U.S. Department of Transportation and NHTSA felt that applying an 8-minute response requirement does not make sense and that response times should not be the sole performance indicator for EMS system contracts.

Similarly, going back to the Santa Clara Grand Jury report that I rec- -- that I mentioned earlier, um, they, again, highlight the speed of

their response versus the nature of their response. And they felt that the EMS agency really could be a catalyst for change instead of another cog in the machine of entrench- -- of entrenched response protocols.

When Physicians' Forum looks at this, we proposed consolidating the time performance into two categories, hot and cold, rather than the four that are listed in, uh, in the current RFP.

We proposed a hot response time of 9 minutes, urban, and 15 minutes, rural, which is what's in the RFP. And then, we proposed shortening the 60 minutes down to 30 minutes.

Um, the current contractor has shown that they can get there in -- with 15 minutes 90 percent of the time. And we did not want, uh, potentially a new contractor to come in and take advantage of that, uh, 60 minutes when we know that it's possible to get there in a much shorter time.

We also proposed longer response time for cold responses, but we deferred the specific metrics to the consultant. And then, as I mentioned, we proposed shortening, uh, the 60 to 90-minute response times for hot and cold remote calls.

We also felt that response times for the

remote calls could be evaluated quarterly or after 10 calls, uh, have been completed, whichever comes last, so that a provider would not be pen- -- a contractor would not be penalized if they had, you know, two calls and -- two calls in the review period and one of them was over the limit.

Moving on to the EMS, uh, public-private partnership, we focused primarily on we felt -- on what we felt could be medical aspects of this. Uh, none of us are business -- business men and women.

We tried to focus on the medical aspects that really lies within our expertise. So currently, there's payment to the PPP for all responses. There's no payment for assisting on scene or accompanying a transport and no annual increase.

The changes in the RFP are that payment to PPP would be required only for required or high-acuity responses. And then, the agency would also receive payment for assisting the contractor on scene or accompanying in transport. And there would be an annual increase relative to the contract -- contractor's charges.

Um, the rationale for this, as Mr. Wolfberg outlined earlier, was requiring a contractor to pay for a fire first response that is unnecessary based

on dispatch response priorities as cost to the EMS system as a whole.

Uh, we've seen two recent cases of subsidies from county to the contractors to prevent EMS system collapse in Alameda County and Sara- -- Santa Clara County. So both -- both nearby and both very recent.

Um, and the goal here was to really -- to unburden the contractor and the EMS system for potentially unsustainable costs that are not benefitting patients.

So we -- our consensus was that we support ALS with required first responder response for the higher acuity. Meaning, Echo, Delta, and Charlie calls, with BLS and first responder optional response for the lower acuity Alpha and Bravo calls.

We support the EOA provider payment to the PPP agency only for required first responder response. However, we did not support payments to the PPP agency for assisting the contractor on scene or accompanying transport.

Uh, we felt that could lead to a lot of attention and potentially patient harm if the fire agencies and the contractor were not able to

collaborate effectively.

Um, we do support a mechanism to ensure collaboration between the fire first response and the EOA provider, particularly in situations when the fire first responder is providing an optional response.

Interfacility transports, as we heard earlier, currently, the EOA provides ALS with Aura [ph] and we have an open market for CCT. The proposed RFP includes CCC in the RFP and also makes provisions for rapid re-triage.

The rationale was already discussed. As physicians, we felt -- we feel that timely availability of CCT for patients in Solano County is of utmost importance. And we have concerns if the current system does not meet patient needs.

We agree with the intent of CCT inclusion in -- - and the response times provided in the RFP, but we are also open to alternative means that can achieve the same goal. We also support the removal of rapid re-triage from the EOA contract. We feel that the closest appropriate service should transport rapid re-triage patients.

The experience requirement, uh, again, we already heard about this. And as Doug ment- -- uh,

the rationale we already heard about, um, and as Doug mentioned, this has been -- this has been very common in other, uh, other EOA contracts within California.

Uh, including our own in 2008, [inaudible] is greater than 400,000. Uh, we've dropped it to -- it has been dropped to 300,000, which better reflects the -- the population in our own EOA area.

Physicians' Forum, um, we -- we hedged on this a little bit. Um, but we feel that high-quality EMS care for the citizens of Solano County is of utmost important [sic]. Uh, we feel that provider size, call volume, and duration of service are very important considerations. And we also feel that innovation should not be stifled in the RFP process. Those are the recommendations from Physicians' Forum. I'm happy to take any questions now or sort of wait until the general question period.

MS. CORSELLO: Are there any questions from the board members at this point? Seeing none, we have one more presentation.

MR. MONTASH: Is this on? It's on? Okay. Good afternoon, Board. I'd like to provide, uh, staff feedback and recommendations with recommendation to

the draft RFP.

I -- I do want to note that from, uh, Staff's perspective, our bias, and it is a bias, is that we're -- we look at this from a public health standpoint. So for us, the primary considerations for an EMS system are system integrity and optimum delivery of healthcare to the clients that need to be served by emergency ambulance services.

So, uh, with respect to the, um, to -- to those, uh, proposals that are in Section 1, uh, we largely agree with most of it. Uh, we do recommend, however, modifying the description of the g- -- of the geographic scope of the EAO.

And, um, I'll describe that in greater detail in a couple of slides. Um, and -- and we do -- I do want to note that we do agree with a single contractor for the EOA because of the demonstrated b- -- uh, value of doing so for consistency of care for patients, as well as for system stability.

With regard to Section 2, uh, we do have some recommendations on changing, uh, points in a scoring matrix. Criteria 4, 5, and 7 reflect areas that focus on healthcare delivery, which, uh, we believe should be given greater weight than they currently are within the scoring.

Um, uh, and the recommended increases are as indicated there. With regard to Section 3, uh, and this also pertains to the language in Section 1, um, we recommend that referencing -- reference to Zone C be replaced by a -- a more accurate description of what should be excluded from the EOA; which is areas that have continuously, at least since 1980, received emergency ambulance services provided by the city of Vacaville, save for those portions annexed by the city of Fairfield.

And the attended map in the RFP would, uh, would clearly delineate the boundaries of that -- of that. This is based on, uh, clarifying conversations with officials from the city of Vacaville, um, and -- and our reflection that the EOA should be described in this RFP as the EOA for service delivery.

We -- we -- we don't believe that we need to, um, to engage in references to anything in the realm of legal in describing the excluded areas. That's not really necessary. What's necessary is identifying what portion of the county would be part of the EOA.

In Section 4, with respect to minimum proposal

requirements, we strongly agree with the intent of the experience requirement because the -- this type of a requirement is routine for EMS EOA RFPs in California and because of what it -- it reflects, which is that we want our EMS provider to have demonstrated capabilities to perform the services that our county's residents and visitors should require.

Um, with regard to the experience requirement, I think we can separate it into the timeframe requirement and into the capacity of experience element of the requirement. We strongly agree with the required timeframe.

We think demonstrated, um, ex- -- experience is extremely important in all aspects of healthcare and it's essential, in our opinion, to system integrity, to system capacity, and to healthcare delivery. Um, however, we do believe that there are probably multiple ways to demonstrate the concept of capacity of experience.

So you -- for example, the vendor could have had an EOA in an area of greater than 300,000. It could have had, um -- it could have served as one of multiple vendors in a much, much larger county where its proportion represented 300,000.

Um, or perhaps more usefully, that it has served, uh, a population whose demographics are similar to the demographics of our county. That they are c- -- uh, have the capacity to serve in urban, suburban, rural, and remote areas and to serve with enough, uh, depth to cover a county the size of -- of the EOA in Solano.

With regard to Section 5 in the -- the competitive proposal criteria, um, it probably shouldn't be surprising that public health very strongly agrees with the provision of EMD and PAI are the current best practices for EMS delivery.

Um, and attendant with EMD and PAI are tiered responses and then the tiered performance metrics and in many cases, but not all cases, the modified RLS. And, um, you know, I want to note that there is very substantial evidence to support this.

And when I say that there's substantial evidence, I'm not talking about theoretical constructs that -- that academics talk about.

I'm saying that there are many, many, um, studies in which jurisdictions that have implemented EMD are compared to those that haven't and are compared to themselves prior to implementation. And in every one of those cases,

they show substantial improvement in healthcare delivery, in system integrity, and in reduction of costs for operating the system.

So this is not a theoretical issue. This is simply reality. And I think it -- it might not be clear to all of us just how widespread EMD is in our country.

Um, for example, 84 of 100 counties in North Carolina use EMD. The entire states of West Virginia and Indiana require EMD. There are multiple counties in Florida, multiple counties in Iowa, Kansas, Missouri that use EMD. And here in California, there are multiple jurisdictions that use EMD.

Counties that have been mentioned include El Dorado; Northern San Diego County, which is actually the county portions of San Diego, not just the city; Fresno; Kings; Madera; San Francisco; and Santa Clara, among many other jurisdictions, including cities.

So this is not a theoretical issue. This is reality. EMD is the current standard of care in the EMS systems throughout much of the country. Vacaville uses it, uses it successfully.

Uh, we -- we have lots of demonstrated

evidence that this is the best way to support the needs of -- of victims of emergencies. Now, having said that, there are multiple EMD PSAP models that are feasible.

So supporting EMD does not mean that we necessarily have to go with centralized PSAP for the EMD itself. Uh, and, uh, as was noted, uh, earlier, um, by -- by, uh, Brian Dale, all types of PSAP models exist across the country. So there are private sector models, there are public sector models, there are distributed models.

And so, Staff doesn't have a recommendation as to which model to utilize. We simply recommend strongly that the board consider implementation of EMD PAI and the attended elements.

And then, consider what works best for our county in terms of the model for the PSAP. Um, and then, we agree with the -- the, uh, remaining elements that are in Section 5 in the competitive proposal criteria.

Uh, finally, I just wanted to note with regard to CCT interfacility transports that from the public health staff perspective, we have some concerns about it that we just want to note. I'm not suggesting that you should or should not

include CCT in the EOA.

Uh, but -- but a philosophical issue that -- that we ask for you to consider is that CCT is part of the continuum of discretionary medical decision-making. It is akin to the concept of a physician deciding that a patient should be transferred from the floor to the ICU or from the floor to surgery or to the CCU.

And so, it is a medical decision in the context of healthcare. And as such, it is not a decision-making process in the public sector realm of EMS. EMS covers pre-hospital transport. In our county, because it's ALS, it also covers the ALS-related interfacility transports.

We don't currently include CCT because the feeling on the part of -- of -- well, from the public health and, uh, standpoint, the feeling is that CCT is a healthcare decision and not an EMS decision. And its inclusion will have impact on the stability of the EOA contract.

Um, there are also -- so -- so having said that, it is very important, again, to -- to remember that the most important aspect is patient care. So we strongly want to optimize the timely provision of patient care in CCT.

But our contention is that there are multiple models that can accomplish that that do not involve including CCT in the EOA. That's it for comments, thanks. Open to questions.

MS. CORSELLO: Are there any questions of -- of, uh, Bayla [ph] at this point? Okay.

MR. MONTASH: I'm sorry. I did neglect to introduce myself. I'm sorry. I'm Bayla Montash [ph], health officer for the county. I know who I am, so it never occurred to me to --

MS. CORSELLO: All right. I believe we have come to the end of the formal presentations. We've now all patiently been sitting here since 9:30 this morning. Um, I have no idea how many public comments we have or how many public comment cards we have received.

Are there any that have not been submitted? There are no cards? Is there a list? H- -- how -- how do we handle public comment? There are cards or there are not cards?

Okay. How about, um, I could use a restroom break. How about we take a 10-minute break? Those of you who wish to fill out a card, please do so and hand them to the clerk while we take a break. And then, we will take public comment.

[audio break]

I would invite everyone to come back in and have a seat. It looks like I have 32 speaker cards. So I'm going to call the meeting back to order.

Um, f- -- we are taping the meeting today, so when you come up, if you would correct -- if I've slaughtered your name, correctly state your name and who you're with. That would be helpful for our records.

Um, in addition, um, I would ask, because there's so many speakers and we've been -- we still haven't even had a chance to have a conversation, uh, if you could keep your -- your comments to two minutes.

That would be helpful. I know some are more verbose, but we'll see how that works. I don't have a timer. I'm going to keep you on the honor system, although I guess I -- no. That's not even got a second one.

So we're just -- we're just going to see how this goes. So, uh, the first speaker is Ross Elliott.

MR. ELLIOTT: There we go. Hi. My name's Ross Elliott. I'm the executive director of the California Ambulance Association. We represent

about 75 percent of the private ambulance companies in California and our members conduct about 3 million transports per year.

The association began in 1948 and we're celebrating our 70th year. Our members have been providing ambulance service for a very long time. Private ambulance companies conduct about 85 percent of the ambulance transports in California.

Although fire departments are highly visible and we love our fire departments and they're often the, uh, subject of exciting TV shows and movies, um, the responsibility of providing ambulance service in California really falls to the private industry.

Um, uh, the interest of the CAA in Solano County and the reasons for my attendance today is to monitor the RFP process. There have been a couple of, uh, processes recently where it appears the bid process has been rigged, and we want to make sure that, um, the process used in Solano County is upright and fair.

Um, I won't go on about the -- each of the recommendations, the tiered response and the MPDS. It looks like you're headed in that direction. That's a really good thing. Um, my jaw kind of

dropped when I learned that wasn't actually happening in Solano County in 2018.

Uh, so I'm really glad that your -- your body is taking that seriously. Ted, Birgitta, and the rest of you are looking at this seriously and your leadership in this is really beneficial to the, uh, residents of Solano County. So congratulations to all of you for taking that on.

Now, some of the fears expressed by the commenters over time delays and bounced calls between disa- -- dispatch centers are easily solved with today's technology. I've witnessed this myself.

There aren't those problems in reality. Um, the recommendations three and four dealing with lights and siren and response time performance standards go hand-in-hand with an EMD process and the MPDS centralized dispatch.

Uh, the consultant's recommendations are sound, and that'll really make the, uh, streets of Solano County safer.

And I hope you move forward with those recommendations. A lot of the comments submitted about the blueprint, uh, recommendations imply that a private-for-profit company cannot be trusted to

make decisions based on the patient's best interest.

Rather, private companies are only capable of, um, being profit-oriented, uh, fudging standards, lying, and cheating, and they just cannot be trusted. Because only public agencies can be trusted to do the right thing. Well, baloney.

As someone who's worked for county government for 32 years and managed an EMS system for 10 years, I can say without hesitation that's baloney.

When a private-for-profit ambulance company takes a patient to the hospital, it takes care of that patient; the for-profit hospital; the for-profit ER doc; the for-profit surgeon; the for-profit medical labs; the for-profit radiologist and diagnostic functions; the for-profit rehabilitation institutions; the for-profit in-home nurses; the for-profit hospi- -- hospice care facilities.

It's nonsense and insulting to insinuate that private ambulance industry is incapable of making medical decisions because of profit motives. This country is built on free enterprise.

Basically, to -- to diss that is un-American. Local EMS agencies, your body, set the standards that -- that are to be followed. And private

ambulance companies have a long history of compliance and being able to achieve those standards. That's what they do.

Private ambulance industry is also held accountable for its performance. Now, fire departments can't make the same claim, really. Rarely are fire departments actually measured for their performance.

And rarely does a local EMS agency hold them accountable for performance. Not the same for a contracted private ambulance company. But casting aspersions against the private ambulance industry, um, is just -- it's just wrong.

Um, we measure performance. We do data reporting and are accountable, um, every day. So that insinuation is insulting. It's patently untrue and simply a scare tactic used by those that are incapable of honestly competing against services and quality that private ambulance industry provides.

Uh, do you think fire departments aren't interested in money? Um, why do you think they want to be dispatched on every call? They want that statistic.

They want that visibility. They want that

public support. Um, doesn't matter if it's not clinically necessary. Uh, they want to roll with lights and siren on every call to demonstrate to the public that they're worthy.

Now, don't get me wrong. I love firefighters. My two sons are both firefighters. One's a superintendent of a hotshot crew in Idaho. One's on a crash truck at a military airbase. Um, firefighters are brave.

They run towards danger. They rescue us from terrible situations. And they're highly capable and skilled. I don't want anyone to think that I have anything against fire departments. Our society benefits greatly from the services that they provide.

But I see them realistically and hope Solano County can find the optimum role for them in the EMS system. They're enormously expensive. Look at Vacaville. They provide -- they spend $10 million a year to provide ambulance service, yet they only generate about $8 million in revenue.

It's a $2 million loss every year. Ambulance service in Vacaville could be provided for free, a $10 million annual savings, if Vacaville would allow Solano County or your body to include the

city in the ELA.

Um, the city can insist on maintaining its 201 position and retained administrative contol- -- control if they want to. But that cost of that decision is $10 million annually. Is it worth it? That's $100 million over 10 years. That'd go a long way in offsetting that, uh, $124 million unfunded pension liability to stave off bankruptcy.

Bottom line is private for-profit ambulance companies do provide excellent service, high-quality medical care, and continually meet local requirements and performance standards. The fear tactic to imply that private companies are solely motivated my money is total bunk.

One of the things that, um, we often see with fire departments are they're -- they are willing to play the for-profit fear card. Um, yet, they're also the first in line to demand money from private ambulance companies.

Fire departments receive tax dollars and they invoice for their direct services. Yet, these two revenue sources are often not enough to sustain them. Uh, the -- the demands through programs such as the PPP, uh, from private companies is really a sham because it hides their true costs.

There should be absolutely no requirement in this RFP that private ambulance companies be forced to pay or compensate fire departments in any way. Placing these kinds of financial burdens on private companies typically leads to failed EMS systems. Look at Santa Clara, Alameda, and Monterey.

The private companies already have myriad costs and challenges to achieve their own financial viability. Being required to subsidize a government function that's incapable of standing on its own is a burden that should not be placed on the ambulance contractor.

The city or the district, whoever runs the, uh, fire department, should either tax their citizens appropriately for the service they're getting or cut back on those services.

MS. CORSELLO: Mr. Elliott, can I ask you to wrap up.

MR. ELLIOTT: Thank you, Birgitta. Um, these other two points, the -- the recommendation about experience is absolutely vital. It's a key public safety issue and I urge you to take that seriously.

And the fines liquidated damages, um, that'll simply increase the cost of your ambulance service. It won't necessarily achieve compliance. Um, and

so, I urge you not to have any fines at all.

If your contractor isn't performing, you fire him and find one that will do it. Um, but fines simply add cost to the service and don't ultimately achieve compliance. It's a way to buy your -- your way out of compliance. So thank you for listening to me and appreciate being here.

MS. CORSELLO: Thank you. The next speaker is Tony Velazquez.

MR. VELAZQUEZ: Good, uh, afternoon, board members. I had a prepared statement today. I had some comments that I wanted to share. I am the president of the Solano County Fire Chiefs Association.

But based on the developments this morning, I just want to make sure that we work through this conflict and it is the utmost importance that we have a member of the fire service representing us on this board.

There's -- this is a critical decision that we have to make and it's very disturbing that we have to go through this this morning when we found at the eleventh hour about this conflict.

We need to have a representative. We -- as the president of the association that selects the

representative that sits on this board, we will work closely with you so that we can get through this.

But this decision is too serious of a decision that impacts us so much over the future of EMS and the fire service, public safety, and the community we serve.

And I just want to leave you with that, that we want to get through this, and I'm going to leave my comments at that. That we need to have a representative from the fire service sitting on this board making decisions. Thank you.

MS. CORSELLO: Thank you. The next card -- and -- and I'm just taking them in the order I got them. Uh, John Cardin [ph].

MR. CARDIN: Thank you and good afternoon. Today, I represent not only the city of Vacaville but also for this interest, the, uh, the Solano County Law Enforcement Administrative Association, which is represented by the police chiefs within Solano County and the sheriff of Solano County.

I think it's important also to understand that, um, while Vacaville may have a slightly different model that I may not be particular to all the details, but I am very familiar as a resident

for 30 years its response and how it works within our community.

I do believe I have an insider-outsider perspective in managing a PSAP that delivers EMD and pre-arr- -- arrival instructions. Because under my command, I manage that. I manage the dispatch center.

I hire the dispatchers. I make sure that they're trained. I understand the expectations that the city council provides in directing myself and the police or the fire chief for the city to make sure that the level of services are part of the equation, not just simply a financial decision.

And I think that that would be a paramount oversight if we didn't recognize it even during the downturn of the economy. That that was a very contentious issue to understand that service is important.

I can't speak to those financial implications, but I am disturbed about what I'm not hearing today and in this RFP process. I do have considerable experience in walking through RFPs.

In the sense of some that are very, uh, particular to Solano County, which do play a part here today that I think are important for everyone

to understand.

While research and data and expertise also suggest, uh, many different paths that we can take, what we've learned in Solano County also is -- is there is times when parts of an RFP may be redirected or suspended when they don't make sense. And I'll give you an example.

As we work towards a county-wide, uh, communication improvement, all the agencies along with Solano County also want to work towards how to improve communication. This occurs through radio systems.

So there's a lot of work behind the scenes that -- that don't show up in an RFP when you think of emergency medical response. But it has everything to do with the level of coordination to look at Solano County with its uniqueness and how to provide emergency response, which includes police, fire, and EMS.

I'm very familiar with, um, all of these different issues and I will say this. It really comes down to a few items that I didn't hear, and that is communication, coordination, control, and care.

In the area of communication, another RFP

process potentially is being suspended so that all PSAPs will have the common CAD [ph] system so that there is collaboration between the first e- -- emergency response dispatchers.

And while it may be true that some provide EMD and pre-arrival instructions, this board could easily direct that that would be the standard throughout the county to advance the level of services. I see this every day, because I walk into a dispatch center every single day.

I would -- I would also say that any decision that directs any type of redirecting of phone calls for 911 is really missing the point.

And that is is one of the biggest things that we have seen is through technologies of e-911, it's so that the coordination of calls into a call center are immediately directed within the center.

And if it has that higher level of training, what you end up with is usually what occurs. It's oversimplifying the issue, thinking that we can just say this is not an EMS call or this can be redirected in a different way.

More often than not, whether it's a traffic accident that we hear about, it's the coordinated resources between police, fire, and EMS that's

occurring simultaneously. Any redirecting of calls potentially has that risk, and that is a study that I haven't heard here today.

We can go back to 9/11 when we talk about the failure in this area. But Solano County is unique and so, its response and its solutions need to be unique and don't necessarily -- can be oversimplified by an RFP. This is -- this is the data that supports the best response.

And in closing, I would just want to say that, um, I work very closely with Solano County Office of Emergency Services and I attend monthly tra- -- or discussions on communication, where representatives of all the different PSAP, uh, managers throughout the -- the county are looking and working towards advancing a more, uh, progressive way of communicating and working together.

But also, being able to back up each other. Resiliency and redundancy occurs also when you recognize that, as we're progressing these -- these comm centers forward, whether there's a single one or there's two or there's six or currently seven, the ability to back each other up and to have redundant systems in there gets lost in this idea

that if you're going to outsource this to a third party.

It also excludes the responsibility that we have as leaders within police and fire. The expectation that we answer also to an elected council or board of supervisors, who also is representing the will of the people.

And this cannot be overstated, and that's something that I hope also gets understood in the decisions that are made by this board in making sure that we provide the highest level of care to our citizens within the -- within Solano County, but also not losing the local f- -- uh, flavor of what it means to provide exceptional service.

And I'll leave you with this other point of mine. From my experience in seeing the first response within Solano County in nearly over 30 years, I have never witnessed a more professional level of staff that operate on our fire department engines.

The ALS system that works in Solano County is in coordination with all the cities, providing not only police and fire response.

But the level of emergency care by professionals that are not simply early entry

professional within the EMS system, but long-term professionals that work together in mass casualty and mutual aid events. That's something that you cannot outsource. And I just thank you for your time today.

MS. CORSELLO: Thank you. Okay. The next speaker in the -- in the pile here is Jeff Armstrong.

MR. ARMSTRONG: Good afternoon. My name is Jeff Armstrong. I'm the fire chief for the city of Rio Vista, the Delta Fire Protection District, and the River Delta Fire Protection District, which are the two fire districts in Sacramento County that were spoken about earlier.

But today, I'm here representing the California Fire Chiefs Association, where I am the past president of the operations section, and I'm representing Solano County Fire Chiefs Association, of which I am a member.

I'm here to deliver a letter to you today that was written on behalf of the California Fire Chiefs Association. I believe it may have gone out electronically as well, but there are seven hard copies that I will give to Staff.

This letter draws your attention to issues in

the RFP draft that violate the Health and Safety Code and subsequent violations of the Brown Act that occurred with regard to this, uh, RFP.

Page 3 specifically addresses, uh, the RFP -- portions of the RFP that conflict with impacted agencies' 201 rights. Page 3 and 4 has a timeline and discusses the timeline of this RFP draft being released only seven days before today's meeting.

And understanding that there are changes in the draft from the blue- -- draft RFP from the blueprint, I think that's important to no- -- note.

What it does not do is it does not address the consultant's own conflicts, which he stood here tonight and told you about on proposing this product.

Oh, by the way, we own a portion of this product. And I think that's important as well to point out. Fire chief representative is not the dais for a much less issue -- perceived issue, and I think that it's important to point that out.

Speaking for the organizations that I mentioned and I represent, we have grave concern regarding violation of law and a potential for decreased responder and public safety with regard to how this RFP is proposed.

Specifically with -- a couple things with Rio Vista -- since everyone else was a little liberal with time, I'll mention specifically my agency.

Specifically in Rio Vista, um, I think we agreed that EMD has its benefits, but it has its benefits when it's built on your data, not somebody else's data. Pennsylvania, Australia, that's not Rio Vista's data.

So if we're going to go forward with this, I would like all of you to be willing to come out to Trilogy, which is our senior homes, and I'd like you to talk to Ms. Smith, who's an 80-year-old female, and let her know that response times do not matter for her outcome. And that she may have to sit on the floor by herself for 40 minutes while she waits for help.

Lastly, I'm glad to see the volume brought down a little bit. Ross Elliott started talking and I was really worried that this was not going to be a good afternoon, and it sounds like we've turned the volume down a little bit. Thank you for your time.

MS. CORSELLO: Thank you. You're going to leave the letter somewhere for us? Okay

MR. ARMSTRONG: [inaudible]

MS. CORSELLO: That'd be great. No. That's fine. Thank you. All right. Uh, our next speaker is Kurt Henke. Did I say that right?

MR. HENKE: Well, it's good to be back in Solano County. Spent 25 years here in the fire service, as a matter of fact. Some people might remember. Most probably don't. Um, I want to cover a couple things.

I'm representing the California, uh, Fire Chiefs Association; the California Metropolitan Fire Chiefs Association, which represents the 15 largest fire agencies in the state of California; and, of course, special districts and others that, uh, are represented with the fire service.

Um, one of the first things I want to point out is -- is that there's been a lot of talk about, um, the RFP. And clearly, there's a lot of tension in the air and there's a lot of different stakeholders that have different opinions.

And, uh, you know, I came from an agency, Sacramento Metropolitan Fire Protection District, as fire chief. Ran over 100,000 calls for service a year and over 50,000 transports.

We have an ambulance system. And we have a county-wide dispatch system that all fire agencies

belong to. And we do EMD and we do all the dispatch.

So to Mr. Elliott, what I would say is -- is that I'm pretty knowledgeable in the ambulance system. And our consulting firm consults U.S.-wide on ambulance transport. And I didn't hear anybody here today slam the private ambulance industry.

We all believe that they have an important role to play, just like the fire department does. So I'm not going to stand up here and do that. I know the Manfredis personally. I know, uh, uh, AMR, uh, Fawk [ph] Ambulance, you name it. There's a lot of them that we deal with out there across -- across the country.

But what I would propose today is in the letter that was submitted is that on behalf of Cal Chiefs, and I do, uh, run their litigation on -- on a regular basis, that you hold off and correct the Brown Act violation.

We honestly believe there was a Brown Act violation. It's easy to cure in regards to conversations that happen outside the presence of the full body.

We would urge that you do an extension. Mr. Selby did exactly what happened in, uh, in, uh,

Sonoma County, where we're working with the Sonoma County, uh, LEMSA and the fire agencies and the ambulance companies.

You requested an extension. You called up. I'm sure you talked to Dan Smiley or Howard Backer. Yeah. He's nodding. And what did Dan Smiley say? Oh, no. We're probably not going to give you an extension. But they won't put that in writing. Why won't they put that in writing? Because it's an underground regulation.

And on a conference call, not four months ago, Mr. Smiley in -- admitted in front of County Counsel for Sonoma County that they don't have any regulation on how long an RFP extension is. They just go by the way they feel. And I see a lot of smiles. That's them. It's underground regulations.

In Sonoma County we're -- we're -- we were able to get a one-year extension. But it has to come as a request from the LEMSA.

The LEMSA in Sonoma County worked very, very closely with both the ambulance companies and with the, uh, labor unions and with the fire chiefs and the different stakeholders and LAFCO. And they all requested an extension, and eventually, it went to the governor's office.

Now, the current LEMSA dir- -- EMSA director and his deputy director aren't necessarily fans of the fire service. But as we know, elections have consequences. We have a new governor coming in in a few weeks.

So I feel pretty comfortable that if you were to work together, ask for an extension, with all the stakeholders, you would be able to get an extension under the new administration moving forward. Which would allow you to resolve some of the things that are before you.

First, 201 dispatch. That's a serious issue. These people have been dispatching ambulances and fire agents, uh, fire engines since 1980.

They have 201 rights. I'm not going to argue that EMD is not an important component and that it should be in -- as a part of every one of those PSAPs, and you should work towards that.

But 201, you can't just take that administrative function away. I'm not talking about patient care now. I'm talking about what the law says. But we can work together to bring them together and come up with a solution for dispatch to have EMD and have that local control flavor.

Number two, I thought the, uh, police chief

summed this up great. There's what's best from the medical doctors that are talking about, uh, related outcomes, and that's important. What's the actual outcome for the patient? Okay?

And you get that in a clinical setting. But as he said, Ms. Smith, who's 80 years old, who dials 911, is not going to understand why her public expectation is not met when the fire department doesn't respond or she doesn't get a -- a quick response to what her request is.

And that causes challenges for the local elected officials. If you had a county fire department, it would cause problems for the County Board of Supervisors. So at the end of the day, that public expectation is that when they call, somebody's going to be there.

The other additional issues that I have is this. You trust your fire departments to manage multimillion-dollar budgets and deal with crisis after crisis in Solano County. Let's just take a look at the Paradise fires. Let's look at the major incidents that have happened across this state.

You trust your firefighters on those engines as medics and BLS, basic life support people, who go and treat people every day. But in your RFP,

much the same as some of the counties you cited, you don't trust them to run what essentially is a taxi service.

They will provide all the medical care all the way up to the point that the person needs a drive to get -- a ride from the incident to the hospital. And we hear Mr. Elliott and we hear everybody say, er, got to have experience; got to have experience in driving those ambulances.

We drive engines that weighs tons out there every day. We're capable of driving the ambulances. Fire departments do it all up and down the state.

But in this RFP, it doesn't allow for a true partnership because no fire department could qualify in Solano County to able to do a joint venture bid. Because your qualifications say that the criteria is such that they won't qualify for that.

So even Vacaville, who's in the ambulance industry, would not qualify to bid this system with a private subcontractor. I think that's a problem that you guys need to address.

The other thing is I don't see a lot about supplemental reimbursement in here. Such as GEMT; IGT; uh, QAF, what that amount of quality assurance

fee money is going to be. But I can tell you we've done a study and it's fair enough to say that if you had an accurate contract -- and you'll hear from another county.

If you had a -- a realistic RFP that went out and you had a realistic bid that came in, our estimate is you probably, after you pay the private ambulance company their unit hour cost, built in with a profit, you probably are sitting county-wide of about $7 million in excess revenue.

That could be pumped back into the county to design and develop things such as coordinated communications, a county-wide dispatch system, bringing the local, uh, PSAPs up to, uh, EMD.

So you'll hear the ambulance companies say the fire agencies are accusing them of profiteering. I think in a free market society, they should make as much money as they can.

But I also think that when it's a government function, which it is in California to provide ambulance service, that revenue needs to be reinvested back into the county from which those dollars came; okay?

So I think you should slow down. You should cure the Brown Act. You should ask for an extension

and move this process into a longer period of time where you can get more cohesion and get more buy-in from the groups.

Because I'm standing here from the outside looking in and it's not going to be a good outcome coming back.

Mr. Elliott's comments were pretty incendiary towards the fire service. I certainly don't think that about the private ambulance company; okay? Nor does the California fire chiefs; okay? They are a quality group of people.

But let's be fair. Let's analyze it. Fix the Brown Act. And as we're asking for, uh, extend this. Go to Mr. Selby. Go through the state EMSA. Work with the stakeholders to make that happen; okay? Thank you very much.

MS. CORSELLO: Thank you. And for those of you who are keeping track, that was eight minutes. So I'm -- I'm not cutting anybody off at two, but I am going to ask you, because I still got another 30 cards to go. So thank you. All right. Next. Mark Sharpe.

MR. SHARPE: Good afternoon. I'm Deputy Chief Mark Sharp with the city of Vallejo. I've been there for the last 30 years.

And I'm speaking on behalf of the four member cities, uh, the fire departments, uh, that is Benicia, Dixon, Fairfield, and Vallejo, in regards to the public-private partnership and the funding that each of your agencies receive, uh, currently. And I just want you to know how important it is for us to continue receiving, um, the funding that we -- - that we get.

Because what we do, although we're not getting rich from it, i- -- we are able to put it back into the system. It allows us to continue the training and provide, uh, the equipment that's needed for our high-performance system.

Any loss of the current $1.6 million that we are currently receiving and distributing am- -- along the four cities, any loss will be a loss to the system itself. And as you just heard, it's very important for us to able to put money back into the system to make sure that we're able to sustain it.

This current blueprint and the RFP that was put forward today, it really fails to outline, really, how future city allocations and funds are going to be acknowledged in this funding proposal.

And because of that, it's going to put a substantial impact on the cities that are currently

participating in it. It's going to put additional, um, cost to the city.

So what we're asking and what we're proposing is that there be an update on the unit, um, hours saving calculations that gets done, uh, to identify what the member city allocations of funds will be. Because they've changed over the last decade and we think it needs to be updated.

In addition, if there's any increases in the service fees for the medical transport, um, that they should be applied to the unit costs as well.

Uh, we also are recommendi- -- uh, recommending that any updated calculations be done prior to the contract award versus afterwards. And what that will do for us is that will make sure that the establishment and the agreed upon, uh, allocations of funds are decided beforehand.

And then, finally, uh, what we experienced during the course of these last 10 years is that, uh, call volumes went up substantially over the cost -- over the -- the time period.

And we're asking that in order to avoid any conflict that occurs during the -- that period of time, that, uh, we do an annual evaluation, uh, to the call volume to make the appropriate, um,

adjustments that need to be made for the cities that are in partnership.

Again, one of the things I'll just include with -- and so, I think I'm still with- -- pretty close to that two-minute mark. Um, even though we talked about having stakeholders' meetings and we really thought that that was a good idea, to get all the principal players involved in the conversation, from the fire point of view, we felt like we were pretty much ignored in terms of the recommendations that were put forward.

I had a conversation with our contractor, and in that conversation, I asked a very distinct question. And that was how much of this is going to really come into play and to the outcomes of what we see in the final draft?

He said I haven't even drafted it. Yet and still, when the RFP finally came out, many of the suggestions that were put in it were things that were so, quote-unquote, "possibilities."

Well, they showed up, which lets us know that many of the things that were already -- they were already decided upon. And really, some of the stakeholders' comments were ignored.

And so, that's not good for our citizens

because we know that directly from the fire point of view and the 30 years of experience that I've had, it's going to have an impact on the delivery of care to the citizens of Vallejo, Benicia, and all the other agencies.

So we ask that you really con- -- reconsider some of the things that you'll hear from some of my colleagues. Thank you.

MS. CORSELLO: Thank you. All right. Next speaker. Um, Kris Concepcion.

MR. CONCEPCION: Thank you, Chair. Uh, good afternoon. And, uh, this af- -- this afternoon, uh, I was, uh, prepar- -- or I was prepared to read a, uh, prepared statement, um, that is timed right at two minutes.

So I'm going to read that, um, and then, uh, if you'll indulge me, uh, I feel like I have to respond to some previous comments that were -- were said.

So, um, I am the fire chief for the city of Vacaville. However, today, I want to make it clear that I am speaking as an officer of and on behalf of the Solano County Fire Chiefs Association. Fire Chiefs Association has some serious concerns with the draft EMS blueprint, as well as the draft RSP -

- RFP. As a result, we are asking you to not move the RFP forward until such time that our concerns are addressed.

Given my time limit, I will only be able to voice, uh, our two primary concerns today. Specifically, dispatch of EMS being transitioned to the private provider and the experience requirement of the RFP.

We agree EMD is a good thing, and we've heard it over and over this meeting -- or, uh, this meeting already, um, that it is a good thing. It works in Vacaville and we want to implement it throughout the county.

However, implementing EMD by giving dispatch over to the private contractor is not the answer. We believe this solution is fiscally motivated rather than in the interest of better patient care.

Private EMS dispatch will lead to a disruption in the delivery of emergency services and longer response times. In Solano County, EMS is integral-- integrally intertwined with the fire and other emergency services.

The fire chiefs request the SCEMSC [sic] board direct the consultant and staff to explore other alternatives to getting EMD implemented in Solano

County. One potential option is to have the private contractor fund the implementation of EMD for the current public safety answering points.

Within the next year, as you heard from, uh, Chief Carly [ph], most of the dispatch centers in the county will be on the same computer-aided dispatch system, bringing us closer to full interoperability with regard to communications.

Adding EMD capability to the current dispatch centers, rather than giving EMS dispatch to a private provider, would be beneficial to all parties and will serve to improve an already integrated system, rather than disrupting it. Our conc- -- our other concern is with the experience requirements of the RFP.

This requirement unfairly excludes any fire department in Solano County. It does not allow for the exploration of implementing successful alliance, such as the one currently in place in a neighboring county. We respectfully request that the board remove this requirement so all ambulance deliveries models can be explored.

And that concludes my prepared statement. Now, let me take off my, uh, county fire chief's hat and put back my -- my Vacaville fire chief hat back on.

And I -- I -- I feel like, um, the, uh, comments by Mr. Elliott, that, uh, uh, I feel like I need to defend the city of Vacaville on that.

Um, his comments that, uh, you could potentially save $100 million over the next 10 years simply by privatizing ambulance services, um, in the city of Vacaville is misleading and disingenuous. I don't know -- I don't know what kind of fuzzy math he's using, but it's fuzzy math at best.

Um, I just want to, uh, you've been hearing throughout this whole meeting how well the ambulance services are, how well they work in the city of Vacaville. We've got EMD. Our system works well.

And the funds, as far as the -- the revenue that's generated by ambulance services actually go back into improving and is reinvested into -- into the city and goes to improve al- -- an already well-coordinated system. Thank you.

MS. CORSELLO: Thank you. Nicely done. Under four minutes. The next card I have is Alex M- -- Mourot? Is that --

MR. NOUROT: So, uh, I'm battalion chief Alex Nourot. I'm representing the city of Vacaville Fire

Department and, uh, since my boss went a couple minutes over his two minutes there, I'll keep this real brief.

Um, and -- and these are -- these are, uh, some comments related to the RFP, um, from the -- from the, uh, from the fire department. Uh, we had -- when the -- when the blueprint was released, we had some significant concerns.

And as was alluded to earlier by Dr. Mattea [ph] and, uh, and some other folks, we had conversations with -- with officials from the county, uh, regarding those concerns. Specifically to the -- what was previously referred to as ambulance Zone C.

And, uh, since that, uh, since the RFP has been released, and that was -- that was removed, our primary concern with this -- with this issue has -- has been resolved. And I'd like to acknowledge and, uh, we certainly appreciate those -- those conversations and that -- and that, uh, that that issue was, uh, was -- was taken out of the, uh, of the release draft.

Um, the fir- -- the other -- the other issue we had was with the dispatch piece. It wasn't clear in the blueprint whether or not that was going to

affect our, uh, our PSAP. As we've mentioned earlier, we've been providing EMD.

We've been successfully dispatching our own ambulances as a primary answering point and -- and also, as an EMD provider for many years. We've been successful with that.

We think our system works really well. We think it's efficient with our -- within our, uh, within our city and we're glad that that is clarified in the current RFP, that that was left alone and, uh, not affected.

We still do have a bit of concern regarding the, uh, what we've re- -- what we'll refer to as our historic service area outside the city of Vacaville. That's the area where we provide ambulance service to, um, outside of our city limits, uh, previously called -- called Zone C.

It's not clear in this current draft RFP whether or not that's going to be in the -- in the RFP as a -- as a EMD answering, uh, secondary answering point or if that will be, uh, EMD provided by our, uh, PSAP.

We think the best model for that would be the county dispatch center that currently dispatches our ambulance into those zones. If they became an

EMD dispatch center, that would alleviate, uh, both of those concerns.

And -- and the system right now, as far as coordination and dispatch goes, works really well having our, um, our PSAP initially dispatch our ambulances and then, they immediately are -- are turned over to the county.

The county's dispatch center, we have good coordination with the fire agencies in that -- in that zone. Communication and coordination-wise, it's working really well. However, there's no EMD being performed out there and -- and we think that's a good thing. As alluded to earlier, um, we -- we think we've demonstrated that the EMD in -- in Vacaville is a good thing and it's a successful model. So, uh, I just wanted to thank the -- the county officials we had conversations with for, uh, for hearing our concerns and taking those into account in the draft RFP. Thank you very much.

MS. CORSELLO: So can I ask you, did you provide the comments you just made to the county in writing in some fashion so that the staff could follow up on that?

MR. NOUROT: So -- I'm sorry. The comments? We -- we've provided all our comments to the county --

MS. CORSELLO: The comments with regard -- well. So I know there's Zone C and then I heard Staff say today they've got a new Zone D or whatever that is. Some- -- something new. Uh, your comment about EMD, did you, uh, provide that to them to deal with?

MR. NOUROT: We initiated that conversation in the meeting we had with Dr. Mattea --

MS. CORSELLO: Okay.

MR. NOUROT: -- and -- and Mr. Selby. And, I mean, they understood the concern. I don't -- I don't know that there's been time yet to put that into the -- into the RFP. So that -- that piece is still a little bit fuzzy.

The other piece that's slightly fuzzy is the -- the map that we provided that we believe is our historic service area. And, you know, in our good faith conversations, I'm pretty confident that that's the map that's eventually going to be released with the RFP.

The draft version references the map, but we haven't -- we haven't seen the map that's -- that's released yet. We belie- -- I -- I certainly believe that we are all in agreement now on what our historic service area is.

Um, there was some discrepancy in -- in the whole documents and that. So -- tho- -- I -- I've made those comments to the county staff and we're hoping that that gets resolved. Thank you.

MS. CORSELLO: Thank you. So the next speaker I have is -- is Erik Newman.

MR. NEWMAN: Good afternoon, members of the board. Erik Newman, fire chief, city of Stockton. And I'm here representing on behalf of the Solano County Fire Chiefs. Um, it's been a long day and, uh, but let me start by this.

You heard about the RFP and you heard about everybody's different, uh, opinions on what you guys are debating on going into. Well, I'm living it. I'm living on what you guys are trying to go into. So let me kind of give you a little history.

So I've been the fire chief for the city of Stockton for three years. I inherited a dispatch center. Um, and I call the city of Stockton ground zero for a lot of EMS challenges that's been up and down our state.

People use our city as kind of, Stockton, on what to do and what not to do. And what I'm here to tell you folks on the board is you might want to pause for a caution or, as my grandmother would

say, for station identification on this.

So city of Stockton, we respond to, uh, last year, 47,000 calls for 12 stations. Forty-one thousand out of those calls was EMS. EMS with no control. We had no control of those EMS calls that came into our dispatch center.

So what happens in the city of Stockton is that anyone that calls, uh, CHP are the PSAP for the city of Stockton. It goes to the police department and it gets transferred over -- on EMS-only, it gets transferred over to, um, our contractor.

Our contractor then transfer it back to us, um, and it's 127 Main Street, Alpha Charlie, uh, breathing. And then, we put it in our CAD system and then we're off and dispatching.

So imagine you go into that difficulty breathing. We're coming to your house; right? And now, uh, your patient that's, uh, or the person that called in and says, hey, uh, now, you have a cardiac arrest.

So now, because they didn't -- lost the call, now they got to call to PSAP again. Transferred you back over to, uh, the contractor, and then back to my dispatch to update the -- the engine company

that's responded to you now. We got a -- it's now turned into a heart attack.

That's what's going on in the city of Stockton, with no control. Uh, for the city of Stockton, we do not respond to Alphas and Bravos. We talked about EMD. And so, all of our calls that come into our center are EMD by our contractor, but the city of Stockton has elected not to go on Alphas and Bravos.

Because, I had mentioned to you, we're on 47,000 calls. We have 7,000 calls of Alphas and Bravos that we elected not to go to. There's a city in my dispatch center that I dispatch for that wants to go to Alphas and Bravos.

But because of the contractor and how things work out as it relates to EMD and local control, they were not able to go. So there was a -- a big fight. Um, I'm telling you that that model is not best practice. It's not best practice.

Um, so, uh, what are the landmines? I kind of gave you one; right? Call comes from the contractor over to our dispatch center. Uh, our dispatchers send it off. We don't talk to the person, at all.

We don't know who the person was on the other end. So if the crews get on scene, they need

additional information, they call our dispatch back. And then, our dispatch has to call the contractor to get information. Think about that.

Think about if you were the person that's sick and all of those transactions. And then, think about if the car, uh, excuse me, if the call is lost. Then what? Now, you got to dial 911 again.

These are the little things that are not being put into -- or not -- what you guys are not seeing. One thing I -- I will offer, uh, is that I would like to invite each and every one of you to come out to our dispatch center so you can see for yourself. Come take a look.

See, it's easy for people to put stuff on paper and say, hey, what of this data and this analysis is going to work and -- and some of that stuff is true. Not here to shoot down any proposal or anything, but I think you folks need to come to our dispatch center. Because we're just over the hill.

We're doing what you're thinking about doing right now. You can talk to our dispatch center. You can talk to my emergency communications guy. And they will tell you the pros and cons of both.

You're going to be flooded and bombarded with

a lot of different opinions, but I think that right now, if there was someone in your backyard where -- and I'll be more than happy to pick you up and take you over to take a look to where you can see for your own eyes, sit in our dispatch center, and take a look.

Um, so I think the other thing that needs to be talked about is interoperability. How are you going to talk? You got 30 stations in Solano County, over 30,000 calls, and if folks can't talk to each other, now you're thinking about throwing in another medical component to it, which is kind of a curve.

And if -- if the ambulance cr- -- tracker for the county can't talk to the fire and now, we're talking about putting in things and changing the -- the playing field, uh, I think that we might want to rethink. But I just wanted to kind of share with you some of our dispatch problems in Stockton.

Um, yes, some of it was inherited. But I think that, uh, if you come and take a look and see what we've got going on right now, I think that it w- -- it will open your eyes a little bit more.

Uh, I truly humble -- I truly humbly believe that. Um, I think that, uh, uh, as I mentioned

earlier, Stock has been ground zero for EMS issues since 2007 and '08. A- -- and -- and I -- and I -- I won't say I beg of you, but I think that this decision is very critical.

Uh, the men and women in Solano County that work in the fire service and public safety, especially your -- your citizens, you know, they deserve -- they deserve the best. They deserve that -- they deserve that whoever comes to their door, ALS or BLS, that they get there in a timely fashion. That's all that matters; right?

That's what we're here for. And whether you're ambl- -- ambulance or fire, people don't care. They just want you there on time. But the decision that you're about to make as it relates to dispatching and EMD and which -- thumbs up. But I think you need to understand and see the process on how that works and talk to some people that is actually doing it.

We can give you paperwork about Salt Lake, which I -- I totally disagree with my colleague about roll-overs don't hurt and that people get mad. I think anyone who's been in a roll-over knows they're pretty bruised up.

Um, I -- I disagree about the fire service as

it relates to, uh, profits. We never been in this game for profits. We do it for -- because we want the people to be safe. We want to serve our citizens and businesses.

But I'll leave you with this, and I've said it three or four times, is that, Chair, members of the board, before you make this decision, come to Stockton. Sit in our dispatch center.

You get a chance to see real-time and take a look at what you're going to be adopting. And it's about local control and serving the citizens, uh, of this county. Thank you.

MR. BROSCHARD: Uh, good afternoon, Madam Chair and members of the commission. My name is Lewis Broschard. I'm the deputy fire chief of the Contra Costa County Fire Protection District.

Uh, we operate what you may, uh, have to come to know as the Alliance Model. Uh, we prefer the name the Contra Costa Model, but the Alliance Model was a temporary name that has since, uh, stuck with the program ever since its inception in 2015.

So I was asked to come, uh, speak to you just to give you more or less the facts of what our model is, how it came to be, um, and, uh, uh, for your consideration as to, uh, maybe including that

in -- in one of your potential options for your RFP.

Uh, for full and fair disclosure, I will tell you that, uh, I am a 40-year resident of Solano County, um, as is my father, one of the, uh, founding members of the Fairfield Medical Group, Dr. Lewis Broschard. Um, uh, my wife, my kids, my wife's family. Uh, and I was also, uh, never thought I'd say this, but, uh, uh, starting to feel old now.

Um, I was, uh, one of the fire chiefs that was, uh, uh, one of the first members of the public-private partnership almost 20 years ago.

Very young fire chief, but, uh, uh, I actually used that model that you and we put together that many years ago as the basis for coming up with the Alliance Model, um, that has become so successful in Solano County, namely some version of a partnership between the public sector and the private sector to deliver the best possible emergency medical services to the community.

So with that, the Alliance, uh, really was the strategic partnership between AMR, uh, and the Contra Costa County Fire Protection District in the legal form of a contractor-sub-contractor

relationship. We consider AMR to be our partners.

We treat them like partners. But it is not a partnership; it is a contractor-sub-contractor relationship. We were awarded the contract to provide 911 emergency ambulance service to serve most of Contra Costa County. When I say most, that's 90 percent of Contra Costa County.

The areas excluded from this contract for this areas served by the San Ramon Valley Fire Protection District and the Moraga-Orinda Fire Protection District, who provide their own fire-based ambulance programs. We cover everything else. The goal of the Alliance is and was very simple. Build and maintain the best possible system to provide service to the public.

To do this, we aim to enhance the existing service model, uh, under the original, uh, incumbent of a provide ambulance provider, create efficiencies and a synergy between the private ambulance company and the public service by reducing response times, increasing capacity in the system, improving overall communications and resource control and accountability through a combined fire and EMS dispatch center. And also, to maintain a fiscally sustainable emergency transport

system for our county.

I'm happy to say almost three years into this, um, we not only did that, we exceeded ours and others' expectations. We added the equivalent of one 24-hour ambulance crew over what was provided prior. Uh, combined our communications center.

We already were the regional fire dispatch center. We already were doing EMD, using all, um, the pro-QA, uh, systems that were discussed earlier this morning. But the ambulance dispatch center was located in Sacramento. By combining, uh, private ambulance system status managers in our dispatch center, we shaved almost a full minute off of the response time continuum.

We also, uh, increased com- -- common communications between, uh, the ambulances and every fire service provider in the county, as well as enabled, uh, better automatic vehicle locating systems, uh, for every fire crew and every ambulance to see each other and know exactly where we all were at all times.

Uh, the AMR system status managers give us the ability to move ambulances throughout the county, as necessary, to main c- -- maintain coverage levels.

Uh, we have documented improvements in patient outcomes. We have aligned medical direction from the county medical director to the fire district medical director to AMR's medical director. All three physicians, they get together on a regular basis.

Um, they're no longer in a position of conflict. They're in a position of collaboration and coming up with innovative ideas to increase and enhance even further emergency medical services within the county.

We provide joint training between fire and ambulance crews. Uh, and we have a mandated collaboration committee between the local emergency medical services authority and their staff, the fire district staff, and the private ambulance provider.

Uh, we provide a career path for paramedics and EMTs should they choose to, uh, leave the private sector and search for jobs in the fire service. Uh, that partnership, uh, provides some benefit for the employees.

And last but not least, uh, we have created, uh, a very robust and fiscally sustainable system. Uh, it's a not-for-profit system. We're a public

entity. Our books are absolutely and completely transparent. They must be.

Uh, audited financial statements happen every year. And what we're able to do is take what were corporate profits, turn them into retained earnings, and redirect those back to direct public benefit for Contra Costa County.

So as I said, uh, we were awarded the contract in mid-2015. Uh, we started providing service on January first of 2016. Uh, we essentially provide coverage to 90 percent of Contra Costa County, um, in regards to total number of responses.

And then, we, uh, transport 92 percent of, uh, the transports within Contra Costa County. As I said before, it's, uh, it's a contractor-sub-contractor relationship, uh, between AMR and Contra Costa County Fire.

So the two biggest, uh, benefits to this program, and -- and there's a lot of naysayers. There's a lot of people that with misinformation, misguided information, uh, uh, misaligned information, uh, I don't know why, uh, because the facts, basically, speak for themselves.

Um, this, uh, previously untested system, one of a kind system within California, and to our

knowledge, one of a kind throughout the nation, uh, basically provides, uh, an improvement over the old traditional private ambulance company and then public service provider. It's blended together.

2015 was the last year that AMR, uh, had the exclusive contract. Um, and just brief statistics. Uh, in 2015, within the city of Richmond, uh, the average response time from AMR was 4 minutes and 41 seconds.

Uh, in this new relationship, last year, in 2017, the average response time was reduced to 4 minutes and 5 seconds. Throughout all of West County, so figure the I-80 corridor, it used to be a little over 5 minutes. Now, it's 4.5 minutes; 30 seconds shaved off.

For, uh, the 680 corridor, Walnut Creek, Pleasant Hill, Concord, Lafayette, uh, and so forth, it was over 5.5 minutes. The average response time is now 4.5 minutes.

Out in the east, Highway 4, out to Brentwood, Byron, Pittsburg, Antioch, uh, the average response time was close to 6 minutes and 40 seconds. It's now 4 minutes and 34 seconds. We didn't reinvent the wheel. I think we just made it a little bit better.

With regards to, uh, compliance, because it's not all just about response times. It's also about how we treat patients and how we're able to deliver care. Um, but sticking with response times, before I -- I get into that, uh, just like you contract supposes, uh, 90 percent of the time, we are required to meet performance, uh, standards for response times.

Within the city of Richmond, 10 minutes 90 percent of the time. Uh, in tw- -- in, uh, t- -- 2015, uh, AMR was able to do that 93 percent of the time. We're upwards of 96, 97 percent of the time.

We don't have zones in the county with regards to rural or suburban or remote. Some of them are very remote. Some of them are very urban.

Uh, we have 11 minutes and 45 seconds to every single 911 call throughout the entire county. Again, 93 percent was the average compliance prior to the alliance. Average compliance now is, uh, 95 to 97 percent, um, in certain zones.

There's a lot of synergies that can be created, um, by allowing that contractor-sub-contractor relationship and allowing the best and brightest to come through, uh, between private and public sectors.

MS. CORSELLO: You're at 8.5 minutes.
[talking over each other]
MR. BROSCHARD: Oh, really? I thought it was more, like, 2.5. All right. So--
MS. CORSELLO: Can I ask you --
[talking over each other]
MR. BROSCHARD: I will wrap it up.
MS. CORSELLO: Thanks.
MR. BROSCHARD: Yes. Yes. Thank you very much. So, um, let's just finish with the financial stability and transparency. Uh, as a public entity, you're all aware the books have to be transparent.
Um, there was some question we had, uh, uh, Citygate come in, um, to do a final analysis as to whether or not this was a sustainable system. They estimated there might be about $1 million either way.
Um, last year, uh, we -- we had retained earnings of over $7 million, uh, in our system. Those dollars all go back to add more dispatchers. Um, to put other systems in place to make better improvements in this system.
Um, our fund balance, after three years, uh, actually, only after two years, was $10.5 million, uh, in our system. Uh, we were able to pay ourself

back for the, uh, start-up costs very quickly and, uh, we're well on our way to establishing our six-month reserve, uh, which is approximately $18 million, um, and -- and we may be able to do that by the end, uh, end of this fiscal year. So, um, those are the facts.

Um, as Chief Newman, um, uh, gave an invitation, I would certainly give the same or similar invitation for you to come down. Spend some time with us. Learn about the system. Um, uh, ask whatever questions you might have.

Uh, talk with our sub-contractor. Talk with AMR's leadership. Um, uh, take a look at the dispatch center. Whatever it might be. Uh, we're here to, uh, provide answers to whatever questions you might have and, uh, hopefully, you would consider this a potential model for, uh, uh, Solano County, uh, moving forward. Thank you.

MS. CORSELLO: Thank you. Do you have any information you want to leave for the board at this point?

MR. BROSCHARD: You know, I don't. What I was thinking of was, um, I -- I will send the, um, the annual report, uh, that was given to the board, uh, with the LEMSA director and the fire chief in, uh,

uh, August. And I'll -- I'll e-mail that, uh, so you can review those, uh, facts and figures.

MS. CORSELLO: You'll send that to Ted, I think.

MR. BROSCHARD: Will do.

MS. CORSELLO: All of us would appreciate that.

MR. BROSCHARD: Okay.

MS. CORSELLO: Thank you. Okay. The next one is Aaron McAlister.

MR. MCALISTER: I'll see what I can do. Thank you. Good afternoon. Uh, Aaron McAlister. Lifelong resident of Solano County and a 25-year veteran of our fire services, including six years as the fire chief for the city of Dixon.

Um, I'm here today as an elected member of the board of directors of the Cordelia Fire District. Uh, late last night, we transmitted a letter to the chair, um, expressing our opposition to the program as-is. Uh, we think it kind of missed the mark, so to speak.

Uh, in fact, the blueprint 2020 failed to even acknowledge the existence of the Cordelia Fire District and our advanced life support NGA [ph] based program.

Um, EMD is a good thing. We've seen that be very successful in other communities and the board supports efforts to bring EMD to our county. Uh, Salt Lake is a very high-performing system.

Putting RNs in the communication center is cutting-edge. But Solano County needs to walk before it can run. We have a lot of work to do. Within one mile of this building, we have not two but three public safety communication centers. Within one mile. That is the true problem.

If we want to improve response times, we need to consolidate fire communication centers. We have fire stations all over this county within one mile of each other that are dispatched by different public safety answering points and operate on different radio systems.

I can order a pizza or an Uber to this building electronically without having to make a phone call. But four of our communication centers can't order ambulances without making a telephone call.

We could shave one to two minutes off response times by building CAD-to-CAD links between the contractor and our 911 centers. Please, don't further complicate an already complicated

communication center by adding another communication center.

Um, we only need to look as far as our neighbors. Napa County, Contra Costa County, Alameda County have embedded ambulance dispatch in fire communication centers. Those systems work well and it's shaving response times.

What calls any particular community need to respond to need to be community-based decisions. We've heard it here today.

The political bodies that authorize the budgets for those entities need time to digest this report, provide feedback, and on behalf of the Cordelia Fire District Board, um, we urge the rejection of the documents as-is, and it needs more work. Thank you.

MS. CORSELLO: Thank you. Um, Howard Wood. Actually, there's two names on here. Howard Wood or Chris [ph] Culver. So are you both speaking?

MR. HOWARD: Hi. My name's Howard Wood, fire chief of Vacaville Fire Protection District. I've been with the district for 56 years and watched Solano County grow and the fire departments grow.

Um, the chairman was going to be here to speak, but he had to go to another meeting at 1:00

o'clock. So -- but just short and easy is that, uh, we want to make sure that it was known that we support EMD.

We'll do whatever has to. The board will take action and make that work. And they're happy they didn't see, uh, we're basically, uh, [inaudible], a little bit of Dixon. But, uh, that, uh, we didn't lose the services that we've had from the city of Vacaville for -- since the beginning.

So, uh, the residents out there are more than happy with what service were p- -- provided through, uh, Vacaville city. So -- and I can cut it that short and thank you and, uh, under two minutes.

MS. CORSELLO: That you are. Thank you. All right. I have Todd Matthews.

MR. MATTHEWS: Good afternoon. My paper says good morning, but it's good afternoon. So, um, Todd Matthews, president of Fire Fighters Local 1186.

All of you guys should have received a position paper from our local, uh, last week sometime with our concerns with the RFP proposal. I am going to go -- I had a two-minute speech, but I will go into some other issues that I see after I read my position on.

One of the things that we see in the RFP. We have the following concerns regarding the draft, proposal evaluation process and scoring.

There is a description of the independent review panel on how the scoring of the proposals will take place, as stated in the RFP, is meetings of the review panel will be closed to the public and may include SEMSC staff and/or consultants. May.

SEMSC staff and the consultants have made their positions clear regarding the future of EMS in Solano County. But we don't feel the direction or coaching of the review panel will be in the best interest of all the parties represented here.

Also stated in the draft, the outcome of the deliberations of the review panel shall be submitted to the local EMS agency administrator. The administrator shall review the submission and may consider any and all pertinent information.

The administrator shall recommend a proposal to the SEMSC board. Once again, the MS staff has made their positions clear through what's going on today and public records requests that we have requested.

We do not feel that the interest of all

parties will be taken into account. We would like to see an additional option of having a second panel comprised of public and private entity stakeholders currently providing EMS within the county and also make a recommendation to the SEMSC board.

This will give the board the final decision of who to award the contract and give a voice to the first responders a l- -- and labor, who are grossly underrepresented here. Putting the next 10 years on -- in the hand of a panel describes [sic] as disintres- -- disinterested individuals appears risky at besk -- at best.

Um, if you were to ask me, should be five people on this panel -- on this second panel should be presented from the largest first responder in the county. That's us, 1186.

We have almost 200 EMTs and paramedics. A fire manager rep, a dispatch rep, a hospital emergency department rep, and a representative from Solano County. So that being my initial two minutes.

Um, there was some discussion earlier from the consulting group that many of the municipalities have failed to provide EMD dispatching, that the fire departments are dropping the ball. It's their

responsibility.

It is the responsibility of the county to require it. Health and Safety Code 1797.220 puts the -- the responsibility in the hands of the EMS office to create the policies and procedures and accepted guidelines for this program. The city of Benicia or Vallejo cannot tomorrow start an EMD program without the county's direction.

So if you go back historically, there is a grand jury report. They need to combine dispatch centers. Go back further, back in 2010, probably at the last RFP proposal. The fire chiefs probably said they couldn't afford it or couldn't do it.

That's been 10 years. We're not -- we're not arguing EMD. It's a good thing. Our concern is that it go into a private for dispatch. And so, that'll come off that from there.

The new proposal for the dispatch center or the new language where -- how the dispatch will work from the consultant, it's smoke and mirrors. And we'll get the -- EMD will be done by the private ambulance company, but we'll still get to dispatch our fire engines. That's how it was going to be inig- -- originally.

The call's going to come in to Benicia. We're

going to say it's a medical. We're going to pass it off to the ambulance provider.

And then, we will get a phone call back. There's nothing different. It's just he changed some words upon the screen to make it sound better. It's like lipstick on a pig.

I think you can find it in probably some of your public records requests. The local PSAPs need to maintain the live caller. They need to maintain contact with that citizen that's within their community.

Everybody's aware, I'm pretty sure, on the panel, that I and my local conducted a public records request against Solano County EMS, the administration, and all correspondence between the current ambulance provider and between Doug -- between Wolfberg, Wirth, and Page.

Um, for Josh, the fire chief, to be recused today, at the eleventh hour, it's -- I almost want to use a bad word, but it's crazy. Because right here, Doug Wolfberg is outstepping his bounds of his contract, 62 days ago, questioning Josh' and the city managers' right to be on this panel and vote.

You guys right here -- and I'll read them.

This is from Doug Wolfberg. August 15th. They're going to be -- the -- we're going to need to stand up against the fire chiefs on this issue.

But with a city manager and a fire chief on board, it's going to be tough. This was sent to Ted Selby. October 12th. This is from Doug Wolfberg to Br- -- to Mumba [sic]. I was hardened to bid [ph] and speaking with Birgitta and the city, uh, uh, I'm going to hands it [ph] with the meeting.

Birgitta said that she thought that there was -- that she had presented them with an excellent system, but she was not sure that she would be able to get there given com- -- uh, given the composition of the board and the fundamental irres- -- uh, ir- -- irrevoc -- sorry.

Irrevocable interest they are all had. She wondered whether the new RFP process might present so many fundamental irre- -- sorry. Differences, that is, and might need to be disillu- -- uh, dissolve the JPA.

So you guys are talking dissolving the JPA two months ago. The more significant question is my view is whether there are procedures or bylaws provisions for the forced recusal of a self-interested director who refuses to voluntarily

recuse himself because my read of this [sic] tea leaves is that I would not see -- I did not see eith Josh Chadwick or Mr. White, both of whom have potential conflicts of interest with their cities in becoming bidders. This is two months ago. Uh, no.

MR. WHITE: Uh, I'm sorry. Wh- -- so can you tell me who that e-mail was from and who --

MR. MATTHEWS: This is from Doug Wolfberg to Bryn Mumba [sic] and Ted Selby.

MR. WHITE: I'll point out to the board that we did receive this communication as part of documentation from the attorney, uh, for, uh, fellow member Chadwick. So we all do have it handy.

MR. MATTHEWS: So another one from Doug -- or from Bryn from -- to Doug. Uh, we intentionally avoided the RPA -- RFP discussion during the MD forum to avoid an appearance of a bias or during the process, including tiered response. Uh, so they're looking for a way to get better t- -- t- -- tiered response.

And then, Ms. -- from Bryn, I do believe that we should address the real and perceived conflicts of interest on the board. But I am not sure of the best approach to do this. In the ideal world, this

and perceived conflict with voluntary recused themselves from the discussion and vote.

However, I do not see that happening. I think Josh's conflict as a fire chief is most clear. Even if he says it is not a real conflict of interest, I would argue that it's perceived conflict of interest that gives the appearance of bias in the process.

David White is a little hazier. Sorry that you're not as clear as Josh. Because he is not directly employed by a representing potential bidder. Happy to discuss via phone later in the afternoon. This makes it easier.

Here's some more biased on the panel. This is from Bryn. She wrote an e-mail to somebody. Last e-mail from me now. Just pursuing the mission statements from various organizations.

Why would the board want to give a contract to an agency that doesn't see emergency medical care as part of its misi- -- vision statement? And she lists the city of Vacaville, the city of Fairfield, and Medic Ambulance.

And I'll make it clear. I made the public records request. Do I want to find anything? No. But we did. Is it collusion? I think Trump would

probably call it that.

But the consultant is overstepping his bounds by making recommendations to have somebody on the board recuse themselves. I think you probably need to go back and look at the job descriptions of everybody on this panel and look at the expectations of this panel as well, which you cannot find online.

And I would say that this board probably reports directly to the supervisors, not to anybody sitting up here. And I would recommend that you probably start over.

As a parent, my child would have brought me this RFP as their first project, I would have told them to go back and be more creative. Bring back another alliance model. Bring back two -- two systems. But I'm going to sit here and tell you, you guys probably need to back off a little bit.

It's right here. And when I met with Mr. Selby on Tuesday last week -- or maybe Wednesday, he was upset that I made a public res- -- records request against him. That I didn't come see him first.

So with that being said, you have something hide, the reason why you're upset. So, uh, as part of the local union representing everybody, we have

no -- I know I made the video. I have no issues with the current provider.

This has nothing to do against the current provider. It is a consultant that is coming in and giving you a cookie cutter approach to a system that if you look at his bibliography, there's 78 entries.

If you go read every collu- -- conclusion, every one needs more time to be studied. They are put in there to make his recommendations work. There is nothing out there that he hasn't presented that puts first responder ALS on scene prior.

What is the benefit? Maybe we call somebody an Uber. Maybe we give people taxi credits to let the ambulance go home.

But ultimately, I think you guys need to step back, push yourselves away from the dais. Maybe pick a new contractor. So that's my opinion. Um, doesn't weigh much, but I got 181 members on the back of my shoulders and I'm here, standing behind me.

And unfortunately, we have to go back to classes, get back to our families. So to see a red as thin [ph], but we're here. So thank you very much. If you guys need the public records request,

I can send -- you guys all share a drive. So --

MS. CORSELLO: Thank you. That was 12 minutes. So I gave you the longest of all the others to be fair and let you air your concerns. Uh, I have the next card, is Shawn Stark.

MR. STARK: Good afternoon. My name is Shawn Stark. I'm the deputy political director for the California Professional Firefighters. We represent 30,000 professional firefighters protecting the state of California.

And, uh, I was asked to come here today by, uh, Brian Rice, our president. He wanted me to read a, uh, letter that he wrote to, uh, Todd Matthews, uh, in regards to the dispatching issue.

It says, uh, Brother Matthews, uh, it's been brought to our attention that a draft blueprint for the EMS services in Solano County proposes to consolidate dispatch services for seven fire departments under the control of a private for-profit ambulance company.

As president of the California Professional Firefighters and as a 31-year first responder, I am writing to strongly urge that this risky and potentially damaging model be rejected.

Few private outsourcing models exist in

California and where they have been implemented, the results have proven to be disastrous and ineffective. Based on the experience in San Joaquin County, the evidence suggests this model.

A roads effectiveness and timeliness of fire department response. In San Joaquin County, the same model has severely limited fire department participation in the EMS system.

Dispatchers routinely bypass Stockton and Tracy firefighter paramedics on calls, giving preferences to corporate providers. This has resulted in documented delays in response. It removes accountability.

Under the tiered EMS response model, decisions on how or whether to respond are made by private contractors accountable to its shareholders, not the taxpaying public. It threatens the standard of care. By placing emergency medical response decisions in the hands of a private contractor, the potential for cost-based medicine, uh, medical decisions increases.

The experience is clear. Private for-profit dispatch doesn't streamline response. It makes responses more complicated. As you know, emergency medical transport is evolving.

There are many models of care and response that can provide efficiency and centralization without ceding accountability, the sworn authority of the fire departments. Emergency medical response dispatch is a core public safety responsibility.

It should remain the providence of the agencies for whom it is a sacred mission, the sworn, publicly accountable fire agencies. Fraternally, Brian Rice, president, California Professional Firefighters.

Uh, on a personal note, um, I take, uh, issue with Mr. Elliott's statement. Uh, I've served, uh, recently retired as a 17-year, uh, fire-medic in Alameda County, and I watched three providers there in the time that I was there.

Three times, they've come in -- in one case, I'm not going to mention the actual individual companies, they underbid the contract. And then, they came back to the county for relief when they couldn't meet the, uh, uh, the standards.

So they would be audited. And so, we would be sitting out there. And when they were being audited, there'd be plenty of ambulances that would arrive on the scene.

As soon as that was over, to get their profits

back, they would take away the surge and we would be sitting on scene for 30 minutes waiting for an ambulance. This is not reflective of the crews at all. They were outstanding. But it was the reflection of the profit-driven, uh, method that they were -- they were dispatching.

So for him to say that profit margin has nothing to do with how they operate is ridiculous. And in fact, it's been a revolving door in Alameda County. This is -- now, they're -- they're in negotiations for a third provider in, uh, 20 years.

So, uh, the idea that -- that the for-profit model is the way to go is absolutely absurd. The fire service in Alameda County does not surge. We have minimum staffing. We have the same amount of firefighter-medics on the scene.

And we're, uh, in the firehouses responding every single day. We don't surge for profit. We serve the citizens with the highest level of care. Thank you.

MS. CORSELLO: Uh, the next card I have is Danny Gutierrez.

MR GUTIERREZ: Um, Chair, Board, Staff, my name is Danny Gutierrez. I'm the, uh, vice president for the Vallejo Firefighters Association.

I'm also a representative on 1186.

As a field provider for the past decade, I support the mission of Solano EMS of a strong commitment to providing quality pre-hospital care whose main goal is the best possible outcome for the patient.

I believe this board and Solano EMS agree. But that's not what this RFP will provide, and we'll talk a little bit about what's on the website of Solano EMS when we talk about the three core elements.

Pillar one of the core mission is to provide a rapid response that minimizes the time from emergency even to the arrival of resources. This RFP would increase response times for our citizens, and it would do so with experienced professional paramedics who are strategically placed in firehouses across the county, sitting idly by, possibly not even knowing that a call for care had gone out.

Pillar two of the core mission. From the website, again. Competenc- -- competency in practice. This is by applying clinical field medicine to the highest standards using best practices. I believe we, as providers, do provide

clinical field medicine to the highest standards.

But this RFP is asking us to alter our practices based on zero local baseline data, nothing, from this county. And that's information from the staff themselves. They didn't have baseline data, but they are developing it.

So how are we going to be able to compare where we were to where we are in five years if we don't have that data? It's also based on limited sample size studies provided by a consultant that do not reflect the demographics of Solano County, the Bay Area, or even the state of California. That is hardly the best.

Pillar three. A goal of accountability through improving processes for the delivery of care. The delivery of care is not improved by incentivizing a private for-profit provider to offer BLS ambulances when they think they can get away with it. Erase the calls to avoid honoring unit hour savings agreements. All expecting that there will be or that there will never be a mistake in patient triage.

The men and women you see here today behind me in the red and other shir- -- other color shirts, black, from Vallejo, uh, from Benicia, Cordelia,

Dixon, Vacaville, we took an oath, we had to put our hand up when we got hired, that we would provide the best care for the citizens we serve.

This RFP does not meet that vow. We request that this board ask for an extension of the current RFP, for at least a year. Hopefully, that's enough time to iron out the issues that we have. So that both the good and the bad ideas before you may be fleshed out before we m- -- commit to a flawed proposal.

And secondarily, I -- I wasn't going to address anything else, but, I feel that I have to address the issue that was brought before us by the Physicians' Forum. I'm deeply concerned and disturbed, actually.

I know there's individuals on this board that I've personally delivered patients to, and many people back here have -- have as well. And the understanding of the value that firefighter ALS first responder medics throughout the county provide was completely absent from that Physicians' Forum report.

And I'm -- I hope that over time, maybe if it's an education issue, we'd be happy to become involved and get on the same page about the value

that we provide. Maybe it's a failure on our part, but I'd like to think it's not. Because I've always had good interactions with the doctors that I've dealt with.

But the lack of information and the lack of understanding of the value of having strategically placed fire- -- experienced professional fire-medics, um, was very glaring in that report. So thank you.

MS. CORSELLO: Thank you. Um, Mr. Ben Hill.

MR. BROWN: Uh, good afternoon. My name is Kevin Brown. Ben had to leave. Uh, so you can scratch Kevin Brown off if you'd like. Um, I'll read the speech prepared by -- by Mr. Hill.

So again, my name's Kevin Brown. I am the secretary-treasurer for the Vallejo Firefighters Association. I also serve as a representative for local 1186 firefighters. Ben is the vice president to local 1186 and the president for Vallejo Firefighters Association.

As written by Ben, this week, I was able to review a series of e-mails, some of which you've now heard, between Doug Wolfberg of Page, Wolfberg & Wirth Consulting firm; Solano County EMS employees; and members of Medic Ambulance.

The documents paint a picture of what I would consider a collaborative effort to push an agenda for a RFP package that is highly financially beneficial to the local ambulance provider at the detriment of public health and safety.

There's clear evidence of a bias of opinion for private ambulance companies against local municipalities with Doug Wolfberg. In his e-mails, Mr. Wolfberg stated, when referring to a Ninth Circuit Court decision in Orange County favoring local cities maintaining 201 rights as lipstick on a pig but still a pig.

Wolfberg has shown that he's colluded with employees of Solano County EMS to push out voting members of the SEMSC panel who don't fall in line with his recommendations.

This collusion is a direct legal violation of the procurement process. His inability to take direction from the SEMSC panel and come up with a viable solution to improve EMS response in Solano County is concerning.

Another key item brought to light is the recommendation of Physicians' Forum regarding PPP funds. It is their sole responsibility to provide medical direction, not financial direction or

recommendations.

There's a clear line crossed. I think it is the responsibility of the SEMSC panel and higher governing body to slow down and investigate the intentions of Doug Wolfberg and other influential membor- -- members involved in the RFP process, as their motivation and biased approach to the terms of the RFP, which will be detrimental to the public health and safety of the citizens of Solano County.

So that was written by Ben. I'd just like to add that, uh, o- -- one piece that was presented earlier in, uh, Dr. Mumma's presentation regarding ALS, uh, versus BLS survivability outcomes in cardiac arrests.

Uh, it showed that there was a -- a -- a lower out- -- uh, lower survivability outcome of cardiac arrest in many ALS cases, as compared to BLS. So I've attended a lot of EMS conventions. I've read a lot of EMs reports.

That -- that appear- -- appears to be true. I -- I've seen it time and time again myself. And she was correct when she, uh, followed that up by stating that we believe that's tied directly to airway management. At least, as the predominant factor.

Uh, so having said that, I want to make it clear, because I don't feel it was made clear in her presentation, that it isn't ALS responders that are causing a decrease in survivability rates. It's the protocols which we follow.

So that means the protocols of this county need to be updated to reflect the new studies as they -- as they've come out over recent years.

Decreasing the number of paramedics that respond to a call or increasing the amount of time that we're allotted to arrive to that call doesn't improve survivability outcomes. ALS responders are those who save lives. It's the protocols that need to be updated. Thank you.

MS. CORSELLO: Thank you. Okay. I have two more names. Patrick Wong, Shawn Grukens? Gogens? So which one is it? I'm assuming you're Shawn?

MR. WONG: I'm Patrick Wong. Shawn Gugins had to go back to work. So --

MS. CORSELLO: Oh. Okay.

MR. WONG: Uh, good afternoon. My name's Patrick Wong. I'm the treasurer of firefighters' local 1186 and I've been a, uh, paramedic for almost 10 years. Uh, almost 8 years in this county.

Um, I had some key points that I was going to

talk about. Um, however, uh, President Matthews kind of hit them all, um, in his 12 minutes he was up here. So, uh, I just wanted to go with the quick little thing that I have, is, uh, if you decide that allowing a private enterprise to be in charge of your family's 911 call, let it be known that you're derelict in your duties of public service.

911 calls are not a business model. They are a basic need to society ever since doctors made house calls. It can never be properly addressed by fines, shareholders, or meetings, or end of the month quotas.

It's a minimum service not to be profitable, but beneficial to the people you represent. Thank you.

MS. CORSELLO: Thank you. Uh, I've got Carl L-- Littorno. Did I say that right? Sorry.

MR. LITORNO: How you guys doing today? Uh, thank you for letting me address this board. I hope you appreciate the time that went into it.

Uh, got up at 6:00 A.M. with my three-year-old and six-year-old daughters, and they had the time clock out. So we're at exactly two minutes. So it's a family effort. Uh, first of all, I'm Carl Littorno.

I'm a fire captain in the city of Benicia. I'm also the vice president of the, uh, Benicia Firefighters Association. And, uh, most importantly, I live in the city of Benicia as well, so I'm here as a citizen.

Uh, my family lives in Benicia. My parents live in Benicia. We're members of Solano County. So I'm speaking on their behalf.

Uh, first of all, um, this wasn't originally my speech. Uh, but I saw Dr. Mumma's presentation. I thought a lot of facts that you said were valid and I appreciate them. One thing that you did say, however, is a study shows that citizens don't care whether it's a ambulance paramedic or a firefighter paramedic who show up to their house on calls.

Um, I would say to you come to Benicia. Respond to calls with us. They care. Uh, every time I'm to a house, uh, two minutes away from our station, they say thank you so much. We cannot believe how fast you get to our house. That is an expectation of our community. That is something we provide. So that side, that is a reality.

Wanted to voice my extreme disappointment in how this process has unfolded and even more disappointment about how it has gotten this far. In

this room, you have stakeholders from all parts of the county who are all dis- -- disappointed in how this has unfolded.

That's not a good process. There should be a little bit on each side. This entire proce- -- process should have stopped from the moment the contractor ignored a lot of the board's requests for this blueprint.

If we refer to Policy 1760, which I have right over there, there is a direct line in the chain of command from this board to the board of Supervisors. And then, you can draw a little line over to the contractor.

We don't r- -- we don't respond to other people, so I don't understand how what we presented today with people having input fits into that chain of command. Again, that's policy 1760.

This entire process really should have been stopped the moment its author tried to strip cities of their -- in this county of their 201 rights. Dispar- -- dispatch is part of a city's legal 201 rights. I know we all throw that term out when we read the law.

Section 1797.201 of the Health and Ca- -- Safety Code states, quote, upon the request of a

city or a fire district that contracted for or provided as of June 1st, 1980, free hospital emergency medical services. It says nothing about transport. Free hospital emergency medical services. That includes dispatch.

Uh, I don't think any of us who are sitting in this room today, um, have a problem with emergency medical dispatch. Great idea. But like happened and, uh, Mr. Selby can talk more about this, because he probably has better stats than I do, when you guys required for us to go to electronic PCRs in the county. What happened? We all went to electronic PCRs. Not a big deal.

I'm a fire captain in the city of Benicia. Our main and only objective is to provide the highest level of services to our citizens. I don't care about profit. This doesn't change my salary.

This doesn't change my need to provide the highest level of service to my citizens. If there needs to be a PPP to assure a level of care to my citizens that they expect, then so be it. I would ask the board consider the average, uh, the average for a unit cost in California across when coming up with unit cost hours. So taking that into consideration.

Finally, I want to say this blueprint is not the service they expect in the city of Benicia. This passes, you guys think there was not going to be a backlash from our citizens? You guys are incorrect. Thank you for your time.

MS. CORSELLO: Thank you. Kevin Brown. Okay. Steve, uh, McGraw.

MR. MCGRAW: Yeah. To represent my brothers and sisters in the back of the room. I got in trouble for not wearing red this morning. So, uh, good afternoon. Uh, my name is Steve McGraw.

I'm the president of Fairfield Professional Firefighters Association and a vice president for Firefighters Local 1186. I'd like to make mention that I'm also volunteering my time to be here today and I have no financial ties to this RFP.

I will be sharing fire local 1186's comments on the proposed tiered EMS response. Our union and many other unions in this room agrees with the benefit an A and B program consisting of pre-arrival instructions and criteria to determine the appropriate level of s- -- response.

However, we are not supportive of any system that would not include the fire departments' simultaneously response -- or simultaneous response

for all medical 911 calls in Solano County.

Our resources are strategically located in the communities we are sworn to protect and it would be a disservice to our residents have trained experienced paramedics in the neighborhood not included in the response, especially with the excessive increase in response times proposed by the consultant.

Under this proposed tiered EMS response model, the decision on whether to respond a fire unit to a medical call for service would be made by the private for-profit contractor that is responsible to its stakeholders, not to the taxpaying residents of this county.

In my 20 years of experience as a medic in Solano County, I would say hundreds of calls per year are improperly triaged due to several reasons outside of the dispatcher's control.

Per Mr. Dale's stats, uh, the first presenter that we heard today, roughly 2 percent of the calls are mis- -- uh, -triaged or dispatched. That equates to about 750 per year here in Solano County. That's one to two a day.

So with my closing statement in a few minutes, I want you to think about those one to two calls

per day when I give my closing statement. With this proposed model, an improperly triaged Alpha or Bravo call would not recommend that a local fire unit respond to the call for service and could potentially allow the appointed contractor up to 60 minutes to arrive on scene.

In this scenario, a fire unit is not dispatched to the call, and that unit could be only blocks away or literally just around the corner from the call.

The fire unit could have provided lifesaving measures on an under-triaged patient within a few minutes when, in reality, immediate ALS intervention was actually required. This proposed model makes no sense to me as a public servant or as a tax-paying resident.

These types of scenarios occur on a daily basis and I hope that one of your family members, one of your coworkers, or one of your close friends, or a citizen that you swore to serve are not involved in this flawed model of tiered EMS response. Thank you.

MS. CORSELLO: Anthony Lasala [ph]. Okay. Uh, uh, J.T. Hoyle [ph]. Did I say that right? No? Ryan Lareau [ph].

MR. LAREAU: Good afternoon, Board. Um, the, uh, blueprint states clearly on Page 6, Section E, uh, that the SEMC- -- SEMSC's number one goal is for public health and safety. Uh, the question arrives why there are so many e-mails going back and forth from our LEMSA administrator, medical director, and the author of the RFP about trying to force out the fire chief and the city manager that sit on the board.

Other topics of the e-mails include convincing the board to accept this blueprint since it's dramatically different than their current mode of operations.

Um, I'd also like to add that, uh, if -- if it's a conflict of interest for the Benicia chief to sit on the board due to him potentially bidding, I mean, we -- we all in this room have potential conflicts of interest. I -- I'm conflicted because my family lives here.

We have physicians that operate here. And maybe for a non-profit hospital, but this is where we live. This is where we're vested. Um, this -- this is -- this is of grave importance to us.

Um, why is our EM- -- uh, our EMS administrator having conversations with the RFP bl-

-- blueprint author via e-mail about how the RFP is written, up to, including, and, uh, commenting on how the Orange County 201 rights case would affect this process, both calling it a lipstick on a pig policy, 1706. Uh, this would suggest he's well outside the scope of practice.

Uh, uh, in closing, uh, if you refer to the flowchart, it's policy 1706, uh, this committee reports directly to the Board of Supervisors for the overall direction of the EMS system. I believe we've already gone over this.

One thing I would like to add is, uh, I mean, we're all for the, you know, putting this, uh, in this RFP, having central dispatch and having, uh, EMD. But, uh, putting a public interest, uh, we've seen drastic results recently.

Uh, I know it's in a different area, but PG&E, where it's a public interest, that's put in a private -- private hands with little to no oversight, it can have disastrous results. Thank you.

MS. CORSELLO: Thank you. Matt Marino.

MR. MARINO: Good afternoon. Uh, Matt Marino. [inaudible] Sorry. Um, today, I think, threw a curveball for us all. Uh, honestly, thought I was

going to come here so we could all collectively work out, uh, a contract to improve EMS in Solano County.

I think that was the mission of everyone in this room, including you, the board. Um, unfortunately, I think what we've discovered here, uh, really starts with the author of the draft, and that's a bias.

Uh, we're seeing a power grab. We're seeing an extreme, uh, this is an agenda being pushed and I honestly -- I almost feel bad for you folks up here that now have to make these decisions, uh, based on, uh, somebody's, uh, power struggle or power grab.

Uh, you had the -- the first speaker attacking the fire service. Uh, there's no one that I'm aware of here in the fire service that would attack our current provider or, uh, a private entity, uh, that we all came from.

So, uh, I think today, really, like I said, took a turn. Um, I think it showed in the public records request with e-mails prior to today, and that really set the tone. Um, it's appalling that the folks that are going that are making this decision are spending more time trying to recuse

members of this board to have a vote, rather than to try to i- -- improve our EMS.

Let's go back to what EMS stands for, emergency medical service. It is not a service to ourselves. It is a service to the citizens that we protect. And those of us in the fire service took an oath, as the gentleman said, to do so.

And -- and I was also, uh, I'll be respectful in my comments to, uh, Dr. Mumma. Uh, you -- you signed my paramedic card, so I want to be respectful of that. Uh, but some of the -- the Physicians' Forum, and it may not have, uh, respectfully, may not have come from you.

You're just presenting the Physicians' Forum. Uh, it talked about firefighter-paramedics being, um, uh, over -- over, uh, I think you said expensive on the system.

Um, that's false. You're getting two-for-one. The communities are getting a two-for-one. You're getting a firefighter and a paramedic. And it also was stated that, uh, fire engines spend too much time on Alpha-Bravo calls when they can be responding to other emergencies.

I would, uh, offer that I would imagine these fire chiefs would be knocking -- kicking down your

door if these Alpha-Bravo calls were preventing us from responding to put out fires. That's the nature of the fire service, is we move around and protect each other.

Uh, it almost came across as it's an inconvenience for us, uh, uh, on a fire engine to respond to Alpha-Bravo calls. Uh, and there's no inconvenience.

I think you see, uh, a sea of red shirts back there, of folks that, uh, they're showing up to say they want to work harder because they care about the community they serve. And I think that has to be the mission of this board.

Is -- we see today such a bias a- -- and it is concerning the public records request and -- and trying to recuse members of the board prior to this meeting. Uh, that only reveals that bias.

So how do we get through this? H- -- how do we come together and figure out how to put a fair contract together that -- that helps the community? When we argue with one another, when you guys are witnessing this power grab, this agenda needs to be a mission and not an agenda.

The mission needs to be about the people, and that's what's being lost here. This is a power grab

and it needs to stop. The way you -- the -- the way to resolve it -- I'm not going to complain without giving recommendations. Is offer up the same system for all entities.

So if it's central dispatch, make that -- or I'm sorry, EMD. Make that available for all entities, not just the provider. It can- -- it can work. So let's -- let's work together.

Let's, uh, uh, and in closing, I think that what you see before you today is a business plan and it needs to be a service plan. Because when you create a business plan out of a service plan, it is the citizens that we are here to serve that have become collateral damage. Thank you.

MS. CORSELLO: So I have a card from Jon Miller.

MR. MILLER: Good afternoon, Board. My name's Jon Miller. Um, I'm the vice president of Fairfield Professional Firefighters Association. And I just wanted to bring up, uh, four problems that we -- that we've noticed with the centralized dispatch study that is making this blueprint evidence biased.

Problem one is that there's no study to support claims what is best for this county is a

centralized dispatching station. On page 47, claims that -- that the county should be using the NAED standards for dispatching calls.

I have no problem with this. It gives a standardized protocol for dispatch that can be used across the county. However, nowhere in the NAED standard do they call for a centralized dispatch. In their eight points, they only call for common sets of protocols for the dispatch.

Wolfberg cites the study Emergency Medical Dispatching authored by Dr. Clawson. Unfortunately, nowhere in Dr. Clawson's study does he state that there needs to be a centralized dispatch. Like the NAED, he makes the argument for a single set of protocols. Excuse me.

There is no public entity in this room that has an issue with creating a single set of protocols for dispatch through EMD. What we do have a problem with is handing over dispatch to a private entity that makes decisions based on profits. Thank you.

MS. CORSELLO: James Pierson.

MR. PIERSON: Good afternoon, Board. Jim Pierson, Medic Ambulance. Um, I first want to start off with, obviously, we are members of the

California Association, but, um, those thoughts are -- are not Medic's thoughts.

I mean, people can say what they want, but we have relationships in this county, we've had them for 20 years, and we've kept those. And, you know, uh, uh, this is a trying time. You know, we're caught in the middle of multiple cases.

Um, one of the things I know, dispatch has been a main focus here. I actually do have other contract-related things I would like to address with you. But being dispatched, I do think that -- obviously, as a potential bidder, we're going to bid what's in a document; right?

Um, but we have good PSAPs in our county. Yes. I think, uh, I heard Todd say it or multiple people say it. We need a centrali- -- and I think Aaron said it best. We need a centralized dispatch center; right? Uh, but we need to walk first, and EMD is the walk that has to happen for our citizens.

We had a three-year-old code blue in Vallejo yesterday. We had a seven-year-old in Fairfield today; right? We have to ensure that people are getting pre-arrival instructions. And I think that's a commonality, which is fantastic; right?

Um, but we can achieve that by allowing -- think, uh, uh, a good middle ground is allowing the PSAPs to -- to come to standard before the new contract. Building in EMD protocols that we all can agree to.

Um, the thing about EMD, when we've gone across the country and looking at this and we're educated on it, i- -- uh, I haven't heard anybody say it, which I'm kind of surprised. But every EMS sys- -- if you've seen one EMS system, you've seen one; right?

And Solano has its unique characteristics; right? And we need to be able to address those. And we can address those collaboratively, not attacking the for-profit model. Medic's a 40-year service inside of Solano County. We've proven to put our citizens first. People that know Medic know that. So I just want that to be out there.

Um, now, where do I start? So, you know, one of the biggest things, too, as we go kind of into the contract now; right? A performance security bond of $5 million; right? The last contract had $1 million.

I'm just trying to understand how we jumped to $5 million. We talked about not overburdening the

contractor, whoever wins the contract, overburdening them with incentives and all these diff- -- well, I think we're doing that.

An irre- -- irre- -- irrevocable letter of credit for $5 million versus $1 million is significantly more expensive than a. contractor.

Uh, currently, you don't mandate audited financials. Medic does do audited financials. We don't do them every year. We're reviewed and audited, but we don't have them for every year of exis- -- and this contract's requesting three years of audited financials.

Well, if we're in full compliance, as we are with our current agreement, we wouldn't even meet that qualification. So we have to go back and audit our books, which our recent ones would be, but we'd have to go back two years and do that as well.

So those are just things that I think that -- I don't know where the communication got dropped. Um, and then, when you look at also -- and I have other things. But when you look at, um, the -- the -- I just lost it. Sorry about that.

It's been sitting for four hours, so, um, the -- the fine model. Let's go to the fine model; right? So I totally agree with the new concept and

looking at performance-based fine models. Th- -- those make sense.

But we also talk about workforce engagement and workforce retention. A lot of our employees that you see in the back right now are ex-employees of Medic Ambulance. They went to the fire service.

That's what they wanted to do. They -- or they went to the police service or they went into county government. To have 30 percent workforce retention, there just needs to be some form of -- I get -- looking at that; right?

If our employees are leaving us to go to Burger King, then we have a problem and we all need to talk about it. But if they're going to Fairfield Fire Department, is that really something to penalize the contractor for?

Um, so I think that that -- that plays into. And when you talk about workforce retention, if you're fining us for every time a paramedic misses a 12-lead, you know, that -- then, you know, we're trying to -- you know, you don't want to have -- come down too hard on the employees. You're trying to find a happy balance. And so, if we're penalized $1,000 for every person that misses a 12-lead, what are we trying to do?

Now, let's look at the overall scope; right? What are our STEMI receiving times; right? How -- how quickly are we transmitting every EKG? Now, let's look at -- we look at 90 percent on response times. I'm not saying don't look at how many EKGs we missed, but let's find the percentage, or something that works.

Because if you go on that, then it really turns into a fractionalized, penalized system that becomes over- -- you know, just overburdensome to the contractor. So I just think those are things that need to be looked at.

Um, sustainability is important. Um, we have good fire partners. Obviously, we have -- I mean, great fire partners. I want to say that. Uh, we all work well together. Um, you know, the -- the PPP, uh, I do not believe, should be a scored option.

You know, 10 years ago, it was a mandated response. We had to lay out exactly what our costs -- it l- -- it's kind of the same layout, but I think when you're scoring what we're offering, I don't know how you're really going to delineate how you -- how you get the highest score.

By offering the most money? I mean, those are the things that, uh, I just think we have to look

at that. We really have to analyze what that is.

Should the PPP be part of the RFP? Absolutely. But should it be scored? That's the part we're -- I think we need to look at. Other part is when you look at fire first response system.

There's literally no mention in the fire first response system of how we take care of the non-PPP cities. You know, is there a med exchange?

Is there -- so, you know, Rio Vista Fire, Cordelia Fire, uh, Montezuma. There's a lot of, you know, non-PPP cities. [inaudible] City. There's a lot of non-PPP cities, and they're not even being graded.

And so, that's a complete reversal of how the last RFP went. And I'm not saying to do the same RFP 10 years ago, because everything needs to be updated. But those are just things that we have to look at as, um, as a system.

So, you know, we're not a big proponent of the Alliance Model. I will say that. I don't know -- I mean, one county, you could say it's somewhat successful. Um, however, you know, there are more facts, and maybe Kirk can speak to that.

But I know there's a letter from EMSA that's out there that wasn't discussed. There's a

possible, you know, statewide -- or not p- -- there is an investigation going on with the deputy -- or the attorney general in California.

So I'm not saying that that model's bad; right? Uh, I'm just saying it's not proven; right? One model with all these different things going on does not make it proven. So -- but we need to look at the different -- the different ideas.

Um, I'm not -- Medic's not going to sit up here and tell the city of Fairfield or the city of Vallejo what calls they should go on. I think that's a system-wide call. I think that's something we can identify as a team. Um, as a -- I mean, as a -- as a county.

Um, you know, I just -- I don't want to get caught up in the weeds here. I really don't like the finger pointing. I don't like the -- the push at the for-profit.

Uh, I think the biggest failure of our county right now is not having EMD on 100 percent of our calls, and that hurts our system. That hurts our residents. That hurts -- that hurts everything.

Um, the last thing I will say, um, as it said, the contractor was against it, um, which is true. We don't feel CCT should be included. There's a lot

of other factors in the reason than just saying, well, ALS RN program.

There was a lawsuit. It wasn't related to the RFP. It was related to lack of enforcement of the ALS franchise; right? They -- SEMSC, county staff resolved that to through the ALS RN program. And it's proven to be a high-level service.

That doesn't mean it's -- that our hospitals are less served on CCT. Since ALS RNs program, all of our hospitals have gone out for bid and there's three contracted CCT providers in our county.

So I think you should allow those hospitals to maintain that free market approach. Why you use the cost shifting in the ALS franchise when the current providers that are contracted with the hospitals have done that cost shifting through their non-emergency business and BLS?

So those are things that I just think that need to really be looked at. And that, it's not saying, you know, as an entrepreneur, bring it all. We'll take it all. But it just doesn't make sense; right?

It just doesn't make a lot of sense. Allow the hospitals to have that enterprise. Um, unless there's any questions for us, uh, that's really

kind of where I'd like to -- and I don't know that. How'd I do? Was it -- was it under four --

MS. CORSELLO: Eight minutes. That's not bad; right? Okay. So, um, Andrew Tomolusu [ph].

MR. TOMOLUSU: Yeah.

MS. CORSELLO: Okay. You can tell the air conditioning is working. That's why the nameplates are moving.

MR. WHITE: Um, Chair [inaudible]. Um, how many more, uh --

MS. CORSELLO: Uh, well, I have three cards. I don't know if they're all here. There's an Alan Shear. Okay. Could, uh, I'm not sure your mic is on.

MR. SHEAR: Sorry about that. Okay. Um, what's most concerning to us is the -- is that the recommendations signal a significant policy change in how emergency response is conducted in our city without actual financial information and patient outcome data from our city and without a robust public engagement process.

The city asks that the board consider the following points, uh, in your deliberation. Centralized medical dispatching. The city understands that there is a need to work

collaboratively with agencies county-wide to ensure that resources are dispatched appropriately to address emergencies.

The bluep- -- the blueprint report recommends, quote, converting to central dispatching for emergency medical calls, unquote, without considering the harmful and dangerous implications of bifurcating EMS dispatch from police and fire dispatch.

We are concerned about the negative impacts on communication and coordination that could occur with our police and fire units that need to be deployed by adding yet another dispatch center. More analysis and outreach should b- -- should be performed with Solano County and all of the participating cities to develop a long-term approach to address this issue.

Privatized medical dispatching. A transition to private dispatch services provided by the selected ambulance service provider is a fundamental shift in our services that are -- are currently provided and needs significant discussion with the affected agencies m- -- moving forward.

Tiered EMS response. Implementing this recommendation would result in a reduction in

services to our residents. We are concerned about the degradation and the level of customer service provided in our community and to our public safety staff.

Often, what is conveyed to a dispatcher is quite different than what is found by emergency responders in the field.

Deploying an ALS response to calls ensures that the resources are in place to address circumstances in the field that may be different than what was conveyed to a dispatcher over the phone.

Financial impacts. The blueprint report needs to -- needs to clearly articulate the financial impacts of its recommendations not only on the city of Benicia but on all of the member agencies in the public-private partnership. This funding stream is returned directly back to the EMS system and assists in providing excellent emergency medical services to our residents.

Uh, despite the concerns that I just mentioned, there are recommendations in the blueprint report that are promising.

Uh, more specifically, a new approach to liquidated damages based on patient outcomes and

other changes that would ensure a greater level of financial transparency and accountability are all items that should be continued.

Uh, in conclusion, uh, the city asks that you consider our concerns and allow more time to engage the parti- -- the participating cities, such as Benicia, in the decision-making around these changes. Thank you.

MS. CORSELLO: Last two cards. Jarrod Inf- -- Infante? I'm sorry if I said that wrong.

MR. INFANTE: Good morning, Chair, Board, Staff. Uh, Jarrod Infante, uh, Dixon Professional Firefighters Association, Local 4665, uh, secretary. Two issues, please.

Um, Wolf- -- Wolfberg cites a study of lack of association between pre-hospital response times and patient outcomes. This is a single study and in the first sentence of the study, it admits that there is limited data to support the claims it's trying to make.

Uh, if you have a Bachelor's of Science in any field, as many of the people in this room have, uh, you know that, uh, it takes rigorous effort, uh, in order to prove a hypothesis.

Uh, this is a single study, uh, without any

counter studies, uh, to disprove its hypothesis. Um, this study uses a 10-minute 59-second response time as a standard. Uh, in this county, we currently ensure that firefighter-paramedics are on scene in 7 minutes 90 percent of the time and we are highly successful with this number.

In the study, they only look at a total of 373 patients. Just 373 patients. We run r- -- roughly 30,000 EMS calls a year in this county. In this study, they made their claim that there was only a 2 percent difference in the mortality, uh, when the patient received, uh, care below the 10-minute 59-s- -- second, uh, mark, versus the -- versus, uh, going beyond that.

Again, they only look at 373 patients, um, uh, and that was an improvement. Please understand there are multiple locations in the study, uh, in the blueprint, with citings like this. Please do due dil- -- diligence and, uh, research, um, the work that they did.

The other issue, uh, Bryn Mumma, uh, becoming involved in the RFP process. Uh, she was -- she was contracted by UC Davis, um, to be the medical director for the sole purpose of overseeing the clinical aspects of the LEMSA.

Her duties include, per policy 1705, evaluating the care of paramedics and EMTs, reviewing medical components of the dispatch system, optimizing patient care, oversight of legal documentation, DEA licensing, and participation of, uh, on the Physicians' Forum.

Nowhere in these roles and responsibilities does it state that the medical director have a part in drafting, uh, of, uh, the RFP. Nowhere does it state that the medical director should have contact with the ar- -- author of R- -- RFP or how it is written.

Nowhere in the medical director's roles and responsibility does it state that she should be asking for more money disbursed to the LEMSA. And nowhere does it state in the medical director's roles and responsibilities that she has any right to talk to the author of the blueprint about forcing city governments off the voting board for the RFP adoption.

It can be seen through public record e-mails that Dr. Mumma has overstepped her responsibilities and we kindly ask that the board use Dr. Mumma for what she was paid for, her professional expertise in clinical aspects of our medical system. Thank

you for your time.

MS. CORSELLO: Thank you. Okay. There's multiple names on here. So this is Casey Vanier.

MR. VANIER: Members of the board, uh, Staff, I appreciate the opportunity to, uh, speak with you today. Uh, my name's Casey Vanier. I'm a labor representative with, uh, UEMSW, uh, uh, United EMS Workers Local 4911, AFSCME local. We represent all the EMTs and paramedics that currently work at Medic Ambulance.

Um, what we have to bring forward today is that we hope that you cont- -- continue to support some of the things that we've suggested that have gotten into, uh, what appears to be into the draft.

Um, myself, as a -- I worked in this county, um, with a lot of these individuals for almost eight years. Uh, I know some of the challenges of the county and the system.

Um, some of the things that we really, uh, push for is, uh, things that support the environment and conditions of our workers, uh, to make sure that they're taken care of.

Such as things as, um, that were put into the draft as, uh, making sure that they're provided with posts that give them the, uh, the ability to

use restrooms, heat up food, um, take breaks.

Even, someone brought up the fact of, uh, you know, maybe even a boots up type of station, which gives them the opportunity to recharge, refuel, get the food they need. Um, they work long shifts, uh, long hours, several days in a row. So we need to make sure that they're being taken care of.

Uh, another thing that's been put in the draft that we really want you guys to support is mental health and suicide prevention. Uh, I think everybody is probably privy to the numbers that are out there, plus, some of the increased activity we've had in those areas, um, with suicide, uh, in private industry and public industry.

Uh, another thing that we asked for was improvement on infrequent skills, uh, to make sure that those are being used. Um, if they're not being used, then that gets implemented into a program to where the provider, um, whoever it may be, continues and -- and -- and will further, um, be training of infrequent skills, such as things as, you know, needle cric, um, even down to intubation and IOs, which are things, you know, that we don't use every day.

Um, of course, um, another thing that's, uh,

very important to our group is incumbent workforce language.

Um, if we -- if there is to be a change of the, uh, providers or who you select. Uh, we want to make sure that our -- our workforce is taken care of and not just swept aside by a new provider.

Um, they want -- we want to be heavily cons- -- be considered, whether that be through a process or whatever. But we want to ensure that our members are taken care of in case that transition needs to happen.

Uh, one of the previous speakers, um, spoke to the language that we proposed about retention. Um, we've had issues with retention as being the representation of the members in Solano County.

And we're not talking about the type of retention where you have somebody who's worked as a paramedic and then is now furthering themselves or taking a different position or trying a new challenge as a firefighter or a flight medic or things of that nature.

What we're looking at is things of -- due to, uh, you know, burnout, um, you know, sh- -- being short-staffed and working excessive hours to where, you know, people aren't functioning properly, which

even ends up in, um, you know, making mistakes on calls and things of that nature.

So s- -- watching staffing levels. Um, and just to make sure that, uh, you know, people are being treated fairly and correctly, whoever the provider is. So we ask that you guys have some oversight in that.

Because we all know the continuity of care is what we're after; right? And, I mean, if you have people turning over at the bottom, so to speak, um, there's no continuity between the fire crews, even the person you're sitting next to.

Um, and that's no good for anybody's level of service. So those are the things that we have, and I appreciate the opportunity.

MS. CORSELLO: Thank you. That is the last speaker card. So I take it back in our hands. Uh, it's the pleasure of the board as to how you'd like to proceed.

MR. WHITE: Well, I guess the question is, um, how are we going to address, uh, these issues that have been raised, um, Chair?

So, uh, I'll just read two quotes from Mr. Wolfberg that I think are particularly germane to this conversation and I think are problematic, that

we should talk about. So he says in this -- I received this through, again, a letter that the board receives. So I have something that we all have.

Mr. Wolfberg wrote on August 15th, uh, to Mr. Selby, this reminds me. I think we're going to need to be sure we lay some groundwork with the board before this RFP goes to them for approval.

There's going to be a lot of opposition to some of the things we're going to want to put in there and the board, certainly, is going to hear about it. Want to make sure they know why these things, like centralized medical dispatch, are going to be good for the system.

They're going to need to stand up to the fire chiefs on this issue. But with the city manager and a fire chief on the board, it's going to be tough. I'll let that sit out there for a moment.

The second comments from Mr. Wolfberg to, uh, Dr. Mumma, who I absolutely respect and adore. So this is not aimed at you. Mr. Wolfberg says to her regarding the, uh, disclosure from the Physicians' Forum.

Do you know what the timetable would be for finalizing such a statement? Would it have to wait

until the next committee meeting? Obviously, this statement would need to be timed to be able to positively impact the process given the timetable that was set forth yesterday, probably the sooner, the better.

Also, do you know if there's any chance we could see a draft of the statement before it would be released and circulated? So I don't know Mr. Wolfberg. I've certainly never been through this process before.

I can certainly tell you as a city manager and as the representative for all the cities in the county that my number one interest is to ensure the highest level of care and safety for the residents and businesses in this county.

Why? Because we will thrive if that the is the foundation we build from. So my perspective is -- is that these statements, along with what is shared to us, is quite damaging.

It shows a high level of manipulation and I certainly think this board should agendize the very focused discussion on whether or not we should be working with Mr. Wolfberg. Because I do not think he's doing you service, Chair.

You have committed to me a process of

accountability and a process of transparency. And I will have to say, from what I saw from you today, I've absolutely seen those, uh, principles and values upheld.

You let people speak longer than I've ever seen anyone speak in a public meeting. And I think that is very commendable. I think that you have also done a fabulous job in terms of ensuring that, uh, our voices are heard, and I think that's commendable.

I do not think this consultant is doing you any service or us any service. And I think it is extremely problematic we have a consultant that is specifically undermining the process by which we have known could be highly litigious.

I think that we are all wonderful at what we do. We are all public servants. I don't think that anyone h- -- here who knows me, specifically those who work for me, will say that I operate from a perspective of deception, manipulation, or lack of integrity.

And I think Mr. Wolfberg's actions are deplorable. So I do ask this board to consider putting on the next agenda a discussion of whether or not he can serve us in good faith and in good

duty.

MS. CORSELLO: Are you making that as a motion?

MR. WHITE: Absolutely.

MS. CORSELLO: So do I have a second for that request?

FEMALE BOARD MEMBER: Second.

MS. CORSELLO: Okay. So I have a motion and a second. Any further comment or conversation?

MALE BOARD MEMBER: Uh, I have a question for Mr. White. So, um, I think that there is -- you know, there -- there's a lot of kind of information that's -- that's been going around today.

Um, you know, I'd love to get your opinion whether you would be okay if we had a closed session, uh, so that we could discuss this with Counsel, um, to have a better understanding of, you know, what's at stake and --

MS. DARBINIAN: We couldn't have closed session today and this isn't something that would be a closed session item. So we couldn't discussion in closed session.

MALE BOARD MEMBER: So this is appropriate to discuss openly, then?

MS. DARBINIAN: You don't have a choice.

MALE 1: Okay. Something I'd love to hear from Mr. Wolfberg, I'd love to hear from you, I'd love to hear from Dr. Mumma about these e-mails that are going around. They seem to be fairly contentious.

Um, I -- I think that we all, um, function from this position that -- that we're all trying to do the right thing. Um, and so, uh, I imagine there's a response to all this.

MS. CORSELLO: Although that item isn't on the agenda today, I -- I think it would be -- I -- I've got a motion and a second to put it on our next agenda.

MS. DARBINIAN: You can put it on your next agenda for -- to specifically address that, but I think Mr. Wolfberg today can address some of the comments that were raised in the e-mail. That would be fine because it's him responding, um, to the comments.

FEMALE BOARD MEMBER: Uh, could I just a couple of other questions of the board. Um, we got a blueprint in October. We got an RFP. We've now got 25 people that have spoken to us and countless comments and, uh, correspondence over the last few days.

Um, are you prepared to at least, uh, separate

from Mr. Wolfberg, good, bad, or indifferent, to talk through some of the key components so we can provide direction to somebody on this RFP process, um, uh, as we move forward?

Is that, uh, is that even a remote possibility? I mean, I've got a list of things I -- I've heard people say they want us to change.

But we have to direct somebody to do something. So separate from questioning whether our consultant has integrity or not, whether our consultant has misled, are we collectively in a position -- and I -- and I do regret that we don't have a fire person.

I hope we get on and we get this issue resolved. Um, are we collectively able to have -- to start to talk about what this is going to look like? Or willing to do so? So I'm looking for some sort of response from the members.

FEMALE BOARD MEMBER: I'm very new to this board, so I don't what's been going on for the past several months. But I think there was so many good points brought up by everybody that, uh, have had points today.

I do think that we need to extend our, um, decisions and address all of that. I mean, perhaps

you have already and I've missed out on that. But they all had really good points and a lot of concerning things to me that I think need to be, uh, discussed further before we move forward.

MR. WHITE: Also, my -- my sense is that there is some consensus around this. It seems like there's consensus around, uh, you know, centralized dispatch. Uh, there's some consensus, um, as I understand it, around, uh, creating an RFP that allows for the public entities to apply.

So that would be removing the population requirement. Um, I think that those are a couple areas where I would feel comfortable directing Staff to revise the RFP at this point. Uh, so --

DR. MUMMA: Well, I -- I agree that if we could build on where there's some consensus now and figure out what our next steps would be around those, that might at least keep us moving in a positive direction and then work out the rest, um, in parallel.

DR. DJAVAHERIAN: And just specifically around centralized dispatch. I mean, to have, uh, the public entities, uh, be able to bid for that as well so that it's not a part of, uh, necessarily, uh, of what the contractor, uh, gets to control.

I think that's -- as the Physicians' Forum representative, that was, uh, one of the things that came up in our -- in our meeting recently. Was this idea that we -- we felt strongly that it should be, uh, in the -- the public sector as far as the, uh, dispatch goes.

MALE BOARD MEMBER: I have a point of order. You guys have a motion and a second. And then, you guys are going sideways.

MS. CORSELLO: We're not -- we're not going sideways. My question -- my follow-up question was going to be do we want to discuss with Mr. Wolfberg the communication or do we want to discuss the RFP and changes we want to direct happen? I thought that would be important.

MALE BOARD MEMBER: Do you have a motion on the floor [inaudible]?

MS. CORSELLO: Yes. So, uh, and if you're going to challenge me, fine. Give me a chance.

MALE BOARD MEMBER: [inaudible]

MS. CORSELLO: Uh, uh, you know, most people know that I'm pretty fair and very ethical on this whole process. So there's a motion and a second to put Mr. Wolfberg on next -- the next agenda for a conversation.

Is there a -- is there a -- is there a willingness on everyone -- I'm looking for all ayes or -- so that's going to -- I'm calling for it because I've got a motion and a second. So I see one. I'm willing to put it on the agenda. You made the motion. That's two. So there's three.

MALE BOARD MEMBER: Yeah. [inaudible]

MS. CORSELLO: At least. Pardon? Yes. I'm willing to put it on the agenda.

MALE BOARD MEMBER: I move --

MS. CORSELLO: Okay. All right. So -- so we will put him on the agenda. Legal said we have the ability to call him on the carpet and ask questions about the -- the communications.

Do we feel that's necessary today or are we ready to deal with anything else? So, one, do you feel that's necessary today?

MALE BOARD MEMBER: I think if he's on the agenda for next time, we don't need to -- to bring him back.

MS. CORSELLO: Okay. And I saw at least one other head nod no. And you're also in agreement? Okay. So we're not going to ask him to come up to speak to it today. All right. I did ask the question of do we want us to try and weigh in on --

based on the comments we've heard today any piece of this RFP process?

So I'm looking for -- I've heard so far emergency medical dispatch. Is that a subject that we are prepared to at least discuss and provide direction on?

MALE BOARD MEMBER: Yes.

MS. CORSELLO: That's one yes. I'm willing to discuss it. You are too? Okay. So Caesar, would you like to discuss what your suggestion is?

DR. DJAVAHERIAN: Well, I -- I think that we've h- -- heard compelling arguments from the, uh, from the public entities that, uh, they feel like they can put together a consortium to control, uh, the dispatch process.

And -- and so, I -- I think that as the RFP stands today, uh, they wouldn't be allowed to, uh, participate, um, un- -- unless they win the contract fully. And, um, the Physicians' Forum group felt strongly that dispatch should be in the public sector.

And so, I'd love to get everyone's feedback on that, uh, conversation. And Dr. Mumma, if I'm misrepresenting that, please, uh, correct me since you were there.

MS. CORSELLO: Further discussion from any member?

MR. WHITE: One of the questions I have is on emergency medical dispatch. There seems to be unanimous, um, consensus for it and I've heard both, uh, best practice from it and I've heard from the numerous speakers about the value that it serves.

One of the questions I have is, um, is -- given that it's really, um, certainly under the purview of party dispatching the core purpose of this board to be looking at that, is that something that necessarily we do through the RFP?

Or can we talk about that, as a board, as something that we work with the fire agencies on, um, separately? I -- I heard a reference to EPCR, so I'm just wondering, you know, what are the dis-- what are the policy and the implementation things that we can do outside of this process? Is this something that can -- the dialog can start?

MALE BOARD MEMBER: Uh, Mr. White, I'd be happy to address that. We can, in fact, address, uh, emergency medical dispatch through medical control through policy if -- if we're directed to do that by the board. So it is an option.

MR. WHITE: And the -- and the reason why I raise that is because it's clear to me that this is, um, something that everyone is interested in doing and I -- and I've heard a- -- another comment that I can't quite, uh, put a name to, and I apologize.

But, you know, I think it's important to, you know, sort of dip our toe in the water before we jump all in with this. And, um, I think it'd be wonderful for us to think about how we can be innovative and talk about how do we work with the various fire agencies and the various PSAPs to try pilot projects and empower that to occur.

So that we can start gathering evidence locally and understand sort of within our own systems how this would work so that we can really be proactive in accomplishing, you know, meaningful change and -- and something different that we all acknowledge will help patient outcomes and be, uh, useful.

MS. CORSELLO: Any further comment? All right. Is that going to be -- so is there going to be a motion to take it out of the RFP, which is what I think I heard you say? To cha- -- or is it to change how it's reflected in the RFP?

MALE BOARD MEMBER: Well, I think it -- you know, there's sort of a bigger level discussion that I -- I think we need some facilitation -- assistance on in terms of what is the system that we are putting together?

So, you know, EMD belongs in this RFP if you're going with a centralized approach. That makes a lot of intuitive sense. But, you know, given, I think, what we're hearing, I think we have to start from the basics of what does that system look like?

And then, we can figure out where it belongs. So if -- if there's unanimous agreement that we're going to continue with the PSAP approach that we have, then I think it's -- I would love to be -- have that discussion with staff about where EMD fits into the bigger picture.

MALE BOARD MEMBER: And I'd love to get some direction on how we could, uh, accomplish that. I think I have a general idea of, uh, putting together both the evidence, the medical evidence, as well as the comments that this county have a general idea of what seems like it should be.

But I -- I don't know, um, what the process is for us to direct Staff to -- to do that. So --

MS. CORSELLO: Okay. So in light of the fact that there have been -- you're asking to speak with Staff -- you're asking to speak with Staff and we actually need to do that in this setting. Let me see if I can take a stab at this.

Uh, I am not supportive of a private EMD, emergenc- -- I'm -- I'm not supportive of that. Uh, we have enough dispatches, enough PSAPs in Solano County already. And we've been working really hard to get us all on the same playing field.

Um, so if -- if I have to make a motion that says we're not going to require that to be a privatized piece, I'm willing to make that as motion.

And it'll be up to the rest of you to decide whether you want to second that motion or whether we move on. How's that? Okay? So, uh, I'm going to make a motion that the RFP at least be modified that it does not require the privatization of our emergency medical dispatch.

Now, that said, uh, I am supportive of us moving forward with emergency medical dispatch in some fashion. Uh, I -- I didn't hear anybody speak against that today.

They may have spoken against a lot of other

things, but I didn't hear any speak about -- so how we get there, I think, is going to be a challenge for, uh, all the fire chiefs and the police chiefs and the EMS staff.

So I'm willing to make that motion and I'm just looking if there's going to be a second to that or not. Okay. So David has made a second. All right. So we're clear.

MALE BOARD MEMBER: And can we add maybe a timeframe for that?

MS. CORSELLO: Okay.

MALE BOARD MEMBER: So perhaps a year. Is that too -- you guys tell me. Is that too short a period of time to --

MS. CORSELLO: So you want to make it -- you want to make an amendment--

MALE BOARD MEMBER: -- coordinate --

MS. CORSELLO: -- to my motion a year from when? Now? Or when we award the contract?

MALE BOARD MEMBER: Uh, I h- -- I have no practical knowledge about how long it would take to -- to train and implement.

MALE BOARD MEMBER: So, uh, I mean, I -- I think if we're in agreement about not privatizing the dispatch and we're in unanimous agreement about

the EMD, I think that would be another good agenda discuss for us to hear, for example, like, the fir-- from the first speaker.

And really talk about how we can work with our fire departments, our police departments, and have a collaborative discussion and develop a timeframe; right? Is it within -- before the next contract comes up?

Or is it going to take longer in how we deliver that? I think that would be a -- a wonderful discussion for us to have a board, um, to move that forward.

MS. CORSELLO: Okay. So now, I have two amendments. One, that we established a timeframe. I'm willing to accept that as the original maker of the motion; and the second that we agendize that.

So agendize in January and ask somebody to come and talk to us we can figure out what we're putting in. Is that -- I'm -- I'm -- come on, guys. You're going to have to --

MALE BOARD MEMBER: Yeah.

MS. CORSELLO: -- help a little bit here. I'm tired too.

MALE BOARD MEMBER: I -- I support what you said.

MS. CORSELLO: Okay. So --

MALE BOARD MEMBER: Well, I -- I guess the question is, I mean, uh, I -- I can put a -- a ton of work on Staff's shoulders; right?

I'm -- so I'm going to be mindful about where we are in the year what we have to accomplish. So if our mission, number one, is to shape and mold this RFP, I guess the question is, you know, instead of doing that discussion in January, do we wait for our next meeting, which is -- I don't know.

I mean, so you can get some thought to who the people we should speak to, what that discussion looks like. I just want to be mindful of that part of it. About how much do we have to bite off immediately.

So I would say, to be clear, that we, uh, save that for the second meeting in 2019, as an agenda discussion. And that, uh, so that's how I would amend your motion.

MS. CORSELLO: I'm willing to accept that. You were the m- -- you were the second. So where we sit today is the RFP would not reflect the privatization of EMD. The com- -- the -- this board is supportive of having a follow-up presentation on

EMD in the timeframe that it would take in our jurisdictions and how we would go about that, for April.

Um, uh, and then, the question really is w- -- what do we say in the RFP? And right now, since we're still working on it, I guess we can tackle that in January if we need to. So I had a motion and a second. I'm going to call for --

MALE BOARD MEMBER: Uh, Madam Chair, can I -- can I ask for a clarification --

MS. CORSELLO: Yes.

MALE BOARD MEMBER: -- before you vote? Uh, the iss- -- the RFP doesn't call for EMD in the private sector.

It calls for a PSAP model that is centralized in the private sector. And so, I just -- I -- if you're voting on not having that, that's different from not -- privatizing EMD. EMD is just a concept. It's a practice.

And -- and many private sector ambulance companies already practice EMD. The idea -- the -- the issue that was brought into question consistently was the PSAP being privatized.

MS. CORSELLO: And my motion was I don't want that part privatized.

MALE BOARD MEMBER: No, no, no. I appreciate that.

[talking over each other]

MALE BOARD MEMBER: But -- but I want to -- I -- I -- I thought that --

MS. CORSELLO: I would like to figure out how to do through the existing PSAPs.

MALE BOARD MEMBER: Correct.

MS. CORSELLO: However many there are. I mean, I'd love to see us get to one centralized, because I think redundancy is nice, but it's expensive. Uh, but, uh, I -- I think we, uh, as an EMS group, our responsibility should address healthcare, not pl- -- politics of this particular --

MALE BOARD MEMBER: No, no. I completely agree with all of that. Uh, I just wanted to -- to be clear that the RFP calls for a PSAP model that you are suggesting be removed. And that doesn't reflect EMD per se.

MS. CORSELLO: Just let us get through this piece first, please. Okay. I think you'll have to -- in January, you're going to have to put that on the list of things we didn't provide direction on because I'm not clear.

Uh, so can I call for the motion at least to

what we have so far? Is everyone clear on what we -- what we're doing? Okay. So all in favor?

ALL: Aye.

MS. CORSELLO: Opposed? None. Abstain? Okay. We got through one decision. Okay. Um, are there any other items -- I mean, I've got a list of things I know we're supposed to provide during on.

Are there any other items at this point that you are prepared to provide direction on with regards to the RFP?

DR. DJAVAHERIAN: I thi- -- I think the, uh, issue about, um, uh, the criteria for being allowed to participate in the RFP process, requiring the 300,000, uh, population served, we'd li- -- I'd like to move to strike that and retain the five-year requirement. Uh, I mean, the benefit is that we get to see more applicants.

MS. CORSELLO: Okay. So is there a second to that recommendation?

MALE BOARD MEMBER: I guess what I would love to do before, uh, we vote on that and save that for January is that you, um, Mr. Broschard indicated that he'd be sending us over some information from Contra Costa. I think I would just like to see what that looks like and what that -- how that is.

Um, because I don't how that impacts the experience discussion. And so, I would just like to better understand the various models out there.

I would also like to hear a little bit more from Dr. Mumma in the recommendation from the Physicians' Forum.

You talked about wanting to see innovation in that regard and I would just be interested to hear from your perspective how to craft an experience requirement that would cultivate innovation, because that seems to be something that's important.

DR. MUMMA: The -- I can briefly summarize the discussion from Physicians' Forum. Um, we agreed that this was -- you know, this is a big project. This is not something that we want to take a risk on and take a gamble on.

Uh, so we -- we -- in that exe- -- in that sense, we agreed with the experience requirement. We wanted someone who knew -- we knew would be reliable and would take good care of our citizens.

But at the same time, we didn't want to completely cite motivation if there was potentially -- we -- we used analogy of a sta- -- a start-up. So a smaller company that was still scaling up.

We felt that if it was going to be a smaller, uh, a smaller contractor bidding, that we would want to see a clear plan for scalability. Uh, cl- -- some clear evidence.

Um, just a very clear plan, that it wasn't just innovative, we're going to try this, but a clear, um, plan that that entity would be able to provide the service. So that's, I think, what we were getting at with innovation. Does that make -- does that answer your question?

MS. CORSELLO: So does that result in, uh, okay. So I think the suggestion is -- Caesar would like us to, uh, change the population requirement.

Uh, I think, David, you have indicated you'd like for us to look at that in the bigger picture and agendize that for January. So I don't have a second on either of those at this point. Um, is there a second on Caesar's suggestion?

MALE BOARD MEMBER: Got to say I'm okay, uh, moving on with -- with what David suggested. Because I -- I would also be interested in seeing the, uh, Contra Costa model.

MS. CORSELLO: Okay. So direction to Staff is we want to agendize the question with regards to the 300,000 population. We would like to have

information on how Contra Costa is set up, uh, if I understand. That's -- that's David's motion. Caesar, you just seconded that?

DR. DJAVAHERIAN: I would second it. Yeah.

MS. CORSELLO: Okay. Uh, I will call for the question to make sure we're all on the same page. Is everyone in favor of that?

ALL: Ayes.

MS. CORSELLO: I see no nos. No abstentions. Okay. Um, there are other items that were identified today. I've got a lot of notes too.

Um, uh, so I'm going to ask are there other items today that you are prepared to take an action on or that you would like to specifically discuss in our next meeting I'm taking and requesting additional information on?

MALE BOARD MEMBER: Um, well, a couple of areas. As I flip through this, I definitely would like to talk about, uh, the review panel, um, uh, criteria in the proposal.

What -- I had a different, uh, reaction to it than what was commented. I was just more concerned about the lack of local, um, uh, requirement for local, uh, input.

And so, I just -- I think it would be good for

us to talk about what that makeup is and I'd love to hear from Staff about one or two panels, what discussion would look like. That was an innovative approach I'd never thought of. Um, so I think that would be, uh, useful.

MS. CORSELLO: So you're -- you would like to have that agendized as well?

MALE BOARD MEMBER: Correct.

MS. CORSELLO: Is anyone else prepared to discuss that today or are you comfortable with it being agendized as one and then, uh, one or the other topics that needs to be addressed? I'm looking for a second on David's suggestion. Yes?

FEMALE BOARD MEMBER: I second the motion.

MS. CORSELLO: Okay. I have a second. T- -- uh, is everyone else comfortable with that's another area we want detail on? Uh, then, I'm going to call for the question. All in favor?

ALL: Aye.

MS. CORSELLO: Anyone opposed? Any abstentions? Okay. So that's another topic. Uh, I would like to see, uh, at the next meeting the actual map that clarifies the question that was raised by the city of Vacaville so that we have no more confusion about what is in and what is out in

terms of the area that's covered. Is everyone okay with that? Okay. See lots of heads nodding.

MR. WHITE: I'll second that.

MS. CORSELLO: David has seconded that. Do we need a vote on that or are you okay, that we know that's part of what we need? Okay. Um, okay. As you're going through your notes, what else?

DR. DJAVAHERIAN: Um, I have one, um, regarding the CPI, uh, rates. So -- so essentially, uh, under G1 [ph] core requirements and then NMG [ph], it says contractor's sole compensation of the contract shall -- yadda.

Essentially, in seeing -- in the event that the annual average CPI figure is zero or negative, the contractor shall not be entitled to an automatic increase in charges. I think what we're really saying is that in cases of recession, where everyone's hurting, so even though you have more uninsured people, we're telling the contractor that they can't continue to raise rates.

Even though, probably, there's a greater percentage of their patients who are uninsured and they're providing free care to. So this -- this seems to be hurtful to the contractor.

And so, I would -- I would m- -- move to

remove that and that the CPI increase continues regardless, uh, maybe to some minimum that's -- that's reasonable, maybe 1 or 2 percent, during those periods of time.

But that -- but you can imagine that their uninsured population is going to increase, um, you know, during times of recession and so --

MS. CORSELLO: Can you cite the section that you're referring to? Because I -- I see everybody flipping through their documents. All right. So would you restate that? I want to see if anyone is ready to make a -- to second your suggestion that we make that change at this point as well.

DR. DJAVAHERIAN: Yeah. So -- so I would move to amend item G to in -- uh, essentially the last sentence, where it says in -- in the event that the annual average CPI figure is zero or negative, the contractor shall not be entitled to an automatic increase in charges.

I would move to change that to, uh, the contractor shall be entitled to an automatic increase of 1 percent.

MS. CORSELLO: Is there a second for that?

DR. DJAVAHERIAN: Uh, [inaudible] --

MS. CORSELLO: Somebody -- okay.

MALE BOARD MEMBER: Just in regards to medical CPI. I mean, Caesar brought up a good point, that, you know, for recession, you know, you have the parent exchanges, but also, you -- you're requiring of a contractor to keep up competitive wages too; right?

So, uh, putting a number on it's tough. I would just say, uh, that they can get a raise, but they have to come and explain to you what they need and why. So I would just, you know, make it more common sense than actual, you know, number.

Then, having to prove that 1 or 2 percent go to Y and -- allow the contractor [inaudible] to explain to you why they need a raise.

MS. DARBINIAN: I -- I believe that's addressed in the next section down, in letter H.

DR. DJAVAHERIAN: So you're saying that if we remove G, you're saying that H would then take over as a --

MS. DARBINIAN: That's how I'm interpreting those two together.

MS. CORSELLO: So what's the suggestion? That we would strike that one sentence and interpret that G and H are linked? Is that -- is that what you were suggesting?

[inaudible]

MS. CORSELLO: Okay. Oh, we turned your -- go ahead. Restate.

MS. DARBINIAN: I'm suggesting that it can stay as-is because of the provision that's in H.

MS. CORSELLO: Okay. So Caesar, are you okay with leaving it in given that H would allow them to make a justification? That's the counter. That's, like, the second motion.

DR. DJAVAHERIAN: Yeah. That -- I guess if everyone has that understanding, uh, then that -- that would be fine with me.

MS. CORSELLO: All right. So you're withdrawing your -- your suggestion?

DR. DJAVAHERIAN: Can I heard from you what y-- what -- what you think if --

MALE BOARD MEMBER: Well, the thing I didn't like about keeping it as-is is that it's extraneous circumstances.

Which -- how would you define that? It's really vague. You know what I mean? If you, uh, obviously, [inaudible] exchanges, you could argue that's extraneous, but I just think that if the CPI is zero and the contractor wants it, they're going to have to come and explain it to the board why

they need it.

So just -- you're just taking out the verbiage that says it has to be this extenuating circumstance. If the CPI is zero, the only way to get it raised is that you have to come and ask the board for why you need a raise.

MR. WHITE: So with that feedback, I -- I wonder, Caesar. She asked you the question of maybe is that acceptable language to say that if we have that event where it's zero, negative, then they would have to come to us for any kind of raise in -- in the case if there's a conflict with that Section H?

MS. CORSELLO: Are you offering that as, uh, a language? Uh, it sounds to me like that might address the comment that's made.

MR. WHITE: Yes. In elegant language, yes. But I'm offering something like that.

MS. CORSELLO: Okay. So -- so we're back to Caesar.

motion.

DR. DJAVAHERIAN: Yeah. Um, I would accept that.

MS. CORSELLO: All right. So David, see if you can ineloquently restate that.

MR. WHITE: Well, I think the -- the concept we're trying to get across is that -- and maybe it's a new -- maybe we create a new subsection.

But just to be very explicit, that in the event the annual CPI figure is zero or negative, then I think we're putting the -- on the shoulders of the contractor to come to the board to justify any kind of increase that may be necessary.

And we -- I'm sure there's some better language to add to that, but that's the concept we're trying to incorporate into the RFP.

MS. CORSELLO: Okay. So that's a motion.

DR. DJAVAHERIAN: I second.

MS. CORSELLO: You second. Any further discussion? Okay. All in favor of that amendment?

ALL: Aye.

MS. CORSELLO: No? I hear no nos and no opposition, so that's another change that we can agree to. Excuse me. Any others at this point?

MALE BOARD MEMBER: Well, flipping, uh, Bayla had some suggestions and recommendations to us around the scoring criteria and scoring matrix.

I don't know if that's a discussion we'd want to save for the January meeting, but I'd love to hear him flesh out some of the thinking about

reallocating some of the scoring. Um, there was some thoughtfulness put into that recommendation.

Uh, when I look at it, it resonated with me, but I would like to hear more about it and have some discussion on it.

MS. CORSELLO: Everyone else okay with putting that on next time's agenda as the specific subject, the scoring criteria? I'm watching heads nod. Okay. Are there any other directions you want to provide in terms of changes?

MS. DARBINIAN: I would also suggest that perhaps some of our discussion around the response time.

It seemed like we had a lot of conflicting information today about people's perception of, uh, the current response times in this document. Are they longer? Shorter? Um, public perception of that relative to how we're really performing today as a system.

Perhaps being able to lay all those things out side by side and look at the facts of -- of what that looks like to make a determination as to what we'd want to build into the RFP.

MS. CORSELLO: Any other comments on that subject? Because I'm inclined to agree with you.

What I heard today was from the Physicians' Forum. They have a suggested change, I think I heard, in the private sector.

They're doing better than some of what's in there. Okay. So we want to agendize that item as a subject and ask Staff to bring back comparisons of some of the things that are real today.

What we have today, some of what you heard today is the subject that we can provide direction on; okay? I'm watching heads nodding. Okay. Other subjects on the list?

MALE BOARD MEMBER: Um, something that arose to me from the last speaker was about the incumbent workforce.

Um, the language here, uh, as it pertains to incumbent workforce, walks about maintaining it at substantially equivalent compensation and conditions of employment.

I guess my only concern is -- is that, as opposed to -- is that creating downward pressure so that if the new contractor wanted to do something more rich for the employees, I just want to make sure we're not putting, uh, an artificial ceiling.

Uh, rather, ensuring that people aren't any worse off but could be in a better situation. And I

just want to make sure I understand that language correctly.

MS. CORSELLO: Are you seeking clarification now or at -- in our next meeting?

MALE BOARD MEMBER: We can do it at our next meeting, so I could look at it some more.

MS. CORSELLO: Okay. Everyone okay with that one, for being brought back? Is there anything else you want to either address today and/or provide direction on or bring back?

DR. DJAVAHERIAN: I just -- I have one last one. On Page 75, Item N2 [ph]. Um, so I -- I would just ask that the total revenue collected be broken down between, uh, uh, patient and insurance company.

So just the breakdown of those two to be specified. So Item N2, um, requiring, um, disclosure of how much revenue is collected. I think -- I think having that information by how much is collected from patients, uh, versus insurance company would be helpful.

MS. CORSELLO: Everyone else okay with asking for that additional piece of the submittal?

MR. WHITE: Yes.

MS. CORSELLO: Okay. So I've got a -- I saw

heads nod. This is actually a change. So David, you're making a second on Caesar's suggestion?

MR. WHITE: Yes.

MS. CORSELLO: Okay. And I'm going to call for the question so we have clear direction that we're going to make that an -- as an amendment. So, uh, any further discussions? All in favor?

ALL: Aye.

MS. CORSELLO: Okay. Any opposed? Hearing none, seeing no abstentions, that one, at least, is another change we can take forward at this point. Any further -- any others?

MALE BOARD MEMBER: Uh, we've heard -- we heard some opposing discussion about the CCT issue.

Um, so I think it would be good if we could have discussion as well, just to understand better in the contract and out of the contract. Um, I'll just say I'm honestly not clear, so I'm not in a position to make a position about what I would recommend or what I would suggest.

But I would like to hear more about that, the benefits and the tradeoffs in -- in versus out.

MS. CORSELLO: And I -- I would agree. I will second that because what I heard today is the Physician' forum has one interpretation. I think

the health staff has another. The ambulance company has a third.

Um, if we're going to open this up in some fashion, my guess is this is not one that other jurisdictions are necessarily going to be able to put forward. So we would like to see that item on the agenda with kind of the positions from various people and the -- and of the analysis. Everyone else okay with that?

MALE BOARD MEMBER: Mm-hmm. Yes.

MS. CORSELLO: Okay. All right. Uh, let's see. That leaves us with, um, let's see. I think -- I think the concerns about tiered response, we addressed this part of emergency medical conversation and with regards to dispatch.

Uh, I think that's how we get a chance to talk about whether we have any jurisdiction or interest in that.

MALE BOARD MEMBER: Mm-hmm.

MS. CORSELLO: Okay. Because I heard comments to that effect. Um, I heard comments with regard to -- we're going to talk about the 300,000 population. What about the five-year, uh, requirement?

Is -- can we put that in front of the group as

well? I -- I've heard different recommendations and different requests. Um, I would like to at least hear more about that as a specific subject when we come back, if everyone else is okay with that. I see -- I see heads nodding. Okay. Anything else?

MALE BOARD MEMBER: Can we somehow reserve the right as we digest all the comments and review this that we may have further discussion on the enti- -- the totality of the RFP?

Or -- how do you want to handle this, Chair, in terms of -- because I just want to reflect on all my notes that I took for --

MS. CORSELLO: S- -- so --

MALE BOARD MEMBER: Not that I want to open up the whole thing, but just I'm not -- just not sure.

MS. CORSELLO: Well, since we aren't taking an action on the document and we have provided direction, um, I'm going to look to legal. I -- I think we could continue the entire document to the next time.

Hit the subjects you've ea- -- each identified. Uh, and then, if there are others you've identified between now and our next meeting, then, uh, you know, out of fear of communications ex parte or whatever you want to call this, uh, I

almost think you're going to have to -- sorry.

You're going to have to put it in writing and send it to Ted. And he's not going to be able to share with the rest of you what you've asked for. He's just going to have a list of all the things we've asked to discuss. Does that make sense? Okay.

Are we finished picking this apart for today? Okay. I want to thank everyone who's here. You've had a very long day with us. I'm hoping we're getting closer and -- and -- and that we've at least identified the items.

Uh, hopefully, you can tell we heard you, collectively. And we have identified the items that we now need to deliberate on. If you have additional information, since you've heard what those are, I ask that you provide those to Ted for consideration in the next packet.

Uh, and hopefully, the next meeting, we will have some of the other concerns addressed visually for everyone.

So, uh, with that, I want to thank my fellow members who took the day off from their regular jobs, and don't get paid to do this, either, just like the rest of you, uh, very much for your time. And I want to thank the public as well. We are

adjourned at 3:25.

MS. DARBINIAN: Chair?

MS. CORSELLO: Yes?

MS. DARBINIAN: I apologize. Can we confirm the January 10th date, and that is scheduled from -- starting at 9:00 o'clock and just confirm that everybody is available on that date?

MS. CORSELLO: So we've been asked to confirm that our calendars are clear for January the 10th.

FEMALE BOARD MEMBER: I'm actually not available, but I can try to switch my schedule.

MS. CORSELLO: And I -- I would like to make a commitment or that we finish at a reasonable time, not 3:30 in the afternoon. So can you make any part of that day at all?

FEMALE BOARD MEMBER: I'm working from 6:00 to 3:00.

MS. CORSELLO: Okay. That's our normal regular meeting; isn't it?

FEMALE BOARD MEMBER: I can try to switch it [inaudible].

MS. CORSELLO: Okay. Well, if you -- if you are able to make an adjustment, I'd like to start at 9:00 and then -- and -- and commit that we're going to go till noon, so people can plan

accordingly.

And then, if we need more time, we'll decide that day how we're going to proceed again. I'm watching all the heads nodding.

Okay. With that, we are adjourned. Thank you very much.

I, Chris Naaden, a transcriber, hereby declare under penalty of perjury that to the best of my ability the above 284 pages contain a full, true and correct transcription of the tape-recording that I received regarding the event listed on the caption on page 1.

I further declare that I have no interest in the event of the action.

December 27, 2018

Chris Naaden

(Solano EMS Agency Board Meeting, 12-13-18)

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