

SOLANO COUNTY EMS AGENCY BOARD
Public Hearing on 12/13/2018

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8 TRANSCRIPT OF TAPE-RECORDED

9 PUBLIC HEARING OF THE

10 SOLANO COUNTY EMS AGENCY BOARD

11 DECEMBER 13, 2018

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

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

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

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

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

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

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

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

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

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1 challenge.

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

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

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

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

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

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

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

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

13 MS. CORSELLO: Yes.

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

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

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

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

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1 to the FPC it would be --

2 [talking in background, inaudible]

3 MS. DARBINIA: Sorry. Can you hear me now?

4 Okay. Uh, when you reach out to the FPPC it's your
5 request. So I would be happy to work with you, but
6 each of you have representatives that I received
7 letters from, so I suspect you want to work with
8 them.

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

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

18 I went back and looked at what happened in
19 2008, uh, the last time that we did an RPF, um, by
20 my predecessor and none of us up here were involved
21 in that, not a one of us was involved in that, uh,
22 including legal staff, including the -- the staff,
23 uh, in the EMS authority.

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

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

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

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

20 MS. DARBINIAN: Correct.

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

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

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

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

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

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

1 that has been recommended.

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

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

13 Every year it's responsible for managing over
14 90 million EMS calls world-wide. And the only
15 reason I bring that up is that we have the only
16 product on the market that has one version.
17 Everybody in every country and every language uses
18 the same one.

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

25 So when they find those things, every one of

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

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

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

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

20 Uh, Dr. Jeff Clauson [ph], who is my direct
21 supervisor, was a medical director from Salt Lake
22 City fire department and we sent everything on
23 everything including a police ambulance back in the
24 '70s, and he felt that there was a way to do this
25 better.

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

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

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

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

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

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

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

15 We have developed what we call ECNS, Emergency
16 Communication Nurse System and for my department,
17 when we implemented ECNS in Salt Lake, we had about
18 8 percent of our 911 call line would be [inaudible]
19 to the nurse to do an interrogation.

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

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

3 If you look at the alpha bravo tier, those are
4 clinically speaking, basic life support needed.

5 People say, well, we have an all ALS system. That's
6 fine.

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

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

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

1 but still the need is BLS.

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

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

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

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

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

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

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

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

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

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

25 We have millions and millions of cases where

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

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

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

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

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

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

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

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

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

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

25 Some of the stuff I can show you people talk

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 but respond cold. Closest vehicle cold, ambulance
2 code.

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

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

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

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

1 reason.

2 Our department in 1996, we had a total of
3 19,000 EMS runs, 9,000 of those were that bravo
4 level response. Uh, a kid today's a coffee taste
5 test has got two similar lacerations over his eye,
6 he's bleeding, he's awake, he's breathing, he's
7 fine. That would be lights and siren response.

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

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

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

25 And I was the brand new fire captain who was

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 MS. DARBINIAN: Correct.

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

3 MS. DARBINIAN: Correct.

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

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

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

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

1 And so when you start looking at that we have
2 never seen that to a -- we've never seen -- all the
3 litigations we have seen in emergency dispatching
4 going back to the early '70s, we've never seen an
5 agency sued for doing something. There are at least
6 14 multi-million dollar lawsuits associated with
7 those agencies who have chose to do nothing.

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

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

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

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

1 call takers are using it correctly.

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

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

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

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

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

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

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

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

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

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

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

11 That becomes a proposal for change to the
12 academy to adapt that to our next version of our
13 protocol. We implemented a version, 13.1 for
14 medical last year. We're half way through version
15 13.2, over 400 proposals for changes and 80 percent
16 of those come from our users.

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

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

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

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

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

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

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

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1 MS. CORSELLO: Are there any other questions?

2 So I have two --

3 MR. DALE: Okay.

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

6 MR. DALE: Mm-hmm.

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

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

11 MS. CORSELLO: -- are those cities --

12 MR. DALE: -- those are larger.

13 MS. CORSELLO: Okay. Are those city --

14 MR. DALE: Yes.

15 MS. CORSELLO: -- or county wide?

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

17 MS. CORSELLO: I mean I know --

18 MR. DALE: -- Sacramento is city, San Jose is
19 city, but Santa Clara county also, use it, they're
20 also a center -- they're also a credited center.

21 Uh, LA had us, the fire department went away from
22 us in LA City. Uh, San Diego, it's the city itself.
23 San Francisco it's the city.

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

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

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

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

7 MR. DALE: Well --

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

10 MR. DALE: Mm-hmm.

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

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

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

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

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

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

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

18 MS. CORSELLO: No. Your product --

19 MR. DALE: Uh-huh.

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

22 MR. DALE: Mm-hmm.

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

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1 coordination.

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

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

10 MS. CORSELLO: Privately operated and owned --

11 MR. DALE: There are --

12 MS. CORSELLO: -- as well as --

13 MR. DALE: Yeah.

14 MS. CORSELLO: -- publicly operated --

15 MR. DALE: Mm-hmm.

16 MS. CORSELLO: -- and owned?

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

25 MS. CORSELLO: Okay. Thank you.

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

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

5 MR. DALE: Okay.

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

9 MR. DALE: Sure.

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

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

14 MALE 2: Yeah.

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

18 MR. DALE: Okay. Thank you.

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

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

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

3 MALE 4: Yeah.

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

6 MALE: I'll second.

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

9 GROUP: Aye.

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

12 MALE: [inaudible]

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 event our timeline couldn't be adhered to.

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

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

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

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

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

22 MS. CLERK: [inaudible]

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

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

1 regular calendar, you'll see some background
2 information with, uh, the staff recommendation that
3 recruitment for the vacant SEMSC health care
4 consumer representative be opened on December 17th
5 of this year, uh, with a closing date of January
6 18th, uh, allowing for just over a month of
7 recruitment time since we do have holidays that
8 fall within there -- it seemed that we needed to
9 have an adequate amount of time for people to see
10 this.

11 Uh, reflecting the process that was used in
12 2010, the last time that we did this, um, we would
13 recommend that we adhere to basically the same
14 process which would initially, um, require us
15 advertising the position in the local news media.
16 I've listed out the local news media in your
17 packet.

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

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

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

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

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

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

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

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

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

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

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

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

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

25 So the bylaws read for the health care

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

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

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

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

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

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

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

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

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

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

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

25 MS. CORSELLO: Okay. And a second.

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1 FEMALE 1: I'll second the motion.

2 MS. CORSELLO: Thank you. All in favor.

3 GROUP: Aye.

4 MS. CORSELLO: Opposed? Abstention? Hearing

5 none, that carriers. All right. So now -- now I'm

6 looking for two volunteers.

7 MALE 5: I'll volunteer.

8 MS. CORSELLO: So we have a fire

9 representative. Can I get one more volunteer?

10 MALE 6: I'll volunteer.

11 MS. CORSELLO: And a hospital representative.

12 Thank you. So the rest of the committee -- oh, is

13 the rest of the group okay with that? We have two

14 individuals that -- whatever recommendation is

15 going to come to the full board anyway; okay?

16 Do I need to have a vote on that? Okay. Seeing

17 -- all right. Yes. On to the second item on the

18 regular calendar. Madam Clerk can you read the

19 item, please?

20 MS. CLERK: [inaudible]

21 MALE 7: [inaudible] yes.

22 MS. CLERK: [inaudible] services. [inaudible]

23 services [inaudible].

24 MR. WOLFBERG: Good morning. Uh, it's a

25 pleasure to be back and to see all of you again in

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

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

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

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

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

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

1 to be here.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 participated in making some of that case law.

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

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

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

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

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

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1 let that speak for itself.

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

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

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

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

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

25 Uh, so no matter what position people take, I

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

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

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

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

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

1 official policy.

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

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

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

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

25 All I would remind the board is that many of

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

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

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

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

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

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

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

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

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

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

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

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

11 MS. CORSELLO: I want to stop.

12 MR. WOLFBERG: Yes.

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

14 MR. WOLFBERG: Yeah.

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

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

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

25 MR. WOLFBERG: I understand. But do you guys

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

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

4 MR. WOLFBERG: So --

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

10 MR. WOLFBERG: Yeah.

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

14 MR. WOLFBERG: I understand that. But --

15 MS. CORSELLO: Okay.

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

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

25 So my point is -- is that economic

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

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

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

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

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

1 that.

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

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

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

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

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

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

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

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

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

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

22 That is an important distinction because a
23 local EMS agency is bound to respect 201 rights.
24 224 is a voluntary section. It gives the EMS agency
25 an option of either putting it in a bid or using an

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1 -- an -- an existing provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 at.

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

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

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

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

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

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

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

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

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

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

25 And we did just receive, uh, recently some

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 And multiple types of insurance requirements,

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

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

7 MR. WOLFBERG: I'm back.

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

10 MR. WOLFBERG: Yeah. You knew.

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

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

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

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

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

25 So we start, of course, with dispatch and the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 MR. WHITE: Excuse me, Mr. Wolfberg.

22 MR. WOLFBERG: Yeah.

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

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

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

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

14 And I know you're well aware of that, Mr.
15 White, but obviously, many people in this room are
16 not. And our job is not to put a new cover on your
17 2008 RFP. Our job is to make sure that this board
18 knows what these issues are.

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

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

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

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

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

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

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

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

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

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

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

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

1 not currently have.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 out.

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

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

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

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

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

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

10 That means ALS ambulance, ALS first response,
11 in the same response times that they have now. And
12 actually, I would point out that the 2008 RFP had a
13 90-minute response time for the remote areas. Ours
14 has a 60-minute response time.

15 So for true emergencies, not only would the
16 public get the exact same response that was in the
17 2008 system, but it would improve in outlying areas
18 of the county.

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

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

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

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

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

25 Then, you do see the response time standards

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 now.

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

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

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

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

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

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

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

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

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

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

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

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

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

19 So we spend, uh, time in the RFP talking about
20 making sure the medics know how to, you know, apply
21 12-lead EKG, that they know how to interpret the
22 12-lead EKG, that they remember to promptly notify
23 the STEMI, uh, centers and stroke centers of these
24 patients coming in so the teams can be on the
25 alert. Um, and, uh, incorporates those clinical

1 best practices in the RFP.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 The next thing that is new is based also on

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 those damages are relating to things other than
2 response time.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Sure. Let me get the microphone closer. Is

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

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

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

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

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

25 We already heard a lot about EMD and MPTS, so

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

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

8 So 27 percent of their calls were going out
9 priority one, 23.5 percent were priority two, and
10 49.5 percent were priority three. In terms of the
11 response level, uh, and this is based just on local
12 practices, they were having 94.5 percent receiving
13 an ALS response.

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

17 I do also want to mention, uh, that a 2010-
18 2011 Santa Clara, uh, County civil grand jury
19 report. Again, a county in California somewhat
20 similar to ours. Um, they looked at sort of the
21 sustainability of the fire system, uh, with a --
22 with a, uh, bend toward tiered response.

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

1 firefighting equipment as first responders is
2 unnecessarily costly.

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

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

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

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

1 ambulances.

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

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

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

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

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

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

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

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

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

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

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

1 ALS intervention.

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

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

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

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

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

25 There- -- this is probably multifactorial,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 This questio- -- I think this question came up
12 earlier, whether there are contracted medical PSAPS
13 in California.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 We also felt that response times for the

1 remote calls could be evaluated quarterly or after
2 10 calls, uh, have been completed, whichever comes
3 last, so that a provider would not be pen- -- a
4 contractor would not be penalized if they had, you
5 know, two calls and -- two calls in the review
6 period and one of them was over the limit.

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

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

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

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

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

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

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

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

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

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

1 collaborate effectively.

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

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

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

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

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

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

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

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

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

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

1 the draft RFP.

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

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

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

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

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

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

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

25 In Section 4, with respect to minimum proposal

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Uh, we -- we have lots of demonstrated

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

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

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

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

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

1 include CCT in the EOA.

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

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

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

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

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

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

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

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

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

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

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1 [audio break]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 make decisions based on the patient's best
2 interest.

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

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

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

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

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

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

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

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

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

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

25 They want that visibility. They want that

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

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

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

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

22 It's a \$2 million loss every year. Ambulance
23 service in Vacaville could be provided for free, a
24 \$10 million annual savings, if Vacaville would
25 allow Solano County or your body to include the

1 city in the ELA.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 to understand.

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

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

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

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

25 In the area of communication, another RFP

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 This letter draws your attention to issues in

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

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

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

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

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

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

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

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

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

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

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

25 MR. ARMSTRONG: [inaudible]

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

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

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

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

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

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

1 belong to. And we do EMD and we do all the
2 dispatch.

3 So to Mr. Elliott, what I would say is -- is
4 that I'm pretty knowledgeable in the ambulance
5 system. And our consulting firm consults U.S.-wide
6 on ambulance transport. And I didn't hear anybody
7 here today slam the private ambulance industry.

8 We all believe that they have an important
9 role to play, just like the fire department does.
10 So I'm not going to stand up here and do that. I
11 know the Manfredis personally. I know, uh, uh, AMR,
12 uh, Fawk [ph] Ambulance, you name it. There's a lot
13 of them that we deal with out there across --
14 across the country.

15 But what I would propose today is in the
16 letter that was submitted is that on behalf of Cal
17 Chiefs, and I do, uh, run their litigation on -- on
18 a regular basis, that you hold off and correct the
19 Brown Act violation.

20 We honestly believe there was a Brown Act
21 violation. It's easy to cure in regards to
22 conversations that happen outside the presence of
23 the full body.

24 We would urge that you do an extension. Mr.
25 Selby did exactly what happened in, uh, in, uh,

1 Sonoma County, where we're working with the Sonoma
2 County, uh, LEMSA and the fire agencies and the
3 ambulance companies.

4 You requested an extension. You called up. I'm
5 sure you talked to Dan Smiley or Howard Backer.
6 Yeah. He's nodding. And what did Dan Smiley say?
7 Oh, no. We're probably not going to give you an
8 extension. But they won't put that in writing. Why
9 won't they put that in writing? Because it's an
10 underground regulation.

11 And on a conference call, not four months ago,
12 Mr. Smiley in -- admitted in front of County
13 Counsel for Sonoma County that they don't have any
14 regulation on how long an RFP extension is. They
15 just go by the way they feel. And I see a lot of
16 smiles. That's them. It's underground regulations.

17 In Sonoma County we're -- we're -- we were
18 able to get a one-year extension. But it has to
19 come as a request from the LEMSA.

20 The LEMSA in Sonoma County worked very, very
21 closely with both the ambulance companies and with
22 the, uh, labor unions and with the fire chiefs and
23 the different stakeholders and LAFCO. And they all
24 requested an extension, and eventually, it went to
25 the governor's office.

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1 Now, the current LEMSA dir- -- EMSA director
2 and his deputy director aren't necessarily fans of
3 the fire service. But as we know, elections have
4 consequences. We have a new governor coming in in a
5 few weeks.

6 So I feel pretty comfortable that if you were
7 to work together, ask for an extension, with all
8 the stakeholders, you would be able to get an
9 extension under the new administration moving
10 forward. Which would allow you to resolve some of
11 the things that are before you.

12 First, 201 dispatch. That's a serious issue.
13 These people have been dispatching ambulances and
14 fire agents, uh, fire engines since 1980.

15 They have 201 rights. I'm not going to argue
16 that EMD is not an important component and that it
17 should be in -- as a part of every one of those
18 PSAPs, and you should work towards that.

19 But 201, you can't just take that
20 administrative function away. I'm not talking about
21 patient care now. I'm talking about what the law
22 says. But we can work together to bring them
23 together and come up with a solution for dispatch
24 to have EMD and have that local control flavor.

25 Number two, I thought the, uh, police chief

1 summed this up great. There's what's best from the
2 medical doctors that are talking about, uh, related
3 outcomes, and that's important. What's the actual
4 outcome for the patient? Okay?

5 And you get that in a clinical setting. But as
6 he said, Ms. Smith, who's 80 years old, who dials
7 911, is not going to understand why her public
8 expectation is not met when the fire department
9 doesn't respond or she doesn't get a -- a quick
10 response to what her request is.

11 And that causes challenges for the local
12 elected officials. If you had a county fire
13 department, it would cause problems for the County
14 Board of Supervisors. So at the end of the day,
15 that public expectation is that when they call,
16 somebody's going to be there.

17 The other additional issues that I have is
18 this. You trust your fire departments to manage
19 multimillion-dollar budgets and deal with crisis
20 after crisis in Solano County. Let's just take a
21 look at the Paradise fires. Let's look at the major
22 incidents that have happened across this state.

23 You trust your firefighters on those engines
24 as medics and BLS, basic life support people, who
25 go and treat people every day. But in your RFP,

1 much the same as some of the counties you cited,
2 you don't trust them to run what essentially is a
3 taxi service.

4 They will provide all the medical care all the
5 way up to the point that the person needs a drive
6 to get -- a ride from the incident to the hospital.
7 And we hear Mr. Elliott and we hear everybody say,
8 er, got to have experience; got to have experience
9 in driving those ambulances.

10 We drive engines that weighs tons out there
11 every day. We're capable of driving the ambulances.
12 Fire departments do it all up and down the state.

13 But in this RFP, it doesn't allow for a true
14 partnership because no fire department could
15 qualify in Solano County to able to do a joint
16 venture bid. Because your qualifications say that
17 the criteria is such that they won't qualify for
18 that.

19 So even Vacaville, who's in the ambulance
20 industry, would not qualify to bid this system with
21 a private subcontractor. I think that's a problem
22 that you guys need to address.

23 The other thing is I don't see a lot about
24 supplemental reimbursement in here. Such as GEMT;
25 IGT; uh, QAF, what that amount of quality assurance

1 fee money is going to be. But I can tell you we've
2 done a study and it's fair enough to say that if
3 you had an accurate contract -- and you'll hear
4 from another county.

5 If you had a -- a realistic RFP that went out
6 and you had a realistic bid that came in, our
7 estimate is you probably, after you pay the private
8 ambulance company their unit hour cost, built in
9 with a profit, you probably are sitting county-wide
10 of about \$7 million in excess revenue.

11 That could be pumped back into the county to
12 design and develop things such as coordinated
13 communications, a county-wide dispatch system,
14 bringing the local, uh, PSAPs up to, uh, EMD.

15 So you'll hear the ambulance companies say the
16 fire agencies are accusing them of profiteering. I
17 think in a free market society, they should make as
18 much money as they can.

19 But I also think that when it's a government
20 function, which it is in California to provide
21 ambulance service, that revenue needs to be
22 reinvested back into the county from which those
23 dollars came; okay?

24 So I think you should slow down. You should
25 cure the Brown Act. You should ask for an extension

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1 and move this process into a longer period of time
2 where you can get more cohesion and get more buy-in
3 from the groups.

4 Because I'm standing here from the outside
5 looking in and it's not going to be a good outcome
6 coming back.

7 Mr. Elliott's comments were pretty incendiary
8 towards the fire service. I certainly don't think
9 that about the private ambulance company; okay? Nor
10 does the California fire chiefs; okay? They are a
11 quality group of people.

12 But let's be fair. Let's analyze it. Fix the
13 Brown Act. And as we're asking for, uh, extend
14 this. Go to Mr. Selby. Go through the state EMSA.
15 Work with the stakeholders to make that happen;
16 okay? Thank you very much.

17 MS. CORSELLO: Thank you. And for those of you
18 who are keeping track, that was eight minutes. So
19 I'm -- I'm not cutting anybody off at two, but I am
20 going to ask you, because I still got another 30
21 cards to go. So thank you. All right. Next. Mark
22 Sharpe.

23 MR. SHARPE: Good afternoon. I'm Deputy Chief
24 Mark Sharp with the city of Vallejo. I've been
25 there for the last 30 years.

1 And I'm speaking on behalf of the four member
2 cities, uh, the fire departments, uh, that is
3 Benicia, Dixon, Fairfield, and Vallejo, in regards
4 to the public-private partnership and the funding
5 that each of your agencies receive, uh, currently.
6 And I just want you to know how important it is for
7 us to continue receiving, um, the funding that we -
8 - that we get.

9 Because what we do, although we're not getting
10 rich from it, i- -- we are able to put it back into
11 the system. It allows us to continue the training
12 and provide, uh, the equipment that's needed for
13 our high-performance system.

14 Any loss of the current \$1.6 million that we
15 are currently receiving and distributing am- --
16 along the four cities, any loss will be a loss to
17 the system itself. And as you just heard, it's very
18 important for us to able to put money back into the
19 system to make sure that we're able to sustain it.

20 This current blueprint and the RFP that was
21 put forward today, it really fails to outline,
22 really, how future city allocations and funds are
23 going to be acknowledged in this funding proposal.

24 And because of that, it's going to put a
25 substantial impact on the cities that are currently

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1 participating in it. It's going to put additional,
2 um, cost to the city.

3 So what we're asking and what we're proposing
4 is that there be an update on the unit, um, hours
5 saving calculations that gets done, uh, to identify
6 what the member city allocations of funds will be.
7 Because they've changed over the last decade and we
8 think it needs to be updated.

9 In addition, if there's any increases in the
10 service fees for the medical transport, um, that
11 they should be applied to the unit costs as well.

12 Uh, we also are recommendi- -- uh,
13 recommending that any updated calculations be done
14 prior to the contract award versus afterwards. And
15 what that will do for us is that will make sure
16 that the establishment and the agreed upon, uh,
17 allocations of funds are decided beforehand.

18 And then, finally, uh, what we experienced
19 during the course of these last 10 years is that,
20 uh, call volumes went up substantially over the
21 cost -- over the -- the time period.

22 And we're asking that in order to avoid any
23 conflict that occurs during the -- that period of
24 time, that, uh, we do an annual evaluation, uh, to
25 the call volume to make the appropriate, um,

1 adjustments that need to be made for the cities
2 that are in partnership.

3 Again, one of the things I'll just include
4 with -- and so, I think I'm still with- -- pretty
5 close to that two-minute mark. Um, even though we
6 talked about having stakeholders' meetings and we
7 really thought that that was a good idea, to get
8 all the principal players involved in the
9 conversation, from the fire point of view, we felt
10 like we were pretty much ignored in terms of the
11 recommendations that were put forward.

12 I had a conversation with our contractor, and
13 in that conversation, I asked a very distinct
14 question. And that was how much of this is going to
15 really come into play and to the outcomes of what
16 we see in the final draft?

17 He said I haven't even drafted it. Yet and
18 still, when the RFP finally came out, many of the
19 suggestions that were put in it were things that
20 were so, quote-unquote, "possibilities."

21 Well, they showed up, which lets us know that
22 many of the things that were already -- they were
23 already decided upon. And really, some of the
24 stakeholders' comments were ignored.

25 And so, that's not good for our citizens

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1 because we know that directly from the fire point
2 of view and the 30 years of experience that I've
3 had, it's going to have an impact on the delivery
4 of care to the citizens of Vallejo, Benicia, and
5 all the other agencies.

6 So we ask that you really con- -- reconsider
7 some of the things that you'll hear from some of my
8 colleagues. Thank you.

9 MS. CORSELLO: Thank you. All right. Next
10 speaker. Um, Kris Concepcion.

11 MR. CONCEPCION: Thank you, Chair. Uh, good
12 afternoon. And, uh, this af- -- this afternoon, uh,
13 I was, uh, prepar- -- or I was prepared to read a,
14 uh, prepared statement, um, that is timed right at
15 two minutes.

16 So I'm going to read that, um, and then, uh,
17 if you'll indulge me, uh, I feel like I have to
18 respond to some previous comments that were -- were
19 said.

20 So, um, I am the fire chief for the city of
21 Vacaville. However, today, I want to make it clear
22 that I am speaking as an officer of and on behalf
23 of the Solano County Fire Chiefs Association. Fire
24 Chiefs Association has some serious concerns with
25 the draft EMS blueprint, as well as the draft RSP -

1 - RFP. As a result, we are asking you to not move
2 the RFP forward until such time that our concerns
3 are addressed.

4 Given my time limit, I will only be able to
5 voice, uh, our two primary concerns today.
6 Specifically, dispatch of EMS being transitioned to
7 the private provider and the experience requirement
8 of the RFP.

9 We agree EMD is a good thing, and we've heard
10 it over and over this meeting -- or, uh, this
11 meeting already, um, that it is a good thing. It
12 works in Vacaville and we want to implement it
13 throughout the county.

14 However, implementing EMD by giving dispatch
15 over to the private contractor is not the answer.
16 We believe this solution is fiscally motivated
17 rather than in the interest of better patient care.

18 Private EMS dispatch will lead to a disruption
19 in the delivery of emergency services and longer
20 response times. In Solano County, EMS is integral-
21 -- integrally intertwined with the fire and other
22 emergency services.

23 The fire chiefs request the SCEMSC [sic] board
24 direct the consultant and staff to explore other
25 alternatives to getting EMD implemented in Solano

1 County. One potential option is to have the private
2 contractor fund the implementation of EMD for the
3 current public safety answering points.

4 Within the next year, as you heard from, uh,
5 Chief Carly [ph], most of the dispatch centers in
6 the county will be on the same computer-aided
7 dispatch system, bringing us closer to full
8 interoperability with regard to communications.

9 Adding EMD capability to the current dispatch
10 centers, rather than giving EMS dispatch to a
11 private provider, would be beneficial to all
12 parties and will serve to improve an already
13 integrated system, rather than disrupting it. Our
14 conc- -- our other concern is with the experience
15 requirements of the RFP.

16 This requirement unfairly excludes any fire
17 department in Solano County. It does not allow for
18 the exploration of implementing successful
19 alliance, such as the one currently in place in a
20 neighboring county. We respectfully request that
21 the board remove this requirement so all ambulance
22 deliveries models can be explored.

23 And that concludes my prepared statement. Now,
24 let me take off my, uh, county fire chief's hat and
25 put back my -- my Vacaville fire chief hat back on.

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1 And I -- I -- I feel like, um, the, uh, comments by
2 Mr. Elliott, that, uh, uh, I feel like I need to
3 defend the city of Vacaville on that.

4 Um, his comments that, uh, you could
5 potentially save \$100 million over the next 10
6 years simply by privatizing ambulance services, um,
7 in the city of Vacaville is misleading and
8 disingenuous. I don't know -- I don't know what
9 kind of fuzzy math he's using, but it's fuzzy math
10 at best.

11 Um, I just want to, uh, you've been hearing
12 throughout this whole meeting how well the
13 ambulance services are, how well they work in the
14 city of Vacaville. We've got EMD. Our system works
15 well.

16 And the funds, as far as the -- the revenue
17 that's generated by ambulance services actually go
18 back into improving and is reinvested into -- into
19 the city and goes to improve al- -- an already
20 well-coordinated system. Thank you.

21 MS. CORSELLO: Thank you. Nicely done. Under
22 four minutes. The next card I have is Alex M- --
23 Mourot? Is that --

24 MR. NOUROT: So, uh, I'm battalion chief Alex
25 Nourot. I'm representing the city of Vacaville Fire

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1 Department and, uh, since my boss went a couple
2 minutes over his two minutes there, I'll keep this
3 real brief.

4 Um, and -- and these are -- these are, uh,
5 some comments related to the RFP, um, from the --
6 from the, uh, from the fire department. Uh, we had
7 -- when the -- when the blueprint was released, we
8 had some significant concerns.

9 And as was alluded to earlier by Dr. Mattea
10 [ph] and, uh, and some other folks, we had
11 conversations with -- with officials from the
12 county, uh, regarding those concerns. Specifically
13 to the -- what was previously referred to as
14 ambulance Zone C.

15 And, uh, since that, uh, since the RFP has
16 been released, and that was -- that was removed,
17 our primary concern with this -- with this issue
18 has -- has been resolved. And I'd like to
19 acknowledge and, uh, we certainly appreciate those
20 -- those conversations and that -- and that, uh,
21 that that issue was, uh, was -- was taken out of
22 the, uh, of the release draft.

23 Um, the fir- -- the other -- the other issue
24 we had was with the dispatch piece. It wasn't clear
25 in the blueprint whether or not that was going to

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1 affect our, uh, our PSAP. As we've mentioned
2 earlier, we've been providing EMD.

3 We've been successfully dispatching our own
4 ambulances as a primary answering point and -- and
5 also, as an EMD provider for many years. We've been
6 successful with that.

7 We think our system works really well. We
8 think it's efficient with our -- within our, uh,
9 within our city and we're glad that that is
10 clarified in the current RFP, that that was left
11 alone and, uh, not affected.

12 We still do have a bit of concern regarding
13 the, uh, what we've re- -- what we'll refer to as
14 our historic service area outside the city of
15 Vacaville. That's the area where we provide
16 ambulance service to, um, outside of our city
17 limits, uh, previously called -- called Zone C.

18 It's not clear in this current draft RFP
19 whether or not that's going to be in the -- in the
20 RFP as a -- as a EMD answering, uh, secondary
21 answering point or if that will be, uh, EMD
22 provided by our, uh, PSAP.

23 We think the best model for that would be the
24 county dispatch center that currently dispatches
25 our ambulance into those zones. If they became an

1 EMD dispatch center, that would alleviate, uh, both
2 of those concerns.

3 And -- and the system right now, as far as
4 coordination and dispatch goes, works really well
5 having our, um, our PSAP initially dispatch our
6 ambulances and then, they immediately are -- are
7 turned over to the county.

8 The county's dispatch center, we have good
9 coordination with the fire agencies in that -- in
10 that zone. Communication and coordination-wise,
11 it's working really well. However, there's no EMD
12 being performed out there and -- and we think
13 that's a good thing. As alluded to earlier, um, we
14 -- we think we've demonstrated that the EMD in --
15 in Vacaville is a good thing and it's a successful
16 model. So, uh, I just wanted to thank the -- the
17 county officials we had conversations with for, uh,
18 for hearing our concerns and taking those into
19 account in the draft RFP. Thank you very much.

20 MS. CORSELLO: So can I ask you, did you
21 provide the comments you just made to the county in
22 writing in some fashion so that the staff could
23 follow up on that?

24 MR. NOUROT: So -- I'm sorry. The comments? We
25 -- we've provided all our comments to the county --

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1 MS. CORSELLO: The comments with regard --
2 well. So I know there's Zone C and then I heard
3 Staff say today they've got a new Zone D or
4 whatever that is. Some- -- something new. Uh, your
5 comment about EMD, did you, uh, provide that to
6 them to deal with?

7 MR. NOUROT: We initiated that conversation in
8 the meeting we had with Dr. Mattea --

9 MS. CORSELLO: Okay.

10 MR. NOUROT: -- and -- and Mr. Selby. And, I
11 mean, they understood the concern. I don't -- I
12 don't know that there's been time yet to put that
13 into the -- into the RFP. So that -- that piece is
14 still a little bit fuzzy.

15 The other piece that's slightly fuzzy is the -
16 - the map that we provided that we believe is our
17 historic service area. And, you know, in our good
18 faith conversations, I'm pretty confident that
19 that's the map that's eventually going to be
20 released with the RFP.

21 The draft version references the map, but we
22 haven't -- we haven't seen the map that's -- that's
23 released yet. We belie- -- I -- I certainly believe
24 that we are all in agreement now on what our
25 historic service area is.

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1 Um, there was some discrepancy in -- in the
2 whole documents and that. So -- tho- -- I -- I've
3 made those comments to the county staff and we're
4 hoping that that gets resolved. Thank you.

5 MS. CORSELLO: Thank you. So the next speaker
6 I have is -- is Erik Newman.

7 MR. NEWMAN: Good afternoon, members of the
8 board. Erik Newman, fire chief, city of Stockton.
9 And I'm here representing on behalf of the Solano
10 County Fire Chiefs. Um, it's been a long day and,
11 uh, but let me start by this.

12 You heard about the RFP and you heard about
13 everybody's different, uh, opinions on what you
14 guys are debating on going into. Well, I'm living
15 it. I'm living on what you guys are trying to go
16 into. So let me kind of give you a little history.

17 So I've been the fire chief for the city of
18 Stockton for three years. I inherited a dispatch
19 center. Um, and I call the city of Stockton ground
20 zero for a lot of EMS challenges that's been up and
21 down our state.

22 People use our city as kind of, Stockton, on
23 what to do and what not to do. And what I'm here to
24 tell you folks on the board is you might want to
25 pause for a caution or, as my grandmother would

1 say, for station identification on this.

2 So city of Stockton, we respond to, uh, last
3 year, 47,000 calls for 12 stations. Forty-one
4 thousand out of those calls was EMS. EMS with no
5 control. We had no control of those EMS calls that
6 came into our dispatch center.

7 So what happens in the city of Stockton is
8 that anyone that calls, uh, CHP are the PSAP for
9 the city of Stockton. It goes to the police
10 department and it gets transferred over -- on EMS-
11 only, it gets transferred over to, um, our
12 contractor.

13 Our contractor then transfer it back to us,
14 um, and it's 127 Main Street, Alpha Charlie, uh,
15 breathing. And then, we put it in our CAD system
16 and then we're off and dispatching.

17 So imagine you go into that difficulty
18 breathing. We're coming to your house; right? And
19 now, uh, your patient that's, uh, or the person
20 that called in and says, hey, uh, now, you have a
21 cardiac arrest.

22 So now, because they didn't -- lost the call,
23 now they got to call to PSAP again. Transferred you
24 back over to, uh, the contractor, and then back to
25 my dispatch to update the -- the engine company

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1 that's responded to you now. We got a -- it's now
2 turned into a heart attack.

3 That's what's going on in the city of
4 Stockton, with no control. Uh, for the city of
5 Stockton, we do not respond to Alphas and Bravos.
6 We talked about EMD. And so, all of our calls that
7 come into our center are EMD by our contractor, but
8 the city of Stockton has elected not to go on
9 Alphas and Bravos.

10 Because, I had mentioned to you, we're on
11 47,000 calls. We have 7,000 calls of Alphas and
12 Bravos that we elected not to go to. There's a city
13 in my dispatch center that I dispatch for that
14 wants to go to Alphas and Bravos.

15 But because of the contractor and how things
16 work out as it relates to EMD and local control,
17 they were not able to go. So there was a -- a big
18 fight. Um, I'm telling you that that model is not
19 best practice. It's not best practice.

20 Um, so, uh, what are the landmines? I kind of
21 gave you one; right? Call comes from the contractor
22 over to our dispatch center. Uh, our dispatchers
23 send it off. We don't talk to the person, at all.

24 We don't know who the person was on the other
25 end. So if the crews get on scene, they need

1 additional information, they call our dispatch
2 back. And then, our dispatch has to call the
3 contractor to get information. Think about that.

4 Think about if you were the person that's sick
5 and all of those transactions. And then, think
6 about if the car, uh, excuse me, if the call is
7 lost. Then what? Now, you got to dial 911 again.

8 These are the little things that are not being
9 put into -- or not -- what you guys are not seeing.
10 One thing I -- I will offer, uh, is that I would
11 like to invite each and every one of you to come
12 out to our dispatch center so you can see for
13 yourself. Come take a look.

14 See, it's easy for people to put stuff on
15 paper and say, hey, what of this data and this
16 analysis is going to work and -- and some of that
17 stuff is true. Not here to shoot down any proposal
18 or anything, but I think you folks need to come to
19 our dispatch center. Because we're just over the
20 hill.

21 We're doing what you're thinking about doing
22 right now. You can talk to our dispatch center. You
23 can talk to my emergency communications guy. And
24 they will tell you the pros and cons of both.

25 You're going to be flooded and bombarded with

1 a lot of different opinions, but I think that right
2 now, if there was someone in your backyard where --
3 and I'll be more than happy to pick you up and take
4 you over to take a look to where you can see for
5 your own eyes, sit in our dispatch center, and take
6 a look.

7 Um, so I think the other thing that needs to
8 be talked about is interoperability. How are you
9 going to talk? You got 30 stations in Solano
10 County, over 30,000 calls, and if folks can't talk
11 to each other, now you're thinking about throwing
12 in another medical component to it, which is kind
13 of a curve.

14 And if -- if the ambulance cr- -- tracker for
15 the county can't talk to the fire and now, we're
16 talking about putting in things and changing the --
17 the playing field, uh, I think that we might want
18 to rethink. But I just wanted to kind of share with
19 you some of our dispatch problems in Stockton.

20 Um, yes, some of it was inherited. But I think
21 that, uh, if you come and take a look and see what
22 we've got going on right now, I think that it w- --
23 it will open your eyes a little bit more.

24 Uh, I truly humble -- I truly humbly believe
25 that. Um, I think that, uh, uh, as I mentioned

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1 earlier, Stock has been ground zero for EMS issues
2 since 2007 and '08. A- -- and -- and I -- and I --
3 I won't say I beg of you, but I think that this
4 decision is very critical.

5 Uh, the men and women in Solano County that
6 work in the fire service and public safety,
7 especially your -- your citizens, you know, they
8 deserve -- they deserve the best. They deserve that
9 -- they deserve that whoever comes to their door,
10 ALS or BLS, that they get there in a timely
11 fashion. That's all that matters; right?

12 That's what we're here for. And whether you're
13 ambl- -- ambulance or fire, people don't care. They
14 just want you there on time. But the decision that
15 you're about to make as it relates to dispatching
16 and EMD and which -- thumbs up. But I think you
17 need to understand and see the process on how that
18 works and talk to some people that is actually
19 doing it.

20 We can give you paperwork about Salt Lake,
21 which I -- I totally disagree with my colleague
22 about roll-overs don't hurt and that people get
23 mad. I think anyone who's been in a roll-over knows
24 they're pretty bruised up.

25 Um, I -- I disagree about the fire service as

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1 it relates to, uh, profits. We never been in this
2 game for profits. We do it for -- because we want
3 the people to be safe. We want to serve our
4 citizens and businesses.

5 But I'll leave you with this, and I've said it
6 three or four times, is that, Chair, members of the
7 board, before you make this decision, come to
8 Stockton. Sit in our dispatch center.

9 You get a chance to see real-time and take a
10 look at what you're going to be adopting. And it's
11 about local control and serving the citizens, uh,
12 of this county. Thank you.

13 MR. BROSCARD: Uh, good afternoon, Madam
14 Chair and members of the commission. My name is
15 Lewis Broschard. I'm the deputy fire chief of the
16 Contra Costa County Fire Protection District.

17 Uh, we operate what you may, uh, have to come
18 to know as the Alliance Model. Uh, we prefer the
19 name the Contra Costa Model, but the Alliance Model
20 was a temporary name that has since, uh, stuck with
21 the program ever since its inception in 2015.

22 So I was asked to come, uh, speak to you just
23 to give you more or less the facts of what our
24 model is, how it came to be, um, and, uh, uh, for
25 your consideration as to, uh, maybe including that

1 in -- in one of your potential options for your
2 RFP.

3 Uh, for full and fair disclosure, I will tell
4 you that, uh, I am a 40-year resident of Solano
5 County, um, as is my father, one of the, uh,
6 founding members of the Fairfield Medical Group,
7 Dr. Lewis Broschard. Um, uh, my wife, my kids, my
8 wife's family. Uh, and I was also, uh, never
9 thought I'd say this, but, uh, uh, starting to feel
10 old now.

11 Um, I was, uh, one of the fire chiefs that
12 was, uh, uh, one of the first members of the
13 public-private partnership almost 20 years ago.

14 Very young fire chief, but, uh, uh, I actually
15 used that model that you and we put together that
16 many years ago as the basis for coming up with the
17 Alliance Model, um, that has become so successful
18 in Solano County, namely some version of a
19 partnership between the public sector and the
20 private sector to deliver the best possible
21 emergency medical services to the community.

22 So with that, the Alliance, uh, really was the
23 strategic partnership between AMR, uh, and the
24 Contra Costa County Fire Protection District in the
25 legal form of a contractor-sub-contractor

1 relationship. We consider AMR to be our partners.

2 We treat them like partners. But it is not a
3 partnership; it is a contractor-sub-contractor
4 relationship. We were awarded the contract to
5 provide 911 emergency ambulance service to serve
6 most of Contra Costa County. When I say most,
7 that's 90 percent of Contra Costa County.

8 The areas excluded from this contract for this
9 areas served by the San Ramon Valley Fire
10 Protection District and the Moraga-Orinda Fire
11 Protection District, who provide their own fire-
12 based ambulance programs. We cover everything else.
13 The goal of the Alliance is and was very simple.
14 Build and maintain the best possible system to
15 provide service to the public.

16 To do this, we aim to enhance the existing
17 service model, uh, under the original, uh,
18 incumbent of a provide ambulance provider, create
19 efficiencies and a synergy between the private
20 ambulance company and the public service by
21 reducing response times, increasing capacity in the
22 system, improving overall communications and
23 resource control and accountability through a
24 combined fire and EMS dispatch center. And also, to
25 maintain a fiscally sustainable emergency transport

1 system for our county.

2 I'm happy to say almost three years into this,
3 um, we not only did that, we exceeded ours and
4 others' expectations. We added the equivalent of
5 one 24-hour ambulance crew over what was provided
6 prior. Uh, combined our communications center.

7 We already were the regional fire dispatch
8 center. We already were doing EMD, using all, um,
9 the pro-QA, uh, systems that were discussed earlier
10 this morning. But the ambulance dispatch center was
11 located in Sacramento. By combining, uh, private
12 ambulance system status managers in our dispatch
13 center, we shaved almost a full minute off of the
14 response time continuum.

15 We also, uh, increased com- -- common
16 communications between, uh, the ambulances and
17 every fire service provider in the county, as well
18 as enabled, uh, better automatic vehicle locating
19 systems, uh, for every fire crew and every
20 ambulance to see each other and know exactly where
21 we all were at all times.

22 Uh, the AMR system status managers give us the
23 ability to move ambulances throughout the county,
24 as necessary, to main c- -- maintain coverage
25 levels.

1 Uh, we have documented improvements in patient
2 outcomes. We have aligned medical direction from
3 the county medical director to the fire district
4 medical director to AMR's medical director. All
5 three physicians, they get together on a regular
6 basis.

7 Um, they're no longer in a position of
8 conflict. They're in a position of collaboration
9 and coming up with innovative ideas to increase and
10 enhance even further emergency medical services
11 within the county.

12 We provide joint training between fire and
13 ambulance crews. Uh, and we have a mandated
14 collaboration committee between the local emergency
15 medical services authority and their staff, the
16 fire district staff, and the private ambulance
17 provider.

18 Uh, we provide a career path for paramedics
19 and EMTs should they choose to, uh, leave the
20 private sector and search for jobs in the fire
21 service. Uh, that partnership, uh, provides some
22 benefit for the employees.

23 And last but not least, uh, we have created,
24 uh, a very robust and fiscally sustainable system.
25 Uh, it's a not-for-profit system. We're a public

1 entity. Our books are absolutely and completely
2 transparent. They must be.

3 Uh, audited financial statements happen every
4 year. And what we're able to do is take what were
5 corporate profits, turn them into retained
6 earnings, and redirect those back to direct public
7 benefit for Contra Costa County.

8 So as I said, uh, we were awarded the contract
9 in mid-2015. Uh, we started providing service on
10 January first of 2016. Uh, we essentially provide
11 coverage to 90 percent of Contra Costa County, um,
12 in regards to total number of responses.

13 And then, we, uh, transport 92 percent of, uh,
14 the transports within Contra Costa County. As I
15 said before, it's, uh, it's a contractor-sub-
16 contractor relationship, uh, between AMR and Contra
17 Costa County Fire.

18 So the two biggest, uh, benefits to this
19 program, and -- and there's a lot of naysayers.
20 There's a lot of people that with misinformation,
21 misguided information, uh, uh, misaligned
22 information, uh, I don't know why, uh, because the
23 facts, basically, speak for themselves.

24 Um, this, uh, previously untested system, one
25 of a kind system within California, and to our

1 knowledge, one of a kind throughout the nation, uh,
2 basically provides, uh, an improvement over the old
3 traditional private ambulance company and then
4 public service provider. It's blended together.

5 2015 was the last year that AMR, uh, had the
6 exclusive contract. Um, and just brief statistics.
7 Uh, in 2015, within the city of Richmond, uh, the
8 average response time from AMR was 4 minutes and 41
9 seconds.

10 Uh, in this new relationship, last year, in
11 2017, the average response time was reduced to 4
12 minutes and 5 seconds. Throughout all of West
13 County, so figure the I-80 corridor, it used to be
14 a little over 5 minutes. Now, it's 4.5 minutes; 30
15 seconds shaved off.

16 For, uh, the 680 corridor, Walnut Creek,
17 Pleasant Hill, Concord, Lafayette, uh, and so
18 forth, it was over 5.5 minutes. The average
19 response time is now 4.5 minutes.

20 Out in the east, Highway 4, out to Brentwood,
21 Byron, Pittsburg, Antioch, uh, the average response
22 time was close to 6 minutes and 40 seconds. It's
23 now 4 minutes and 34 seconds. We didn't reinvent
24 the wheel. I think we just made it a little bit
25 better.

1 With regards to, uh, compliance, because it's
2 not all just about response times. It's also about
3 how we treat patients and how we're able to deliver
4 care. Um, but sticking with response times, before
5 I -- I get into that, uh, just like you contract
6 supposes, uh, 90 percent of the time, we are
7 required to meet performance, uh, standards for
8 response times.

9 Within the city of Richmond, 10 minutes 90
10 percent of the time. Uh, in tw- -- in, uh, t- --
11 2015, uh, AMR was able to do that 93 percent of the
12 time. We're upwards of 96, 97 percent of the time.

13 We don't have zones in the county with regards
14 to rural or suburban or remote. Some of them are
15 very remote. Some of them are very urban.

16 Uh, we have 11 minutes and 45 seconds to every
17 single 911 call throughout the entire county.
18 Again, 93 percent was the average compliance prior
19 to the alliance. Average compliance now is, uh, 95
20 to 97 percent, um, in certain zones.

21 There's a lot of synergies that can be
22 created, um, by allowing that contractor-sub-
23 contractor relationship and allowing the best and
24 brightest to come through, uh, between private and
25 public sectors.

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1 MS. CORSELLO: You're at 8.5 minutes.

2 [talking over each other]

3 MR. BROSCHARD: Oh, really? I thought it was
4 more, like, 2.5. All right. So--

5 MS. CORSELLO: Can I ask you --

6 [talking over each other]

7 MR. BROSCHARD: I will wrap it up.

8 MS. CORSELLO: Thanks.

9 MR. BROSCHARD: Yes. Yes. Thank you very much.

10 So, um, let's just finish with the financial
11 stability and transparency. Uh, as a public entity,
12 you're all aware the books have to be transparent.

13 Um, there was some question we had, uh, uh,
14 Citygate come in, um, to do a final analysis as to
15 whether or not this was a sustainable system. They
16 estimated there might be about \$1 million either
17 way.

18 Um, last year, uh, we -- we had retained
19 earnings of over \$7 million, uh, in our system.
20 Those dollars all go back to add more dispatchers.
21 Um, to put other systems in place to make better
22 improvements in this system.

23 Um, our fund balance, after three years, uh,
24 actually, only after two years, was \$10.5 million,
25 uh, in our system. Uh, we were able to pay ourself

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1 back for the, uh, start-up costs very quickly and,
2 uh, we're well on our way to establishing our six-
3 month reserve, uh, which is approximately \$18
4 million, um, and -- and we may be able to do that
5 by the end, uh, end of this fiscal year. So, um,
6 those are the facts.

7 Um, as Chief Newman, um, uh, gave an
8 invitation, I would certainly give the same or
9 similar invitation for you to come down. Spend some
10 time with us. Learn about the system. Um, uh, ask
11 whatever questions you might have.

12 Uh, talk with our sub-contractor. Talk with
13 AMR's leadership. Um, uh, take a look at the
14 dispatch center. Whatever it might be. Uh, we're
15 here to, uh, provide answers to whatever questions
16 you might have and, uh, hopefully, you would
17 consider this a potential model for, uh, uh, Solano
18 County, uh, moving forward. Thank you.

19 MS. CORSELLO: Thank you. Do you have any
20 information you want to leave for the board at this
21 point?

22 MR. BROSCARD: You know, I don't. What I was
23 thinking of was, um, I -- I will send the, um, the
24 annual report, uh, that was given to the board, uh,
25 with the LEMSA director and the fire chief in, uh,

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1 uh, August. And I'll -- I'll e-mail that, uh, so
2 you can review those, uh, facts and figures.

3 MS. CORSELLO: You'll send that to Ted, I
4 think.

5 MR. BROSCHARD: Will do.

6 MS. CORSELLO: All of us would appreciate
7 that.

8 MR. BROSCHARD: Okay.

9 MS. CORSELLO: Thank you. Okay. The next one
10 is Aaron McAlister.

11 MR. MCALISTER: I'll see what I can do. Thank
12 you. Good afternoon. Uh, Aaron McAlister. Lifelong
13 resident of Solano County and a 25-year veteran of
14 our fire services, including six years as the fire
15 chief for the city of Dixon.

16 Um, I'm here today as an elected member of the
17 board of directors of the Cordelia Fire District.
18 Uh, late last night, we transmitted a letter to the
19 chair, um, expressing our opposition to the program
20 as-is. Uh, we think it kind of missed the mark, so
21 to speak.

22 Uh, in fact, the blueprint 2020 failed to even
23 acknowledge the existence of the Cordelia Fire
24 District and our advanced life support NGA [ph]
25 based program.

1 Um, EMD is a good thing. We've seen that be
2 very successful in other communities and the board
3 supports efforts to bring EMD to our county. Uh,
4 Salt Lake is a very high-performing system.

5 Putting RNs in the communication center is
6 cutting-edge. But Solano County needs to walk
7 before it can run. We have a lot of work to do.
8 Within one mile of this building, we have not two
9 but three public safety communication centers.
10 Within one mile. That is the true problem.

11 If we want to improve response times, we need
12 to consolidate fire communication centers. We have
13 fire stations all over this county within one mile
14 of each other that are dispatched by different
15 public safety answering points and operate on
16 different radio systems.

17 I can order a pizza or an Uber to this
18 building electronically without having to make a
19 phone call. But four of our communication centers
20 can't order ambulances without making a telephone
21 call.

22 We could shave one to two minutes off response
23 times by building CAD-to-CAD links between the
24 contractor and our 911 centers. Please, don't
25 further complicate an already complicated

1 communication center by adding another
2 communication center.

3 Um, we only need to look as far as our
4 neighbors. Napa County, Contra Costa County,
5 Alameda County have embedded ambulance dispatch in
6 fire communication centers. Those systems work well
7 and it's shaving response times.

8 What calls any particular community need to
9 respond to need to be community-based decisions.
10 We've heard it here today.

11 The political bodies that authorize the
12 budgets for those entities need time to digest this
13 report, provide feedback, and on behalf of the
14 Cordelia Fire District Board, um, we urge the
15 rejection of the documents as-is, and it needs more
16 work. Thank you.

17 MS. CORSELLO: Thank you. Um, Howard Wood.
18 Actually, there's two names on here. Howard Wood or
19 Chris [ph] Culver. So are you both speaking?

20 MR. HOWARD: Hi. My name's Howard Wood, fire
21 chief of Vacaville Fire Protection District. I've
22 been with the district for 56 years and watched
23 Solano County grow and the fire departments grow.

24 Um, the chairman was going to be here to
25 speak, but he had to go to another meeting at 1:00

1 o'clock. So -- but just short and easy is that, uh,
2 we want to make sure that it was known that we
3 support EMD.

4 We'll do whatever has to. The board will take
5 action and make that work. And they're happy they
6 didn't see, uh, we're basically, uh, [inaudible], a
7 little bit of Dixon. But, uh, that, uh, we didn't
8 lose the services that we've had from the city of
9 Vacaville for -- since the beginning.

10 So, uh, the residents out there are more than
11 happy with what service were p- -- provided
12 through, uh, Vacaville city. So -- and I can cut it
13 that short and thank you and, uh, under two
14 minutes.

15 MS. CORSELLO: That you are. Thank you. All
16 right. I have Todd Matthews.

17 MR. MATTHEWS: Good afternoon. My paper says
18 good morning, but it's good afternoon. So, um, Todd
19 Matthews, president of Fire Fighters Local 1186.

20 All of you guys should have received a
21 position paper from our local, uh, last week
22 sometime with our concerns with the RFP proposal. I
23 am going to go -- I had a two-minute speech, but I
24 will go into some other issues that I see after I
25 read my position on.

1 One of the things that we see in the RFP. We
2 have the following concerns regarding the draft,
3 proposal evaluation process and scoring.

4 There is a description of the independent
5 review panel on how the scoring of the proposals
6 will take place, as stated in the RFP, is meetings
7 of the review panel will be closed to the public
8 and may include SEMSC staff and/or consultants.
9 May.

10 SEMSC staff and the consultants have made
11 their positions clear regarding the future of EMS
12 in Solano County. But we don't feel the direction
13 or coaching of the review panel will be in the best
14 interest of all the parties represented here.

15 Also stated in the draft, the outcome of the
16 deliberations of the review panel shall be
17 submitted to the local EMS agency administrator.
18 The administrator shall review the submission and
19 may consider any and all pertinent information.

20 The administrator shall recommend a proposal
21 to the SEMSC board. Once again, the MS staff has
22 made their positions clear through what's going on
23 today and public records requests that we have
24 requested.

25 We do not feel that the interest of all

1 parties will be taken into account. We would like
2 to see an additional option of having a second
3 panel comprised of public and private entity
4 stakeholders currently providing EMS within the
5 county and also make a recommendation to the SEMSC
6 board.

7 This will give the board the final decision of
8 who to award the contract and give a voice to the
9 first responders a l- -- and labor, who are grossly
10 underrepresented here. Putting the next 10 years on
11 -- in the hand of a panel describes [sic] as
12 disintres- -- disinterested individuals appears
13 risky at besk -- at best.

14 Um, if you were to ask me, should be five
15 people on this panel -- on this second panel should
16 be presented from the largest first responder in
17 the county. That's us, 1186.

18 We have almost 200 EMTs and paramedics. A fire
19 manager rep, a dispatch rep, a hospital emergency
20 department rep, and a representative from Solano
21 County. So that being my initial two minutes.

22 Um, there was some discussion earlier from the
23 consulting group that many of the municipalities
24 have failed to provide EMD dispatching, that the
25 fire departments are dropping the ball. It's their

1 responsibility.

2 It is the responsibility of the county to
3 require it. Health and Safety Code 1797.220 puts
4 the -- the responsibility in the hands of the EMS
5 office to create the policies and procedures and
6 accepted guidelines for this program. The city of
7 Benicia or Vallejo cannot tomorrow start an EMD
8 program without the county's direction.

9 So if you go back historically, there is a
10 grand jury report. They need to combine dispatch
11 centers. Go back further, back in 2010, probably at
12 the last RFP proposal. The fire chiefs probably
13 said they couldn't afford it or couldn't do it.

14 That's been 10 years. We're not -- we're not
15 arguing EMD. It's a good thing. Our concern is that
16 it go into a private for dispatch. And so, that'll
17 come off that from there.

18 The new proposal for the dispatch center or
19 the new language where -- how the dispatch will
20 work from the consultant, it's smoke and mirrors.
21 And we'll get the -- EMD will be done by the
22 private ambulance company, but we'll still get to
23 dispatch our fire engines. That's how it was going
24 to be inig- -- originally.

25 The call's going to come in to Benicia. We're

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1 going to say it's a medical. We're going to pass it
2 off to the ambulance provider.

3 And then, we will get a phone call back.

4 There's nothing different. It's just he changed
5 some words upon the screen to make it sound better.
6 It's like lipstick on a pig.

7 I think you can find it in probably some of
8 your public records requests. The local PSAPs need
9 to maintain the live caller. They need to maintain
10 contact with that citizen that's within their
11 community.

12 Everybody's aware, I'm pretty sure, on the
13 panel, that I and my local conducted a public
14 records request against Solano County EMS, the
15 administration, and all correspondence between the
16 current ambulance provider and between Doug --
17 between Wolfberg, Wirth, and Page.

18 Um, for Josh, the fire chief, to be recused
19 today, at the eleventh hour, it's -- I almost want
20 to use a bad word, but it's crazy. Because right
21 here, Doug Wolfberg is outstepping his bounds of
22 his contract, 62 days ago, questioning Josh' and
23 the city managers' right to be on this panel and
24 vote.

25 You guys right here -- and I'll read them.

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1 This is from Doug Wolfberg. August 15th. They're
2 going to be -- the -- we're going to need to stand
3 up against the fire chiefs on this issue.

4 But with a city manager and a fire chief on
5 board, it's going to be tough. This was sent to Ted
6 Selby. October 12th. This is from Doug Wolfberg to
7 Br- -- to Mumba [sic]. I was hardened to bid [ph]
8 and speaking with Birgitta and the city, uh, uh,
9 I'm going to hands it [ph] with the meeting.

10 Birgitta said that she thought that there was
11 -- that she had presented them with an excellent
12 system, but she was not sure that she would be able
13 to get there given com- -- uh, given the
14 composition of the board and the fundamental irres-
15 -- uh, ir- -- irrevoc -- sorry.

16 Irrevocable interest they are all had. She
17 wondered whether the new RFP process might present
18 so many fundamental irre- -- sorry. Differences,
19 that is, and might need to be disillu- -- uh,
20 dissolve the JPA.

21 So you guys are talking dissolving the JPA two
22 months ago. The more significant question is my
23 view is whether there are procedures or bylaws
24 provisions for the forced recusal of a self-
25 interested director who refuses to voluntarily

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1 recuse himself because my read of this [sic] tea
2 leaves is that I would not see -- I did not see
3 either Josh Chadwick or Mr. White, both of whom have
4 potential conflicts of interest with their cities
5 in becoming bidders. This is two months ago. Uh,
6 no.

7 MR. WHITE: Uh, I'm sorry. Wh- -- so can you
8 tell me who that e-mail was from and who --

9 MR. MATTHEWS: This is from Doug Wolfberg to
10 Bryn Mumba [sic] and Ted Selby.

11 MR. WHITE: I'll point out to the board that
12 we did receive this communication as part of
13 documentation from the attorney, uh, for, uh,
14 fellow member Chadwick. So we all do have it handy.

15 MR. MATTHEWS: So another one from Doug -- or
16 from Bryn from -- to Doug. Uh, we intentionally
17 avoided the RPA -- RFP discussion during the MD
18 forum to avoid an appearance of a bias or during
19 the process, including tiered response. Uh, so
20 they're looking for a way to get better t- -- t- --
21 tiered response.

22 And then, Ms. -- from Bryn, I do believe that
23 we should address the real and perceived conflicts
24 of interest on the board. But I am not sure of the
25 best approach to do this. In the ideal world, this

1 and perceived conflict with voluntary recused
2 themselves from the discussion and vote.

3 However, I do not see that happening. I think
4 Josh's conflict as a fire chief is most clear. Even
5 if he says it is not a real conflict of interest, I
6 would argue that it's perceived conflict of
7 interest that gives the appearance of bias in the
8 process.

9 David White is a little hazier. Sorry that
10 you're not as clear as Josh. Because he is not
11 directly employed by a representing potential
12 bidder. Happy to discuss via phone later in the
13 afternoon. This makes it easier.

14 Here's some more biased on the panel. This is
15 from Bryn. She wrote an e-mail to somebody. Last e-
16 mail from me now. Just pursuing the mission
17 statements from various organizations.

18 Why would the board want to give a contract to
19 an agency that doesn't see emergency medical care
20 as part of its misi- -- vision statement? And she
21 lists the city of Vacaville, the city of Fairfield,
22 and Medic Ambulance.

23 And I'll make it clear. I made the public
24 records request. Do I want to find anything? No.
25 But we did. Is it collusion? I think Trump would

1 probably call it that.

2 But the consultant is overstepping his bounds
3 by making recommendations to have somebody on the
4 board recuse themselves. I think you probably need
5 to go back and look at the job descriptions of
6 everybody on this panel and look at the
7 expectations of this panel as well, which you
8 cannot find online.

9 And I would say that this board probably
10 reports directly to the supervisors, not to anybody
11 sitting up here. And I would recommend that you
12 probably start over.

13 As a parent, my child would have brought me
14 this RFP as their first project, I would have told
15 them to go back and be more creative. Bring back
16 another alliance model. Bring back two -- two
17 systems. But I'm going to sit here and tell you,
18 you guys probably need to back off a little bit.

19 It's right here. And when I met with Mr. Selby
20 on Tuesday last week -- or maybe Wednesday, he was
21 upset that I made a public res- -- records request
22 against him. That I didn't come see him first.

23 So with that being said, you have something
24 hide, the reason why you're upset. So, uh, as part
25 of the local union representing everybody, we have

1 no -- I know I made the video. I have no issues
2 with the current provider.

3 This has nothing to do against the current
4 provider. It is a consultant that is coming in and
5 giving you a cookie cutter approach to a system
6 that if you look at his bibliography, there's 78
7 entries.

8 If you go read every collu- -- conclusion,
9 every one needs more time to be studied. They are
10 put in there to make his recommendations work.
11 There is nothing out there that he hasn't presented
12 that puts first responder ALS on scene prior.

13 What is the benefit? Maybe we call somebody an
14 Uber. Maybe we give people taxi credits to let the
15 ambulance go home.

16 But ultimately, I think you guys need to step
17 back, push yourselves away from the dais. Maybe
18 pick a new contractor. So that's my opinion. Um,
19 doesn't weigh much, but I got 181 members on the
20 back of my shoulders and I'm here, standing behind
21 me.

22 And unfortunately, we have to go back to
23 classes, get back to our families. So to see a red
24 as thin [ph], but we're here. So thank you very
25 much. If you guys need the public records request,

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1 I can send -- you guys all share a drive. So --

2 MS. CORSELLO: Thank you. That was 12 minutes.

3 So I gave you the longest of all the others to be
4 fair and let you air your concerns. Uh, I have the
5 next card, is Shawn Stark.

6 MR. STARK: Good afternoon. My name is Shawn
7 Stark. I'm the deputy political director for the
8 California Professional Firefighters. We represent
9 30,000 professional firefighters protecting the
10 state of California.

11 And, uh, I was asked to come here today by,
12 uh, Brian Rice, our president. He wanted me to read
13 a, uh, letter that he wrote to, uh, Todd Matthews,
14 uh, in regards to the dispatching issue.

15 It says, uh, Brother Matthews, uh, it's been
16 brought to our attention that a draft blueprint for
17 the EMS services in Solano County proposes to
18 consolidate dispatch services for seven fire
19 departments under the control of a private for-
20 profit ambulance company.

21 As president of the California Professional
22 Firefighters and as a 31-year first responder, I am
23 writing to strongly urge that this risky and
24 potentially damaging model be rejected.

25 Few private outsourcing models exist in

1 California and where they have been implemented,
2 the results have proven to be disastrous and
3 ineffective. Based on the experience in San Joaquin
4 County, the evidence suggests this model.

5 A roads effectiveness and timeliness of fire
6 department response. In San Joaquin County, the
7 same model has severely limited fire department
8 participation in the EMS system.

9 Dispatchers routinely bypass Stockton and
10 Tracy firefighter paramedics on calls, giving
11 preferences to corporate providers. This has
12 resulted in documented delays in response. It
13 removes accountability.

14 Under the tiered EMS response model, decisions
15 on how or whether to respond are made by private
16 contractors accountable to its shareholders, not
17 the taxpaying public. It threatens the standard of
18 care. By placing emergency medical response
19 decisions in the hands of a private contractor, the
20 potential for cost-based medicine, uh, medical
21 decisions increases.

22 The experience is clear. Private for-profit
23 dispatch doesn't streamline response. It makes
24 responses more complicated. As you know, emergency
25 medical transport is evolving.

1 There are many models of care and response
2 that can provide efficiency and centralization
3 without ceding accountability, the sworn authority
4 of the fire departments. Emergency medical response
5 dispatch is a core public safety responsibility.

6 It should remain the providence of the
7 agencies for whom it is a sacred mission, the
8 sworn, publicly accountable fire agencies.

9 Fraternally, Brian Rice, president, California
10 Professional Firefighters.

11 Uh, on a personal note, um, I take, uh, issue
12 with Mr. Elliott's statement. Uh, I've served, uh,
13 recently retired as a 17-year, uh, fire-medic in
14 Alameda County, and I watched three providers there
15 in the time that I was there.

16 Three times, they've come in -- in one case,
17 I'm not going to mention the actual individual
18 companies, they underbid the contract. And then,
19 they came back to the county for relief when they
20 couldn't meet the, uh, uh, the standards.

21 So they would be audited. And so, we would be
22 sitting out there. And when they were being
23 audited, there'd be plenty of ambulances that would
24 arrive on the scene.

25 As soon as that was over, to get their profits

1 back, they would take away the surge and we would
2 be sitting on scene for 30 minutes waiting for an
3 ambulance. This is not reflective of the crews at
4 all. They were outstanding. But it was the
5 reflection of the profit-driven, uh, method that
6 they were -- they were dispatching.

7 So for him to say that profit margin has
8 nothing to do with how they operate is ridiculous.
9 And in fact, it's been a revolving door in Alameda
10 County. This is -- now, they're -- they're in
11 negotiations for a third provider in, uh, 20 years.

12 So, uh, the idea that -- that the for-profit
13 model is the way to go is absolutely absurd. The
14 fire service in Alameda County does not surge. We
15 have minimum staffing. We have the same amount of
16 firefighter-medics on the scene.

17 And we're, uh, in the firehouses responding
18 every single day. We don't surge for profit. We
19 serve the citizens with the highest level of care.
20 Thank you.

21 MS. CORSELLO: Uh, the next card I have is
22 Danny Gutierrez.

23 MR GUTIERREZ: Um, Chair, Board, Staff, my
24 name is Danny Gutierrez. I'm the, uh, vice
25 president for the Vallejo Firefighters Association.

1 I'm also a representative on 1186.

2 As a field provider for the past decade, I
3 support the mission of Solano EMS of a strong
4 commitment to providing quality pre-hospital care
5 whose main goal is the best possible outcome for
6 the patient.

7 I believe this board and Solano EMS agree. But
8 that's not what this RFP will provide, and we'll
9 talk a little bit about what's on the website of
10 Solano EMS when we talk about the three core
11 elements.

12 Pillar one of the core mission is to provide a
13 rapid response that minimizes the time from
14 emergency even to the arrival of resources. This
15 RFP would increase response times for our citizens,
16 and it would do so with experienced professional
17 paramedics who are strategically placed in
18 firehouses across the county, sitting idly by,
19 possibly not even knowing that a call for care had
20 gone out.

21 Pillar two of the core mission. From the
22 website, again. Competenc- -- competency in
23 practice. This is by applying clinical field
24 medicine to the highest standards using best
25 practices. I believe we, as providers, do provide

1 clinical field medicine to the highest standards.

2 But this RFP is asking us to alter our
3 practices based on zero local baseline data,
4 nothing, from this county. And that's information
5 from the staff themselves. They didn't have
6 baseline data, but they are developing it.

7 So how are we going to be able to compare
8 where we were to where we are in five years if we
9 don't have that data? It's also based on limited
10 sample size studies provided by a consultant that
11 do not reflect the demographics of Solano County,
12 the Bay Area, or even the state of California. That
13 is hardly the best.

14 Pillar three. A goal of accountability through
15 improving processes for the delivery of care. The
16 delivery of care is not improved by incentivizing a
17 private for-profit provider to offer BLS ambulances
18 when they think they can get away with it. Erase
19 the calls to avoid honoring unit hour savings
20 agreements. All expecting that there will be or
21 that there will never be a mistake in patient
22 triage.

23 The men and women you see here today behind me
24 in the red and other shir- -- other color shirts,
25 black, from Vallejo, uh, from Benicia, Cordelia,

1 Dixon, Vacaville, we took an oath, we had to put
2 our hand up when we got hired, that we would
3 provide the best care for the citizens we serve.

4 This RFP does not meet that vow. We request
5 that this board ask for an extension of the current
6 RFP, for at least a year. Hopefully, that's enough
7 time to iron out the issues that we have. So that
8 both the good and the bad ideas before you may be
9 fleshed out before we m- -- commit to a flawed
10 proposal.

11 And secondarily, I -- I wasn't going to
12 address anything else, but, I feel that I have to
13 address the issue that was brought before us by the
14 Physicians' Forum. I'm deeply concerned and
15 disturbed, actually.

16 I know there's individuals on this board that
17 I've personally delivered patients to, and many
18 people back here have -- have as well. And the
19 understanding of the value that firefighter ALS
20 first responder medics throughout the county
21 provide was completely absent from that Physicians'
22 Forum report.

23 And I'm -- I hope that over time, maybe if
24 it's an education issue, we'd be happy to become
25 involved and get on the same page about the value

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1 that we provide. Maybe it's a failure on our part,
2 but I'd like to think it's not. Because I've always
3 had good interactions with the doctors that I've
4 dealt with.

5 But the lack of information and the lack of
6 understanding of the value of having strategically
7 placed fire- -- experienced professional fire-
8 medics, um, was very glaring in that report. So
9 thank you.

10 MS. CORSELLO: Thank you. Um, Mr. Ben Hill.

11 MR. BROWN: Uh, good afternoon. My name is
12 Kevin Brown. Ben had to leave. Uh, so you can
13 scratch Kevin Brown off if you'd like. Um, I'll
14 read the speech prepared by -- by Mr. Hill.

15 So again, my name's Kevin Brown. I am the
16 secretary-treasurer for the Vallejo Firefighters
17 Association. I also serve as a representative for
18 local 1186 firefighters. Ben is the vice president
19 to local 1186 and the president for Vallejo
20 Firefighters Association.

21 As written by Ben, this week, I was able to
22 review a series of e-mails, some of which you've
23 now heard, between Doug Wolfberg of Page, Wolfberg
24 & Wirth Consulting firm; Solano County EMS
25 employees; and members of Medic Ambulance.

1 The documents paint a picture of what I would
2 consider a collaborative effort to push an agenda
3 for a RFP package that is highly financially
4 beneficial to the local ambulance provider at the
5 detriment of public health and safety.

6 There's clear evidence of a bias of opinion
7 for private ambulance companies against local
8 municipalities with Doug Wolfberg. In his e-mails,
9 Mr. Wolfberg stated, when referring to a Ninth
10 Circuit Court decision in Orange County favoring
11 local cities maintaining 201 rights as lipstick on
12 a pig but still a pig.

13 Wolfberg has shown that he's colluded with
14 employees of Solano County EMS to push out voting
15 members of the SEMSC panel who don't fall in line
16 with his recommendations.

17 This collusion is a direct legal violation of
18 the procurement process. His inability to take
19 direction from the SEMSC panel and come up with a
20 viable solution to improve EMS response in Solano
21 County is concerning.

22 Another key item brought to light is the
23 recommendation of Physicians' Forum regarding PPP
24 funds. It is their sole responsibility to provide
25 medical direction, not financial direction or

1 recommendations.

2 There's a clear line crossed. I think it is
3 the responsibility of the SEMSC panel and higher
4 governing body to slow down and investigate the
5 intentions of Doug Wolfberg and other influential
6 member- -- members involved in the RFP process, as
7 their motivation and biased approach to the terms
8 of the RFP, which will be detrimental to the public
9 health and safety of the citizens of Solano County.

10 So that was written by Ben. I'd just like to
11 add that, uh, o- -- one piece that was presented
12 earlier in, uh, Dr. Mumma's presentation regarding
13 ALS, uh, versus BLS survivability outcomes in
14 cardiac arrests.

15 Uh, it showed that there was a -- a -- a lower
16 out- -- uh, lower survivability outcome of cardiac
17 arrest in many ALS cases, as compared to BLS. So
18 I've attended a lot of EMS conventions. I've read a
19 lot of EMs reports.

20 That -- that appear- -- appears to be true. I
21 -- I've seen it time and time again myself. And she
22 was correct when she, uh, followed that up by
23 stating that we believe that's tied directly to
24 airway management. At least, as the predominant
25 factor.

1 Uh, so having said that, I want to make it
2 clear, because I don't feel it was made clear in
3 her presentation, that it isn't ALS responders that
4 are causing a decrease in survivability rates. It's
5 the protocols which we follow.

6 So that means the protocols of this county
7 need to be updated to reflect the new studies as
8 they -- as they've come out over recent years.

9 Decreasing the number of paramedics that
10 respond to a call or increasing the amount of time
11 that we're allotted to arrive to that call doesn't
12 improve survivability outcomes. ALS responders are
13 those who save lives. It's the protocols that need
14 to be updated. Thank you.

15 MS. CORSELLO: Thank you. Okay. I have two
16 more names. Patrick Wong, Shawn Grukens? Gogens? So
17 which one is it? I'm assuming you're Shawn?

18 MR. WONG: I'm Patrick Wong. Shawn Gugins had
19 to go back to work. So --

20 MS. CORSELLO: Oh. Okay.

21 MR. WONG: Uh, good afternoon. My name's
22 Patrick Wong. I'm the treasurer of firefighters'
23 local 1186 and I've been a, uh, paramedic for
24 almost 10 years. Uh, almost 8 years in this county.

25 Um, I had some key points that I was going to

1 talk about. Um, however, uh, President Matthews
2 kind of hit them all, um, in his 12 minutes he was
3 up here. So, uh, I just wanted to go with the quick
4 little thing that I have, is, uh, if you decide
5 that allowing a private enterprise to be in charge
6 of your family's 911 call, let it be known that
7 you're derelict in your duties of public service.

8 911 calls are not a business model. They are a
9 basic need to society ever since doctors made house
10 calls. It can never be properly addressed by fines,
11 shareholders, or meetings, or end of the month
12 quotas.

13 It's a minimum service not to be profitable,
14 but beneficial to the people you represent. Thank
15 you.

16 MS. CORSELLO: Thank you. Uh, I've got Carl L-
17 -- Littorno. Did I say that right? Sorry.

18 MR. LITORNO: How you guys doing today? Uh,
19 thank you for letting me address this board. I hope
20 you appreciate the time that went into it.

21 Uh, got up at 6:00 A.M. with my three-year-old
22 and six-year-old daughters, and they had the time
23 clock out. So we're at exactly two minutes. So it's
24 a family effort. Uh, first of all, I'm Carl
25 Littorno.

1 I'm a fire captain in the city of Benicia. I'm
2 also the vice president of the, uh, Benicia
3 Firefighters Association. And, uh, most
4 importantly, I live in the city of Benicia as well,
5 so I'm here as a citizen.

6 Uh, my family lives in Benicia. My parents
7 live in Benicia. We're members of Solano County. So
8 I'm speaking on their behalf.

9 Uh, first of all, um, this wasn't originally
10 my speech. Uh, but I saw Dr. Mumma's presentation.
11 I thought a lot of facts that you said were valid
12 and I appreciate them. One thing that you did say,
13 however, is a study shows that citizens don't care
14 whether it's a ambulance paramedic or a firefighter
15 paramedic who show up to their house on calls.

16 Um, I would say to you come to Benicia.
17 Respond to calls with us. They care. Uh, every time
18 I'm to a house, uh, two minutes away from our
19 station, they say thank you so much. We cannot
20 believe how fast you get to our house. That is an
21 expectation of our community. That is something we
22 provide. So that side, that is a reality.

23 Wanted to voice my extreme disappointment in
24 how this process has unfolded and even more
25 disappointment about how it has gotten this far. In

1 this room, you have stakeholders from all parts of
2 the county who are all dis- -- disappointed in how
3 this has unfolded.

4 That's not a good process. There should be a
5 little bit on each side. This entire proce- --
6 process should have stopped from the moment the
7 contractor ignored a lot of the board's requests
8 for this blueprint.

9 If we refer to Policy 1760, which I have right
10 over there, there is a direct line in the chain of
11 command from this board to the board of
12 Supervisors. And then, you can draw a little line
13 over to the contractor.

14 We don't r- -- we don't respond to other
15 people, so I don't understand how what we presented
16 today with people having input fits into that chain
17 of command. Again, that's policy 1760.

18 This entire process really should have been
19 stopped the moment its author tried to strip cities
20 of their -- in this county of their 201 rights.
21 Dispar- -- dispatch is part of a city's legal 201
22 rights. I know we all throw that term out when we
23 read the law.

24 Section 1797.201 of the Health and Ca- --
25 Safety Code states, quote, upon the request of a

1 city or a fire district that contracted for or
2 provided as of June 1st, 1980, free hospital
3 emergency medical services. It says nothing about
4 transport. Free hospital emergency medical
5 services. That includes dispatch.

6 Uh, I don't think any of us who are sitting in
7 this room today, um, have a problem with emergency
8 medical dispatch. Great idea. But like happened
9 and, uh, Mr. Selby can talk more about this,
10 because he probably has better stats than I do,
11 when you guys required for us to go to electronic
12 PCRs in the county. What happened? We all went to
13 electronic PCRs. Not a big deal.

14 I'm a fire captain in the city of Benicia. Our
15 main and only objective is to provide the highest
16 level of services to our citizens. I don't care
17 about profit. This doesn't change my salary.

18 This doesn't change my need to provide the
19 highest level of service to my citizens. If there
20 needs to be a PPP to assure a level of care to my
21 citizens that they expect, then so be it. I would
22 ask the board consider the average, uh, the average
23 for a unit cost in California across when coming up
24 with unit cost hours. So taking that into
25 consideration.

1 Finally, I want to say this blueprint is not
2 the service they expect in the city of Benicia.
3 This passes, you guys think there was not going to
4 be a backlash from our citizens? You guys are
5 incorrect. Thank you for your time.

6 MS. CORSELLO: Thank you. Kevin Brown. Okay.
7 Steve, uh, McGraw.

8 MR. MCGRAW: Yeah. To represent my brothers
9 and sisters in the back of the room. I got in
10 trouble for not wearing red this morning. So, uh,
11 good afternoon. Uh, my name is Steve McGraw.

12 I'm the president of Fairfield Professional
13 Firefighters Association and a vice president for
14 Firefighters Local 1186. I'd like to make mention
15 that I'm also volunteering my time to be here today
16 and I have no financial ties to this RFP.

17 I will be sharing fire local 1186's comments
18 on the proposed tiered EMS response. Our union and
19 many other unions in this room agrees with the
20 benefit an A and B program consisting of pre-
21 arrival instructions and criteria to determine the
22 appropriate level of s- -- response.

23 However, we are not supportive of any system
24 that would not include the fire departments'
25 simultaneously response -- or simultaneous response

1 for all medical 911 calls in Solano County.

2 Our resources are strategically located in the
3 communities we are sworn to protect and it would be
4 a disservice to our residents have trained
5 experienced paramedics in the neighborhood not
6 included in the response, especially with the
7 excessive increase in response times proposed by
8 the consultant.

9 Under this proposed tiered EMS response model,
10 the decision on whether to respond a fire unit to a
11 medical call for service would be made by the
12 private for-profit contractor that is responsible
13 to its stakeholders, not to the taxpaying residents
14 of this county.

15 In my 20 years of experience as a medic in
16 Solano County, I would say hundreds of calls per
17 year are improperly triaged due to several reasons
18 outside of the dispatcher's control.

19 Per Mr. Dale's stats, uh, the first presenter
20 that we heard today, roughly 2 percent of the calls
21 are mis- -- uh, -triaged or dispatched. That
22 equates to about 750 per year here in Solano
23 County. That's one to two a day.

24 So with my closing statement in a few minutes,
25 I want you to think about those one to two calls

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1 per day when I give my closing statement. With this
2 proposed model, an improperly triaged Alpha or
3 Bravo call would not recommend that a local fire
4 unit respond to the call for service and could
5 potentially allow the appointed contractor up to 60
6 minutes to arrive on scene.

7 In this scenario, a fire unit is not
8 dispatched to the call, and that unit could be only
9 blocks away or literally just around the corner
10 from the call.

11 The fire unit could have provided lifesaving
12 measures on an under-triaged patient within a few
13 minutes when, in reality, immediate ALS
14 intervention was actually required. This proposed
15 model makes no sense to me as a public servant or
16 as a tax-paying resident.

17 These types of scenarios occur on a daily
18 basis and I hope that one of your family members,
19 one of your coworkers, or one of your close
20 friends, or a citizen that you swore to serve are
21 not involved in this flawed model of tiered EMS
22 response. Thank you.

23 MS. CORSELLO: Anthony Lasala [ph]. Okay. Uh,
24 uh, J.T. Hoyle [ph]. Did I say that right? No? Ryan
25 Lareau [ph].

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1 MR. LAREAU: Good afternoon, Board. Um, the,
2 uh, blueprint states clearly on Page 6, Section E,
3 uh, that the SEMC- -- SEMSC's number one goal is
4 for public health and safety. Uh, the question
5 arrives why there are so many e-mails going back
6 and forth from our LEMSA administrator, medical
7 director, and the author of the RFP about trying to
8 force out the fire chief and the city manager that
9 sit on the board.

10 Other topics of the e-mails include convincing
11 the board to accept this blueprint since it's
12 dramatically different than their current mode of
13 operations.

14 Um, I'd also like to add that, uh, if -- if
15 it's a conflict of interest for the Benicia chief
16 to sit on the board due to him potentially bidding,
17 I mean, we -- we all in this room have potential
18 conflicts of interest. I -- I'm conflicted because
19 my family lives here.

20 We have physicians that operate here. And
21 maybe for a non-profit hospital, but this is where
22 we live. This is where we're vested. Um, this --
23 this is -- this is of grave importance to us.

24 Um, why is our EM- -- uh, our EMS
25 administrator having conversations with the RFP bl-

1 -- blueprint author via e-mail about how the RFP is
2 written, up to, including, and, uh, commenting on
3 how the Orange County 201 rights case would affect
4 this process, both calling it a lipstick on a pig
5 policy, 1706. Uh, this would suggest he's well
6 outside the scope of practice.

7 Uh, uh, in closing, uh, if you refer to the
8 flowchart, it's policy 1706, uh, this committee
9 reports directly to the Board of Supervisors for
10 the overall direction of the EMS system. I believe
11 we've already gone over this.

12 One thing I would like to add is, uh, I mean,
13 we're all for the, you know, putting this, uh, in
14 this RFP, having central dispatch and having, uh,
15 EMD. But, uh, putting a public interest, uh, we've
16 seen drastic results recently.

17 Uh, I know it's in a different area, but PG&E,
18 where it's a public interest, that's put in a
19 private -- private hands with little to no
20 oversight, it can have disastrous results. Thank
21 you.

22 MS. CORSELLO: Thank you. Matt Marino.

23 MR. MARINO: Good afternoon. Uh, Matt Marino.
24 [inaudible] Sorry. Um, today, I think, threw a
25 curveball for us all. Uh, honestly, thought I was

1 going to come here so we could all collectively
2 work out, uh, a contract to improve EMS in Solano
3 County.

4 I think that was the mission of everyone in
5 this room, including you, the board. Um,
6 unfortunately, I think what we've discovered here,
7 uh, really starts with the author of the draft, and
8 that's a bias.

9 Uh, we're seeing a power grab. We're seeing an
10 extreme, uh, this is an agenda being pushed and I
11 honestly -- I almost feel bad for you folks up here
12 that now have to make these decisions, uh, based
13 on, uh, somebody's, uh, power struggle or power
14 grab.

15 Uh, you had the -- the first speaker attacking
16 the fire service. Uh, there's no one that I'm aware
17 of here in the fire service that would attack our
18 current provider or, uh, a private entity, uh, that
19 we all came from.

20 So, uh, I think today, really, like I said,
21 took a turn. Um, I think it showed in the public
22 records request with e-mails prior to today, and
23 that really set the tone. Um, it's appalling that
24 the folks that are going that are making this
25 decision are spending more time trying to recuse

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1 members of this board to have a vote, rather than
2 to try to i- -- improve our EMS.

3 Let's go back to what EMS stands for,
4 emergency medical service. It is not a service to
5 ourselves. It is a service to the citizens that we
6 protect. And those of us in the fire service took
7 an oath, as the gentleman said, to do so.

8 And -- and I was also, uh, I'll be respectful
9 in my comments to, uh, Dr. Mumma. Uh, you -- you
10 signed my paramedic card, so I want to be
11 respectful of that. Uh, but some of the -- the
12 Physicians' Forum, and it may not have, uh,
13 respectfully, may not have come from you.

14 You're just presenting the Physicians' Forum.
15 Uh, it talked about firefighter-paramedics being,
16 um, uh, over -- over, uh, I think you said
17 expensive on the system.

18 Um, that's false. You're getting two-for-one.
19 The communities are getting a two-for-one. You're
20 getting a firefighter and a paramedic. And it also
21 was stated that, uh, fire engines spend too much
22 time on Alpha-Bravo calls when they can be
23 responding to other emergencies.

24 I would, uh, offer that I would imagine these
25 fire chiefs would be knocking -- kicking down your

1 door if these Alpha-Bravo calls were preventing us
2 from responding to put out fires. That's the nature
3 of the fire service, is we move around and protect
4 each other.

5 Uh, it almost came across as it's an
6 inconvenience for us, uh, uh, on a fire engine to
7 respond to Alpha-Bravo calls. Uh, and there's no
8 inconvenience.

9 I think you see, uh, a sea of red shirts back
10 there, of folks that, uh, they're showing up to say
11 they want to work harder because they care about
12 the community they serve. And I think that has to
13 be the mission of this board.

14 Is -- we see today such a bias a- -- and it is
15 concerning the public records request and -- and
16 trying to recuse members of the board prior to this
17 meeting. Uh, that only reveals that bias.

18 So how do we get through this? H- -- how do we
19 come together and figure out how to put a fair
20 contract together that -- that helps the community?
21 When we argue with one another, when you guys are
22 witnessing this power grab, this agenda needs to be
23 a mission and not an agenda.

24 The mission needs to be about the people, and
25 that's what's being lost here. This is a power grab

1 and it needs to stop. The way you -- the -- the way
2 to resolve it -- I'm not going to complain without
3 giving recommendations. Is offer up the same system
4 for all entities.

5 So if it's central dispatch, make that -- or
6 I'm sorry, EMD. Make that available for all
7 entities, not just the provider. It can- -- it can
8 work. So let's -- let's work together.

9 Let's, uh, uh, and in closing, I think that
10 what you see before you today is a business plan
11 and it needs to be a service plan. Because when you
12 create a business plan out of a service plan, it is
13 the citizens that we are here to serve that have
14 become collateral damage. Thank you.

15 MS. CORSELLO: So I have a card from Jon
16 Miller.

17 MR. MILLER: Good afternoon, Board. My name's
18 Jon Miller. Um, I'm the vice president of Fairfield
19 Professional Firefighters Association. And I just
20 wanted to bring up, uh, four problems that we --
21 that we've noticed with the centralized dispatch
22 study that is making this blueprint evidence
23 biased.

24 Problem one is that there's no study to
25 support claims what is best for this county is a

1 centralized dispatching station. On page 47, claims
2 that -- that the county should be using the NAED
3 standards for dispatching calls.

4 I have no problem with this. It gives a
5 standardized protocol for dispatch that can be used
6 across the county. However, nowhere in the NAED
7 standard do they call for a centralized dispatch.
8 In their eight points, they only call for common
9 sets of protocols for the dispatch.

10 Wolfberg cites the study Emergency Medical
11 Dispatching authored by Dr. Clawson. Unfortunately,
12 nowhere in Dr. Clawson's study does he state that
13 there needs to be a centralized dispatch. Like the
14 NAED, he makes the argument for a single set of
15 protocols. Excuse me.

16 There is no public entity in this room that
17 has an issue with creating a single set of
18 protocols for dispatch through EMD. What we do have
19 a problem with is handing over dispatch to a
20 private entity that makes decisions based on
21 profits. Thank you.

22 MS. CORSELLO: James Pierson.

23 MR. PIERSON: Good afternoon, Board. Jim
24 Pierson, Medic Ambulance. Um, I first want to start
25 off with, obviously, we are members of the

1 California Association, but, um, those thoughts are
2 -- are not Medic's thoughts.

3 I mean, people can say what they want, but we
4 have relationships in this county, we've had them
5 for 20 years, and we've kept those. And, you know,
6 uh, uh, this is a trying time. You know, we're
7 caught in the middle of multiple cases.

8 Um, one of the things I know, dispatch has
9 been a main focus here. I actually do have other
10 contract-related things I would like to address
11 with you. But being dispatched, I do think that --
12 obviously, as a potential bidder, we're going to
13 bid what's in a document; right?

14 Um, but we have good PSAPs in our county. Yes.
15 I think, uh, I heard Todd say it or multiple people
16 say it. We need a centrali- -- and I think Aaron
17 said it best. We need a centralized dispatch
18 center; right? Uh, but we need to walk first, and
19 EMD is the walk that has to happen for our
20 citizens.

21 We had a three-year-old code blue in Vallejo
22 yesterday. We had a seven-year-old in Fairfield
23 today; right? We have to ensure that people are
24 getting pre-arrival instructions. And I think
25 that's a commonality, which is fantastic; right?

1 Um, but we can achieve that by allowing --
2 think, uh, uh, a good middle ground is allowing the
3 PSAPs to -- to come to standard before the new
4 contract. Building in EMD protocols that we all can
5 agree to.

6 Um, the thing about EMD, when we've gone
7 across the country and looking at this and we're
8 educated on it, i- -- uh, I haven't heard anybody
9 say it, which I'm kind of surprised. But every EMS
10 sys- -- if you've seen one EMS system, you've seen
11 one; right?

12 And Solano has its unique characteristics;
13 right? And we need to be able to address those. And
14 we can address those collaboratively, not attacking
15 the for-profit model. Medic's a 40-year service
16 inside of Solano County. We've proven to put our
17 citizens first. People that know Medic know that.
18 So I just want that to be out there.

19 Um, now, where do I start? So, you know, one
20 of the biggest things, too, as we go kind of into
21 the contract now; right? A performance security
22 bond of \$5 million; right? The last contract had \$1
23 million.

24 I'm just trying to understand how we jumped to
25 \$5 million. We talked about not overburdening the

1 contractor, whoever wins the contract,
2 overburdening them with incentives and all these
3 diff- -- well, I think we're doing that.

4 An irre- -- irre- -- irrevocable letter of
5 credit for \$5 million versus \$1 million is
6 significantly more expensive than a. contractor.

7 Uh, currently, you don't mandate audited
8 financials. Medic does do audited financials. We
9 don't do them every year. We're reviewed and
10 audited, but we don't have them for every year of
11 exis- -- and this contract's requesting three years
12 of audited financials.

13 Well, if we're in full compliance, as we are
14 with our current agreement, we wouldn't even meet
15 that qualification. So we have to go back and audit
16 our books, which our recent ones would be, but we'd
17 have to go back two years and do that as well.

18 So those are just things that I think that --
19 I don't know where the communication got dropped.
20 Um, and then, when you look at also -- and I have
21 other things. But when you look at, um, the -- the
22 -- I just lost it. Sorry about that.

23 It's been sitting for four hours, so, um, the
24 -- the fine model. Let's go to the fine model;
25 right? So I totally agree with the new concept and

1 looking at performance-based fine models. Th- --
2 those make sense.

3 But we also talk about workforce engagement
4 and workforce retention. A lot of our employees
5 that you see in the back right now are ex-employees
6 of Medic Ambulance. They went to the fire service.

7 That's what they wanted to do. They -- or they
8 went to the police service or they went into county
9 government. To have 30 percent workforce retention,
10 there just needs to be some form of -- I get --
11 looking at that; right?

12 If our employees are leaving us to go to
13 Burger King, then we have a problem and we all need
14 to talk about it. But if they're going to Fairfield
15 Fire Department, is that really something to
16 penalize the contractor for?

17 Um, so I think that that -- that plays into.
18 And when you talk about workforce retention, if
19 you're fining us for every time a paramedic misses
20 a 12-lead, you know, that -- then, you know, we're
21 trying to -- you know, you don't want to have --
22 come down too hard on the employees. You're trying
23 to find a happy balance. And so, if we're penalized
24 \$1,000 for every person that misses a 12-lead, what
25 are we trying to do?

1 Now, let's look at the overall scope; right?
2 What are our STEMI receiving times; right? How --
3 how quickly are we transmitting every EKG? Now,
4 let's look at -- we look at 90 percent on response
5 times. I'm not saying don't look at how many EKGs
6 we missed, but let's find the percentage, or
7 something that works.

8 Because if you go on that, then it really
9 turns into a fractionalized, penalized system that
10 becomes over- -- you know, just overburdensome to
11 the contractor. So I just think those are things
12 that need to be looked at.

13 Um, sustainability is important. Um, we have
14 good fire partners. Obviously, we have -- I mean,
15 great fire partners. I want to say that. Uh, we all
16 work well together. Um, you know, the -- the PPP,
17 uh, I do not believe, should be a scored option.

18 You know, 10 years ago, it was a mandated
19 response. We had to lay out exactly what our costs
20 -- it l- -- it's kind of the same layout, but I
21 think when you're scoring what we're offering, I
22 don't know how you're really going to delineate how
23 you -- how you get the highest score.

24 By offering the most money? I mean, those are
25 the things that, uh, I just think we have to look

1 at that. We really have to analyze what that is.

2 Should the PPP be part of the RFP? Absolutely.

3 But should it be scored? That's the part we're -- I
4 think we need to look at. Other part is when you
5 look at fire first response system.

6 There's literally no mention in the fire first
7 response system of how we take care of the non-PPP
8 cities. You know, is there a med exchange?

9 Is there -- so, you know, Rio Vista Fire,
10 Cordelia Fire, uh, Montezuma. There's a lot of, you
11 know, non-PPP cities. [inaudible] City. There's a
12 lot of non-PPP cities, and they're not even being
13 graded.

14 And so, that's a complete reversal of how the
15 last RFP went. And I'm not saying to do the same
16 RFP 10 years ago, because everything needs to be
17 updated. But those are just things that we have to
18 look at as, um, as a system.

19 So, you know, we're not a big proponent of the
20 Alliance Model. I will say that. I don't know -- I
21 mean, one county, you could say it's somewhat
22 successful. Um, however, you know, there are more
23 facts, and maybe Kirk can speak to that.

24 But I know there's a letter from EMSA that's
25 out there that wasn't discussed. There's a

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1 possible, you know, statewide -- or not p- -- there
2 is an investigation going on with the deputy -- or
3 the attorney general in California.

4 So I'm not saying that that model's bad;
5 right? Uh, I'm just saying it's not proven; right?
6 One model with all these different things going on
7 does not make it proven. So -- but we need to look
8 at the different -- the different ideas.

9 Um, I'm not -- Medic's not going to sit up
10 here and tell the city of Fairfield or the city of
11 Vallejo what calls they should go on. I think
12 that's a system-wide call. I think that's something
13 we can identify as a team. Um, as a -- I mean, as a
14 -- as a county.

15 Um, you know, I just -- I don't want to get
16 caught up in the weeds here. I really don't like
17 the finger pointing. I don't like the -- the push
18 at the for-profit.

19 Uh, I think the biggest failure of our county
20 right now is not having EMD on 100 percent of our
21 calls, and that hurts our system. That hurts our
22 residents. That hurts -- that hurts everything.

23 Um, the last thing I will say, um, as it said,
24 the contractor was against it, um, which is true.
25 We don't feel CCT should be included. There's a lot

1 of other factors in the reason than just saying,
2 well, ALS RN program.

3 There was a lawsuit. It wasn't related to the
4 RFP. It was related to lack of enforcement of the
5 ALS franchise; right? They -- SEMSC, county staff
6 resolved that to through the ALS RN program. And
7 it's proven to be a high-level service.

8 That doesn't mean it's -- that our hospitals
9 are less served on CCT. Since ALS RNs program, all
10 of our hospitals have gone out for bid and there's
11 three contracted CCT providers in our county.

12 So I think you should allow those hospitals to
13 maintain that free market approach. Why you use the
14 cost shifting in the ALS franchise when the current
15 providers that are contracted with the hospitals
16 have done that cost shifting through their non-
17 emergency business and BLS?

18 So those are things that I just think that
19 need to really be looked at. And that, it's not
20 saying, you know, as an entrepreneur, bring it all.
21 We'll take it all. But it just doesn't make sense;
22 right?

23 It just doesn't make a lot of sense. Allow the
24 hospitals to have that enterprise. Um, unless
25 there's any questions for us, uh, that's really

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1 kind of where I'd like to -- and I don't know that.

2 How'd I do? Was it -- was it under four --

3 MS. CORSELLO: Eight minutes. That's not bad;

4 right? Okay. So, um, Andrew Tomolusu [ph].

5 MR. TOMOLUSU: Yeah.

6 MS. CORSELLO: Okay. You can tell the air
7 conditioning is working. That's why the nameplates
8 are moving.

9 MR. WHITE: Um, Chair [inaudible]. Um, how
10 many more, uh --

11 MS. CORSELLO: Uh, well, I have three cards. I
12 don't know if they're all here. There's an Alan
13 Shear. Okay. Could, uh, I'm not sure your mic is
14 on.

15 MR. SHEAR: Sorry about that. Okay. Um, what's
16 most concerning to us is the -- is that the
17 recommendations signal a significant policy change
18 in how emergency response is conducted in our city
19 without actual financial information and patient
20 outcome data from our city and without a robust
21 public engagement process.

22 The city asks that the board consider the
23 following points, uh, in your deliberation.
24 Centralized medical dispatching. The city
25 understands that there is a need to work

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1 collaboratively with agencies county-wide to ensure
2 that resources are dispatched appropriately to
3 address emergencies.

4 The bluep- -- the blueprint report recommends,
5 quote, converting to central dispatching for
6 emergency medical calls, unquote, without
7 considering the harmful and dangerous implications
8 of bifurcating EMS dispatch from police and fire
9 dispatch.

10 We are concerned about the negative impacts on
11 communication and coordination that could occur
12 with our police and fire units that need to be
13 deployed by adding yet another dispatch center.
14 More analysis and outreach should b- -- should be
15 performed with Solano County and all of the
16 participating cities to develop a long-term
17 approach to address this issue.

18 Privatized medical dispatching. A transition
19 to private dispatch services provided by the
20 selected ambulance service provider is a
21 fundamental shift in our services that are -- are
22 currently provided and needs significant discussion
23 with the affected agencies m- -- moving forward.

24 Tiered EMS response. Implementing this
25 recommendation would result in a reduction in

1 services to our residents. We are concerned about
2 the degradation and the level of customer service
3 provided in our community and to our public safety
4 staff.

5 Often, what is conveyed to a dispatcher is
6 quite different than what is found by emergency
7 responders in the field.

8 Deploying an ALS response to calls ensures
9 that the resources are in place to address
10 circumstances in the field that may be different
11 than what was conveyed to a dispatcher over the
12 phone.

13 Financial impacts. The blueprint report needs
14 to -- needs to clearly articulate the financial
15 impacts of its recommendations not only on the city
16 of Benicia but on all of the member agencies in the
17 public-private partnership. This funding stream is
18 returned directly back to the EMS system and
19 assists in providing excellent emergency medical
20 services to our residents.

21 Uh, despite the concerns that I just
22 mentioned, there are recommendations in the
23 blueprint report that are promising.

24 Uh, more specifically, a new approach to
25 liquidated damages based on patient outcomes and

1 other changes that would ensure a greater level of
2 financial transparency and accountability are all
3 items that should be continued.

4 Uh, in conclusion, uh, the city asks that you
5 consider our concerns and allow more time to engage
6 the parti- -- the participating cities, such as
7 Benicia, in the decision-making around these
8 changes. Thank you.

9 MS. CORSELLO: Last two cards. Jarrod Inf- --
10 Infante? I'm sorry if I said that wrong.

11 MR. INFANTE: Good morning, Chair, Board,
12 Staff. Uh, Jarrod Infante, uh, Dixon Professional
13 Firefighters Association, Local 4665, uh,
14 secretary. Two issues, please.

15 Um, Wolf- -- Wolfberg cites a study of lack of
16 association between pre-hospital response times and
17 patient outcomes. This is a single study and in the
18 first sentence of the study, it admits that there
19 is limited data to support the claims it's trying
20 to make.

21 Uh, if you have a Bachelor's of Science in any
22 field, as many of the people in this room have, uh,
23 you know that, uh, it takes rigorous effort, uh, in
24 order to prove a hypothesis.

25 Uh, this is a single study, uh, without any

1 counter studies, uh, to disprove its hypothesis.
2 Um, this study uses a 10-minute 59-second response
3 time as a standard. Uh, in this county, we
4 currently ensure that firefighter-paramedics are on
5 scene in 7 minutes 90 percent of the time and we
6 are highly successful with this number.

7 In the study, they only look at a total of 373
8 patients. Just 373 patients. We run r- -- roughly
9 30,000 EMS calls a year in this county. In this
10 study, they made their claim that there was only a
11 2 percent difference in the mortality, uh, when the
12 patient received, uh, care below the 10-minute 59-
13 s- -- second, uh, mark, versus the -- versus, uh,
14 going beyond that.

15 Again, they only look at 373 patients, um, uh,
16 and that was an improvement. Please understand
17 there are multiple locations in the study, uh, in
18 the blueprint, with citings like this. Please do
19 due dil- -- diligence and, uh, research, um, the
20 work that they did.

21 The other issue, uh, Bryn Mumma, uh, becoming
22 involved in the RFP process. Uh, she was -- she was
23 contracted by UC Davis, um, to be the medical
24 director for the sole purpose of overseeing the
25 clinical aspects of the LEMSA.

1 Her duties include, per policy 1705,
2 evaluating the care of paramedics and EMTs,
3 reviewing medical components of the dispatch
4 system, optimizing patient care, oversight of legal
5 documentation, DEA licensing, and participation of,
6 uh, on the Physicians' Forum.

7 Nowhere in these roles and responsibilities
8 does it state that the medical director have a part
9 in drafting, uh, of, uh, the RFP. Nowhere does it
10 state that the medical director should have contact
11 with the ar- -- author of R- -- RFP or how it is
12 written.

13 Nowhere in the medical director's roles and
14 responsibility does it state that she should be
15 asking for more money disbursed to the LEMSA. And
16 nowhere does it state in the medical director's
17 roles and responsibilities that she has any right
18 to talk to the author of the blueprint about
19 forcing city governments off the voting board for
20 the RFP adoption.

21 It can be seen through public record e-mails
22 that Dr. Mumma has overstepped her responsibilities
23 and we kindly ask that the board use Dr. Mumma for
24 what she was paid for, her professional expertise
25 in clinical aspects of our medical system. Thank

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1 you for your time.

2 MS. CORSELLO: Thank you. Okay. There's
3 multiple names on here. So this is Casey Vanier.

4 MR. VANIER: Members of the board, uh, Staff,
5 I appreciate the opportunity to, uh, speak with you
6 today. Uh, my name's Casey Vanier. I'm a labor
7 representative with, uh, UEMSW, uh, uh, United EMS
8 Workers Local 4911, AFSCME local. We represent all
9 the EMTs and paramedics that currently work at
10 Medic Ambulance.

11 Um, what we have to bring forward today is
12 that we hope that you cont- -- continue to support
13 some of the things that we've suggested that have
14 gotten into, uh, what appears to be into the draft.

15 Um, myself, as a -- I worked in this county,
16 um, with a lot of these individuals for almost
17 eight years. Uh, I know some of the challenges of
18 the county and the system.

19 Um, some of the things that we really, uh,
20 push for is, uh, things that support the
21 environment and conditions of our workers, uh, to
22 make sure that they're taken care of.

23 Such as things as, um, that were put into the
24 draft as, uh, making sure that they're provided
25 with posts that give them the, uh, the ability to

1 use restrooms, heat up food, um, take breaks.

2 Even, someone brought up the fact of, uh, you
3 know, maybe even a boots up type of station, which
4 gives them the opportunity to recharge, refuel, get
5 the food they need. Um, they work long shifts, uh,
6 long hours, several days in a row. So we need to
7 make sure that they're being taken care of.

8 Uh, another thing that's been put in the draft
9 that we really want you guys to support is mental
10 health and suicide prevention. Uh, I think
11 everybody is probably privy to the numbers that are
12 out there, plus, some of the increased activity
13 we've had in those areas, um, with suicide, uh, in
14 private industry and public industry.

15 Uh, another thing that we asked for was
16 improvement on infrequent skills, uh, to make sure
17 that those are being used. Um, if they're not being
18 used, then that gets implemented into a program to
19 where the provider, um, whoever it may be,
20 continues and -- and -- and will further, um, be
21 training of infrequent skills, such as things as,
22 you know, needle cric, um, even down to intubation
23 and IOs, which are things, you know, that we don't
24 use every day.

25 Um, of course, um, another thing that's, uh,

1 very important to our group is incumbent workforce
2 language.

3 Um, if we -- if there is to be a change of
4 the, uh, providers or who you select. Uh, we want
5 to make sure that our -- our workforce is taken
6 care of and not just swept aside by a new provider.

7 Um, they want -- we want to be heavily cons -
8 - be considered, whether that be through a process
9 or whatever. But we want to ensure that our members
10 are taken care of in case that transition needs to
11 happen.

12 Uh, one of the previous speakers, um, spoke to
13 the language that we proposed about retention. Um,
14 we've had issues with retention as being the
15 representation of the members in Solano County.

16 And we're not talking about the type of
17 retention where you have somebody who's worked as a
18 paramedic and then is now furthering themselves or
19 taking a different position or trying a new
20 challenge as a firefighter or a flight medic or
21 things of that nature.

22 What we're looking at is things of -- due to,
23 uh, you know, burnout, um, you know, sh- -- being
24 short-staffed and working excessive hours to where,
25 you know, people aren't functioning properly, which

1 even ends up in, um, you know, making mistakes on
2 calls and things of that nature.

3 So s- -- watching staffing levels. Um, and
4 just to make sure that, uh, you know, people are
5 being treated fairly and correctly, whoever the
6 provider is. So we ask that you guys have some
7 oversight in that.

8 Because we all know the continuity of care is
9 what we're after; right? And, I mean, if you have
10 people turning over at the bottom, so to speak, um,
11 there's no continuity between the fire crews, even
12 the person you're sitting next to.

13 Um, and that's no good for anybody's level of
14 service. So those are the things that we have, and
15 I appreciate the opportunity.

16 MS. CORSELLO: Thank you. That is the last
17 speaker card. So I take it back in our hands. Uh,
18 it's the pleasure of the board as to how you'd like
19 to proceed.

20 MR. WHITE: Well, I guess the question is, um,
21 how are we going to address, uh, these issues that
22 have been raised, um, Chair?

23 So, uh, I'll just read two quotes from Mr.
24 Wolfberg that I think are particularly germane to
25 this conversation and I think are problematic, that

1 we should talk about. So he says in this -- I
2 received this through, again, a letter that the
3 board receives. So I have something that we all
4 have.

5 Mr. Wolfberg wrote on August 15th, uh, to Mr.
6 Selby, this reminds me. I think we're going to need
7 to be sure we lay some groundwork with the board
8 before this RFP goes to them for approval.

9 There's going to be a lot of opposition to
10 some of the things we're going to want to put in
11 there and the board, certainly, is going to hear
12 about it. Want to make sure they know why these
13 things, like centralized medical dispatch, are
14 going to be good for the system.

15 They're going to need to stand up to the fire
16 chiefs on this issue. But with the city manager and
17 a fire chief on the board, it's going to be tough.
18 I'll let that sit out there for a moment.

19 The second comments from Mr. Wolfberg to, uh,
20 Dr. Mumma, who I absolutely respect and adore. So
21 this is not aimed at you. Mr. Wolfberg says to her
22 regarding the, uh, disclosure from the Physicians'
23 Forum.

24 Do you know what the timetable would be for
25 finalizing such a statement? Would it have to wait

1 until the next committee meeting? Obviously, this
2 statement would need to be timed to be able to
3 positively impact the process given the timetable
4 that was set forth yesterday, probably the sooner,
5 the better.

6 Also, do you know if there's any chance we
7 could see a draft of the statement before it would
8 be released and circulated? So I don't know Mr.
9 Wolfberg. I've certainly never been through this
10 process before.

11 I can certainly tell you as a city manager and
12 as the representative for all the cities in the
13 county that my number one interest is to ensure the
14 highest level of care and safety for the residents
15 and businesses in this county.

16 Why? Because we will thrive if that is the
17 foundation we build from. So my perspective is --
18 is that these statements, along with what is shared
19 to us, is quite damaging.

20 It shows a high level of manipulation and I
21 certainly think this board should agendize the very
22 focused discussion on whether or not we should be
23 working with Mr. Wolfberg. Because I do not think
24 he's doing you service, Chair.

25 You have committed to me a process of

1 accountability and a process of transparency. And I
2 will have to say, from what I saw from you today,
3 I've absolutely seen those, uh, principles and
4 values upheld.

5 You let people speak longer than I've ever
6 seen anyone speak in a public meeting. And I think
7 that is very commendable. I think that you have
8 also done a fabulous job in terms of ensuring that,
9 uh, our voices are heard, and I think that's
10 commendable.

11 I do not think this consultant is doing you
12 any service or us any service. And I think it is
13 extremely problematic we have a consultant that is
14 specifically undermining the process by which we
15 have known could be highly litigious.

16 I think that we are all wonderful at what we
17 do. We are all public servants. I don't think that
18 anyone h- -- here who knows me, specifically those
19 who work for me, will say that I operate from a
20 perspective of deception, manipulation, or lack of
21 integrity.

22 And I think Mr. Wolfberg's actions are
23 deplorable. So I do ask this board to consider
24 putting on the next agenda a discussion of whether
25 or not he can serve us in good faith and in good

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1 duty.

2 MS. CORSELLO: Are you making that as a
3 motion?

4 MR. WHITE: Absolutely.

5 MS. CORSELLO: So do I have a second for that
6 request?

7 FEMALE BOARD MEMBER: Second.

8 MS. CORSELLO: Okay. So I have a motion and a
9 second. Any further comment or conversation?

10 MALE BOARD MEMBER: Uh, I have a question for
11 Mr. White. So, um, I think that there is -- you
12 know, there -- there's a lot of kind of information
13 that's -- that's been going around today.

14 Um, you know, I'd love to get your opinion
15 whether you would be okay if we had a closed
16 session, uh, so that we could discuss this with
17 Counsel, um, to have a better understanding of, you
18 know, what's at stake and --

19 MS. DARBINIAN: We couldn't have closed
20 session today and this isn't something that would
21 be a closed session item. So we couldn't discussion
22 in closed session.

23 MALE BOARD MEMBER: So this is appropriate to
24 discuss openly, then?

25 MS. DARBINIAN: You don't have a choice.

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1 MALE 1: Okay. Something I'd love to hear from
2 Mr. Wolfberg, I'd love to hear from you, I'd love
3 to hear from Dr. Mumma about these e-mails that are
4 going around. They seem to be fairly contentious.

5 Um, I -- I think that we all, um, function
6 from this position that -- that we're all trying to
7 do the right thing. Um, and so, uh, I imagine
8 there's a response to all this.

9 MS. CORSELLO: Although that item isn't on the
10 agenda today, I -- I think it would be -- I -- I've
11 got a motion and a second to put it on our next
12 agenda.

13 MS. DARBINIAN: You can put it on your next
14 agenda for -- to specifically address that, but I
15 think Mr. Wolfberg today can address some of the
16 comments that were raised in the e-mail. That would
17 be fine because it's him responding, um, to the
18 comments.

19 FEMALE BOARD MEMBER: Uh, could I just a
20 couple of other questions of the board. Um, we got
21 a blueprint in October. We got an RFP. We've now
22 got 25 people that have spoken to us and countless
23 comments and, uh, correspondence over the last few
24 days.

25 Um, are you prepared to at least, uh, separate

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1 from Mr. Wolfberg, good, bad, or indifferent, to
2 talk through some of the key components so we can
3 provide direction to somebody on this RFP process,
4 um, uh, as we move forward?

5 Is that, uh, is that even a remote
6 possibility? I mean, I've got a list of things I --
7 I've heard people say they want us to change.

8 But we have to direct somebody to do
9 something. So separate from questioning whether our
10 consultant has integrity or not, whether our
11 consultant has misled, are we collectively in a
12 position -- and I -- and I do regret that we don't
13 have a fire person.

14 I hope we get on and we get this issue
15 resolved. Um, are we collectively able to have --
16 to start to talk about what this is going to look
17 like? Or willing to do so? So I'm looking for some
18 sort of response from the members.

19 FEMALE BOARD MEMBER: I'm very new to this
20 board, so I don't what's been going on for the past
21 several months. But I think there was so many good
22 points brought up by everybody that, uh, have had
23 points today.

24 I do think that we need to extend our, um,
25 decisions and address all of that. I mean, perhaps

1 you have already and I've missed out on that. But
2 they all had really good points and a lot of
3 concerning things to me that I think need to be,
4 uh, discussed further before we move forward.

5 MR. WHITE: Also, my -- my sense is that there
6 is some consensus around this. It seems like
7 there's consensus around, uh, you know, centralized
8 dispatch. Uh, there's some consensus, um, as I
9 understand it, around, uh, creating an RFP that
10 allows for the public entities to apply.

11 So that would be removing the population
12 requirement. Um, I think that those are a couple
13 areas where I would feel comfortable directing
14 Staff to revise the RFP at this point. Uh, so --

15 DR. MUMMA: Well, I -- I agree that if we
16 could build on where there's some consensus now and
17 figure out what our next steps would be around
18 those, that might at least keep us moving in a
19 positive direction and then work out the rest, um,
20 in parallel.

21 DR. DJAVAHERIAN: And just specifically around
22 centralized dispatch. I mean, to have, uh, the
23 public entities, uh, be able to bid for that as
24 well so that it's not a part of, uh, necessarily,
25 uh, of what the contractor, uh, gets to control.

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1 I think that's -- as the Physicians' Forum
2 representative, that was, uh, one of the things
3 that came up in our -- in our meeting recently. Was
4 this idea that we -- we felt strongly that it
5 should be, uh, in the -- the public sector as far
6 as the, uh, dispatch goes.

7 MALE BOARD MEMBER: I have a point of order.
8 You guys have a motion and a second. And then, you
9 guys are going sideways.

10 MS. CORSELLO: We're not -- we're not going
11 sideways. My question -- my follow-up question was
12 going to be do we want to discuss with Mr. Wolfberg
13 the communication or do we want to discuss the RFP
14 and changes we want to direct happen? I thought
15 that would be important.

16 MALE BOARD MEMBER: Do you have a motion on
17 the floor [inaudible]?

18 MS. CORSELLO: Yes. So, uh, and if you're
19 going to challenge me, fine. Give me a chance.

20 MALE BOARD MEMBER: [inaudible]

21 MS. CORSELLO: Uh, uh, you know, most people
22 know that I'm pretty fair and very ethical on this
23 whole process. So there's a motion and a second to
24 put Mr. Wolfberg on next -- the next agenda for a
25 conversation.

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1 Is there a -- is there a -- is there a
2 willingness on everyone -- I'm looking for all ayes
3 or -- so that's going to -- I'm calling for it
4 because I've got a motion and a second. So I see
5 one. I'm willing to put it on the agenda. You made
6 the motion. That's two. So there's three.

7 MALE BOARD MEMBER: Yeah. [inaudible]

8 MS. CORSELLO: At least. Pardon? Yes. I'm
9 willing to put it on the agenda.

10 MALE BOARD MEMBER: I move --

11 MS. CORSELLO: Okay. All right. So -- so we
12 will put him on the agenda. Legal said we have the
13 ability to call him on the carpet and ask questions
14 about the -- the communications.

15 Do we feel that's necessary today or are we
16 ready to deal with anything else? So, one, do you
17 feel that's necessary today?

18 MALE BOARD MEMBER: I think if he's on the
19 agenda for next time, we don't need to -- to bring
20 him back.

21 MS. CORSELLO: Okay. And I saw at least one
22 other head nod no. And you're also in agreement?
23 Okay. So we're not going to ask him to come up to
24 speak to it today. All right. I did ask the
25 question of do we want us to try and weigh in on --

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1 based on the comments we've heard today any piece
2 of this RFP process?

3 So I'm looking for -- I've heard so far
4 emergency medical dispatch. Is that a subject that
5 we are prepared to at least discuss and provide
6 direction on?

7 MALE BOARD MEMBER: Yes.

8 MS. CORSELLO: That's one yes. I'm willing to
9 discuss it. You are too? Okay. So Caesar, would you
10 like to discuss what your suggestion is?

11 DR. DJAVAHERIAN: Well, I -- I think that
12 we've h- -- heard compelling arguments from the,
13 uh, from the public entities that, uh, they feel
14 like they can put together a consortium to control,
15 uh, the dispatch process.

16 And -- and so, I -- I think that as the RFP
17 stands today, uh, they wouldn't be allowed to, uh,
18 participate, um, un- -- unless they win the
19 contract fully. And, um, the Physicians' Forum
20 group felt strongly that dispatch should be in the
21 public sector.

22 And so, I'd love to get everyone's feedback on
23 that, uh, conversation. And Dr. Mumma, if I'm
24 misrepresenting that, please, uh, correct me since
25 you were there.

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1 MS. CORSELLO: Further discussion from any
2 member?

3 MR. WHITE: One of the questions I have is on
4 emergency medical dispatch. There seems to be
5 unanimous, um, consensus for it and I've heard
6 both, uh, best practice from it and I've heard from
7 the numerous speakers about the value that it
8 serves.

9 One of the questions I have is, um, is --
10 given that it's really, um, certainly under the
11 purview of party dispatching the core purpose of
12 this board to be looking at that, is that something
13 that necessarily we do through the RFP?

14 Or can we talk about that, as a board, as
15 something that we work with the fire agencies on,
16 um, separately? I -- I heard a reference to EPCR,
17 so I'm just wondering, you know, what are the dis-
18 -- what are the policy and the implementation
19 things that we can do outside of this process? Is
20 this something that can -- the dialog can start?

21 MALE BOARD MEMBER: Uh, Mr. White, I'd be
22 happy to address that. We can, in fact, address,
23 uh, emergency medical dispatch through medical
24 control through policy if -- if we're directed to
25 do that by the board. So it is an option.

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1 MR. WHITE: And the -- and the reason why I
2 raise that is because it's clear to me that this
3 is, um, something that everyone is interested in
4 doing and I -- and I've heard a- -- another comment
5 that I can't quite, uh, put a name to, and I
6 apologize.

7 But, you know, I think it's important to, you
8 know, sort of dip our toe in the water before we
9 jump all in with this. And, um, I think it'd be
10 wonderful for us to think about how we can be
11 innovative and talk about how do we work with the
12 various fire agencies and the various PSAPs to try
13 pilot projects and empower that to occur.

14 So that we can start gathering evidence
15 locally and understand sort of within our own
16 systems how this would work so that we can really
17 be proactive in accomplishing, you know, meaningful
18 change and -- and something different that we all
19 acknowledge will help patient outcomes and be, uh,
20 useful.

21 MS. CORSELLO: Any further comment? All right.
22 Is that going to be -- so is there going to be a
23 motion to take it out of the RFP, which is what I
24 think I heard you say? To cha- -- or is it to
25 change how it's reflected in the RFP?

1 MALE BOARD MEMBER: Well, I think it -- you
2 know, there's sort of a bigger level discussion
3 that I -- I think we need some facilitation --
4 assistance on in terms of what is the system that
5 we are putting together?

6 So, you know, EMD belongs in this RFP if
7 you're going with a centralized approach. That
8 makes a lot of intuitive sense. But, you know,
9 given, I think, what we're hearing, I think we have
10 to start from the basics of what does that system
11 look like?

12 And then, we can figure out where it belongs.
13 So if -- if there's unanimous agreement that we're
14 going to continue with the PSAP approach that we
15 have, then I think it's -- I would love to be --
16 have that discussion with staff about where EMD
17 fits into the bigger picture.

18 MALE BOARD MEMBER: And I'd love to get some
19 direction on how we could, uh, accomplish that. I
20 think I have a general idea of, uh, putting
21 together both the evidence, the medical evidence,
22 as well as the comments that this county have a
23 general idea of what seems like it should be.

24 But I -- I don't know, um, what the process is
25 for us to direct Staff to -- to do that. So --

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1 MS. CORSELLO: Okay. So in light of the fact
2 that there have been -- you're asking to speak with
3 Staff -- you're asking to speak with Staff and we
4 actually need to do that in this setting. Let me
5 see if I can take a stab at this.

6 Uh, I am not supportive of a private EMD,
7 emergenc- -- I'm -- I'm not supportive of that. Uh,
8 we have enough dispatches, enough PSAPs in Solano
9 County already. And we've been working really hard
10 to get us all on the same playing field.

11 Um, so if -- if I have to make a motion that
12 says we're not going to require that to be a
13 privatized piece, I'm willing to make that as
14 motion.

15 And it'll be up to the rest of you to decide
16 whether you want to second that motion or whether
17 we move on. How's that? Okay? So, uh, I'm going to
18 make a motion that the RFP at least be modified
19 that it does not require the privatization of our
20 emergency medical dispatch.

21 Now, that said, uh, I am supportive of us
22 moving forward with emergency medical dispatch in
23 some fashion. Uh, I -- I didn't hear anybody speak
24 against that today.

25 They may have spoken against a lot of other

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1 things, but I didn't hear any speak about -- so how
2 we get there, I think, is going to be a challenge
3 for, uh, all the fire chiefs and the police chiefs
4 and the EMS staff.

5 So I'm willing to make that motion and I'm
6 just looking if there's going to be a second to
7 that or not. Okay. So David has made a second. All
8 right. So we're clear.

9 MALE BOARD MEMBER: And can we add maybe a
10 timeframe for that?

11 MS. CORSELLO: Okay.

12 MALE BOARD MEMBER: So perhaps a year. Is that
13 too -- you guys tell me. Is that too short a period
14 of time to --

15 MS. CORSELLO: So you want to make it -- you
16 want to make an amendment--

17 MALE BOARD MEMBER: -- coordinate --

18 MS. CORSELLO: -- to my motion a year from
19 when? Now? Or when we award the contract?

20 MALE BOARD MEMBER: Uh, I h- -- I have no
21 practical knowledge about how long it would take to
22 -- to train and implement.

23 MALE BOARD MEMBER: So, uh, I mean, I -- I
24 think if we're in agreement about not privatizing
25 the dispatch and we're in unanimous agreement about

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1 the EMD, I think that would be another good agenda
2 discuss for us to hear, for example, like, the fir-
3 -- from the first speaker.

4 And really talk about how we can work with our
5 fire departments, our police departments, and have
6 a collaborative discussion and develop a timeframe;
7 right? Is it within -- before the next contract
8 comes up?

9 Or is it going to take longer in how we
10 deliver that? I think that would be a -- a
11 wonderful discussion for us to have a board, um, to
12 move that forward.

13 MS. CORSELLO: Okay. So now, I have two
14 amendments. One, that we established a timeframe.
15 I'm willing to accept that as the original maker of
16 the motion; and the second that we agendize that.

17 So agendize in January and ask somebody to
18 come and talk to us we can figure out what we're
19 putting in. Is that -- I'm -- I'm -- come on, guys.
20 You're going to have to --

21 MALE BOARD MEMBER: Yeah.

22 MS. CORSELLO: -- help a little bit here. I'm
23 tired too.

24 MALE BOARD MEMBER: I -- I support what you
25 said.

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1 MS. CORSELLO: Okay. So --

2 MALE BOARD MEMBER: Well, I -- I guess the
3 question is, I mean, uh, I -- I can put a -- a ton
4 of work on Staff's shoulders; right?

5 I'm -- so I'm going to be mindful about where
6 we are in the year what we have to accomplish. So
7 if our mission, number one, is to shape and mold
8 this RFP, I guess the question is, you know,
9 instead of doing that discussion in January, do we
10 wait for our next meeting, which is -- I don't
11 know.

12 I mean, so you can get some thought to who the
13 people we should speak to, what that discussion
14 looks like. I just want to be mindful of that part
15 of it. About how much do we have to bite off
16 immediately.

17 So I would say, to be clear, that we, uh, save
18 that for the second meeting in 2019, as an agenda
19 discussion. And that, uh, so that's how I would
20 amend your motion.

21 MS. CORSELLO: I'm willing to accept that. You
22 were the m- -- you were the second. So where we sit
23 today is the RFP would not reflect the
24 privatization of EMD. The com- -- the -- this board
25 is supportive of having a follow-up presentation on

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1 EMD in the timeframe that it would take in our
2 jurisdictions and how we would go about that, for
3 April.

4 Um, uh, and then, the question really is w- --
5 what do we say in the RFP? And right now, since
6 we're still working on it, I guess we can tackle
7 that in January if we need to. So I had a motion
8 and a second. I'm going to call for --

9 MALE BOARD MEMBER: Uh, Madam Chair, can I --
10 can I ask for a clarification --

11 MS. CORSELLO: Yes.

12 MALE BOARD MEMBER: -- before you vote? Uh,
13 the iss- -- the RFP doesn't call for EMD in the
14 private sector.

15 It calls for a PSAP model that is centralized
16 in the private sector. And so, I just -- I -- if
17 you're voting on not having that, that's different
18 from not -- privatizing EMD. EMD is just a concept.
19 It's a practice.

20 And -- and many private sector ambulance
21 companies already practice EMD. The idea -- the --
22 the issue that was brought into question
23 consistently was the PSAP being privatized.

24 MS. CORSELLO: And my motion was I don't want
25 that part privatized.

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1 MALE BOARD MEMBER: No, no, no. I appreciate
2 that.

3 [talking over each other]

4 MALE BOARD MEMBER: But -- but I want to -- I
5 -- I -- I thought that --

6 MS. CORSELLO: I would like to figure out how
7 to do through the existing PSAPs.

8 MALE BOARD MEMBER: Correct.

9 MS. CORSELLO: However many there are. I mean,
10 I'd love to see us get to one centralized, because
11 I think redundancy is nice, but it's expensive. Uh,
12 but, uh, I -- I think we, uh, as an EMS group, our
13 responsibility should address healthcare, not pl- -
14 - politics of this particular --

15 MALE BOARD MEMBER: No, no. I completely agree
16 with all of that. Uh, I just wanted to -- to be
17 clear that the RFP calls for a PSAP model that you
18 are suggesting be removed. And that doesn't reflect
19 EMD per se.

20 MS. CORSELLO: Just let us get through this
21 piece first, please. Okay. I think you'll have to -
22 - in January, you're going to have to put that on
23 the list of things we didn't provide direction on
24 because I'm not clear.

25 Uh, so can I call for the motion at least to

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1 what we have so far? Is everyone clear on what we -
2 - what we're doing? Okay. So all in favor?

3 ALL: Aye.

4 MS. CORSELLO: Opposed? None. Abstain? Okay.

5 We got through one decision. Okay. Um, are there
6 any other items -- I mean, I've got a list of
7 things I know we're supposed to provide during on.

8 Are there any other items at this point that
9 you are prepared to provide direction on with
10 regards to the RFP?

11 DR. DJAVAHERIAN: I thi- -- I think the, uh,
12 issue about, um, uh, the criteria for being allowed
13 to participate in the RFP process, requiring the
14 300,000, uh, population served, we'd li- -- I'd
15 like to move to strike that and retain the five-
16 year requirement. Uh, I mean, the benefit is that
17 we get to see more applicants.

18 MS. CORSELLO: Okay. So is there a second to
19 that recommendation?

20 MALE BOARD MEMBER: I guess what I would love
21 to do before, uh, we vote on that and save that for
22 January is that you, um, Mr. Broschard indicated
23 that he'd be sending us over some information from
24 Contra Costa. I think I would just like to see what
25 that looks like and what that -- how that is.

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1 Um, because I don't how that impacts the
2 experience discussion. And so, I would just like to
3 better understand the various models out there.

4 I would also like to hear a little bit more
5 from Dr. Mumma in the recommendation from the
6 Physicians' Forum.

7 You talked about wanting to see innovation in
8 that regard and I would just be interested to hear
9 from your perspective how to craft an experience
10 requirement that would cultivate innovation,
11 because that seems to be something that's
12 important.

13 DR. MUMMA: The -- I can briefly summarize the
14 discussion from Physicians' Forum. Um, we agreed
15 that this was -- you know, this is a big project.
16 This is not something that we want to take a risk
17 on and take a gamble on.

18 Uh, so we -- we -- in that exe- -- in that
19 sense, we agreed with the experience requirement.
20 We wanted someone who knew -- we knew would be
21 reliable and would take good care of our citizens.

22 But at the same time, we didn't want to
23 completely cite motivation if there was potentially
24 -- we -- we used analogy of a sta- -- a start-up.
25 So a smaller company that was still scaling up.

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1 We felt that if it was going to be a smaller,
2 uh, a smaller contractor bidding, that we would
3 want to see a clear plan for scalability. Uh, cl- -
4 - some clear evidence.

5 Um, just a very clear plan, that it wasn't
6 just innovative, we're going to try this, but a
7 clear, um, plan that that entity would be able to
8 provide the service. So that's, I think, what we
9 were getting at with innovation. Does that make --
10 does that answer your question?

11 MS. CORSELLO: So does that result in, uh,
12 okay. So I think the suggestion is -- Caesar would
13 like us to, uh, change the population requirement.

14 Uh, I think, David, you have indicated you'd
15 like for us to look at that in the bigger picture
16 and agendize that for January. So I don't have a
17 second on either of those at this point. Um, is
18 there a second on Caesar's suggestion?

19 MALE BOARD MEMBER: Got to say I'm okay, uh,
20 moving on with -- with what David suggested.
21 Because I -- I would also be interested in seeing
22 the, uh, Contra Costa model.

23 MS. CORSELLO: Okay. So direction to Staff is
24 we want to agendize the question with regards to
25 the 300,000 population. We would like to have

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1 information on how Contra Costa is set up, uh, if I
2 understand. That's -- that's David's motion.

3 Caesar, you just seconded that?

4 DR. DJAVAHERIAN: I would second it. Yeah.

5 MS. CORSELLO: Okay. Uh, I will call for the
6 question to make sure we're all on the same page.
7 Is everyone in favor of that?

8 ALL: Ayes.

9 MS. CORSELLO: I see no nos. No abstentions.
10 Okay. Um, there are other items that were
11 identified today. I've got a lot of notes too.

12 Um, uh, so I'm going to ask are there other
13 items today that you are prepared to take an action
14 on or that you would like to specifically discuss
15 in our next meeting I'm taking and requesting
16 additional information on?

17 MALE BOARD MEMBER: Um, well, a couple of
18 areas. As I flip through this, I definitely would
19 like to talk about, uh, the review panel, um, uh,
20 criteria in the proposal.

21 What -- I had a different, uh, reaction to it
22 than what was commented. I was just more concerned
23 about the lack of local, um, uh, requirement for
24 local, uh, input.

25 And so, I just -- I think it would be good for

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1 us to talk about what that makeup is and I'd love
2 to hear from Staff about one or two panels, what
3 discussion would look like. That was an innovative
4 approach I'd never thought of. Um, so I think that
5 would be, uh, useful.

6 MS. CORSELLO: So you're -- you would like to
7 have that agendized as well?

8 MALE BOARD MEMBER: Correct.

9 MS. CORSELLO: Is anyone else prepared to
10 discuss that today or are you comfortable with it
11 being agendized as one and then, uh, one or the
12 other topics that needs to be addressed? I'm
13 looking for a second on David's suggestion. Yes?

14 FEMALE BOARD MEMBER: I second the motion.

15 MS. CORSELLO: Okay. I have a second. T- --
16 uh, is everyone else comfortable with that's
17 another area we want detail on? Uh, then, I'm going
18 to call for the question. All in favor?

19 ALL: Aye.

20 MS. CORSELLO: Anyone opposed? Any
21 abstentions? Okay. So that's another topic. Uh, I
22 would like to see, uh, at the next meeting the
23 actual map that clarifies the question that was
24 raised by the city of Vacaville so that we have no
25 more confusion about what is in and what is out in

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1 terms of the area that's covered. Is everyone okay
2 with that? Okay. See lots of heads nodding.

3 MR. WHITE: I'll second that.

4 MS. CORSELLO: David has seconded that. Do we
5 need a vote on that or are you okay, that we know
6 that's part of what we need? Okay. Um, okay. As
7 you're going through your notes, what else?

8 DR. DJAVAHERIAN: Um, I have one, um,
9 regarding the CPI, uh, rates. So -- so essentially,
10 uh, under G1 [ph] core requirements and then NMG
11 [ph], it says contractor's sole compensation of the
12 contract shall -- yadda.

13 Essentially, in seeing -- in the event that
14 the annual average CPI figure is zero or negative,
15 the contractor shall not be entitled to an
16 automatic increase in charges. I think what we're
17 really saying is that in cases of recession, where
18 everyone's hurting, so even though you have more
19 uninsured people, we're telling the contractor that
20 they can't continue to raise rates.

21 Even though, probably, there's a greater
22 percentage of their patients who are uninsured and
23 they're providing free care to. So this -- this
24 seems to be hurtful to the contractor.

25 And so, I would -- I would m- -- move to

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1 remove that and that the CPI increase continues
2 regardless, uh, maybe to some minimum that's --
3 that's reasonable, maybe 1 or 2 percent, during
4 those periods of time.

5 But that -- but you can imagine that their
6 uninsured population is going to increase, um, you
7 know, during times of recession and so --

8 MS. CORSELLO: Can you cite the section that
9 you're referring to? Because I -- I see everybody
10 flipping through their documents. All right. So
11 would you restate that? I want to see if anyone is
12 ready to make a -- to second your suggestion that
13 we make that change at this point as well.

14 DR. DJAVAHERIAN: Yeah. So -- so I would move
15 to amend item G to in -- uh, essentially the last
16 sentence, where it says in -- in the event that the
17 annual average CPI figure is zero or negative, the
18 contractor shall not be entitled to an automatic
19 increase in charges.

20 I would move to change that to, uh, the
21 contractor shall be entitled to an automatic
22 increase of 1 percent.

23 MS. CORSELLO: Is there a second for that?

24 DR. DJAVAHERIAN: Uh, [inaudible] --

25 MS. CORSELLO: Somebody -- okay.

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1 MALE BOARD MEMBER: Just in regards to medical
2 CPI. I mean, Caesar brought up a good point, that,
3 you know, for recession, you know, you have the
4 parent exchanges, but also, you -- you're requiring
5 of a contractor to keep up competitive wages too;
6 right?

7 So, uh, putting a number on it's tough. I
8 would just say, uh, that they can get a raise, but
9 they have to come and explain to you what they need
10 and why. So I would just, you know, make it more
11 common sense than actual, you know, number.

12 Then, having to prove that 1 or 2 percent go
13 to Y and -- allow the contractor [inaudible] to
14 explain to you why they need a raise.

15 MS. DARBINIAN: I -- I believe that's
16 addressed in the next section down, in letter H.

17 DR. DJAVAHERIAN: So you're saying that if we
18 remove G, you're saying that H would then take over
19 as a --

20 MS. DARBINIAN: That's how I'm interpreting
21 those two together.

22 MS. CORSELLO: So what's the suggestion? That
23 we would strike that one sentence and interpret
24 that G and H are linked? Is that -- is that what
25 you were suggesting?

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1 [inaudible]

2 MS. CORSELLO: Okay. Oh, we turned your -- go
3 ahead. Restate.

4 MS. DARBINIAN: I'm suggesting that it can
5 stay as-is because of the provision that's in H.

6 MS. CORSELLO: Okay. So Caesar, are you okay
7 with leaving it in given that H would allow them to
8 make a justification? That's the counter. That's,
9 like, the second motion.

10 DR. DJAVAHERIAN: Yeah. That -- I guess if
11 everyone has that understanding, uh, then that --
12 that would be fine with me.

13 MS. CORSELLO: All right. So you're
14 withdrawing your -- your suggestion?

15 DR. DJAVAHERIAN: Can I heard from you what y-
16 -- what -- what you think if --

17 MALE BOARD MEMBER: Well, the thing I didn't
18 like about keeping it as-is is that it's extraneous
19 circumstances.

20 Which -- how would you define that? It's
21 really vague. You know what I mean? If you, uh,
22 obviously, [inaudible] exchanges, you could argue
23 that's extraneous, but I just think that if the CPI
24 is zero and the contractor wants it, they're going
25 to have to come and explain it to the board why

1 they need it.

2 So just -- you're just taking out the verbiage
3 that says it has to be this extenuating
4 circumstance. If the CPI is zero, the only way to
5 get it raised is that you have to come and ask the
6 board for why you need a raise.

7 MR. WHITE: So with that feedback, I -- I
8 wonder, Caesar. She asked you the question of maybe
9 is that acceptable language to say that if we have
10 that event where it's zero, negative, then they
11 would have to come to us for any kind of raise in -
12 - in the case if there's a conflict with that
13 Section H?

14 MS. CORSELLO: Are you offering that as, uh, a
15 language? Uh, it sounds to me like that might
16 address the comment that's made.

17 MR. WHITE: Yes. In elegant language, yes. But
18 I'm offering something like that.

19 MS. CORSELLO: Okay. So -- so we're back to
20 Caesar.
21 motion.

22 DR. DJAVAHERIAN: Yeah. Um, I would accept
23 that.

24 MS. CORSELLO: All right. So David, see if you
25 can ineloquently restate that.

1 MR. WHITE: Well, I think the -- the concept
2 we're trying to get across is that -- and maybe
3 it's a new -- maybe we create a new subsection.

4 But just to be very explicit, that in the
5 event the annual CPI figure is zero or negative,
6 then I think we're putting the -- on the shoulders
7 of the contractor to come to the board to justify
8 any kind of increase that may be necessary.

9 And we -- I'm sure there's some better
10 language to add to that, but that's the concept
11 we're trying to incorporate into the RFP.

12 MS. CORSELLO: Okay. So that's a motion.

13 DR. DJAVAHERIAN: I second.

14 MS. CORSELLO: You second. Any further
15 discussion? Okay. All in favor of that amendment?

16 ALL: Aye.

17 MS. CORSELLO: No? I hear no nos and no
18 opposition, so that's another change that we can
19 agree to. Excuse me. Any others at this point?

20 MALE BOARD MEMBER: Well, flipping, uh, Bayla
21 had some suggestions and recommendations to us
22 around the scoring criteria and scoring matrix.

23 I don't know if that's a discussion we'd want
24 to save for the January meeting, but I'd love to
25 hear him flesh out some of the thinking about

1 reallocating some of the scoring. Um, there was
2 some thoughtfulness put into that recommendation.

3 Uh, when I look at it, it resonated with me,
4 but I would like to hear more about it and have
5 some discussion on it.

6 MS. CORSELLO: Everyone else okay with putting
7 that on next time's agenda as the specific subject,
8 the scoring criteria? I'm watching heads nod. Okay.
9 Are there any other directions you want to provide
10 in terms of changes?

11 MS. DARBINIAN: I would also suggest that
12 perhaps some of our discussion around the response
13 time.

14 It seemed like we had a lot of conflicting
15 information today about people's perception of, uh,
16 the current response times in this document. Are
17 they longer? Shorter? Um, public perception of that
18 relative to how we're really performing today as a
19 system.

20 Perhaps being able to lay all those things out
21 side by side and look at the facts of -- of what
22 that looks like to make a determination as to what
23 we'd want to build into the RFP.

24 MS. CORSELLO: Any other comments on that
25 subject? Because I'm inclined to agree with you.

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1 What I heard today was from the Physicians' Forum.
2 They have a suggested change, I think I heard, in
3 the private sector.

4 They're doing better than some of what's in
5 there. Okay. So we want to agendize that item as a
6 subject and ask Staff to bring back comparisons of
7 some of the things that are real today.

8 What we have today, some of what you heard
9 today is the subject that we can provide direction
10 on; okay? I'm watching heads nodding. Okay. Other
11 subjects on the list?

12 MALE BOARD MEMBER: Um, something that arose
13 to me from the last speaker was about the incumbent
14 workforce.

15 Um, the language here, uh, as it pertains to
16 incumbent workforce, walks about maintaining it at
17 substantially equivalent compensation and
18 conditions of employment.

19 I guess my only concern is -- is that, as
20 opposed to -- is that creating downward pressure so
21 that if the new contractor wanted to do something
22 more rich for the employees, I just want to make
23 sure we're not putting, uh, an artificial ceiling.

24 Uh, rather, ensuring that people aren't any
25 worse off but could be in a better situation. And I

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1 just want to make sure I understand that language
2 correctly.

3 MS. CORSELLO: Are you seeking clarification
4 now or at -- in our next meeting?

5 MALE BOARD MEMBER: We can do it at our next
6 meeting, so I could look at it some more.

7 MS. CORSELLO: Okay. Everyone okay with that
8 one, for being brought back? Is there anything else
9 you want to either address today and/or provide
10 direction on or bring back?

11 DR. DJAVAHERIAN: I just -- I have one last
12 one. On Page 75, Item N2 [ph]. Um, so I -- I would
13 just ask that the total revenue collected be broken
14 down between, uh, uh, patient and insurance
15 company.

16 So just the breakdown of those two to be
17 specified. So Item N2, um, requiring, um,
18 disclosure of how much revenue is collected. I
19 think -- I think having that information by how
20 much is collected from patients, uh, versus
21 insurance company would be helpful.

22 MS. CORSELLO: Everyone else okay with asking
23 for that additional piece of the submittal?

24 MR. WHITE: Yes.

25 MS. CORSELLO: Okay. So I've got a -- I saw

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1 heads nod. This is actually a change. So David,
2 you're making a second on Caesar's suggestion?

3 MR. WHITE: Yes.

4 MS. CORSELLO: Okay. And I'm going to call for
5 the question so we have clear direction that we're
6 going to make that an -- as an amendment. So, uh,
7 any further discussions? All in favor?

8 ALL: Aye.

9 MS. CORSELLO: Okay. Any opposed? Hearing
10 none, seeing no abstentions, that one, at least, is
11 another change we can take forward at this point.
12 Any further -- any others?

13 MALE BOARD MEMBER: Uh, we've heard -- we
14 heard some opposing discussion about the CCT issue.

15 Um, so I think it would be good if we could
16 have discussion as well, just to understand better
17 in the contract and out of the contract. Um, I'll
18 just say I'm honestly not clear, so I'm not in a
19 position to make a position about what I would
20 recommend or what I would suggest.

21 But I would like to hear more about that, the
22 benefits and the tradeoffs in -- in versus out.

23 MS. CORSELLO: And I -- I would agree. I will
24 second that because what I heard today is the
25 Physician' forum has one interpretation. I think

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1 the health staff has another. The ambulance company
2 has a third.

3 Um, if we're going to open this up in some
4 fashion, my guess is this is not one that other
5 jurisdictions are necessarily going to be able to
6 put forward. So we would like to see that item on
7 the agenda with kind of the positions from various
8 people and the -- and of the analysis. Everyone
9 else okay with that?

10 MALE BOARD MEMBER: Mm-hmm. Yes.

11 MS. CORSELLO: Okay. All right. Uh, let's see.
12 That leaves us with, um, let's see. I think -- I
13 think the concerns about tiered response, we
14 addressed this part of emergency medical
15 conversation and with regards to dispatch.

16 Uh, I think that's how we get a chance to talk
17 about whether we have any jurisdiction or interest
18 in that.

19 MALE BOARD MEMBER: Mm-hmm.

20 MS. CORSELLO: Okay. Because I heard comments
21 to that effect. Um, I heard comments with regard to
22 -- we're going to talk about the 300,000
23 population. What about the five-year, uh,
24 requirement?

25 Is -- can we put that in front of the group as

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1 well? I -- I've heard different recommendations and
2 different requests. Um, I would like to at least
3 hear more about that as a specific subject when we
4 come back, if everyone else is okay with that. I
5 see -- I see heads nodding. Okay. Anything else?

6 MALE BOARD MEMBER: Can we somehow reserve the
7 right as we digest all the comments and review this
8 that we may have further discussion on the enti- --
9 the totality of the RFP?

10 Or -- how do you want to handle this, Chair,
11 in terms of -- because I just want to reflect on
12 all my notes that I took for --

13 MS. CORSELLO: S- -- so --

14 MALE BOARD MEMBER: Not that I want to open up
15 the whole thing, but just I'm not -- just not sure.

16 MS. CORSELLO: Well, since we aren't taking an
17 action on the document and we have provided
18 direction, um, I'm going to look to legal. I -- I
19 think we could continue the entire document to the
20 next time.

21 Hit the subjects you've ea- -- each
22 identified. Uh, and then, if there are others
23 you've identified between now and our next meeting,
24 then, uh, you know, out of fear of communications
25 ex parte or whatever you want to call this, uh, I

1 almost think you're going to have to -- sorry.

2 You're going to have to put it in writing and
3 send it to Ted. And he's not going to be able to
4 share with the rest of you what you've asked for.
5 He's just going to have a list of all the things
6 we've asked to discuss. Does that make sense? Okay.

7 Are we finished picking this apart for today?
8 Okay. I want to thank everyone who's here. You've
9 had a very long day with us. I'm hoping we're
10 getting closer and -- and -- and that we've at
11 least identified the items.

12 Uh, hopefully, you can tell we heard you,
13 collectively. And we have identified the items that
14 we now need to deliberate on. If you have
15 additional information, since you've heard what
16 those are, I ask that you provide those to Ted for
17 consideration in the next packet.

18 Uh, and hopefully, the next meeting, we will
19 have some of the other concerns addressed visually
20 for everyone.

21 So, uh, with that, I want to thank my fellow
22 members who took the day off from their regular
23 jobs, and don't get paid to do this, either, just
24 like the rest of you, uh, very much for your time.
25 And I want to thank the public as well. We are

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1 adjourned at 3:25.

2 MS. DARBINIAN: Chair?

3 MS. CORSELLO: Yes?

4 MS. DARBINIAN: I apologize. Can we confirm
5 the January 10th date, and that is scheduled from -
6 - starting at 9:00 o'clock and just confirm that
7 everybody is available on that date?

8 MS. CORSELLO: So we've been asked to confirm
9 that our calendars are clear for January the 10th.

10 FEMALE BOARD MEMBER: I'm actually not
11 available, but I can try to switch my schedule.

12 MS. CORSELLO: And I -- I would like to make a
13 commitment or that we finish at a reasonable time,
14 not 3:30 in the afternoon. So can you make any part
15 of that day at all?

16 FEMALE BOARD MEMBER: I'm working from 6:00 to
17 3:00.

18 MS. CORSELLO: Okay. That's our normal regular
19 meeting; isn't it?

20 FEMALE BOARD MEMBER: I can try to switch it
21 [inaudible].

22 MS. CORSELLO: Okay. Well, if you -- if you
23 are able to make an adjustment, I'd like to start
24 at 9:00 and then -- and -- and commit that we're
25 going to go till noon, so people can plan

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1 accordingly.

2 And then, if we need more time, we'll decide
3 that day how we're going to proceed again. I'm
4 watching all the heads nodding.

5 Okay. With that, we are adjourned. Thank you
6 very much.

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3 I, Chris Naaden, a transcriber, hereby declare
4 under penalty of perjury that to the best of my
5 ability the above 284 pages contain a full, true
6 and correct transcription of the tape-recording
7 that I received regarding the event listed on the
8 caption on page 1.

9

10 I further declare that I have no interest in
11 the event of the action.

12

13 December 27, 2018

14

15



16

Chris Naaden

17

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19

20 (Solano EMS Agency Board Meeting, 12-13-18)

21

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