Fire Department

"Serving the community since 1926"

HEADQUARTERS

4410 Cathedral Oaks Road
Santa Barbara, CA 93110-1042
(805) 681-5500 FAX: (805) 681-5563

Mark A. Hartwig
Fire Chief
County Fire Warden

Rob Heckman
Deputy Fire Chief
Administration

Anthony Stornetta
Deputy Fire Chief
Operations

Wednesday, December 21, 2022

VIA ELECTRONIC MAIL
Phung Loman
Chief Procurement Officer (Purchasing Agent)
General Services Department
Purchasing Division
County of Santa Barbara
260 N. San Antonio Rd.
Santa Barbara, CA 93110
ploman@countyofsb.org (mail to: ploman@countyofsb.org)

RE: Notice of Appeal of Purchasing Agent Decision, Bid Protest, RFP #8010001 – GS Purchasing-Services: Exclusive Ambulance Services Provider for the Santa Barbara County Exclusive Operating Area

Dear Ms. Phung Loman:

Pursuant to Section 2.10(I) of RFP #8010001 – GS Purchasing-Services: Exclusive Ambulance Services Provider for the Santa Barbara County Exclusive Operating Area ("RFP"), the Santa Barbara County Fire Protection District ("District") is providing written notice of its appeal of your December 14, 2022, decision denying District's formal bid protest submitted November 4, 2022, and supplemented on November 23, 2022 ("Protest").

In addition to the reasons outlined in the Protest, the District appeals your decision to deny the Protest as outlined in your letter dated, December 14, 2022. The denial was arbitrary, capricious, entirely lacking in evidentiary/factual support, contrary to established public policy, unlawful, and/or procedurally unfair as follows:

- The Purchasing Agent denied the Protest as to reasons 1, 2, and 6, and the supplemental information on the ground that RFP section 2.10.G.iii prohibits challenges to the judgments of the Review Panel. However, reasons 1, 2, and 6 challenge the LEMSA's, the LEMSA consultant's, and/or the Review Panel's failure to evaluate the American Medical Response West ("AMR") proposal in

accordance with the RFP Proposal Evaluation Criteria, which is expressly allowed under RFP § 2.10.G.iii, and their failure to deem the AMR proposal nonresponsive by failing to conform to the RFP's requirements.

- Fire submitted evidence to support that AMR's proposal contained false and misleading and the supplemental information alleged that the AMR's proposal contained false and misleading statements regarding the AMR's qualifications and, as a result, should have been rejected as nonresponsive under RFP section 2.5, and American Medical Response West ("AMR") is not a responsible proposer eligible for contract award. The Purchasing Agent did not evaluate or make any determinations on the District's allegations, and thus made no findings that: (1) AMR's proposal did not contain false and misleading statements; (2) AMR's proposal was responsive, and (3) AMR is a responsible proposer eligible for contract award.

- The Purchasing Agent denied the Protest as to reason 3 on the ground that AMR's response constituted a "valid rebuttal." Reason 3 alleged AMR violated federal and state law, specifically, the Medicare and Medi-Cal Anti-Kickback Statute ("AKS"), by offering to enter an arrangement with the County of Santa Barbara that would allow the County to receive supplemental reimbursements for transporting Medi-Cal beneficiaries (available only to public providers of ambulance services) in exchange for awarding AMR the exclusive contract to provide services. AMR's response stated District's allegations "[were] without legal merit" but failed to cite any legal authority supporting its denials. The Purchasing Agent accepted AMR's response as a valid rebuttal of the District's allegations without undertaking an independent investigation of the District's allegations or AMR's denials in the response.

- The Purchasing Agent denied the Protest as to reason 4 on the ground that AMR's response constituted a "valid rebuttal." In reason 4, the District alleged AMR's proposal contained fourteen (14) specified false and misleading statements. AMR's response addressed only four (4) of the alleged false and misleading statements and did not offer any evidence in support of its conclusory response. The Purchasing Agent accepted AMR's response as a valid rebuttal of the District's allegations without undertaking an independent investigation of the District's allegations or AMR's factual assertions in the response.

- The Purchasing Agent denied the Protest as to reason 5 on the ground that she disagreed regarding the application of County Code section 2-40(d) and 2-41(a) and reason 5 was not a valid protest ground because it challenged the judgment of the Review Panel. Reason 5 alleged that the County Code allows for the

consideration of economic benefits to County taxpayers as part of the procurement process. As a result of the wording of the RFP and the review process overseen by the LEMSA and its consultants, no evaluation of the fiscal adequacy of the proposals was undertaken by the Review Panel. This was a valid challenge under RFP § 2.10.G.iii to LEMSA's process in soliciting and reviewing proposals. The District's proposal should have been selected as the winning proposal because it offers terms and conditions that are more advantageous to County than AMR's proposal, as required to be considered by County Code section 2-40(d) and 2-41(a).

Additionally, please find enclosed the following records for review required by RFP section 2.10(l):

1. District's Formal Protest in Response to Notice of Intent to Award County of Santa Barbara RFP No. 8010001 (Nov. 4, 2022)
2. American Medical Response West's Response to District's Protest (Nov. 10, 2022)
3. District's Supplemental Information in Support of Formal Protest (Nov. 23, 2022)
4. American Medical Response West's Supplemental Response to District's Supplemental Information (Nov. 29, 2022)
5. RFP Protest Purchasing Agent Decision Letter (Dec. 14, 2022)
6. Original Proof of email submission of District's Formal Protest in Response to Notice of Intent to Award County of Santa Barbara RFP No. 8010001 (Nov. 4, 2022)

In closing, the District requests and reserves its rights to directly submit to the Protest Review Committee (PRC) written materials regarding its reasons for appealing your decision. RFP section 4.10.I does not specify requirements for the contents of the instant notice of appeal, including the grounds for appealing the Purchasing Agent's decisions, nor does it provide for written submissions to the PRC.

Please let me know if you have any questions.

Sincerely,

DocuSigned by:
643A84E63CDE490...

Mark A. Hartwig
Fire Chief / Fire Warden

1. District's Formal Protest in Response to Notice of Intent to Award County of Santa Barbara RFP No. 8010001 (Nov. 4, 2022)

Fire Department

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Anthony Stornetta
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Friday, November 4, 2022

Phung Loman
Chief Procurement Officer
General Services Department
Purchasing Division
County of Santa Barbara
260 N. San Antonio Rd.

AND

American Medical Response West (AMR)
Mike Sanders, Regional Director
240 R. Highway 246, Ste. 300,
Buellton, CA 93427

The name and address of the Protesting party and its relationship to the responding RFP:
Protestor: Santa Barbara County Fire Protection District (RFP 8010001 Respondent)
Representative: Fire Chief/Fire Warden Mark A. Hartwig (Signature provided on page 14)
Address: 4410 Cathedral Oaks Road
Santa Barbara, CA 93110
805-896-6400

Identification of the proposed contract/project: Formal Protest by Santa Barbra County Fire District in Response to Notice of Intent to Award County of Santa Barbara RFP No. 8010001 (Emergency Ambulance Services) to American Medical Response, Inc. (AMR)

Formal Protest by Santa Barbra County Fire District in Response to Notice of Intent to Award County of Santa Barbara RFP No. 8010001 (Emergency Ambulance Services) to American Medical Response, Inc. (AMR)

Based on our review and analysis of the District Proposal, the AMR Proposal, the County of Santa Barbara RFP No. 8010001 (Emergency Ambulance Services), and the review panel's scoring sheets, The District is filing a protest for the following reasons summarized here and detailed further below:

- False and Misleading as to RFP Minimum Qualifications
- Failure to Comply with RFP Proposal Instruction (Page 19 of RFP)
- Failure to Comply with RFP Proposal Evaluation Criteria
- Possible Violation of The Medicare and Medi-Cal Anti-Kickback
- Failure to Consider Economic Benefits to County Taxpayers (County Code of Ordinances, Article VI, Section 2-40(d))

AMR Proposal is False and Misleading as to RFP Section 2.9 Minimum Qualifications because AMR failed to identify recent noncompliance and, thus, the panel should have scored this requirement with a "fail" and discontinued consideration of AMR's proposal.

The RFP sets out "*LEMSA shall entertain proposals only from organizations demonstrating fiscal stability and prudence, as well as a* ***stable track record of rendering emergency, non-emergency, and urgent ambulance services at levels of clinical quality and response time reliability substantially equivalent to the services required under this procurement****. Therefore, all interested Proposers are required to meet minimum qualifications as a part of their RFP response*." (RFP page 20, emphasis added.)

AMR's Proposal states it has "Successful experience as a sole provider of emergency Advanced Life Support (paramedic) services for several areas of comparable size & clinical complexity" and "Demonstrated ability to meet response time standards in all types of EMS systems." However, this information is false and misleading.

In particular, AMR cited within their proposal (page 107) a contract with Santa Clara County to establish its minimum qualifications in their proposal. However, AMR failed to identify that on October 12th, 2022, the Santa Clara EMS Agency provided a report to the Santa Clara Board of Supervisors and the Hospital Committee that includes the table below demonstrating that AMR has failed to comply with the County's Code 3 response times from May 2022- August 2022 (requirement =90%). Per meeting transcripts, the Santa Clara EMS Agency stated they found AMR to be non-compliant with their contract. The Santa Clara EMS Agency stated that AMR had already received one letter regarding its non-compliance, and they would be sending a second letter to reinforce the continued noncompliance. In the October 12th meeting, the Board expressed "the vendor

knows that they're not in compliance, but after three months this is now a trend and not a blip and we have to address it before it becomes an even more deeply established trend." Below is the data provided in the Board Letter:

Emergency Ambulance CODE 3 Performance	*Mar 22*	*Apr 22*	*May 22*	*Jun 22*	*Jul 22*	*Aug 22*
Overall	91.16%	91.42%	89.94%	88.19%	89.72%	88.99%
Zone 1	90.29%	90.11%	88.82%	86.01%	87.44%	86.44%
Zone 2	91.31%	91.00%	90.07%	88.37%	89.83%	88.84%
Zone 3	91.96%	91.82%	89.76%	88.92%	89.68%	89.94%
Zone 4	90.60%	92.20%	90.26%	88.14%	91.20%	89.06%
Zone 5	91.49%	90.17%	91.46%	89.82%	88.85%	91.02%

- AMR's overall countywide compliance rates fell below 90% in May, June, July, and August;
- In May, AMR's compliance rates fell below 90% in two out of five response zones in May;
- In June, AMR's compliance rates fell below 90% in all five response zones;
- In July, AMR's compliance rates fell below 90% in four out of five response zones; and
- In August, AMR's compliance rates fell below 90% in four out of five response zones.

This significant information that was omitted from AMR's proposal and misrepresented by AMR's narrative of minimum qualifications shows AMR does not have a stable track record of rendering emergency, non-emergency, and urgent ambulance services at levels of clinical quality and response time reliability. AMR should have been scored with a fail on this criterion and discontinued from further consideration.

AMR Proposal Is Nonresponsive to sections 4.2 and 4.10 of the RFP and thus the entire AMR Proposal should be considered non-responsive (RFP page 30), and the contract awarded to the District. The proposers were not accorded fair and equal consideration in the evaluation process because the bids were not evaluated in accordance with the stated Proposal Evaluation Criteria.

Per the RFP - The LEMSA's commitment to the Triple Aim approach is demonstrated by utilizing the Contractor's clinical performance as a key contract compliance measurement tool. To maintain high-quality EMS services, the clinical quality of the Contractor's care provided to the patients will be routinely measured. The Contractor shall work with the

LEMSA to develop an electronic reporting method for the measurement of these clinical metrics. A data submission platform shall show clinical metrics in real time and be approved by the LEMSA. Measurement of clinical performance will be conducted through a clinical scorecard measuring system defining clinical KPIs as shown in Appendix 9. . .

The LEMSA intends to evaluate and measure the Clinical Scorecard on a monthly basis, reviewing the Contractor's performance in all clinical measures, as well as tabulating a weighted total compliance value for all clinical KPIs. . .

It is important to note the LEMSA is currently establishing a baseline level of clinical performance and will finalize a beginning baseline as well as establish a phase-in process during the negotiation with the Contractor. References to a baseline clinical scorecard compliance of 90% (or any other percentage) is for illustrative purposes only. Actual percentages may vary and will be finalized during the contract negotiation process. . .

Appendix 10 to the RFP is entitled "Sample Proposal Evaluation Criteria Explained" and contains questions intended to guide the Proposal Review Panel ("PRP") in evaluating the various sections of the proposals. For Section 4.2, Appendix 10 provides evaluators with the following guidance:

Appendix 10 of the RFP is entitled "Sample Proposal Evaluation Criteria Explained" and contains questions intended to guide the Proposal Review Panel ("PRP") in evaluating the various sections of the proposals. For Section 4.2, Appendix 10 provides evaluators with the following guidance:

- *Has the Proposer fully outlined what data/metrics it will collect and how it will be used to improve the clinical practice within the EMS system?*

In Section 4.2 of the Proposal, AMR states:

> *We look forward to participating in the LEMSA's clinical scorecard approach and have experience with similar models that prioritize better patient outcomes over response time performance. Our technology package will let us monitor and report on all clinical, operational and response time performance, with web-based access for LEMSA stakeholders.*
>
> *We agree to the clinical KPIs and bundles of care listed in the RFP and will work closely with the LEMSA to create a mutually agreeable list and mutually agreeable changes as system needs and processes evolve. AMR has used FirstWatch and FirstPass in Santa Barbara County for years and will work with the LEMSA to develop a percentage that strives for quality. We have unique experience working in the early developmental phases of scorecard and incentive programs in San Joaquin and Santa Cruz counties, as well as in other EMS systems across the country.*

> *This scorecard approach will fit well with our commitment to clinical excellence and follows an established philosophy in modern EMS – such as staying on scene and stabilizing a patient in cardiac arrest rather than rushing immediately to the hospital. We are excited to participate in this and similar ways to make the Santa Barbara County system perform at its highest potential.*

The above response fails to "fully outline" the data/metrics AMR will collect or how such data will be used to improve clinical practice within the EMS system. Because it fails to provide the information requested in Section 2.1 of the RFP, the Proposal is nonresponsive and cannot be accepted by County.

Furthermore, Section 4.10 of the RFP provides:

The Proposer shall provide a list of recent clinical innovations that they have implemented within the past five (5) years. The list should include, but not limited to:

i) Stated clinical problem/issue being addressed
ii) Process used to identify solution
iii) Clinical innovation
iv) Training development and deployment
v) EMS system/partner engagement/inclusion
vi) How the impact was measured/evaluated
vii) How associated costs were mitigated

In the corresponding section of the Proposal, AMR identifies two examples of clinical innovation. First, AMR describes its implementation of a "nurse navigation line" for 911 calls:

> *Part of our proposal to Santa Barbara County is including a nurse navigation line to better serve less critical 911 callers and preserve our paramedic resources for the most urgent emergencies. The key objective is to provide the low acuity patient with alternatives to the emergency department (like nurse advice, urgent care or primary care visits) and assure follow-up.*
>
> *We have seen proven success with this approach, beginning with our first nurse navigation line used for EMS in Washington, D.C. In the first two years of operation, nearly 30% of 911 callers were routed through our nurses. Of these, 25% resulted in self-care/nurse care, 65% resulted in alternative transportation (Lyft, Uber, Taxi) to a clinic and 10% resulted in transportation by a BLS ambulance to an emergency department. We now operate more than a dozen nurse lines across the country, some in partnership with fire agencies.*

AMR's description of the nurse navigation line fails to respond to six of seven of the required elements for a complete answer (the clinical problem/issue being address, the process it used to identify the solution, innovation in clinical practices, training development and deployment, and mitigation of associated costs).

> **Second, AMR describes its innovation in preventing and handling patient elopement:**
>
> *Another example of AMR's clinical innovation is our work on preventing patient elopement. Elopement is when a patient flees or leaves an ambulance in the middle of transport. Although these events are rare, they create an extremely high risk for patient and caregiver safety when they occur. This problem is also complicated by the fact that many elopement events occur during mental health transports, or with similar vulnerable patient populations.*
>
> *In California, our clinical teams are actively underway with a pilot program aimed at eliminating elopement when transporting involuntary behavioral patients between healthcare facilities. This includes a standardized "elopement playbook" used by our caregivers, paired with a four-point soft restraint for involuntary patients.*
>
> *We have been testing the program in San Francisco for the past two months. We are exclusively testing the new process on involuntary interfacility patients and collecting data on its effectiveness. We started by laying the groundwork with community partners and educating our caregivers on the importance of the program and why elopement prevention matters. Our caregivers compassionately place these vulnerable patients in soft restraints and follow a comprehensive elopement playbook. This provides valuable information on event mitigation, de-escalation, safe restraint placement, seating and positioning and more.*
>
> *We are currently incorporating the San Francisco data and caregiver feedback to further refine the program, with plans to expand the scope to emergency and on-scene involuntary transports in the future. This direct investment in the safety of our patients and employees is just one example of our commitment to innovation, safety and clinical excellence.*

AMR's description of its elopement prevention program fails to respond to four of seven of the required elements for a complete answer (the process it used to identify the solution, innovation in clinical practices, EMS system/partner engagement/inclusion, impact measurement/evaluation, and mitigation of associated costs). Notably, AMR's elopement program is unrelated to clinical practice by EMS personnel as the physical restraint of mental health patients during involuntary interfacility transports is not an

EMS skill within the authorized scope of practice for EMTs, advanced EMTs, or paramedics. (See Cal. Code Regs, title 22, 100063-64, 100106-100106.1, 100146)

The AMR Proposal, therefore, fails to fully respond to the instructions in Section 4.10 of the RFP, should have thus been scored as unsatisfactory by 3+ reviewers, and the entire AMR Proposal should be deemed non-responsive. (RFP page 30.)

The County must award a contract based on "public bidding, the proposals and specifications inviting such bids must be sufficiently detailed, definite and precise so as to provide a basis for full and fair competitive bidding upon a common standard and must be free of any restrictions tending to stifle competition." (Baldwin-Lima-Hamilton Corp. v. Superior Court of San Francisco (1962) 208 Cal.App.2d 803, 821.)

Sections 4.2 and 4.10 are insufficiently detailed, definite, and precise or achieve fair competitive bidding on common standards because the RFP contains different and contradictory instructions to proposers and the PRP regarding the evaluation of those sections. Bidders cannot be required to guess at the standards by which they will be measured and are entitled to expect that the bid that most fully satisfies the specified criteria would be awarded the contract> Furthermore, a public agency must comply with the requirements in its bid solicitation concerning how a bid scoring is to be calculated.

Section 4.2 is worth 75 out of 460 points. (RFP 21.1(A), pp. 32-33.) There are no instructions for bidders in Section 4.2. Instead, those instructions are found in the RFP evaluation criteria in Appendix 10.

The District carefully evaluated the RFP and followed the instructions in Appendix 10 in preparing its Proposal and "fully outlined what data/metrics it will collect and how it will be used to improve the clinical practice within the EMS system" in Appendix E of the District's Proposal.

AMR's Proposal did not fully outline this information as required by Section 4.2 when read together with the scoring criteria in Appendix 10, yet based on the scores it appears the PRP only looked to Section 4.2 when scoring and did not apply Appendix 10 when reviewing Proposals. Failure of the PRP to follow the evaluation criteria clearly set forth in the RFP demonstrates the proposals were not evaluated in accordance with the Proposal Evaluation Criteria:

	Reviewer 1		Reviewer 2		Reviewer 3		Reviewer 4		Reviewer 5		Totals	
Section 4.2 (75 points)	Fire	AMR	Fire	AMR	Fire	AMR	Fire	AMR	Fire	AMR	Fire	AMR
	63.75	75	63.75	63.75	63.75	75	37.5	63.75	63.75	63.75	292.5	341.25

The District went to great lengths to ensure compliance with the many requirements of the RFP, yet the PRP failed to do so in evaluating and scoring the Proposals. If the criteria set out in the RFP were followed by the PRP, AMR's scores would be

significantly lower or considered non-responsive. The proposers were not accorded fair and equal consideration in the evaluation process.

Section 4.10

Section 4.10 is worth 40 out of 460 points. (RFP 21.1(A), pp. 32-33.) As noted, Section 4.10 requires proposers to "*provide a list of recent clinical innovations that they have implemented within the past five (5) years*" and requires that the list include, but not be limited to seven specific elements. Additionally, Appendix 10 instructs evaluators to ask two questions when evaluating responses to Section 4.10:

- *Since the RFP contemplates a clinically sophisticated system involving [sic] has the Proposer sufficiently described suggested clinical benchmarks and what commitments it makes to collaborate and otherwise support the system's ongoing research initiatives?*

- *Does the Proposer describe any additional research initiative commitments?*

Neither AMR's Proposal section 4.10 nor Proposal attachment 04 address all seven elements in describing its recent clinical innovations nor suggest any clinical benchmarks. (AMR Proposal page 31-32). In contrast, Section 4.10 and Appendix 4h of the District's Proposal fully responded to requirements in both Section 4.10 and Appendix 10 of the RFP.

However, based on the scoring, it appears the PRP interpreted the seven elements to not be mandatory, contrary to what the RFP sets out in Section 4.10 and Appendix 10:

	Reviewer 1		Reviewer 2		Reviewer 3		Reviewer 4		Reviewer 5		Totals	
Section 4.10 (45 points)	Fire	AMR	Fire	AMR	Fire	AMR	Fire	AMR	Fire	AMR	Fire	AMR
	38.25	45	38.25	38.25	38.25	45	22.5	38.25	22.5	45	159.75	211.5

Furthermore, AMR's responses to Sections 4.2 and 4.10 provided its winning margin. The following table shows the two proposers' total points (per the PRP) and the total points for each proposer if AMR were given a zero on its responses for failing to follow the RFP's instructions:

	AMR	Fire
PRP Total Points	**2,077.75**	1,760
Total Points (AMR receives zero points on Section 4.2)	1,736.25	**1,760**
Total Points (AMR receives zero points on Section 4.10)	**1,866.25**	1,760
Total Points (AMR receives zero points on Sections 4.2 and 4.10)	**1,525**	1,760

Notably, County cannot claim to be unaware of these flaws in Sections 4.2 and 4.10 of the RFP. The California Fire Chiefs Association, Inc. and the Fire Chiefs Association of Santa Barbara County expressly discussed this exact problem with these provisions and their ambiguity on pages 17-20 of their letter to the County Board of Supervisors dated May 9, 2022.

Because RFP Sections 4.2 and 4.10 are ambiguous, insufficiently detailed, definite or precise, and fail to provide for full and fair competitive bidding upon a common standard, the competitive process must be thrown out and County cannot award the contract to AMR.

County Must Reject The AMR Proposal And Refuse To Contract With AMR Because The Proposal Appears To Offer To Allow The County To Access PPIGT Funding In Violation Of The Medicare and Medi-Cal Anti-Kickback Statute (AKS).

The Medicare and Medi-Cal Anti-Kickback Statute makes it a felony to offer or pay any remuneration to induce or reward the referral of patients or the purchasing or recommending the purchasing of goods or services which are paid for or reimbursable by Medicare or Medi-Cal. See Section The Medicare and Medicaid Fraud and Abuse Statute, 42 U.S.C. § 1320a-7b(b). The Anti-Kickback Statute explicitly includes within "remuneration" any kickback, bribe, or rebate. Further, they constitute remuneration whether paid directly or indirectly, in cash or in kind. Thus, remuneration includes goods or services. Congress's intent in placing the term "remuneration" in the statute in 1977 was to cover the transferring of anything of value in any form or manner whatsoever. (See *United States v. Paramedics Plus LLC* (E.D.Tex. Oct. 25, 2017, No. 4:14-CV-00203)

Contracts with cities or other EMS sponsors for the provision of emergency medical services may raise antikickback concerns. Ambulance suppliers should not offer anything of value to cities or other EMS sponsors to secure an EMS contract.

AMR Proposal section 10.2 (System Innovation) provides:

> Alternative Proposal Offering: EMS / Public Health Cooperative
>
> [PPIGT] funding may be made available at some point during the life of this contract. This is a Centers for Medicare and Medicaid Services (CMS) program that may in the future provide certain supplemental funding for Medi-Cal transports to government ambulance providers and the County may be able to participate subject to terms and conditions. This type of program is in lieu of the current quality assurance fee that exists for both government and private ambulance providers today.
>
> Should this funding be available to providers of ambulance transport, and if the funding is substantial and sustainable, AMR is committed to exploring with the County Public Health Department a potential method for access to those potential funding opportunities if they come to fruition. . .
>
> Key Points & Benefits
> In accordance with applicable federal and state laws and necessary approvals, access to potential federal PPIGT funding for Medi-Cal patients directly to the County Public Health Department.

First, AMR's statement in grey above is false. PPIGT is a new program that provides supplementary reimbursements for the transportation of Medi-Cal beneficiaries. It is available **only** to public providers of ground emergency ambulance services, which may rely on private subcontractors to deliver the services. Medi-Cal currently reimburses providers $118.20 for ground emergency ambulance transports. The State of California has passed a law to direct State CMS, using allowable Federal funds for public providers to increase MediCal payments by approximately $946.92 for each ground emergency ambulance transport of a Medi-Cal beneficiary.

Second, the Board of Supervisors in its Ambulance RFP hearing was told in error by the County's consultant and EMS staff that to "balance the bidding between public and private sectors, no revenues would to be considered." As such, the RFP is entirely silent as to supplemental MediCal payments such as PPIGT and its predecessor GEMT, to public providers (not AMR) or providing services through a "cooperative" relationship with County. If fiscal impacts were properly considered in the RFP, this funding could be accessed by Fire, but in a manner consistent with all requirements and not considered a kickback

In other words, AMR is offering in Proposal section 10.2 to enter a "cooperative" (i.e., subcontracting) relationship that would make the County a public provider of ground emergency ambulance service and allow the County Public Health Department to "directly" "access" PPIGT funding—a supplemental reimbursement of $946.92 for each

Medi-Cal beneficiary transported by AMR—in exchange for County awarding the exclusive contract to AMR.

Suggesting the awarded contract later be changed to include public provider revenue to be collected by the County, and to change AMR's relationship with the County is an offer that may violate the Medicare and Medi-Cal Anti-Kickback Statute. The County should reject the Proposal and refuse to contract with AMR.

The AMR Proposal should be rejected because it contains additional significant false or misleading statements. As per the County of Santa Barbara RFP No. 8010001, Section 2.5 False or Misleading Statements, "Responses which contain false or misleading statements, or which provide references which do not support an attribute or condition claimed by the Proposer, must be rejected, subject to the County's ability to waive minor irregularities."

In the AMR Proposal the following statements are false:

- Pg. 6 Map of California counties where AMR provides "Ground & Air" and shows San Luis Obispo County as being covered. AMR does not provide ground ambulances in San Luis Obispo County.
- Pg. 51 AMR Proposal states, "While others simply can't get new vehicles for new contract start-ups" which makes it appear that other respondents wouldn't be able to get a new fleet. Governmental agencies get priority on new emergency vehicle sales.
- Pg. 95-96 "Public Provider Inter-Governmental Transfer" is only available to public response agencies Assembly Bill (AB) 1705 (Chapter 544, Statutes of 2019) deems governmental Medi.Cal providers are eligible to participate in the Public Provider Intergovernmental Transfer (PPIGT) AMR and the County Public Health Department are not government Medi-Cal providers.

In the AMR Proposal the following statements are misleading:

- AMR has a logo that tools and solutions are marked with as "Exclusively AMR" this is dispersed throughout the document. The below marked items are not exclusive to AMR and identifying them as such is significantly misleading.
    - Pg. 15 Ensuring a Just Culture- Per the key on the left of "AMR Exclusive" this is misleading the reviewer that Just Culture is exclusive to AMR. Just Culture is a concept and it's use is to improve patient safety in health care and also available to the District.
    - Pg. 19 Proposing a "Lead CCT-P" is not Exclusive to AMR and is not currently approved by Santa Barbara County LEMSA.
    - Pg. 26 None of the Continuing Education courses listed are Exclusive to AMR.
    - Pg. 29 AMR claims to exclusively have "Local & Regional Clinical Leadership"; however, the District Medical Director is board certified and also operates regionally in Ventura County.

- Pg. 32 shows National Nurse Navigation Success but doesn't currently offer it anywhere in California as listed.
- Pg. 72 "ET3" is not Exclusive to AMR, nor is it currently approved by Santa Barbara County LEMSA.
- Pg. 32 "elopement playbook" practice not currently approved by Santa Barbara County LEMSA.
- Pg. 38 shows an "AMR Enhancement" with a map of the county's "Post Locations", the 3 "New! Proposed Stations" are shown with a red box, however all are existing stations. One is shown in Buellton, which is not new, it is current. The other two are in Vandenberg Village and New Cuyama which District currently provides and the awardee is required to cover.
- Pg. 91 "Public Safety Rehabilitation" not requested by local agencies, will carry "Hydroxocobalamin" not currently approved by Santa Barbara County LEMSA.
- Page 92 AMR claims exclusivity to the Nurse Navigation Line, which is misleading as this service is provided by other agencies/companies the only thing exclusive is the way they title it. By claiming this is exclusive to AMR insinuates that the District cannot provide the service.
- Page 97- Alternate Destinations- the key of "AMR Exclusive" is misleading as this can be done by other agencies. By claiming this is exclusive to AMR insinuates that the District cannot provide the service.

Santa Barbara County Code of Ordinances, Article VI, Section 2-40(d) for competitive bidding requires fiscal statements. Cost is always a factor when the County purchases on behalf of the taxpayer and failure to require this information in soliciting and evaluating bids harms the County and is inconsistent with the County Code.

Santa Barbara County Code of Ordinances, Article VI, Finance and Purchases. allows for consideration of economic benefits to County taxpayers as part of the procurement process. There was **no** evaluation of the fiscal adequacy of both proposers' revenues to expenses and ability to provide services at fair rates, and therefore be able to be fiscally solvent over the term of the contract to the taxpayer and rate payers. The RFP and resultant evaluation did ask for fiscal statements. However, the scoring process only passed the two respondents due to their submission of the required documents, not the content of the documents.

No evaluation, by anyone, scored the strength or weakness of the fiscals. Section 2-40.1 (a) (2) of the County's Purchasing Code allows the County Purchasing Agent to reject all bids or deal directly with a vendor where the purchase can be made under terms and conditions more advantageous to the County. The County should award the contract to Contract to District due to the immense positive fiscal value to improve the County EMS system as the Districts fiscals provide for revenues more than expenses, allowing

investment in expanded EMS services. (See the Financial Attachments of the District's Proposal)

While the Ground Transportation Contract is well in excess of $100M in annual billing, the RFP procedures did not provide financial transparency for the review panel to additionally determine if any of the items referenced below, and throughout the AMR Proposal as "items we (AMR) would like to discuss" further were included in the actual cost of the bid and financial modeling. Because the AMR Proposal is not clear, contract negotiations with AMR to include all of these offered items could decrease the financial viability of AMR's bid to the County even further. These items were referenced in several areas that implied they were included in the proposed system but it is not clear if they are; thus, it appears AMR's proposal was erroneously scored in reliance on these items is included. Last, when the County published the proposals and Notice of Intent to award on the County's purchasing site, none of the financial documents were also provided. Thus, there is zero public and Board level of transparency as to the fiscal value of either respondent.

To include:
Page 3- Combined Air/Ground Membership Program
Page 64- Online Ordering System
Page 65- Care Connection
Page 93- Tactical EMS Support
Page 94- Mobile Integrated Health System
Page 97- Alternate Destinations and ET3
Page 99- Carbyne Technology Solution

County Code requires that the RFP consider fiscal impacts when evaluating bids. Because District's fiscal submittal has been determined to be passed and thus "satisfactory" by the review process and there is an immense economic benefit to County Taxpayers, County should award the contract to District.

AMR's Proposal did not comply with the RFP rigorous proposal instructions (RFP 2.8 Proposal Instruction, Pg 19); therefore, the AMR Proposal should be considered nonresponsive, rejected, and the contract awarded to the District.

Per the RFP instructions within Section 2.8:

The narrative portion of the Proposal shall be limited to one hundred (100) pages, excluding title pages and dividers.

The narrative portion will adhere to the following specifications:
- *Easily readable font, no smaller than 11 point*
- *Line spacing no smaller than 1 ½ lines*
- *Standard 8 ½" by 11" paper*

- *Pages must be numbered sequentially*

Proposals shall be written to directly respond to evaluation criteria and must adhere to the mandatory Table of Contents, as detailed in this RFP.

Proposals shall incorporate all information requested in this RFP, in the order that it is requested. Proposers may elect to use reference "exhibits" or "attachments" in the Proposal to provide additional detail.

AMR failed to answer all bid questions in the body of the document and instead opted to push several responses into the attachments (without reference in the body of the document). Several pages of the required narrative section were moved several pages into an "attachment" instead of complying with the page limit. (See page Pg. 63-64 of the AMR Proposal Interfacility Transport Plan was not responded to within the RFP parameters.)

This Formal Protest is in reference to RFP #8010001 - GS Purchasing-Services: Exclusive Ambulance Services Provider for the Santa Barbara County Exclusive Operating Area.

All documents located are the following publicly accessible website link: https://www.publicpurchase.com/gems/bid/bidView?bidId=160135&sso=5db6362b733a422577f0eda029f0423c

Signed Protestor, Fire Chief/ Fire Warden of the Santa Barbara County Fire Protection District,

DocuSigned by:
643A84E63CDE490...

Mark A. Hartwig
Fire Chief/ Fire Warden
Santa Barbara County Fire Protection District

***Supporting documents are included subsequent to page 14.**

Advanced Life Supprot Agreement Between Santa Barbara County EMSA and Santa Barbara County Fire Protection District

Advanced Life Support Agreement
Between
Santa Barbara County Emergency Medical Services Agency
and
Santa Barbara County Fire Protection District

This Agreement and permit to operate is made by and between the COUNTY OF SANTA BARBARA EMERGENCY MEDICAL SERVICES AGENCY, a political subdivision of the State of California, herein referred to as "EMS AGENCY", and COUNTY OF SANTA BARBARA FIRE PROTECTION DISTRICT, herein referred to as "FIRE DISTRICT".

Recitals

a. FIRE DISTRICT requests approval from EMS AGENCY to provide primary advanced life support (ALS) non-transport and ALS ambulance transport services for emergencies in designated areas within the unincorporated areas of the County to include providing ALS ambulance services to University of California Santa Barbara (UCSB) Campus.(see Exhibit E). FIRE DISTRICT will not provide transport services except in areas designated by the EMS AGENCY.

b. EMS AGENCY acknowledges FIRE DISTRICT may place ALS fire engine/rescue personnel at identified Fire Stations following EMS AGENCY policy as authorized in 404 and 404a.

c. This Agreement updates a prior agreement signed on November 14, 1997 between both agencies.

d. Division 2.5, Section 1797.218, of the Health and Safety Code, gives the County Emergency Medical Services Agency the authority to authorize an advanced life support program which provides services, utilizing EMT-P personnel for the delivery of emergency medical care to the sick and injured at the scene of an emergency and during training within the facilities of a participating general acute care hospital; and

e. California State law at 22 CCR, Division 9, Ch 4,Section 100167 requires that all Paramedic Service (ALS) providers shall have a written agreement with the local emergency medical services system.

f. Both parties agree that by signing this agreement and following the EMS Agency medical policies and procedures, Fire District is not acquiescing their administrative responsibilities and duties in providing emergency medical services.

g. Both parties understand that pending legislation may require clarification that would necessitate parties to meet and confer to amend this agreement.

NOW, THEREFORE, the EMS AGENCY and FIRE DISTRICT agree as follows:

1. ADMINISTRATION

The EMS AGENCY'S Director of Emergency Medical Services (EMS) Agency at phone number (805) 681-5274 shall represent EMS AGENCY in all matters pertaining to the performance under this Agreement and shall administer this Agreement on behalf of EMS AGENCY. The Fire Chief of the Santa Barbara County Fire District, at phone number (805) 681-5500 shall administer this Agreement. All reports, letters, notices, and/or other correspondence shall be sent to the attention of the designated representatives at their respective addresses.

NOTICE:

Any notice or notices required, pursuant to this Agreement, may be personally served on the other party by the party giving such notice, or may be served by certified mail, postage prepaid, return receipt requested, to the Representative at the following address:

To EMS AGENCY:
Director
Emergency Medical Services Agency
300 N. San Antonio Road
Santa Barbara, CA 93110

To FIRE DISTRICT:
Fire Chief
Santa Barbara County Fire Protection District
Fire Headquarters
4410 Cathedral Oaks Road
Santa Barbara, CA 93110

2. SCOPE OF WORK

FIRE DISTRICT agrees to provide services in accordance with Exhibit A attached hereto incorporated herein by reference.

3. TERMS OF THE AGREEMENT

The term of the Agreement shall commence when executed by both parties. FIRE DISTRICT AND EMS AGENCY shall periodically review the Agreement to ensure applicability to current conditions. Either party may terminate this agreement with Board of Supervisor approval, at any time, upon ninety (90) days written notice to the other party.

4. DISPUTE RESOLUTION

In the event the FIRE DISTRICT fails to maintain service levels as identified in Exhibit A and B, the EMS Agency Director and Medical Director and the Fire Chief will engage in good faith efforts to resolve the dispute(s) through the appropriate internal hierarchies of each agency. If the dispute(s) remain(s) unresolved, the parties agree to meet with the Chief Executive Officer's (CEO) Office to assemble a dispute resolution panel in an attempt to resolve the dispute(s).

Nothing in this section shall prohibit the EMS Agency Medical Director from taking action against an individual Emergency Medical Technician EMT's certification or an individual Paramedic's local accreditation in accordance to local policies and State laws.

8. CHANGES AND AMENDMENTS

This Agreement may not be modified or changed orally, but only in writing signed by both parties.

9. RESPONSE TIME REQUIREMENTS

Response Time Definition
The time of completion of first dispatch until the time that the dispatch center is notified by radio (or other reliable method) that the vehicle is fully stopped (wheels not in motion) at the location where the vehicle shall be parked during the incident, or in the event that staging is necessary for personnel safety, at the time the vehicle arrives at the staging area. Response times shall be calculated using minutes and seconds.

Response Time Requirements
FIRE DISTRICT shall adhere to the following response time guidelines (exemptions are listed in Exhibit B):

Code 3 Calls
Each month, within "Urban" areas, FIRE DISTRICT shall have a response time to Code 3 calls of 7:00 minutes or less for an Engine/Squad Rescue and 7:59 or less for an Ambulance, a minimum of ninety percent (90%) of the time.

Each month, within "Semi-Rural" areas, FIRE DISTRICT shall have a response time to Code 3 calls of 14:00 minutes or less for an Engine/Squad Rescue and 14:59 or less for an Ambulance, a minimum of ninety percent (90%) of the time.

Each month, within "Rural" areas, FIRE DISTRICT shall have a response time to Code 3 calls of 29:00 minutes or less for an Engine/Squad Rescue and 29:59 or less for an Ambulance, a minimum of ninety percent (90%) of the time.

Code 2 Calls
Each month, within "Urban" areas, on Code 2 calls, FIRE DISTRICT shall have a response time of 14:00 minutes or less for an Engine/Squad Rescue and 14:59 or less for an Ambulance, ninety percent (90%) of the time.

Each month, within "Semi-Rural" areas, on Code 2 calls, FIRE DISTRICT shall have a response time of 24:00 minutes or less for an Engine/Squad Rescue and 24:59 or less for an Ambulance, ninety percent (90%) of the time.

Each month, within "Rural" areas, on Code 2 calls, FIRE DISTRICT shall have a response time of 39:00 minutes or less for an Engine/Squad Rescue and 39:59 or less for an Ambulance, (90%) of the time.

Delayed Response
Any delayed response times for Code 3 and Code 2 calls by FIRE DISTRICT shall be audited for cause and reported to the EMS Agency. Each call exceeding response times set forth above shall be reported monthly by the FIRE DISTRICT to the EMS AGENCY as part of the contract compliance.

10. CONFIDENTIALITY

The EMS AGENCY and FIRE DISTRICT acknowledge that the services and claims are of a confidential nature. Staff reviewing medical records and handling claims will maintain the confidentiality of records. Confidentiality guidelines shall be consistent with all local, State, and Federal requirements and mandates governing confidentiality and privacy rights, including the Health Insurance Portability and Accountability Act (HIPAA).

11. RECORDS, AUDIT, AND REVIEW

FIRE DISTRICT shall keep such business records related to the provision of emergency medical services pursuant to this Agreement. All accounting records shall be kept in accordance with generally accepted accounting practices. EMS AGENCY shall have the right to audit and review all documents and records related to the provision of emergency medical services at any time during FIRE DISTRICT'S regular business hours or upon reasonable notice. It is understood that EMS AGENCY shall coordinate all such audits and inspections through the FIRE DISTRICT EMS Division Chief.

12. DELEGATION AND ASSIGMENT

FIRE DISTRICT shall not delegate its duties and responsibilities or assign its rights thereunder, or both, either in whole or in part, without the prior written consent of EMS AGENCY.

13. RESPONSIBILITY FOR COSTS

EMS AGENCY and FIRE DISTRICT agree to meet and confer to determine any costs or expenses related to the provision of service under this Agreement.

14. DEFINATIONS

EMS AGENCY and FIRE DRISTRICT agree to the following definitions as defined in EXHIBIT C.

IN WITNESS THEREOF the parties hereto have caused this agreement to be executed on the day and year written below.

Nancy Lapolla, Director
Santa Barbara County
Emergency Medical Services Agency

Date: 8-31-11

Michael Dyer, Chief
Santa Barbara County
Fire Protection District

Date: 8/31/11

EXHIBIT A
SCOPE OF WORK
Advance Life Support (ALS) Fire First Responder and Designated Ambulance Transport

Santa Barbara County Fire Protection District does agree as follows:

1. To provide continuous uninterrupted advanced life support (ALS) services 24 hours a day, 7 days a week in the areas as defined in Exhibit D and identified in the Santa Barbara County EMS plan approved by the California Emergency Medical Services Authority.
2. Provide notification to the EMS Agency at least thirty (30) days prior to making any staffing level changes from basic life support (BLS) fire stations to dedicated ALS fire stations prior to status change.
3. Utilize only Santa Barbara County EMS Agency accredited paramedics to provide the services and to assure that these personnel maintain their accreditation as outlined in Santa Barbara County EMS Agency Policy #700.115.
4. Adhere to EMS Agency policies and procedures, as amended from time to time. A copy of the EMS Agency policies and procedures has been provided to FIRE DISTRICT at www.countyofsb.org/phd/ems.
5. Provide an EMS Program Medical Director who has experience and is currently working in emergency medicine at a local hospital emergency department. The Medical Director is responsible to approve and ensure EMS personnel meet all the training and medical qualifications required to practice in Santa Barbara County. The Medical Director shall be actively involved in the agencies on-going Training and QI Program and shall maintain regular communications with the EMS Agency Medical Director.
6. Maintain communication with the EMS system base hospital for transfer of medical information and medical direction.
7. Assign a "liaison" to work with the EMS Agency on administrative matters and to serve on committees as requested by the Agency or the EMS Medical Director.
8. Implement an internal quality assurance program.
9. Develop a Continuous Quality Improvement (CQI) program that interfaces with the EMS Agency's CQI program and to provide monthly reports and participate in quarterly meetings as specified by the EMS Agency.
10. Furnish the EMS Agency with required data, response times, and other information in a format as specified by EMS Agency policy.
11. Agree to periodic visits by EMS Agency staff to ensure compliance with local, state, federal laws and policies, rules, and regulations.
12. Provide and restock medications, equipment and supplies as inventory for each ALS unit in accordance to EMS Policy 404 and 404A.
13. Respond to requests for mutual aid (i.e. multi-casualty incidents, disasters).
14. Secure or furnish all services and supplies including, but not limited to, medical supplies, drug inventory, equipment, communication equipment and facilities, necessary for the provision of services pursuant to this Agreement.
15. Utilize an electronic patient care record (EPCR) that meets the EMS Agency patient care reports and documentation policies.

EXHIBIT B
RESPONSE TIME EXEMPTIONS

In certain cases, a late response will be exempted from compliance reports. FIRE DISTRICT must file a request for each response time exemption on a monthly basis with the EMS Agency within 15 days of the end of the previous month. Such request shall list the date, the time, and the specific circumstances causing the delayed response. A representative from the EMS Agency will determine good cause for exemption. The burden of proof for good cause of an exemption shall rest with the FIRE DISTRICT.

Good cause for an exemption may include, but is not limited to the following scenarios:

1. Inaccurate dispatch information when unedited dispatch records or tapes verify the following:
   a. Dispatcher gave incorrect call priority, address, or map coordinates that had a delayed response for an on scene response time;
   b. Incorrect or inaccurate dispatch information received from a calling party or 911 Public Safety Answering Point;
   c. Disrupted voice or data transmission; or
2. Dispatcher failure to document/record times; Weather conditions which impair visibility or create other unsafe driving conditions;
3. Unavoidable delays caused by road construction and/or closure;
4. Unavoidable delays caused by trains;
5. Off-road or off-paved road locations;
6. Extraordinary ALS Fire Agency response demands;
7. Inability to locate address due to non-existent or inaccurate address;
8. Unavoidable delay caused by traffic congestion when there is no reasonable alternate access to the incident.
9. A declared state of emergency or disaster.

EXHIBIT C
DEFINITIONS AND ABBREVIATIONS

The following terms and abbreviations are utilized throughout this Agreement:

Advanced Life Support (ALS) – Special services designed to provide definitive prehospital emergency medical care as defined in Health and Safety Code Section 1797.52, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a receiving hospital.

ALS Transport Unit - A ground ALS Unit that transports patients to Emergency Departments, and has all mandatory supplies on board.

ALS Fire Engine/Rescue Unit - An ALS Fire Engine Company or Rescue Unit that responds to emergency calls, and has all mandatory supplies on board.

ALS First Responder Unit - A non-transporting ALS unit that is used as an extra resource in the County. ALS Bike Teams, SWAT Medics, and Fire Extension Kits fall under this definition. Units have limited supplies on board.

Base Hospital – A hospital which, upon entering into written agreement with the local EMS Agency, is responsible for directing the advanced life support system or limited advanced life support system assigned to it.

Base Hospital Physician – A physician licensed to practice medicine in the State of California and approved as a Receiving Hospital Physician by the EMS Agency Medical Director, and knowledgeable in the medical protocols, radio procedure and general operating policies of the EMS system, and a person from whom ambulance personnel may take medical direction by radio or other remote communications device.

Basic Life Support (BLS) – As defined in Health and Safety Code Section 1797.60.

Code One Call – Any non Code 3 or Code 2 request for service which is scheduled or unscheduled where a person has determined a need for an ambulance because of the potential for an emergency or the inability of a patient to be otherwise transported.

Code Two Call – Any request for service designated as non-life threatening by dispatch personnel in accordance with EMS AGENCY policy, requiring the immediate dispatch of an ambulance without the use of lights and sirens.

Code Three Call – Any request for service perceived or actual life threatening, as determined by dispatch personnel, in accordance with EMS AGENCY policy, requiring immediate dispatch with the use of lights and sirens.

EMS – Emergency Medical Services.

EMS Agency – Santa Barbara Emergency Medical Services Agency, a program of the Public Health Department established by the Santa Barbara County Board of Supervisors, which monitors the medical control and standards of the EMS system.

Emergency – Any apparent sudden or serious illness or injury requiring, or having the potential of requiring, immediate medical attention under circumstances that delay in providing such services may aggravate the medical condition or cause the loss of life.

Emergency Call – A request for an emergency vehicle, first responder vehicle or ambulance to transport or assist a person in apparent sudden need of medical attention, or to assist a person who has the potential for sudden need of medical attention, or in a medical emergency as determined by a physician, to transport blood, any therapeutic device, accessory to such device or tissue or organ for transplant.

Emergency Department (ED) – The area of a licensed general acute-care facility that customarily receives patients in need of emergent medical evaluation and/or care.

Emergency Medical Services (EMS) – The provision of services to patients requiring immediate assistance due to illness or injury, including access, response, rescue, prehospital and hospital treatment, and transportation.

EMS Plan – A plan for the delivery of all emergency medical services.

EMS System – A coordinated arrangement of resources (including personnel, equipment, and facilities) which are organized to respond to medical emergencies, regardless of the cause.

Emergency Medical Technician–One or EMT-I – An individual trained in all facets of basic life support according to standards prescribed by this part and who has a valid certificate issued pursuant to this part.

Emergency Medical Technician-Paramedic or EMT-P – An individual whose scope of practice to provide advanced life support is according to standards prescribed by this division and who has a valid state license issued pursuant to this division.

Helicopter Services – (EMS Aircraft) Any aircraft utilized for the purpose of pre-hospital emergency patient response and transportation. This includes "Air Ambulances" and all categories of "Rescue Aircraft".

- **Air Ambulance** - Any aircraft specifically constructed, modified, or equipped and used for the primary purposes of transporting critically ill or injured patients whose flight crew has at a minimum two (2) attendants accredited and/or licensed to provide Advanced Life Support.

- **Rescue Aircraft** - Any aircraft whose function is not primarily a pre-hospital emergency patient transport may be utilized, in compliance with local EMS policy, for pre-hospital emergency patient transport when use of an air or ground ambulance is inappropriate or unavailable. Rescue aircraft included ALS rescue aircraft, BLS rescue aircraft, and Auxiliary Rescue Aircraft.

1. "ALS Rescue Aircraft" means a rescue aircraft whose medical crew has at least one (1) attendant accredited and licensed to provide Advanced Life Support care.
2. "BLS Rescue Aircraft" means a rescue aircraft whose medical flight crew has at least one (1) attendant certified as an EMT-I.
3. "Auxiliary Rescue Aircraft" means a rescue aircraft that does not have a medical flight crew.

- **Air Rescue Service** - An air service using aircraft for medical emergencies, including rescue aircraft and air ambulances.

EMS Agency Medical Director – Person designated pursuant to Section 1797.204 of the Health and Safety Code.

Medical Protocol – Any diagnosis-specific or problem-oriented written statement of standard procedure, or algorithm, promulgated by the EMS Medical Director as the normal standard of prehospital care for the given clinical condition.

Mutual Aid – The furnishing of resources, from one individual or agency to another individual or agency, including but not limited to facilities, personnel, equipment, and services, pursuant to an agreement with the individual or agency, for use within the jurisdiction of the individual or agency requesting assistance.

Paramedic Unit – An emergency vehicle staffed and equipped to provide advanced life support at the scene of a medical emergency of a patient(s) and designated as a paramedic unit by the Medical Director.

Remote Area – Census tracts or enumeration districts without census tracts which have a population density of 5 to 9 persons per square mile.

Response Time – The actual elapsed time between receipt of the request by the FIRE DISTRICT of a call and the arrival of the EMS unit at the requested location.

Rural Area – All census places within a population of less than 2500 and population density of 10 to 99 persons per square mile; or census tracts or enumeration districts without census tracts which have a population density of 10 to 99 persons per square mile.

Santa Barbara Emergency Medical Services Agency – The EMS agency established by the Board of Supervisors for planning and implementation of emergency programs for Santa Barbara County.

Semi-Rural– All census places within a population of 2,500 to 49,999 and population density of 99 to 499 persons per square mile; or census tracts or enumeration districts without census tracts which have a population density of 99 to 499 persons per square mile

System-Status Management – A management tool to define the "unit hours" of production time, their positioning and allocation, by hour and day of week to best meet demand patterns.

Urban Area – All census places with a population of 49,999 to 500,000 and a population density of 499 to 999 persons per square mile; or census tracts and enumeration districts with census tracts which have a population density of 499 to 999 persons per square mile.

Wilderness Area – Census tracts or enumeration districts without census tracts which have a population density of less than 5 persons per square mile.

EXHIBIT D

FIRE DISTRICT Advanced Life Support (ALS) Fire Engine/Rescue units and designated ambulance transport services

ALS Fire Engine/Rescue Units

Fire Station 11
6901 Frey Way
Santa Barbara, CA 93117

Fire Station 21
335 Union Ave. 3510
Orcutt, CA 93455

Fire Station 22
1596 Tiffany Dr
Santa Maria, CA 93455

Fire Station 24
99 Centennial
Los Alamos, CA 93440

Fire Station 31
168 W Hwy 246
Buellton, CA 93427

Fire Station 32
906 Airport Rd
Santa Ynez, CA 93460

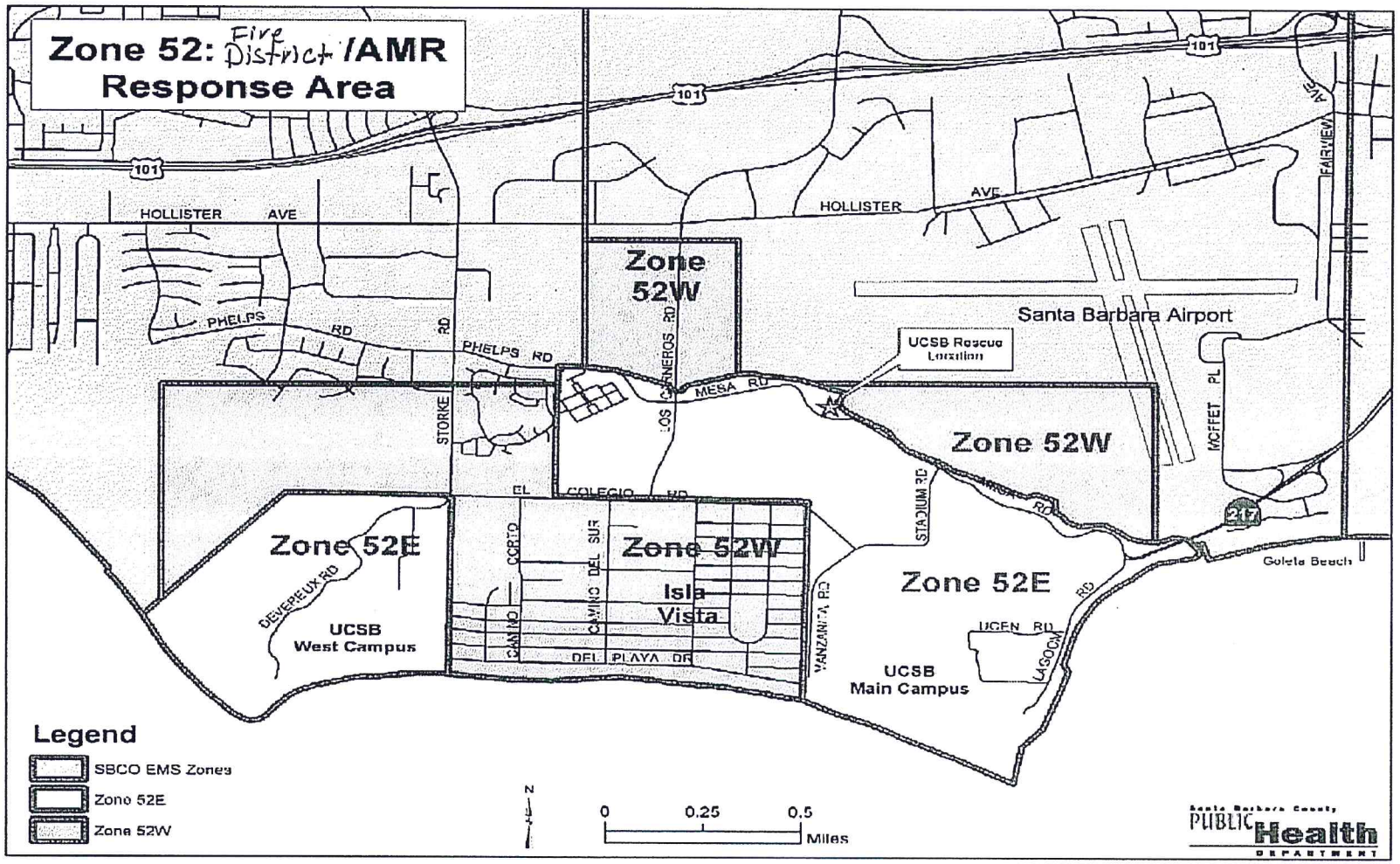
ALS Ambulance Transport Services

Fire Station 17
UCSB, Mesa Road, Bldg 547
Santa Barbara, CA. 93106

Fire Station 41
41 Newsome St
New Cuyama, CA 93254

Fire Station 51
3510 Harris Grade Road
Lompoc, CA 93436

EXHIBIT E
Fire District / AMR RESPONSE ZONE



Assembly Bill 1705

Assembly Bill No. 1705

CHAPTER 544

An act to amend Sections 14105.94, 14129, and 14129.3, and to add Section 14105.945 to, the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor October 7, 2019. Filed with Secretary of State October 7, 2019.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1705, Bonta. Medi-Cal: emergency medical transportation services.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

Existing law authorizes a Medi-Cal provider of ground emergency medical transportation services, that is owned or operated by the state, a city, county, city and county, fire protection district, special district, community services district, health care district, or a federally recognized Indian tribe, to receive supplemental Medi-Cal reimbursement, in addition to the rate of payment the eligible provider would otherwise receive for those services. Existing law requires the department to develop a modified supplemental reimbursement program, with necessary federal approvals, that would seek to increase the reimbursement to the above-described eligible providers. Existing law requires the nonfederal share of any supplemental reimbursement provided under the modified program to be derived from voluntary intergovernmental transfers of local funds. Existing law states the Legislature's intent in enacting these provisions to provide the supplemental reimbursement without any expenditure from the General Fund.

The bill would instead require the department to implement, subject to any necessary federal approvals, and no sooner than July 1, 2021, the Public Provider Intergovernmental Transfer Program (program), for the duration of any Medi-Cal managed care rating period, and would authorize the department to continue conducting any administrative duties related to the above-specified supplemental Medi-Cal reimbursement. The bill would require an eligible provider, defined, in part, as a provider of emergency medical transport, to receive an add-on increase to the associated Medi-Cal fee-for-service payment schedule, and would require the department to develop the add-on increase pursuant to specified standards, including an eligible provider's average cost directly associated with providing a Medi-Cal emergency medical transport under the Medi-Cal program. The bill would require Medi-Cal managed care health plans and emergency medical

transport providers to comply with specified federal standards relating to the payment standards for emergency medical transport. The bill would limit the amount that a noncontract eligible provider may collect for emergency medical transport. The bill would require the department to assess a 10% fee on each transfer of public funds to the state to pay for health care coverage and to reimburse the department for its administrative costs relating to the program. The bill would limit the operation of the program on the condition that the program would be financially and programmatically supportive of the Medi-Cal program. The bill would authorize the department to implement these provisions by various means, including all-county letters or provider bulletins, without taking regulatory action.

Existing law, the Medi-Cal Emergency Medical Transportation Reimbursement Act, commencing July 1, 2018, and subject to federal approval and the availability of federal financial participation, imposes a quality assurance fee for each emergency medical transport provided by an emergency medical transport provider subject to the fee in accordance with a prescribed methodology. Existing law requires the Director of Health Care Services to deposit the collected quality assurance fee into the continuously appropriated Medi-Cal Emergency Medical Transport Fund, for exclusive use in a specified order of priority, including to enhance federal financial participation for ambulance services under the Medi-Cal program. Existing law requires each emergency medical transport provider to report to the department specified data and material, including the number of actual emergency medical transports by payer type. The act increases Medi-Cal reimbursement to emergency medical transport providers for emergency medical transports.

The bill would exempt an eligible provider from the quality assurance fee and add-on increase for the duration of any Medi-Cal managed care rating during which the Public Provider Intergovernmental Transfer Program is implemented.

The people of the State of California do enact as follows:

SECTION 1. Section 14105.94 of the Welfare and Institutions Code is amended to read:

14105.94. (a) An eligible provider, as described in subdivision (b), may, in addition to the rate of payment that the provider would otherwise receive for Medi-Cal ground emergency medical transportation services, receive supplemental Medi-Cal reimbursement to the extent provided in this section.

(b) A provider shall be eligible for supplemental reimbursement if the provider has all of the following characteristics continuously during a state fiscal year:

(1) Provides ground emergency medical transportation services to Medi-Cal beneficiaries.

(2) Is a provider that is enrolled as a Medi-Cal provider for the period being claimed.

(3) Is owned or operated by the state, a city, county, city and county, fire protection district organized pursuant to Part 2.7 (commencing with Section 13800) of Division 12 of the Health and Safety Code, special district organized pursuant to Chapter 1 (commencing with Section 58000) of Division 1 of Title 6 of the Government Code, community services district organized pursuant to Part 1 (commencing with Section 61000) of Division 3 of Title 6 of the Government Code, health care district organized pursuant to Chapter 1 (commencing with Section 32000) of Division 23 of the Health and Safety Code, or a federally recognized Indian tribe.

(c) An eligible provider's supplemental reimbursement pursuant to this section shall be calculated and paid as follows:

(1) The supplemental reimbursement to an eligible provider, as described in subdivision (b), shall be equal to the amount of federal financial participation received as a result of the claims submitted pursuant to paragraph (2) of subdivision (f).

(2) The amount certified pursuant to paragraph (1) of subdivision (e), when combined with the amount received from all other sources of reimbursement from the Medi-Cal program, shall not exceed 100 percent of actual costs, as determined pursuant to the Medi-Cal State Plan, for ground emergency medical transportation services.

(3) The supplemental Medi-Cal reimbursement provided by this section shall be distributed exclusively to eligible providers under a payment methodology based on ground emergency medical transportation services provided to Medi-Cal beneficiaries by eligible providers on a per-transport basis or other federally permissible basis. The department shall obtain approval from the federal Centers for Medicare and Medicaid Services for the payment methodology to be utilized, and may not make any payment pursuant to this section prior to obtaining that approval.

(d) (1) It is the Legislature's intent in enacting this section to provide the supplemental reimbursement described in this section without any expenditure from the General Fund. An eligible provider, as a condition of receiving supplemental reimbursement pursuant to this section, shall enter into, and maintain, an agreement with the department for the purposes of implementing this section and reimbursing the department for the costs of administering this section.

(2) The nonfederal share of the supplemental reimbursement submitted to the federal Centers for Medicare and Medicaid Services for purposes of claiming federal financial participation shall be paid only with funds from the governmental entities described in paragraph (3) of subdivision (b) and certified to the state as provided in subdivision (e).

(e) Participation in the program by an eligible provider described in this section is voluntary. If an applicable governmental entity elects to seek supplemental reimbursement pursuant to this section on behalf of an eligible provider owned or operated by the entity, as described in paragraph (3) of subdivision (b), the governmental entity shall do all of the following:

(1) Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for the ground emergency medical transportation services are eligible for federal financial participation.

(2) Provide evidence supporting the certification as specified by the department.

(3) Submit data as specified by the department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation.

(4) Keep, maintain, and have readily retrievable, any records specified by the department to fully disclose reimbursement amounts to which the eligible provider is entitled, and any other records required by the federal Centers for Medicare and Medicaid Services.

(f) (1) The department shall promptly seek any necessary federal approvals for the implementation of this section. The department may limit the program to those costs that are allowable expenditures under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.). If federal approval is not obtained for implementation of this section, this section shall not be implemented.

(2) The department shall submit claims for federal financial participation for the expenditures for the services described in subdivision (e) that are allowable expenditures under federal law.

(3) The department shall annually submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.

(g) (1) If a final judicial determination is made by any court of appellate jurisdiction or a final determination is made by the administrator of the federal Centers for Medicare and Medicaid Services that the supplemental reimbursement provided for in this section must be made to any provider not described in this section, the director shall execute a declaration stating that the determination has been made and on that date this section shall become inoperative.

(2) The declaration executed pursuant to this subdivision shall be retained by the director, provided to the fiscal and appropriate policy committees of the Legislature, the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and posted on the department's internet website.

(h) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer this section by means of provider bulletins, or similar instructions, without taking regulatory action.

(i) Notwithstanding any other law, this section shall become inoperative during the entirety of any Medi-Cal managed care rating period in which Section 14105.945 is implemented, in whole or in part. The department may conduct any necessary and remaining administrative duties related to any time period during which this provision remained operative, even after this

section becomes inoperative, and may receive all compensation for those activities until paid in full.

(j) The department, in its sole discretion, may determine it has received all compensation for activities conducted pursuant to this section and completed all administrative duties related to time periods when this section was operative.

SEC. 2. Section 14105.945 is added to the Welfare and Institutions Code, to read:

14105.945. (a) For purposes of this section, the following definitions apply:

(1) "Eligible provider" means a provider who is eligible for reimbursement of Medi-Cal emergency medical transports pursuant to this section, and who continually meets all of the following requirements during the entirety of any Medi-Cal managed care rating period that this section is implemented:

(A) Provides emergency medical transports to Medi-Cal beneficiaries.

(B) Is enrolled as a Medi-Cal provider for the period being claimed.

(C) Is owned or operated by the state, a city, county, city and county, fire protection district organized pursuant to Part 2.7 (commencing with Section 13800) of Division 12 of the Health and Safety Code, special district organized pursuant to Chapter 1 (commencing with Section 58000) of Division 1 of Title 6 of the Government Code, community services district organized pursuant to Part 1 (commencing with Section 61000) of Division 3 of Title 6 of the Government Code, health care district organized pursuant to Chapter 1 (commencing with Section 32000) of Division 23 of the Health and Safety Code, or a federally recognized Indian tribe.

(2) (A) "Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations that are billed with billing codes A0429 BLS Emergency, A0434 Specialty Care Transport, A0225 Neonatal Emergency Transport, A0427 ALS Emergency, and A0433 ALS2, and any equivalent, predecessor, or successor billing codes, as may be determined by the director.

(B) "Emergency medical transport" shall not include transportation of beneficiaries by passenger car, taxicab, litter van, wheelchair van, or other forms of public or private conveyances, nor shall it include transportation by an air ambulance provider. An "emergency medical transport" does not occur if a transport is not provided following evaluation of a patient.

(3) "Medi-Cal managed care rating period" means a period selected by the department for which the actuarially sound capitation rates are developed and documented in the rate certification that the department submits to the federal Centers for Medicare and Medicaid Services as required by Section 438.7(a) of Title 42 of the Code of Federal Regulations.

(b) (1) Commencing no sooner than July 1, 2021, the department shall implement the Public Provider Intergovernmental Transfer Program

(program) pursuant to this section for any Medi-Cal managed care rating period that the department has obtained necessary federal approvals.

(2) Notwithstanding any other law, during the entirety of any Medi-Cal managed care rating period for which the requirements of this section are implemented, in whole or in part, supplemental Medi-Cal reimbursements described in Section 14105.94 shall become inoperative.

(c) To the extent authorized under federal and state law, an eligible provider shall receive increased reimbursement by application of an add-on increase, as determined pursuant to subdivision (d), to the associated Medi-Cal fee-for-service payment schedule for emergency medical transports provided to applicable Medi-Cal beneficiaries.

(d) The department shall develop the statewide add-on increase to be provided under the program as follows:

(1) The department shall determine an initial statewide add-on increase that is based on the most recent audited cost reports of eligible providers available at the time the add-on increase is developed, as determined by the department. In determining the initial statewide add-on increase, the department may make adjustments to account for inflation, trend, or other material changes, as appropriate under federal law and actuarial standards.

(2) The initial statewide add-on increase shall represent the difference between both of the following:

(A) The average reimbursement paid pursuant to the applicable base Medi-Cal fee-for-service payment fee schedule for an emergency medical transport during the time period of the applicable cost-report to an eligible provider, and weighted according to those services provided by all eligible providers during the applicable time period.

(B) The average cost directly associated with providing a Medi-Cal emergency medical transport under the Medi-Cal program by an eligible provider during the time period of the applicable cost-report, as determined based on all eligible providers' audited cost reports pursuant to paragraph (1), and weighted according to those services provided by all eligible providers during the applicable time period.

(3) For subsequent Medi-Cal managed care rating periods, the department, in consultation with participating eligible providers, and as determined by the department, may adjust periodically the initial statewide add-on increase to account for inflation, trend adjustments, or other material changes, as appropriate under federal law and actuarial standards.

(4) To the extent that the department deems practicable, the department shall set a schedule for determining the statewide add-on increase before the department submits to the federal Centers for Medicare and Medicaid Services actuarially sound Medi-Cal managed care rates for an applicable Medi-Cal managed care rating period pursuant to subdivision (e).

(5) Once the department determines the add-on increase for a Medi-Cal managed care rating period, the add-on increase shall not be modified for that rating period unless the modification is required for purposes of receiving federal approval or claiming federal financial participation for the requirements of this section.

(e) (1) A Medi-Cal managed care health plan shall satisfy its obligation under Section 438.114(c) of Title 42 of the Code of Federal Regulations for emergency medical transport, and shall provide payment to applicable noncontract emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code.

(2) During the entirety of any Medi-Cal managed care rating period that this section is implemented, the amounts a noncontract eligible provider may collect if a Medi-Cal beneficiary received medical assistance other than through enrollment in a Medi-Cal managed care health plan pursuant to Section 1396u-2(b)(2)(D) of Title 42 of the United States Code shall be the resulting Medi-Cal fee-for-service payment schedule amounts after the application of the add-on increase described in this section. During the Medi-Cal managed care rating period that the requirements of this section are implemented, any reimbursement to a noncontract emergency medical transport provider that is not an eligible provider shall be made in accordance with subdivision (b) of Section 14129.3.

(f) The Medi-Cal reimbursement provided by this section shall be distributed exclusively to eligible providers under a payment methodology based on emergency medical transport provided to Medi-Cal beneficiaries by eligible providers on a per-transport basis or other federally permissible basis.

(g) During the entirety of any Medi-Cal managed care rating period that this section is implemented, in whole or in part, the department shall provide appropriate funding to each applicable Medi-Cal managed care plan to account for the add-on increase obligations of these plans pursuant to this section in federally approved risk based capitation rates developed in accordance with Section 14301.1.

(h) (1) For any Medi-Cal managed care rating period that this section is implemented, the nonfederal share, which is associated with the add-on increase as it applies to the Medi-Cal fee-for-service payment schedule and the portion of the risk-based capitation rate to Medi-Cal managed care health plans, may consist of voluntary intergovernmental transfers of funds provided by eligible providers and their affiliated governmental entities or other public entities pursuant to Section 14164, as applicable. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify, in the form and manner specified by the department, that the transferred funds qualify for federal financial participation pursuant to applicable laws relating to the federal Medicaid program. Any intergovernmental transfer of funds made pursuant to this section shall be voluntary for purposes of federal law.

(2) The department shall assess a 10-percent fee on each transfer of public funds to the state pursuant to this subdivision to pay for health care coverage and to reimburse the department for its costs associated with administering the program. Excluding this fee, the department shall not assess a percentage fee in connection with any intergovernmental transfer of funds made pursuant to this subdivision.

(3) The department shall develop and maintain, in consultation with participating eligible providers, a protocol and schedule for funding the nonfederal share of expenditures during a Medi-Cal managed care rating period that this section is implemented using voluntary intergovernmental transfers.

(4) This section does not limit or otherwise alter any existing authority of the department to accept intergovernmental transfers for purposes of funding the nonfederal share of expenditures in the Medi-Cal program.

(i) During the entirety of any Medi-Cal managed care rating period for which this section is implemented, in whole or in part, an eligible provider shall be exempt from the quality assurance fee and add-on increase pursuant to Article 3.91 (commencing with Section 14129).

(j) This section shall cease to be operative on the first day of the Medi-Cal managed care rating period beginning on or after the date the department determines, after consultation with participating eligible providers, that implementation of this section is no longer financially and programmatically supportive of the Medi-Cal program. The department shall make this determination if the projected amount of nonfederal share funds available for an applicable Medi-Cal managed care rating period is insufficient to support implementation of this section in the subject Medi-Cal managed care rating period. The department shall post notice of the determination on its internet website.

(k) The director may modify any process or methodology specified in this section to the extent necessary to comply with state or federal law or regulations, or to secure or maintain federal approval or federal financial participation. If the director determines, after consulting with participating eligible providers, that a modification to the process or methodology is necessary, the director shall execute a declaration stating that this determination has been made and describing the modification. The director shall retain the declaration and provide a copy, within five working days of the execution of the declaration, to the fiscal and appropriate policy committees of the Legislature. The director shall post the declaration on the department's internet website.

(*l*) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of all-county letters, provider bulletins, plan letters, or other similar instructions without taking regulatory action.

(m) (1) The department shall implement this section only to the extent that federal financial participation is available and any necessary federal approvals are obtained.

(2) The department shall promptly seek any necessary federal approvals for the implementation of this section for an applicable Medi-Cal managed care rating period.

SEC. 3. Section 14129 of the Welfare and Institutions Code is amended to read:

14129. For purposes of this article, the following definitions apply:

(a) "Annual quality assurance fee rate" means the quality assurance fee assessed on each emergency medical transport during each applicable state fiscal year.

(b) "Aggregate fee schedule amount" means the product of the fee-for-service add-on increase described in Section 14129.3 and the Medi-Cal emergency medical transports, including both fee-for-service transports paid by the department and managed care transports paid by Medi-Cal managed care health plans, utilizing the billing codes for emergency medical transport for the state fiscal year.

(c) "Available fee amount" shall be calculated as the sum of the following:

(1) The amount deposited in the Medi-Cal Emergency Medical Transport Fund established under Section 14129.2 during the applicable state fiscal year, less the amounts described in subparagraphs (A) and (B) of paragraph (2) of subdivision (f) of Section 14129.2.

(2) Any federal financial participation obtained as a result of the deposit of the amount described in paragraph (1) in the Medi-Cal Emergency Medical Transport Fund, created pursuant to Section 14129.2, for the applicable state fiscal year.

(d) "Department" means the State Department of Health Care Services.

(e) "Director" means the Director of Health Care Services.

(f) "Effective state medical assistance percentage" means a ratio of the aggregate expenditures from state-only sources for the Medi-Cal program divided by the aggregate expenditures from state and federal sources for the Medi-Cal program for a state fiscal year.

(g) "Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an emergency medical transport provider by means of an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations that are billed with billing codes A0429 BLS Emergency, A0427 ALS Emergency, A0434 Specialty Care Transport, A0225 Neonatal Emergency Transport, and A0433 ALS2, and any equivalent, predecessor, or successor billing codes as may be determined by the director. "Emergency medical transport" excludes transportation of beneficiaries by passenger car, taxicabs, litter vans, wheelchair vans, other forms of public or private conveyances, and transportation by an air ambulance provider. An "emergency medical transport" does not occur when, following evaluation of a patient, a transport is not provided.

(h) "Gross receipts" means gross payments received as patient care revenue for emergency medical transports, determined on a cash basis of accounting. "Gross receipts" includes all payments received as patient care revenue for emergency medical transports, including payments for billing codes A0429 BLS Emergency, A0427 ALS Emergency, and A0433 ALS2, and any equivalent, predecessor, or successor billing codes as may be determined by the director, and any other ancillary billing codes associated with emergency medical transport as may be determined by the director.

"Gross receipts" excludes supplemental amounts received pursuant to Sections 14105.94 or 14105.945.

(i) "Emergency medical transport provider" means any provider of emergency medical transports, except that during any Medi-Cal managed care rating period for which Section 14105.945 is implemented "emergency medical transport provider" shall exclude "eligible providers" as defined in paragraph (1) of subdivision (a) of Section 14105.945 for purposes of this article.

(j) "Emergency medical transport provider subject to the fee" means all emergency medical transport providers who bill and receive patient care revenue from the provision of emergency medical transports, except emergency medical transport providers that are exempt pursuant to subdivision (c) of Section 14129.6.

(k) "Medi-Cal managed care health plan" means a "managed health care plan" as that term is defined in subdivision (ab) of Section 14169.51.

SEC. 4. Section 14129.3 of the Welfare and Institutions Code is amended to read:

14129.3. (a) Except as provided in subdivision (i) of Section 14105.945, commencing July 1, 2018, and for each state fiscal year thereafter for which this article is operative, reimbursement to emergency medical transport providers for emergency medical transports shall be increased by application of an add-on to the associated Medi-Cal fee-for-service payment schedule. The add-on increase to the fee-for-service payment schedule under this section shall be calculated on or before June 15, 2018, and shall remain the same for later state fiscal years for which this article is operative, to the extent the department determines federal financial participation is available and is not otherwise jeopardized. The add-on increase to the fee-for-service payment schedule under this section shall apply only to those billing codes identified in, or any equivalent, predecessor, or successor billing codes as may be determined by the director pursuant to, subdivision (g) of Section 14129. The department shall calculate the projections required by this subdivision based on the data submitted pursuant to Section 14129.1. The fee-for-service add-on shall be equal to the quotient of the available fee amount projected by the department on or before June 15, 2018, for the 2018–19 state fiscal year, divided by the total Medi-Cal emergency medical transports, including both fee-for-service transports paid by the department and managed care transports paid by Medi-Cal managed care health plans, utilizing these billing codes projected by the department on or before June 15, 2018, for the 2018–19 state fiscal year. The resulting fee-for-service payment schedule amounts after the application of this section shall be equal to the sum of the Medi-Cal fee-for-service payment schedule amount for the 2015–16 state fiscal year and the add-on increase.

(b) (1) Each applicable Medi-Cal managed care health plan shall satisfy its obligation under Section 438.114(c) of Title 42 of the Code of Federal Regulations for emergency medical transports and shall provide payment to noncontract emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code. Effective July 1,

2018, and for each state fiscal year thereafter for which this article is operative, the amounts a noncontract emergency medical transport provider could collect if the beneficiary received medical assistance other than through enrollment in a Medi-Cal managed care health plan pursuant to Section 1396u-2(b)(2)(D) of Title 42 of the United States Code shall be the resulting fee-for-service payment schedule amounts after the application of this section.

(2) This subdivision shall not apply to an eligible provider, as defined in paragraph (1) of subdivision (a) of Section 14105.945, who provides noncontract emergency medical transports to an enrollee of a Medi-Cal managed care plan during any Medi-Cal managed care rating period that Section 14105.945 is implemented.

(c) The increased payments required by this section shall be funded solely from the following:

(1) The quality assurance fee set forth in Section 14129.2, along with any interest or other investment income earned on those funds.

(2) Federal reimbursement and any other related federal funds.

(d) The proceeds of the quality assurance fee set forth in Section 14129.2, the matching amount provided by the federal government, and any interest earned on those proceeds shall be used to supplement existing funding for emergency medical transports provided by emergency medical transport providers and not to supplant this funding.

(e) Notwithstanding this article, the department may seek federal approval to implement any add-on increase to the fee-for-service payment schedule pursuant to this section for any state fiscal year or years, as applicable, on a time-limited basis for a fixed program period, as determined by the department.

(f) Notwithstanding this article, the add-on increase to the fee-for-service payment schedule pursuant to this section shall only be required and payable for state fiscal years that a quality assurance fee payment obligation exists for emergency medical transport providers.

O

Carbyne & Nurse Navigation Line

Fire Department

"Serving the community since 1926"

HEADQUARTERS

4410 Cathedral Oaks Road
Santa Barbara, CA 93110-1042
(805) 681-5500 FAX: (805) 681-5563

Mark A. Hartwig
Fire Chief
County Fire Warden

Rob Heckman
Deputy Fire Chief
Administration

Anthony Stornetta
Deputy Fire Chief
Operations

November 4, 2022

To Whom It May Concern:

To date, there have been no discussions with between AMR or the LEMSA and the Santa Barbara County Fire Protection District regarding Carbyne, a Nurse Navigation Line, or other similar programs in regards to the Regional Fire Communications Center.

Sincerely,

Rob Heckman
Deputy Fire Chief of Administration

Fire District Medical Director Resume and Board Certification

TODD LARSEN, M.D.

Medical Director

Key Qualifications

Dr. Todd Larsen, M.D., Medical Director for the County Fire Department Emergency Medical Services, is Board-certified in Emergency Medicine. He has over five years of experience as a Medical Director, and three years of experience as a Medical Director for paramedic operations. Dr. Larsen also has extensive experience in teaching and has conducted medical research.

Professional Experience

Medical Directorships

- Medical Director, County of Santa Barbara Fire Department 2/2020 - Present
- Medical Director, Oxnard Fire Department 7/2018 – Present
- Assistant Medical Director, Vituity (previously CEP America), St. John's Regional Medical Center 7/2011 – Present
- Medical Director, Ventura College Paramedic Program, 8/2015 - Present

Other Professional Leadership Experience

Department of Emergency Medicine, St. John's Regional Medical Center/ St. John's Pleasant Valley Hospital

- Chairman 1/2020 – Present

Vituity (previously CEP America), St. John's Regional Medical Center/ St. John's Pleasant Valley Hospital

- Assistant Medical Director/Emergency Medicine Physician 7/2011 – Present
- Director of Emergency Services 7/2011 – 7/2013, 10/2014 – Present
- CMS Director 8/2013 – 12/2019
- Director of Continuing Medical Education/Research 7/2011 – 7/2013
- Director of Quality Assurance 7/2013 – 10/2014

Emergency Medicine Physician Experience

- St. John's Regional Medical Center/ St. John's Pleasant Valley Hospital 7/2009 – 6/2011
- West Hills Hospitals 9/2009 – 5/2010
- Providence Tarzana Medical Center 3/2009 – 6/2009
- Kaiser Permanente, Baldwin Park 3/2008 – 7/2009
- Malibu Urgent Care 7/2008 – 7/2009

Faculty Appointments

- Faculty, Hospital Procedures Consultants, 8/2018 - current
- Medical Director, Paramedic Program, Ventura College, 8/2015 - current
- Faculty, Resuscitation 2009 - 2014, Las Vegas, NV
- Faculty, USC Essentials 2010, San Francisco, CA, November 2010
- Resident Clinical Instructor in Emergency Medicine, 7/2008 - 6/2009
- Admissions Committee, Keck School of Medicine at USC 2007 -2008
- Faculty Interviewer for the Keck School of Medicine at USC 2005 -2009
- Student Interviewer for the Keck School of Medicine at USC 2002 -2005

Other Experience

- Independent Contractor, formulate CME questions and objectives for online lecture series, CMEDownload.com 3/2007 – 7/2009
- Emergency Service Technician II, Providence St. Joseph Medical Center 1/2000 – 12/2001
- Emergency Medical Technician, American Medical Response 10/1998 – 1/2000
- Emergency Department Technician (Volunteer), Providence St. Joseph Medical Center 5/1999 – 1/2000
- Seasonal Lifeguard II/ Junior Lifeguard Instructor, Department of Parks and Recreation, CA 5/1990 - 2005

Education

Post-Graduate Education

Emergency Medicine, Los Angeles County – University of Southern California Medical Center 7/2006 – 6/2009

Internal Medicine, UCLA – Veterans Administration 6/2005 – 6/2006

Medical Education

Keck School of Medicine, University of Southern California, Doctor of Medicine 5/2005

Graduate/Undergraduate Education

California State University Northridge, Pre-medicine coursework, Fall 1998 – Fall 1999

University of California, Santa Barbara, Bachelor of Arts, English 3/1996

Certification/Licensure

Board Certification in Emergency Medicine

California Medical License and DEA License

Research

- Investigator comparing supine chest x-ray to DEM ultrasound for detection of pneumothorax. Primary Investigator: Diku Mandavia, M.D.
- Investigator in using internet-based ultrasound video clips in assessing residents ability to identify pneumothorax. Primary Investigator: Thomas Mailhot, M.D.
- Co-authored protocol and Institutional Review Board application for proposed study Ultrasound in the Hypotensive Patient. Primary Investigator: Diku Mandavia, M.D.
- Research Assistant on study Needs Assessment of Prehospital Workers' Training Skills in Honoring Advance Directives and Death Notification Skills. Primary Investigator: Susan Stone, M.D.

Presentations

- "Cardiology Review" "Neurology Review" "Senarios" Paramedic Refresher, Oxnard Fire, Nov 6th 2019
- "Airway lab" SJRMC/Oxnard Fire, Monthly to bi-monthly, Oct 2014 -Present
- "Airway lab" Paramedic Program, Ventura College, Jan 7th, 2019
- "EKG Interpretation" Paramedic Program, Ventura College, Oct 9th, 2018
- "Cardiology 1-6" Oxnard Fire Department, Paramedic Program -Aug 5th/27th, 2018
- "Aspirin Overdose" SJRMC, DEM -Aug 15th, 2018
- "Pancreatitis" SJPVH, DEM - June 20th, 2018

- "Pre-Hospital Pharmacology" MICN class, Ventura College - Feb. 24th, 2016; March 21st 2017; March 8th, 2018, Feb 19th 2019
- "Morbidity/Mortality" SJRMC, Hospital M&M - Feb 21st, 2018
- "Emergency Medicine" Avid Career Day, Foothill HS - Jan. 23rd, 2017
- "FY 2017 Pediatric Safe Discharge CMS goal" SJRMC, DEM -Nov. 16th, 2017
- "Atrial Fibrillation" SJPVH, DEM - Aug 17th, 2016
- "Cryptococcal Meningitis" SJPVH, DEM -Aug 17th, 2016
- "Sepsis Updates" SJRMC, DEM - May 18th, 2016
- "Pediatric Arrest" SJRMC, DEM - May 18th, 2016
- "Strange Movements" SJPVH, DEM -April 20th, 2016
- "Altered Mental Status - Looking, Finding, and not Recognizing" SJRMC, DEM - Mar. 16th, 2016
- "Case Review" SJPVH, DEM - Feb. 17th, 2016
- "Case Review" SJPVH, DEM -Oct. 14th, 2015
- "Cardiac Arrhythmias Part One" Ventura College Paramedic Program -Sep. 14th, 2015
- "Cardiac Arrhythmias Part Two" Ventura College Paramedic Program -Sep. 14th, 2015
- "Cardiac Arrhythmias Part Three" Ventura College Paramedic Program -Sep. 14th, 2015
- "EKG Interpretation" Ventura College Paramedic Program -Sep. 14th, 2015
- "Case Review" SJRMC, DEM -Sep. 8th, 2015
- "Case Review" SJRMC, DEM -Aug. 12th, 2015
- "Transcutaneous Pacing" SJPVH, DEM - Feb. 17th, 2015 "Code Sepsis" SJRMC, DEM - Jan. 14th, 2015 Monthly Case Review (Morbidity and Mortality Report), SJPVH /SJRMC, April 2013 -Oct. 2014
- "Foothill Career Day" Foothill High School, Ventura CA - January 8th, 2013
- “Digoxin Toxicity -A Case Presentation" Arrowhead Regional Medical Center, Grand Rounds -August 8th, 2012
- "Syncope - A Missed Diagnosis" SJRMC, DEM -July 18th, 2012
- "Management of New Onset Atrial fibrillation I Flutter" SJRMC, DEM - March 23, 2012
- “MRSA in the Pediatric Population" SJRMC, Pediatric Case Review - February 15th, 2012
- "Pharmacology for Ventura County EMS" SJPVH, VCEMS MICN Training - February 6, 2012
- "What is your responsibility as a Base Hospital Emergency Department Physician in Ventura County" SJRMC, DEM - January 18, 2012
- "The Difficult Airway" SJPVH, DEM - December 21, 2011
- "Pulmonary Embolism" SJRMC, DEM - October 20,2011
- "The Febrile Child" SJRMC, DEM - September 21, 2011
- "Atraumatic Lumbar Puncture Needle" SJRMC, DEM -August 17, 2011
- "Low Risk Chest Pain" SJRMC, DEM -August 17, 2011
- "Airway Course" Pre-hospital Care Airway Course - September 2010, December 2010, February 2011, May 2011, June 2011, October 2011, November 2011, December 2011, April 2012, May 2012, July 2012
- "Latinos and Migrants in the Emergency Department: Barriers to Care, Common reasons for ED utilization" League of United Latin American Citizens, Ventura County - June 2010

- "New Intravenous Pacemaker Review" LAC-USC Grand Rounds - February 2009
- "Metrolink Train Crash" LAC-USC Combined Trauma Conference 2009
- "Calcium Channel Blocker induced Hypotension and Calcium" LAC-USC Grand Rounds -November 11 , 2008
- "Detecting Pneumothorax using Ultrasound" 2008 LAC-USC Ultrasound Course
- "Digoxin Toxicity" LAC-USC Grand Rounds - March 13, 2008
- "Review of Pneumothorax on Ultrasound" LAC-USC Grand Rounds - March 13, 2008
- "Cardiac Glycosides: Bufadienolides and Cardenolides" LAC-USC Grand Rounds - January 24, 2008
- "Otitis Externa" LAC-USC Grand Rounds - October 11, 2007
- "Fast+: Detecting Pneumothorax using Ultrasound" 2007 LAC-USC Ultrasound Course
- "Sub-Arachnoid hemorrhage" 2005 West L.A. VA ICU Conference
- "Pulmonary Embolism" 2005 West L.A. VA Intern Report
- "Platelet Inhibition for Secondary Prevention of Stroke" 2005 West L.A. VA Grand Rounds

Awards & Achievements

Keck School of Medicine

- Teaching Assistantship, Gross Anatomy, 2004
- Salerni Collegium Scholarship, 2003 - 2004
- ARCS Foundation Scholarship, 2004 - 2004
- Honors, Obstetrics and Gynecology, 2004
- Honors, Family Medicine, 2004
- Dean's Recognition, 2003 - 2003

University of California, Santa Barbara

- Dean's Recognition, 2002

Professional Affiliations

- Founding Member, Medical Staff Quality Review Board, SJRMC/SJPVH, Feb. 2016 - Dec. 2019
- Chairman, Pre-hospital Services Committee, Ventura County, Jan. 2016 - present
- Member, Pre-hospital Services Committee, Ventura County, July 2010 - June 2013, Oct 2014 - present
- Chairman, Pharmacy & Therapeutics Committee, St. John's Regional Medical Center, Jan. 2015 - current
- Vice Chair, Pharmacy & Therapeutics Committee, St. John's Regional Medical Center, Jan. 2014 - Dec. 2014
- Member, Pharmacy & Therapeutics Committee, St. John's Regional Medical Center, Aug. 2013 - current
- Base Hospital Physician Liaison, St. John's Regional Medical Center, July 2010 - July 2013, Oct 2014 - present
- EMS Physician Liaison, St. John's Pleasant Valley Hospital, July 2010 -July 2013, Oct 2014 - present
- Member, Education and Research Committee, St. John's Regional Medical Center, Feb 2011 -June 2013 Founding
- Member, Trauma Operational Review Committee, Ventura County, Nov. 2010 - June 2013, Oct 2014 - present

AMERICAN BOARD OF EMERGENCY MEDICINE

Todd Edward Larsen, M.D.

is certified in the specialty of

EMERGENCY MEDICINE

January 01, 2021 - December 31, 2030
Certificate Number 48156

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Todd E. Larsen, M.D.

LEMSA Approved List of Equipment and Medicine

Item	ALS Transporting	ALS First Responder	BLS First Responder	BLS O/S First Responder	ALS Rescue Helicopter	Fireline Paramedic Kit Line/Vehicle	SWAT (SET) Paramedic	Bike/Foot Paramedic
Oxygen and Airway								
Adult Non-Rebreather Masks	3	2	2	2	2	0/2	0	0
Adult Nasal Cannulas	6	2	2	2	2	0/2	0	0
Pediatric Non-Rebreather Masks	6	2	2	2	2	0	0	0
Pediatric Nasal Cannulas	6	2	2	2	2	0	0	0
Adult BVM (1000 ml bag volume)	2	1	1	1	1	1/1	1	1
Pediatric BVM	2	1	1	1	1	0	0	0
Infant BVM	2	1	1	1	1	0	0	1
Set of OPA Airways	1 Adult 1 Child 1 Infant	1	1	1	1	0/1	1	1
Set of NPA Airways	1	1	1	1	1	1/1	1	1
Portable Oxygen Cylinder	2	1	1	1	1	0/1	0	1
Oxygen Regulator	2	2	1	1	2	0/1	0	1

Item	ALS Transporting	ALS First Responder	BLS First Responder	BLS O/S First Responder	ALS Rescue Helicopter	Fireline Paramedic Kit Line/Vehicle	SWAT (SET) Paramedic	Bike/Foot Paramedic
Portable CPAP (if used)	1	1	N/A	N/A	1	0	0	0
Large Adult CPAP Masks	2	1	N/A	N/A	1	0	0	0
Small Adult CPAP Masks	2	1	N/A	N/A	1	0	0	0
Pediatric CPAP Masks	2	1	N/A	N/A	1	0	0	0
Adult Nebulizer Masks	2	1	N/A	1	2	0/1	0	0
Pediatric Nebulizer Masks	2	1	N/A	1	2	0	0	0
Inline / Handheld Nebulizer Kit	2	1	N/A	1	1	0/0	1	0
Set of Cuffed ET Tubes w/ Stylet (5.5, 6, 6.5, 7, 7.5, 8, 8.5mm)	2	1	N/A	N/A	1	0/1 (6.5-8.5only)	1	1
Laryngoscope Handle	1	1	N/A	N/A	1	0/1	1	1
Straight Laryngoscope Blade Set (Size 1, 2, 3)	1	1	N/A	N/A	1	0/1	1	1
Curved Laryngoscope Blade Set (Size 2, 3, 4)	1	1	N/A	N/A	1	0/1	1	1

Item	ALS Transporting	ALS First Responder	BLS First Responder	BLS O/S First Responder	ALS Rescue Helicopter	Fireline Paramedic Kit Line/Vehicle	SWAT (SET) Paramedic	Bike/Foot Paramedic
AirQ or other Santa Barbara County EMS Agency Approved Supraglotic Airway Device (Large and Small)	1	1	N/A	N/A	1	0/1	1	1
Adult ET Tube Holder	2	1	N/A	N/A	2	0/2	1	1
Bulb Style ET Tube Confirmation Device	2	1	N/A	N/A	1	0/1	1	1
Needle Thoracostomy Kit	1	1	N/A	N/A	1	1/1	1	1
Adult Magill Forceps	1	1	N/A	N/A	1	1	1	1
Pediatric Magill Forceps	1	1	N/A	N/A	1	0	0	1
Suction Catheter Set (6F, 8F, 10F, 14F)	1	1	N/A	N/A	1	0/1	0	0
Portable Powered Suction Unit	1	0	0	0	1	0	0	0
Suction Canister and Tubing w/ Tonsil Tip	2	2	1	1	2	0	0	0
Portable Manual Suction (if portable powered suction not carried)	N/A	1	1	1	N/A	0	0	0
Cardiac Monitor, AED, and Assessment Equipment								
Cardiac Monitor w/ SpO2 and End Tidal CO2 Capability	1	1	N/A	N/A	1	0	0	0
Adult SpO2 Cable	1	1	0	1	1	0	0	0

Item	ALS Transporting	ALS First Responder	BLS First Responder	BLS O/S First Responder	ALS Rescue Helicopter	Fireline Paramedic Kit Line/Vehicle	SWAT (SET) Paramedic	Bike/Foot Paramedic
Pediatric SpO2 Cable	1	1	0	1	1	0	0	0
End Tidal CO2 ET Tube Set	2	2	N/A	N/A	2	0	0	0
End Tidal CO2 Cannula Set	2	2	N/A	N/A	2	0	0	0
SpO2 Monitor (if not integrated w/ cardiac monitor)	N/A	N/A	0	1	N/A	1	1	1
Automatic External Defibrillator	N/A	N/A	1	1	N/A	1	1	1
Adult ECG Electrodes	10	4	N/A	N/A	4	2/4	0	0
Pediatric ECG Electrodes	10	2	N/A	N/A	2	0	0	0
Adult Defibrillator Pad Set	2	2	2	2	2	2/1	2	2
Pediatric Defibrillator Pad Set	2	2	2	2	2	0	0	2
Razors For Chest Hair Removal	2	2	2	2	2	1/2	1	1
Glucometer w/ 5 Strips and Lancets	1	1	1	1	1	1	1	1
Large Adult Blood Pressure Cuff	1	1	1	1	1	1	1	1

Item	ALS Transporting	ALS First Responder	BLS First Responder	BLS O/S First Responder	ALS Rescue Helicopter	Fireline Paramedic Kit Line/Vehicle	SWAT (SET) Paramedic	Bike/Foot Paramedic
Regular Adult Blood Pressure Cuff	1	1	1	1	1	1	1	1
Pediatric Blood Pressure Cuff	1	1	1	1	1	1	0	1
Stethoscope with adult and pediatric capability	1	1	1	1	1	1	1	1
Pediatric Color Length Based Tape	1	1	0	1	1	0	0	1
IV, IO, IM, and Nasal Access								
EZ-IO® Device	1	1	N/A	N/A	1	1	1	1
Adult IO Needles	2	2	N/A	N/A	2	1/1	1	1
Pediatric IO Needles	2	2	N/A	N/A	2	0	0	1
Safety Angiocatheter Set (18, 20, 22, and 24 ga)	2 ea.	2 ea.	N/A	N/A	2 ea.	2/2 ea.	2 ea.	2 ea.
Pressure Infusion Bag/Cuff	1	0	N/A	N/A	0	0/0	0	0
Luer Lock Saline Locks	8	2	N/A	N/A	4	3/5	2	2
Luer Lock Macro Drip IV Administration Sets	6	2	N/A	N/A	2	3/5	2	2

Item	ALS Transporting	ALS First Responder	BLS First Responder	BLS O/S First Responder	ALS Rescue Helicopter	Fireline Paramedic Kit Line/Vehicle	SWAT (SET) Paramedic	Bike/Foot Paramedic
Luer Lock Micro Drip IV Administration Sets	2	2	N/A	N/A	2	0	0	0
Adult IM Needles w/ Safety Mechanism	8	4	N/A	4	4	2/5	2	2
Pediatric IM Needles w/ Safety Mechanism	8	4	N/A	4	4	0	2	2
Syringes (1, 3, 5 and 10 ml)	4 ea	2 ea	N/A	2 (1ml only)	4 ea	2 ea/2 ea	2 ea	2 ea
Syringes 20 ml	2	1	N/A	N/A	2	1/1	1	1
Safety Vial Acess Spike or Device	8	4	N/A	N/A	4	5	2	2
Mucosal Atomization Device	2	2	2 (optional)	2 (optional)	2	2	2	2
Medications								
Normal Saline	6 L	2 L	N/A	N/A	2 L	2 L/5 L	1 L	1 L
Normal Saline, 100 ml	2	1	N/A	N/A	2	1/1	1	1
Normal Saline, 10ml Pre-Load Flushes	6	4	n/A	N/A	4	3/5	2	2
Activated Charcoal, 50gm	2	0	N/A	N/A	1	0/1	0	1
Adenosine, 6mg	1	1	N/A	N/A	1	1	0	1

Item	ALS Transporting	ALS First Responder	BLS First Responder	BLS O/S First Responder	ALS Rescue Helicopter	Fireline Paramedic Kit Line/Vehicle	SWAT (SET) Paramedic	Bike/Foot Paramedic
Adenosine, 12mg	2	2	N/A	N/A	2	2	0	2
Albuterol, 2.5mg	10	6	N/A	4	8	Metered Dose Inhaler	Metered Dose Inhaler	Metered Dose Inhaler
Amiodarone, 150mg	2	1	N/A	N/A	1	1	0	0
Amiodarone, 300mg	2	1	N/A	N/A	1	1	0	0
Aspirin, Chewable	729 mg	324 mg	N/A	N/A	324 mg	324mg/729mg	324 mg	324 mg
Atropine, 1mg	4	2	N/A	N/A	2	1/1	1	1
Calcium Chloride, 1gm	1	1	N/A	N/A	1	1	0	0
D10W, 250ml	2	2	N/A	N/A	2	1/1	1	1
Diphenhydramine, 50mg	2	2	N/A	N/A	2	2	2	2
Epinepherine, 1mg/1ml	3	2	N/A	2	3	3	2	2
Epinepherine, 1mg/10ml	6	4	N/A	N/A	4	2/2	2	2
Epinephrine Auto-injector (adult and pediatric)	N/A	N/A	1 ea	N/A	N/A	0	0	0

Item	ALS Transporting	ALS First Responder	BLS First Responder	BLS O/S First Responder	ALS Rescue Helicopter	Fireline Paramedic Kit Line/Vehicle	SWAT (SET) Paramedic	Bike/Foot Paramedic
Fentanyl	200mcg	100mcg	N/A	N/A	200mcg	100mcg/200mcg	100mcg	100mcg
Glucagon, 1mg	1	1	N/A	1	1	1	1	1
Ketamine	200mg	200mg	N/A	N/A	200mg	200mg	200mg	200mg
Magnesium Sulfate, 2gm	2	0	N/A	N/A	1	0	0	0
Midazolam	10 mg	10 mg	N/A	N/A	10 mg	10 mg	10mg	10mg
Naloxone, 2mg	4	N/A	N/A	N/A	2	1/1	2	2
Naloxone, 4mg (IN preload for BLS only)	N/A	2	2	2	2	1/1	2	2
Nitroglycerine Spray or SL, .4mg/dose	1	1	N/A	1	1	1	1	1
Ondansetron (IV/ODT)	8mg/8mg	4mg/4mg	N/A	N/A	8mg/8mg	8mg/8mg (IV optional)	4mg/4mg	4mg/4mg
Sodium Bicarbonate, 50meq	2	2	N/A	N/A	2	1/1	0	0
Tranexamic Acid (TXA), 1gm	2	1	N/A	N/A	1	1	1	1
Double Lock Box for Narcotics, or Mounted Single Locked Safe	1	1	N/A	N/A	1	1	1	1
Trauma, Burns and Bleeding Control								
8"x 10" Abdominal Pad	4	2	2	2	2	1/1	1	1

Item	ALS Transporting	ALS First Responder	BLS First Responder	BLS O/S First Responder	ALS Rescue Helicopter	Fireline Paramedic Kit Line/Vehicle	SWAT (SET) Paramedic	Bike/Foot Paramedic
5"x 9" Abdominal Pad	4	2	2	2	2	1/1	1	1
4"x 4" Gauze	20	8	8	8	8	8/8	8	8
12"x 30" (Trauma Dressing)	4	2	2	2	2	1	1	1
Gauze Rolls (assorted sizes)	10	6	6	6	6	2/4	2	2
Band-Aid type bandages	10	6	6	6	6	10	6	6
Triangular Bandages	4	2	2	2	2	1/1	2	2
LEMSA Approved Tourniquet	1	1	1	1	1	1/1	1	1
LEMSA Approved Hemostatic Dressing (optional): a. Quick Clot®, Combat Gauze® LE b. Quick Clot®, EMS Rolled Gauze, 4x4 Dressing, TraumaPad®	1	1	1	1	1	1	1	1
Large Burn Sheets/Dressing	2	2	2	2	2	1/1	0	0
Medium Burn Sheets/Dressing	2	2	2	2	2	1	0	0
Small Burn Sheets/Dressing	2	2	2	2	2	1	0	0
Back Board	2	1	1	1	1	0/1	0	0
Pediatric Back Board	1	1	0	1	1	0	0	0
Seated Extrication Device (KED)	1	1	0	1	0	0	0	0

Item	ALS Transporting	ALS First Responder	BLS First Responder	BLS O/S First Responder	ALS Rescue Helicopter	Fireline Paramedic Kit Line/Vehicle	SWAT (SET) Paramedic	Bike/Foot Paramedic
Adult Cervical Collars	4	2	2	2	2	1/1	1	1
Pediatric Cervical Collars	2	2	2	2	2	0	1	1
Arm and Leg Splints	4	2	2	2	2	1/2	0	0
Traction Splint	1	0	0	0	1	0/0	0	0
Trauma Shears	2	1	1	1	2	1/1	1	1
Miscellaneous BLS Supplies								
Sterile OB Kit	1	1	1	1	1	0	0	1
Ice Pack	2	2	2	2	2	3/3	2	2
Hot Pack	2	2	0	0	2	0	0	0
2" Cloth Tape	2	2	2	2	2	1/1	1	1
1" Clear Medical Tape	2	2	2	2	2	1	1	1
Oral Glucose	4	2	2	2	2	2	2	2
Miscellaneous Equipment								
UHF Hospital Capable Radio or Cell Phone	1	1	1	1	1	1	1	1

Santa Clara County Board Letter

County of Santa Clara
Emergency Medical Services System

Emergency Medical Services Agency
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San Jose, CA 95128
408.794.0600 voice | emsagency.sccgov.org
www.facebook.com/SantaClaraCountyEMS

To: Health and Hospital Committee

From: Jackie Lowther RN, Director Emergency Medical Services

Subject: Emergency Medical Services Department Monthly Update

Date: October 12, 2022

Through this memo, the Emergency Medical Services (EMS) Agency provides its monthly update to the Health and Hospital Committee (HHC).

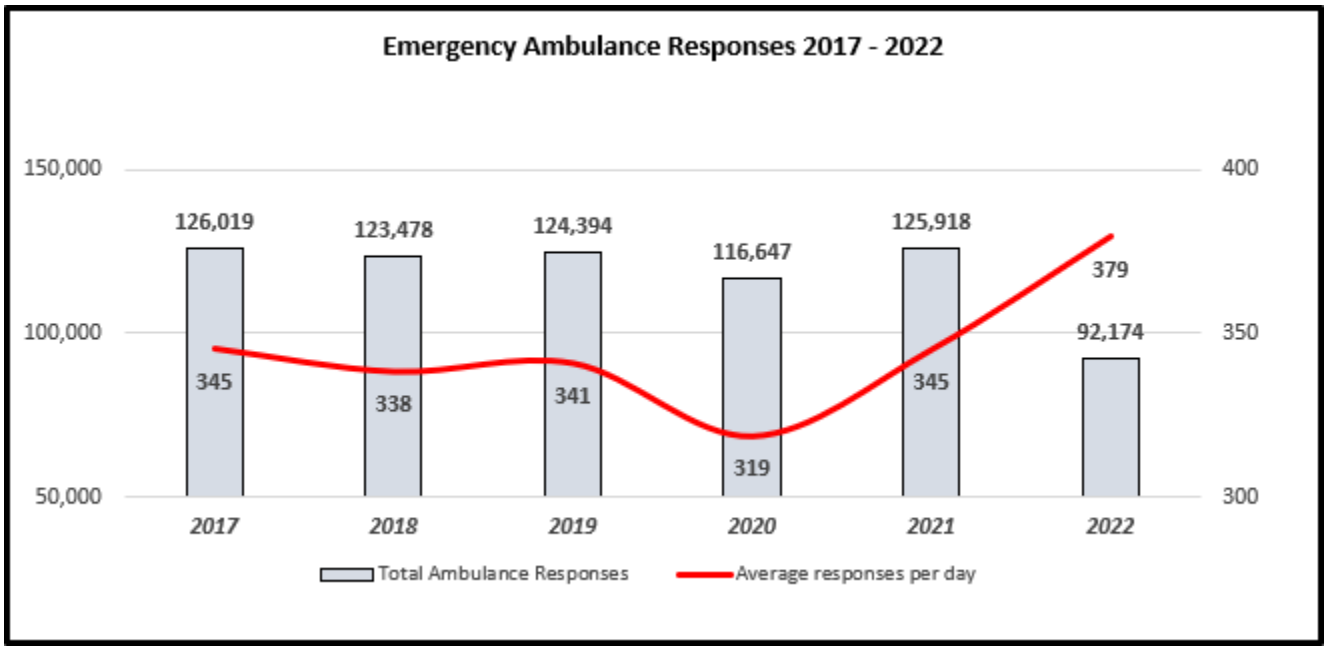
CONTRACT AMBULANCE PERFORMANCE

The County's ambulance provider shall meet the response times to ambulance calls as described in the current agreement with the County. Rural Metro/AMR has had multiple challenges meeting their contract obligations, intermittently, since January 2022. The EMS Agency has notified Rural Metro/AMR and requested a plan of correction for their lack of consistent deployment. Currently, there is a national shortage of paramedics and emergency medical technicians (EMTs). Santa Clara County has seen an unprecedented increase in volume exacerbated by an increase in workforce leave due to illness. Rural Metro has submitted plans to utilize supplemental staffing, aggressive recruiting, scholarships, sign on bonuses, and utilization of private and fire resources to purchase unit hours. Several of these plans are long term solutions, and EMS is working collaboratively with Rural Metro/AMR to come up with solutions that will create immediate results. Rural Metro/AMR is discussing solutions with their labor unions about varying solutions on staffing plans. Compliance is achieved when ninety percent (90.00%) or more of responses in each priority (code of response) and in each zone meet the specified response time requirements. The chart below provides the Code 3 Response time compliance percentages, from March 2022 through August 2022.

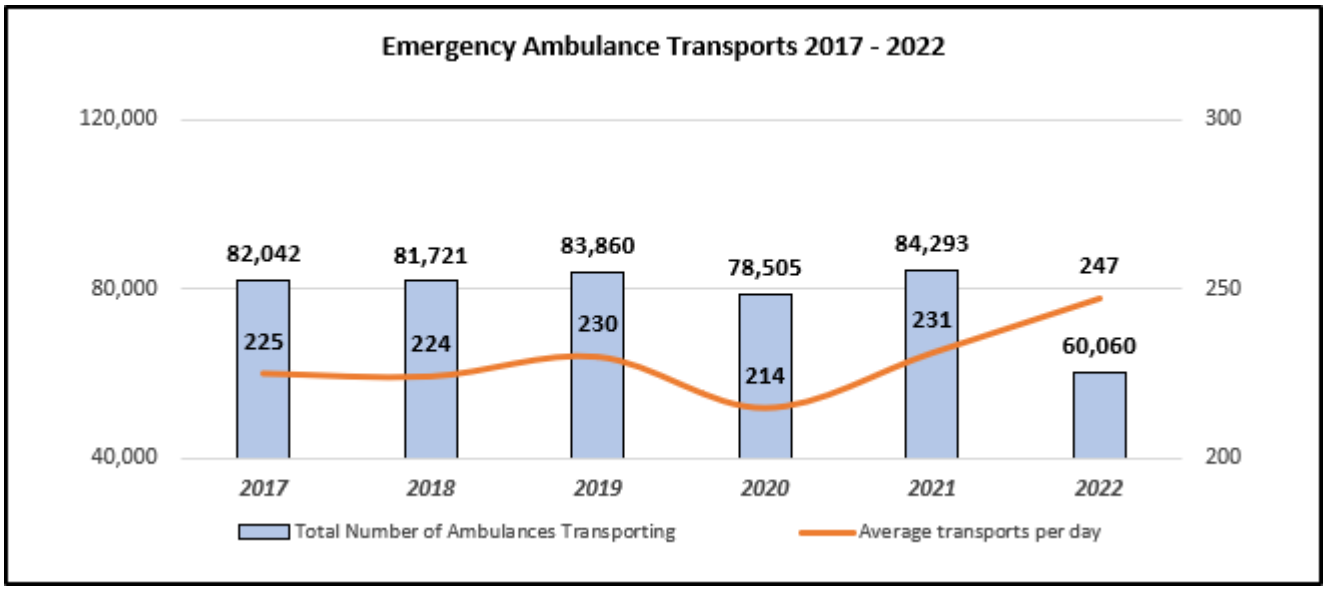
Emergency Ambulance CODE 3 Performance	*Mar 22*	*Apr 22*	*May 22*	*Jun 22*	*Jul 22*	*Aug 22*
Overall	91.16%	91.42%	89.94%	88.19%	89.72%	88.99%
Zone 1	90.29%	90.11%	88.82%	86.01%	87.44%	86.44%
Zone 2	91.31%	91.00%	90.07%	88.37%	89.83%	88.84%
Zone 3	91.96%	91.82%	89.76%	88.92%	89.68%	89.94%
Zone 4	90.60%	92.20%	90.26%	88.14%	91.20%	89.06%
Zone 5	91.49%	90.17%	91.46%	89.82%	88.85%	91.02%

*August performance review and reconciliation processes have not been completed.

The chart below displays year-to-year comparisons of the County's ambulance responses, including average responses per day.



The chart below represents a year-to-year comparison of the total number of county ambulances transporting and the average transports per day.



FIRST RESPONDER COMPLIANCE

Compliance is measured by several key performance indicators that include response time requirements based on population density; designated response areas; type of response priority (RLS: red lights & siren or non-RLS: non-red lights & siren); total number of responses; total number of late responses; and total number of responses exempted (removed) from compliance calculations. Compliance is achieved when ninety (90.00) percent or more of the responses meet the specified response time requirement in each response priority within each designated response area. The chart below provides the requested on-time response by zone by month for the period March 2022 through August 2022.

First Responder CODE 3 Performance	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22
Gilroy, City of	95.69%	96.72%	96.34%	93.14%	94.63%	95.50%
Milpitas, City of	95.78%	93.33%	95.31%	94.85%	96.17%	96.21%
Morgan Hill, City of	99.08%	98.62%	96.96%	99.21%	97.64%	96.03%
Mountain View, City of	97.13%	98.68%	98.38%	97.51%	96.44%	97.59%
San Jose, City of	92.26%	92.47%	91.34%	90.76%	90.77%	90.62%
Santa Clara, City of	98.93%	99.47%	99.74%	98.60%	97.20%	98.32%
Santa Clara County Central FPD	97.11%	95.73%	94.92%	96.52%	97.98%	96.27%
South Santa Clara County FPD	94.74%	94.92%	96.36%	95.37%	97.08%	97.09%
Sunnyvale, City of	94.52%	95.12%	95.20%	94.39%	95.82%	93.31%

AMBULANCE PATIENT OFFLOAD UPDATE

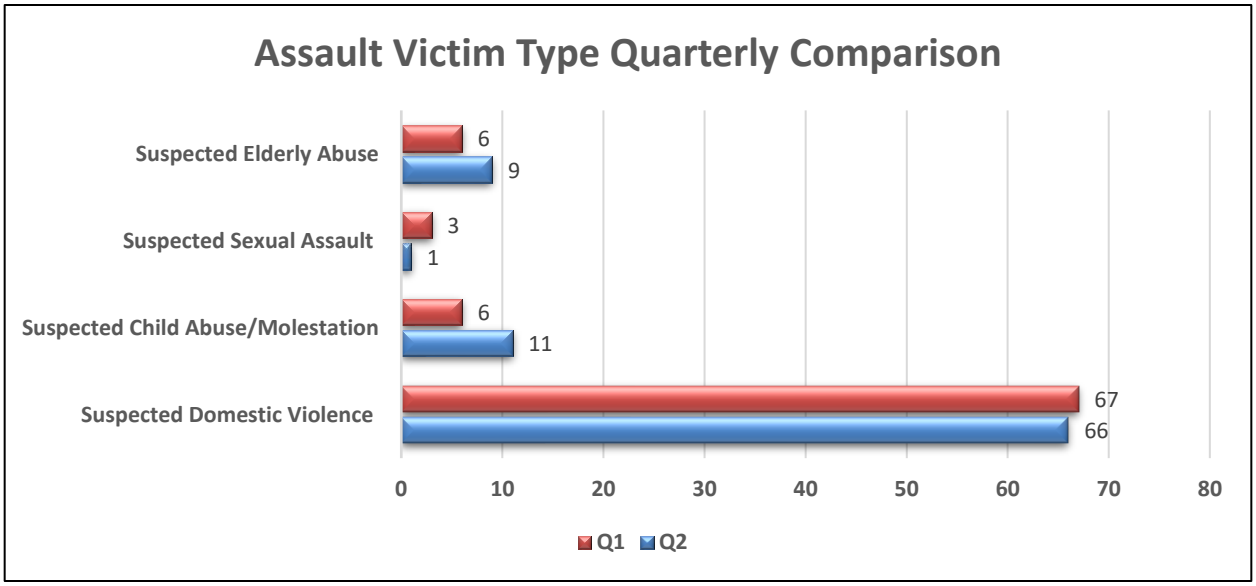
Patient offload update was provided for the September 21 HHC meeting, however, updated data is not available at the time of this report.

ABUSE AND NEGLECT

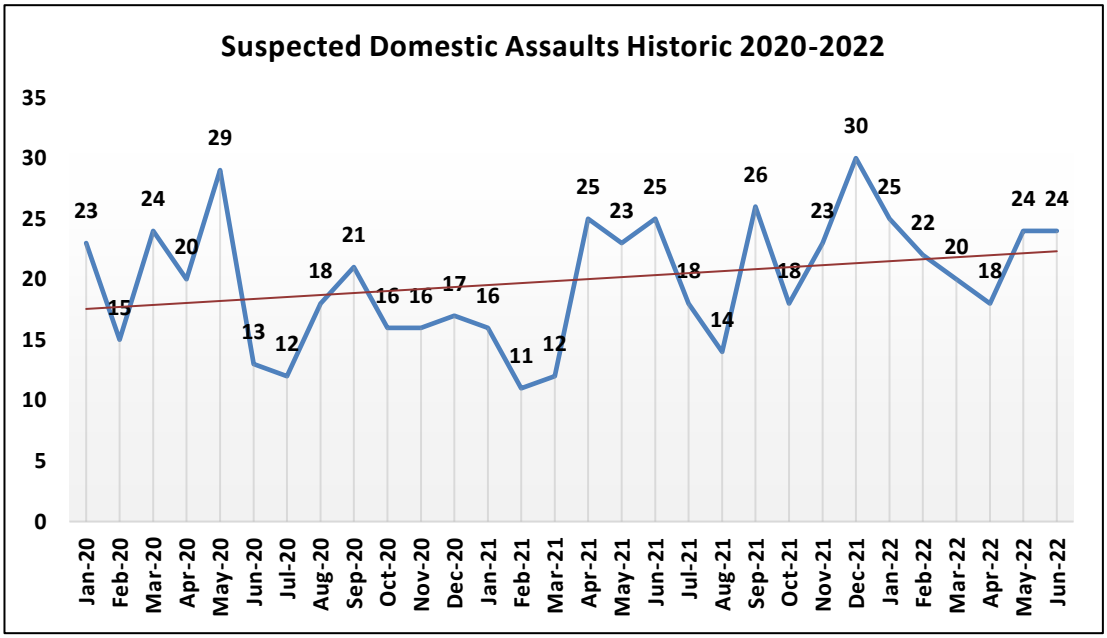
During the June 4, 2019, Board of Supervisors meeting, Supervisor Chavez requested that the EMS Agency provide a report relating to Sexual Assault Response Team (SART) protocols, a sexual assault tracking mechanism for emergency medical services responders, SART training timelines for all first responders countywide, and updates regarding communication between the SART and EMS. In addition to SART, the EMS Agency also wanted to focus on all mandatory reportable events required by first responders. Training was presented on October 1, 2019 to all 911 and non-911 responder Program Managers, who in turn were responsible for training all system providers by December 31, 2019.

The documentation module was implemented January 1, 2020. Each patient is assessed for signs and symptoms of abuse. The providers collect necessary data regarding suspected patient abuse, neglect, or domestic violence. The data is linked to values of "Cause of Injury" accidental Injury "hit, struck, other" by another person, asphyxiation – mechanical suffocation, injury from blunt object (assault), stabbing/cut/laceration (assault), firearm injury, maltreatment/abuse, and sexual abuse. The EMS Agency began to receive data in February 2020 and was able to present the first report to HHC in April of 2020. This report evaluates the overall data in Santa Clara County for the second quarter of 2022, as well as the data collected in 2020 and 2021, and further analysis will continue regarding any patterns and trends throughout the county.

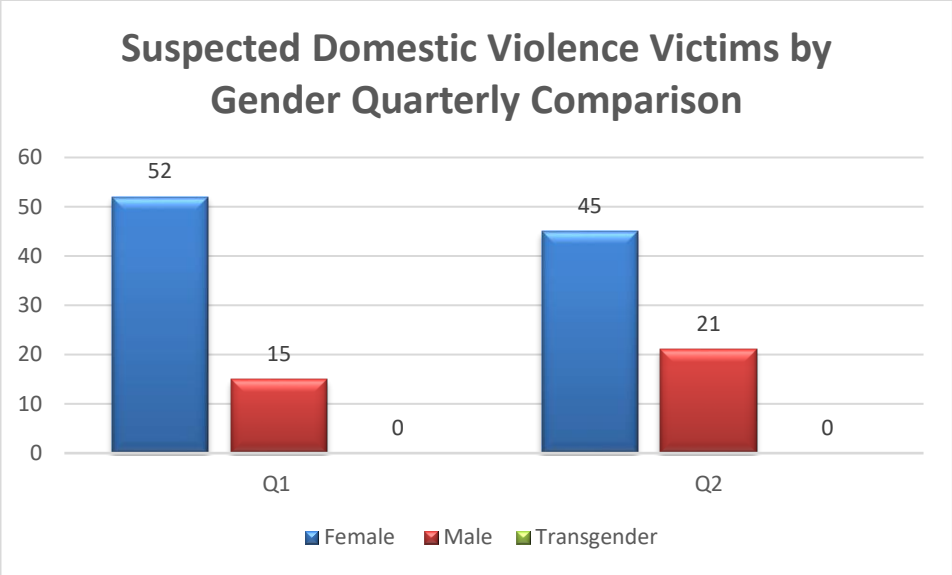
In addition, the Santa Clara County EMS Agency finalized the Assault/Abuse/ Domestic Violence protocol which are posted on our website, Policy #510. These guidelines provide standards for identification of suspected abuse and the requirements for prehospital personnel when incidents of child, elder or dependent adult, or domestic violence is reported or reasonably suspected. All medics have been trained on these requirements, and this policy includes parameters and resources for all field personnel.



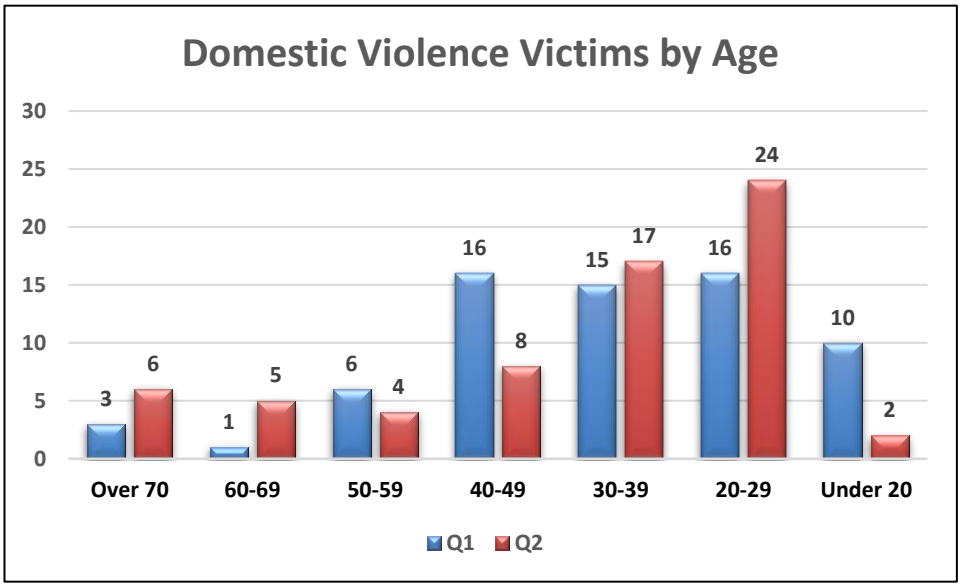
In the above graph, Quarter 2 (Q2) of 2022 showed relatively the same number of suspected domestic violence cases that were recorded in Q1. There was an 83.3% or five (5) cases increase in suspected child abuse/molestation cases from Q1. Q2 had the highest occurrence of recorded cases of suspected child abuse/molestation since data collection began in 2020. In addition to suspected child abuse/molestation, suspected elderly abuse had a 50% or three (3) cases increase in recorded occurrences from Q1. Suspected sexual assault was the only category that showed a 66.66% reduction, or decline by 2 cases, over Q1.



This graph illustrates the historic suspected domestic violence cases from the start of data collection in January 2020. The overall trend in cases continued to decrease until Q2 (2020) with a sharp resurgence of suspected domestic violence cases, followed by a downward trend in Q3 2020 through Q1 2021. Since Q2 2021, the trendline has showed a steady increased trajectory.



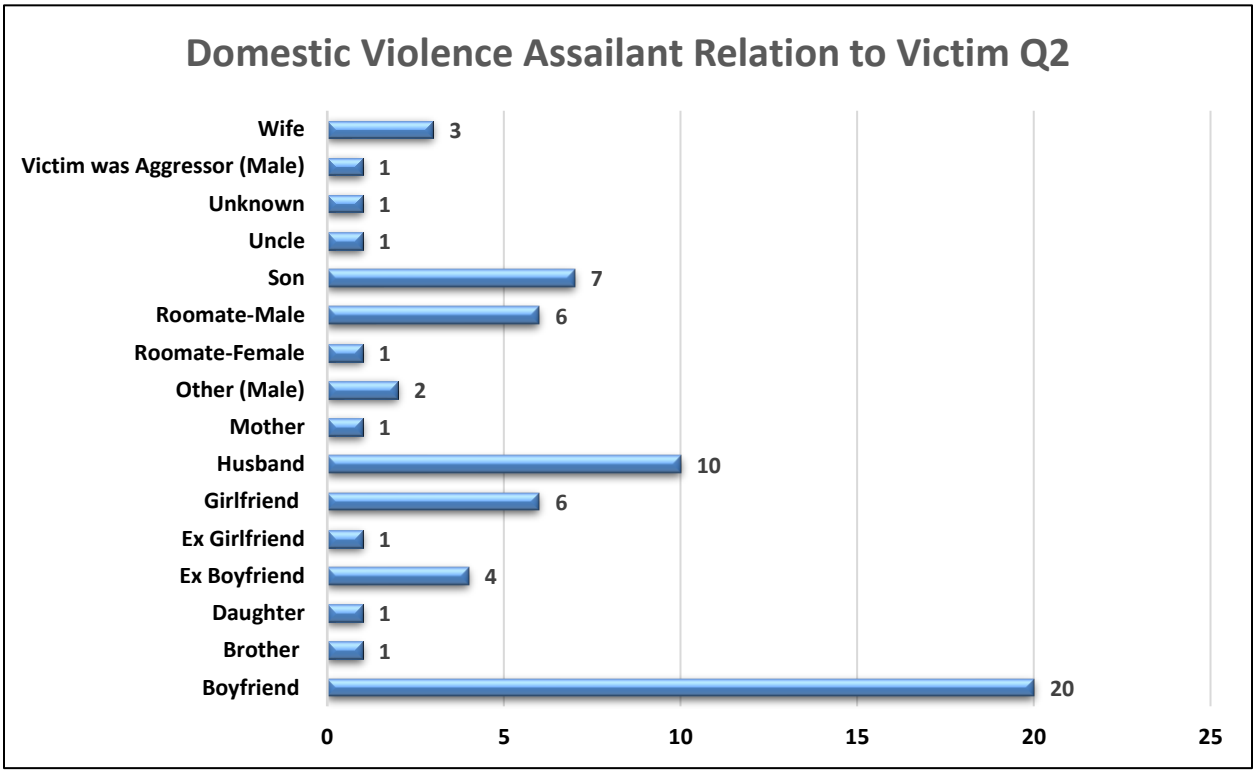
Q2 was the first quarter where the male victim population was over 30% (31.8%). Women, however, continue to be the predominate victim gender at 68%. There were no occurrences of transgender victims.



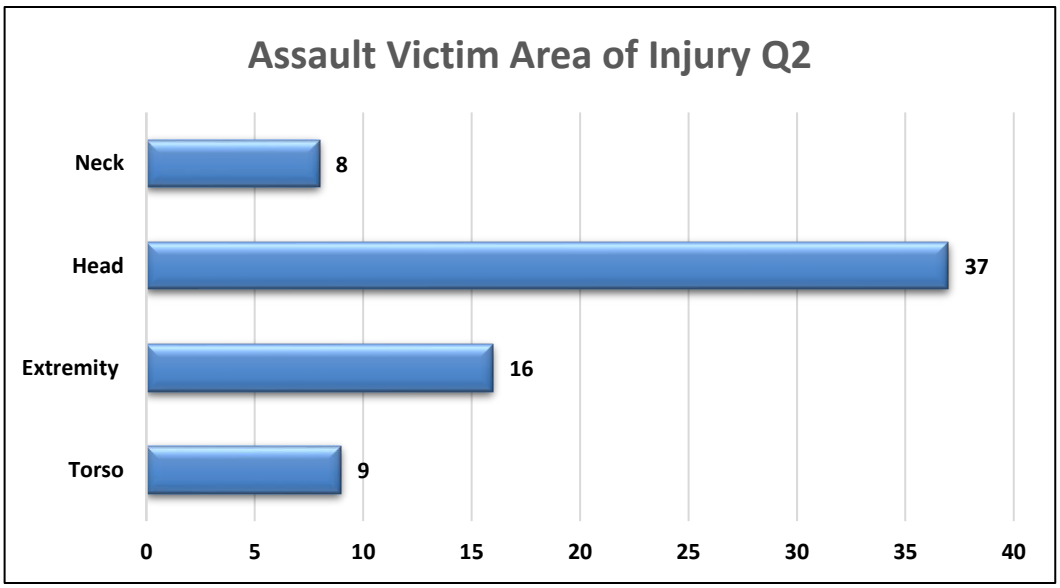
The graph above illustrates the suspected domestic violence victims by age group. Through Q2, the most at-risk age groups are 20-29 (40 cases) and 30-39 (32 cases). When comparing domestic violence cases between all age groups, we generally see a reduction comparing the age groupings in sequential order:

- During Q2, this trend did not hold true with the over 70 demographic recording 1 case more than the 60-69 demographic. The 70 and over showed a 50% increase from the 60-69 demographic.

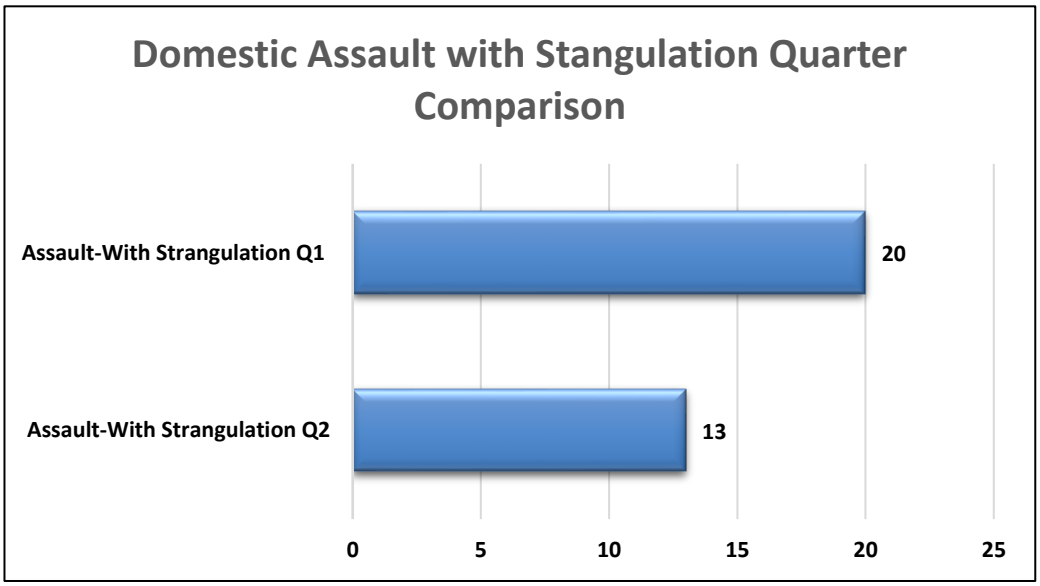
- The 30-39 demographic showed a 20% case reduction when compared to the 20-29 demographic.
- The 40-49 demographic showed a 25% reduction in cases when compared to the 30-39 demographic.
- The 50-59 demographic showed a 58.33% reduction from the 40-49 demographic.
- The 60-69 demographic showed a 40% reduction from the 50-59 demographic.



The assailant gender for Q2 continues to be predominately male, with the most frequent suspected abuser being a Boyfriend (20) or Husband (10). This has continued throughout the period of data collection.

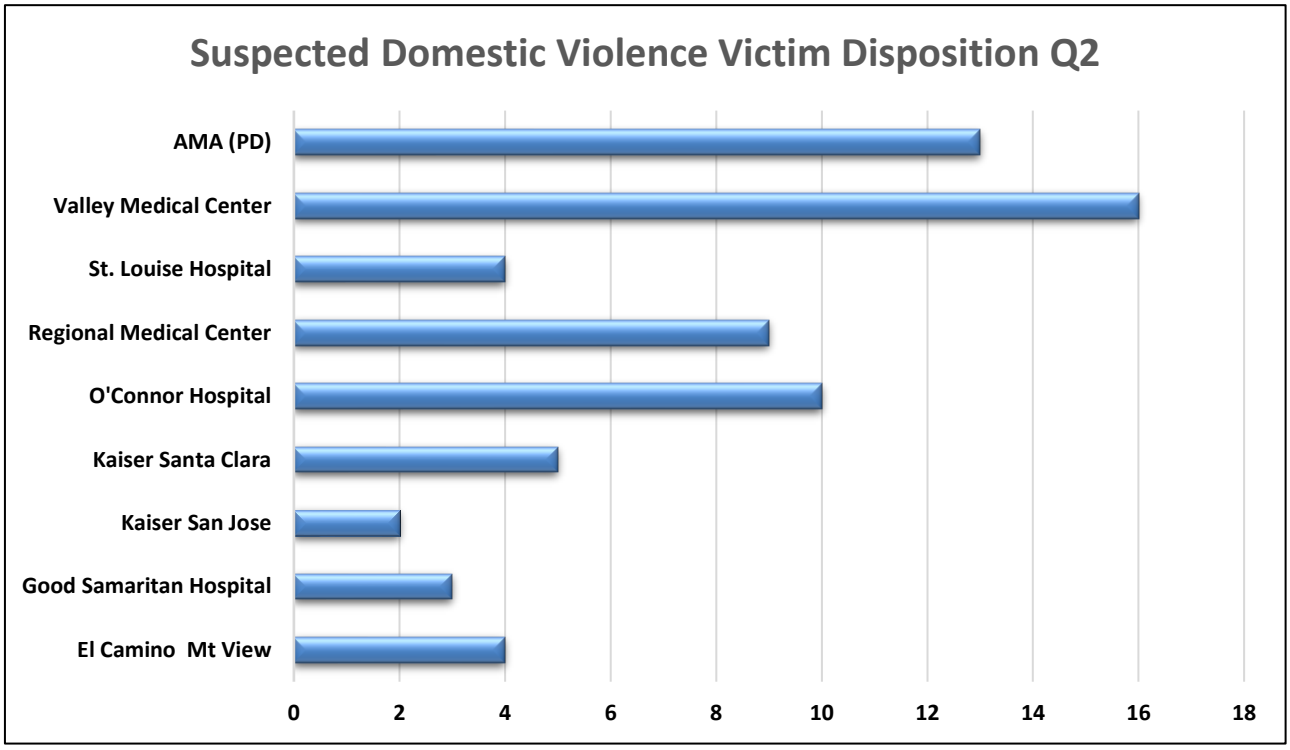


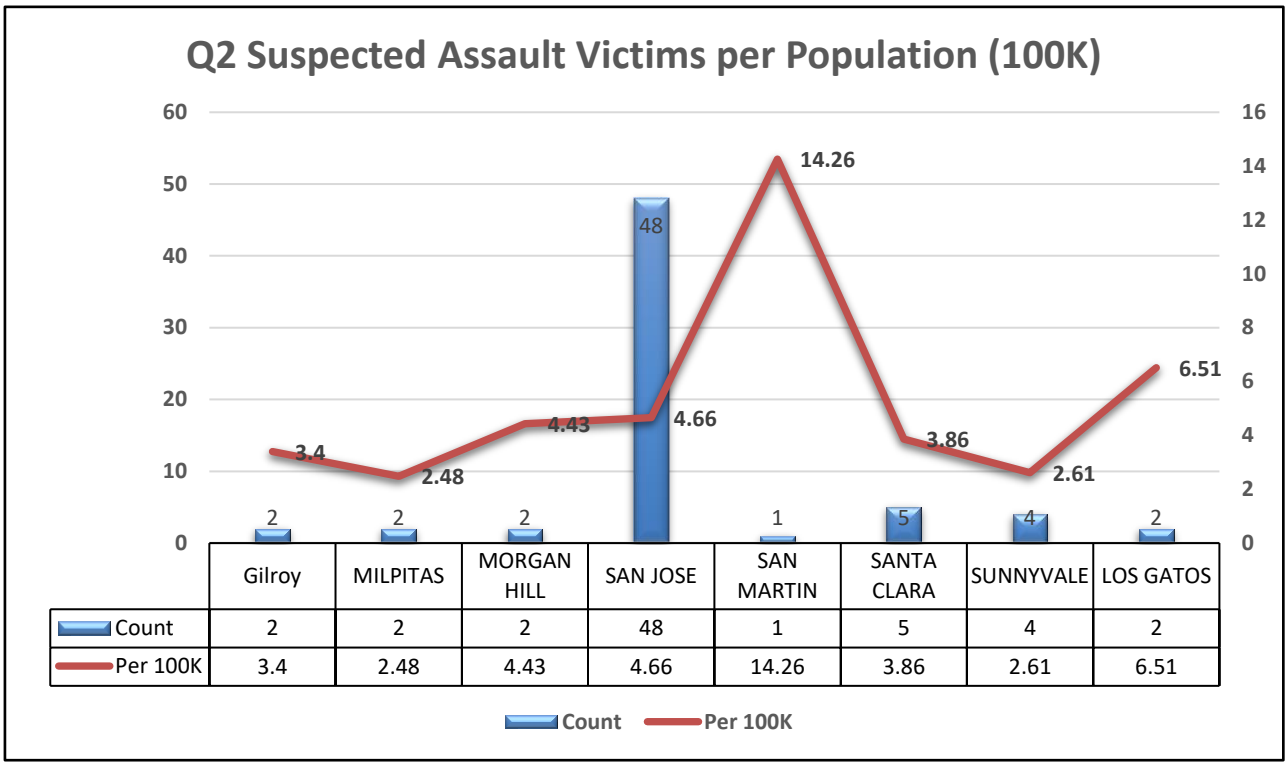
The graph above denotes the total areas of injury from all assault victims for Q2. Please note this total will not match up with the number of victims since the victim may be injured in multiple locations.



This graph illustrates the number of domestic assaults with strangulation for 2022. Q2 saw a 35% reduction from Q1. The average age of these victims was 29 years old. The youngest victim was age 20 while the oldest victim was 58 years of age. Furthermore, 11 out of the 13 victims were female with 2 victims being male. In 10 cases, the suspect assailant relation to the victims were male while 3 were female. This was the first time EMS recorded a female suspect(s).

The below graph illustrates each suspected domestic violence victim's disposition from Q2. Against Medical Advice (AMA) with the presence of law enforcement has consistently been the most frequent disposition over the three (3) years of data collection until Q2 when Valley Medical Center received most of the transported victims followed by O'Connor Hospital.





	Gilroy	MILPITAS	MORGAN HILL	SAN JOSE	SAN MARTIN	SANTA CLARA	SUNNYVALE	LOS GATOS
Count	2	2	2	48	1	5	4	2
Per 100K	3.4	2.48	4.43	4.66	14.26	3.86	2.61	6.51

The above graph illustrates the physical count of suspected domestic violence events that Emergency Medical Services responded to and the incident rate per hundred thousand (100k) population. This adjustment better depicts the impact on the community rather than the physical count, in which the City of San Jose would be at a statistical disadvantage due to gross population. With the incident rate adjustment, San Martin had the most domestic violence responses per 100k. San Jose had the most physical responses at 48.

Mathematical Work Reference:

Population Adjustment:

$$PA = \frac{E}{P} \times 100{,}000$$

E= Events
P= Population

Percentage Change:

$$\frac{(V2 - V1)}{V1} \times 100 = PC$$

STROKE UPDATE

Stroke Center Intravenous Thrombolysis Administration

The Santa Clara County Emergency Medical Services system triages patients with stroke-like symptoms to the 10 EMS Agency-designated stoke centers within the County. Of those 10 hospitals, 4 have endovascular intervention capability. Although those 4 stroke centers have the capability of mechanical clot removal from larger cerebral blood vessels, all 10 stoke centers have the capability to medically treat stroke with intravenous drugs that can disrupt clots in cerebral blood vessels. Intravenous thrombolysis remains the primary intervention in stroke patients whether or not an endovascular intervention will follow.

There are multiple contraindications to intravenous thrombolysis in patients with a diagnosed ischemic stroke. The major contraindications are strokes associated with bleeding into the brain, or if the onset of stroke symptoms was more than four and one-half hours before the drug can be started. Thrombolytics administered beyond 4.5 hours since symptom onset have an increased risk of subsequent bleeding into the brain. There are other contraindications like sustained high blood pressure and preexisting prolonged blood clotting, as well as very low or very high stroke acuity assessment scores and pre-stroke disability. Still others include recent surgery, previous bleeding into the brain or bleeding into the gastrointestinal tract. In addition to stroke associated with bleeding, intravenous thrombolysis would not be indicated in patients with brief resolving stroke symptoms.
In patients with an acute stroke and without contraindications, the administration of intravenous thrombolytics is time-sensitive. The current American Heart Association/American Stroke Association guideline is initiation of an intravenous thrombolytic within 60 minutes of patient arrival at a stroke center. Systemwide stroke center data shows inter-hospital variability in both the proportion of patients who receive intravenous thrombolysis and the timeframe for that administration. The proportion of stroke patients who receive intravenous thrombolysis ranges between 38-41% at comprehensive stroke centers and 25-46% at primary stroke centers. These patients represent stroke patients without a brain bleed and who present within 4.5 hours of stroke symptom onset but patients not receiving the treatment could have had a variety of other contraindications or refused the treatment. The peer-reviewed medical literature reports a wide range for the proportion of eligible ischemic stroke patients going on to receive intravenous thrombolytics. Forty percent or more seems to be consistent with much of that literature while 20% or so is lower than typically reported.

There is also inter-hospital variability in administering intravenous thrombolytics within the national guideline of 60 minutes. Across all 10 stroke centers, the percent of eligible stroke patients receiving intravenous thrombolysis within 60 minutes of arrival at the hospital ranges from 61% to 97%.

Stroke Center Staffing

In 2022, there have been periods of increased stroke center 911 ambulance diversion due to gaps in staffing of interventional laboratories where endovascular treatments are performed to remove clots for larger cerebral blood vessels. Those staffing gaps occurred at two geographically close stroke centers creating the possibility of having to transport higher acuity patients with stroke-like symptoms in the 911 EMS system longer distances to the next available endovascular intervention-capable stroke center. That increased 911 ambulance transport time would reduce time available for the initial treatment of

intravenous thrombolysis. To prevent delays in thrombolysis, the EMS Agency enacted a policy placing a 30-minute maximum on estimated 911 ambulance transport time. If the closest endovascular stroke center is on 911 ambulance diversion and the next closest is more than 30 minutes away, that patient would be transported to the closest stroke center for evaluation, diagnosis and, if appropriate, intravenous thrombolysis. If it is determined that an endovascular procedure is also indicated, then a secondary transfer to an endovascular stroke center can occur expeditiously through 911. That strategy and transport timeframe are consistent with the recommendations of the American Heart Association/American Stroke Association.

Santa Clara County Meeting Transcripts

Health and Hospital Committee
Regular Meeting
Oct 12, 2022 2:00 PM

2:03 PM Test for the health and hospital committee October 12, 2022. Please stand by.

My a poll geez for a moment or two of technical difficulties so let's get right to it and call the meeting to order and i'll turn to the clerk for that duty.

Vice chairperson lee

2:04 PM Present.

And chairperson simitian? vice chairperson submit le vice chairperson submitsimitian.

Present. we have a quorum and ready to go. Thank you, madam clerk. That takes us to item number 2 which is public comment. That's that portion set aside for comment by members of the public on non agendized items. Once again that's comment on items not on today's agenda but within the jurisdiction of our committee. Let me ask if we have anyone who is in the queue.

We have one respect to speak.

Under the raoltz of our board we give that person up toules of o we give that person up to 3 minutes.

2:05 PM Jan you'll have 3 minutes to speak and the timer will start when you begin speaking.

If good afternoon, this is Dr. Ken hor oh wes of our health and advisory commission. I want o give you a heads up in a couple of months our health advisory commission will bring forward a report and hopefully a referral to the full board of supervisors regarding chronic disease. Our health advisory commission has been working n this project for almost two years now and we met with a number of county leaders as well as health aeuz of both supervisor simitian and lee. And we're hopeful that we can begin to start making an impact on chronic disease in our county. Which as you well know is a major driver of spending. So we have been meeting and we will be giving you a report on December 8th regarding integrative functional medicine, which we hope to build a culture within the county health system. We have looked at the models existing which we think would align with our proposal to you. In addition, we think we can get reimbursement for our pilot program through the new calaim program that's been adopted by the state of california. So this is just a heads up to look forward in the next 5 months that we will be reporting to the health and hospital committee, and we're hopeful that you will see it as a positive report, and we can make pra progress toward improving healthcare in our county. Thank you for your time and have a great meeting.

2:07 PM That concludes our request to speak.

Thank you madam clerk and Dr. Horowitz and takes us to item number 3 which is our consent calendar and changes if any. Supervisor lee, a motion to approve the consent calendar as contained in our published agenda along with items 11 and 12, if you are amenable, would be gratefully entertained and if I can get a motion i'll second it and speak briefly to it and then we'll see if there is any public comment.

2:08 PM Yes, motion so moved.

Motion by lee and seconded by simitian. And that is for approval of our consent calendars contained in our published agenda and in addition items 11 and 12 and just an acknowledgment and reminder that items on the consent calendar are often very important items but they're simply placed there because additional comment or question is not needed at this particular time in this particular venue. Let's see if e have any comment from members of the public. Do we have anybody in the cue?

No requests to speak.

Let's call the roll on the consent calendar as amended.

Vice chairperson lee.

Aye.

2:09 PM And chairperson simitian.

Aye. approved. Takes us to item 4 which is recommendations relating to the smell medical staff and the allied health professionals at our 3 hospitals haven't as you can see from our agenda, we have under item 43 different call for actions. The aapartments and reappointments and privileges of various specified medical staff and allied health officials and approval of radiology

privileges and enterprise wide psychiatric privileges. I think we have a presentation from the doctor. Forgive me I have once again -- there we are. I'm back. Dr. Morrison, anything to say by way of introduction?

Yes. i'm the enterprise doctor of the medical staff. I'm here to answer any questions. One clarification I want to make regarding the privilege sets is that the psychiatry privilege it set is bmc only. We do not submit enterprise privilege set for psychiatry.

2:10 PM Thank for that clarification. let me see if I can get motion to approve from supervisor lee.

Yes, so moved.

I'll second. let me ask the clerk if we have any comment from members of the public on item 4.

No requests, Mr. Chair.

All right. then we'll call the roll and send Dr. Morrison back to his duties, if we may.

Vice chairperson lee.

Aye.

Chairperson simitian.

Aye.

Thank ou. the motion carries.

Thank you. motion carries unanimously. Thank you, Dr. Morrison and supervisor lee and takes us to item number 5 which is a report on the child and adolescent psychiatric facility. Let me turn to our county staff and ask who I would like to present.

2:11 PM This is jeff draper and i'll be doing the presentation.

Go right ahead.

Ur demo and excav vagus of the site is on schedule. In the last couple of day we had late breaking underground utility concerns that have impinged on the project and some things that we need to find a solution for. So we're working through trying to can come up with those solutions and recovery schedule to keep us on time. In terms of the construction project we awarded a pre construction agreement given to the county executive this last week. They've been working diligently on the work that's in that agreement which includes developing schedules and construction agreement with us. And we're going through red lines and all this other kind of stuff on the various documents. So we'll continue that negotiation as we move forward and bring in construction agreement hrough board for consideration as early as November or possibly the 6th of December and it's their effort to make sure that they have good solid agreement that's whim be driving that schedule to some degree. That's all I have.

2:12 PM All right. that contract with web corps is coming when?

Hopefully by the middle of november. That's what we are working toward diligently. It could slip to the 6th of december. It will not affect the overall delivery of the project if you will, because we don't anticipate issuing them a notice to proceed with construction work until either late January or early february.

2:13 PM All right. thank you for that clarification. Mr. Draper, I think you know that I have submitted for our full board's consideration on October 18th a referral essentially directing administration to ensure that the management audit division that reports directly to our board and their subcontractors have direct access to pre construction meetings to provide us with some additional oversight and assurances about moving forward on a timely basis. And I just wanted to sunshine that today. I believe the item will be heard Tuesday as I say. I know the action language was submitted on a timely basis. I don't know if the back-up information has been posted. But if not it will be shortly. And then let me turn to supervisor lee and see if he's got comments or questions before I ask the clerk if we have anyone wishing to speak on this item. Supervisor lee, you're muted, sir.

2:14 PM Here we go. thank you very much. First, jeff, I just want to thank you and the team for working hard with our administration and these different potential contractors and project forward. And also I want to say thanks so much for the update in last week's meeting on item number 9 because the report available today at the meet are modest updates so I have a couple of questions. With thought about the preliminary schedule and budget expected from the main building on October 3rd, which was last week, do you really have --

2:15 PM We have some indication of what our construction contractors is thinking but we're still in negotiations and we're willing to push as hard as we can to improve on the schedule. So we're still working the deal out.

Same question I have regarding the demolition itself. The initial demolition data was supposed to owned by end of this year and we're now xtending that to some time in February which is a couple of months. That should not effect the end date that we anticipated at this point, right?

Our intent is to issue a notice proceed by the end of January going into february. And that's what our construction contractor -- potential construction contractor is counting on in order to deliver the project. So far the work on site has been pretty clean. But as I mentioned earlier we have a couple of late breaking underground utility concerns where the mapping wasn't right so we have to work through the process in order to make ure that we can give you a recovery schedule that makes sense and provide you that date. But I talked to the construction contractor not long before the meeting and we think things are in hand at the moment and things can always change.

2:16 PM Ecav vagus, that's the thing about excavation you don't know what you'll find. So let's say there are archeological finds then that could delay it.

You're absolutely correct and hopefully we don't have that problem here.

Okay, all right. last question is, we did talk about the November 15th date by having the construction contract ready for the board approval. Is there anything we can help to make sure that happens on that date instead of december?

2:17 PM A great deal of what we are trying to get done depends on the prime contractor's relationship with their trade partners to get information put together. So that we can have that contract proposed and put together for you.

Okay. all right. very good. And that's all the questions I have.

Thank you, upervisor lee. let me ask the clerk if we have members of the public in the cue to speak to this item?

No request to speak but Mr. Smith does have his hand raised, Mr. Chair.

Dr. Smith for give me for missing that raised hand. Go ahead, sir.

Sorry. I want to expand opt question that supervisor lee asked. The board will remember that a few years ago in the process of construction of another building, we came upon coffins and burial sites that were from previous years when the hospital site was used for a cemetery. This particular site is not too far away from that. We don't think we'll find anything, but I do think it is worth emphasizing to the committee that the background and subterranean maps of the vmc site are very rudimentary. It's very common that we run into things that we didn't expect.

2:18 PM Thank you for that. i'll call it gentle cautionary note, Dr. Smith. and i'll take the opportunity to underscore my earlier comments about making sure that the folks at harvey rose and their subcontractors at veneer ave access to pre construction activity and meetings and conversations consistent with earlier discussion and with the referral that will be on our board agenda, given the concern about delays that we have all expressed. I think it is important that both the public and our board have reassurance provided by independent third party oversight organization like harvey rose/veneer. Let's call to question. Madam clerk go right ahead and I rbl we have a motion -- i'm not sure that we do. Supervisor lee, do we have a motion to move the recommended action some

2:19 PM So moved.

All right. thank you. I'll second it and let's go right ahead with the call on the roll.

Vice chairperson lee.

Aye.

This chairperson simitian.

Aye. that passes 2-0 and we'll say thank to you all concerned and that takes us to item number 6 and this is our public health report on both matters related to covid and mpox I believe. Let's go to public health and who would like to present on behalf of public health?

2:20 PM Good afternoon, chairperson simitian and supervisor lee this is Dr. Cody, public health director, i'll provide you a brief verbal update on both covid and mpox. To start with covid, our case rates and hospitalization rates are both airly stable. As you know, the covid activity sort of stayed at a plateau and has been drifting down. It does continue to drift down which is good news. But as you also know the case rates which look quite low don't really reflect the actual prevalence. For that we rely on the wastewater. But that's also slowly trending down. The big news from today is that earlier today the fda amended the emergency use authorization for both the moderna and pfizer bivalent vaccines authorizing a booster for the 5-11 year olds, and significantly, the

previous booster used in that pediatric population is no longer authorized. And subsequently the cdc director expanded the recommendation to include by veil encounter boosters for kids 5-11. The only hing standing between kids being able to get the by veil divergent booster. We hope it comes soon so we can begin -- we and others can egin offering it to kids 5-11. In addition, we will be updating our dashboard to include bivalent booster data and we hope to have that in place by today, actually. As far as mpox, I would say also good news on this front. To date, our county has recorded 189 cases, but the good news is that the cases are really slowing. And since the beginning of september, we have had a small but steady stream. But it certainly is no longer rising and it's manageable. Our cases continue to be primarily young men who identify as gay or bisexual and disproportionate number are latino. We continue very intensive outreach o try to reach communities at risk, both for education and vaccination. We have not had any shortage of vaccine. Our pharmacy is orking diligently to onboard as many providers as possible so the vaccine is available in many different settings. And to date, through all the different saoeutsz that are administering vaccine, just shy of 11,000 doses of vaccine have been administered. And that's both to residents of our county as well as to people who reside outside of the county. As far as residents vaccinated so far just over 7300 residents have had at least one dose and nearly 4,000 residents have had at least two dses. I think that we will be continuing to need to address mpox for quite some time. I don't think that the infection is going to completely disappear. But the good news is I think we now have the tools and infrastructure in place to support people pao who are most at risk. And that completes my report. I'm appy to answer questions fpltzrisk. And that completes my report. I'm happy to answer questions fpltquestions.

2:24 PM I'm not sure, I think chair simitian might be muted.

You caught me once again. go right ahead with comments or questions, supervisor lee nd then I have comment or question or two myself and then we'll go to the public.

Great. thank you. Thank you very much, Dr. Cody. the stable rates and the fact it's less in the wastewater shows it's drifting down and good news and emergency use authorization for the bivalent from 5-11 years old is exciting news. It will take us a few days or week before we get the shipment so we'll be getting the appointments record but they won't be ready to go out until they apraoeuf, other it? That's correct. We just need the shipment to arrive.

2:25 PM Are these at a lower dose compared to the ormal dosage?

You know, I can't give you details on the speed an at trick booster dough. I imagine that the dosage just like the prior introduceter dose step it's formulated to protect against both the ba. 4, ba. 5 and the original strain. Okay.

2:26 PM It seems like people are so fatigued from the whole pandemic. Very few wearing masks and at the same time when you talk about by veil kwrepblt booster does not seem have to the sense of need or urgency at all. So the percentage of people getting this latest vaccine seems to be very low. From my observation. Is that what you're seeing?

Yes. I think your read is absolutely correct. There is significant fatigue and a loss of other sense of urgency. And so, the uptake of the bivalent booster has not been as broad or brisk as compared to the uptake of previous vaccines and boosters. Of course the bivalent booster is recommended for everyone 5 and up, but we are especially anxious to see people 50 and up get that bivalent booster. We never know what the winter holds but the last two winters have not been kind. And we really urge everyone to get their other booster as well as their flu vaccine. As you know, we have a number of different media campaigns and a lot of channels to try to reach people. If you look at the past performance during the colder months, the covid variant tends to be very strong and that's why our case rates go up as well, like a flu vaccine, right?

2:28 PM Yeah, gathering and traveling are not good for respiratory -- I mean they're great for respiratory viruses but not good for humans.

And for example, i, myself, did get both the flu vaccine and the bivalent vaccine this past Saturday and I just scheduled by Sunday I could be able to rest. I slept most of the day I was so fatigued and felt great by monday. But it's something we need to get a word out. What are we doing to push on the pr campaign in order o remind people how important it is? Because trying to convince individuals who basically don't believe in vaccines is one thing. That's almost impossible we know. But for those who have gotten the vaccine or even boosted, there's really no hesitancy here. How can we make sure that they understand the issue of the waiting that's been many, many months and number 2 accident the fact that the new variant will likely not be

as protectable by whatever they have left. And that's why the new bivalent vaccine is so urgently needed.

2:29 PM This has become another challenge in our pandemic response. Because I think the combination of being almost three years in and the fatigue that sets in as well as right now a member of the public May not be seeing the impact of covid and feel the urgency because everything's pretty much ack to normal. The weather is nice. And not so many people are getting sick. So two thoughts. One, as I mentioned, we continue to do ur communications team doing everything that they can to reach people that they think they can move. And much of that is through individuals telling their story, their family story. And using the information we have about how people react and appealing to their desire to protect their families, for example. And what we May see is a little bit of a delay and uptick until we begin to see a surge in covid activity and that will likely drive another group to get their bivalent boosters.

2:31 PM Right. I think whether we're using tv ads or social media or current ads or word of mouth, I really do think that we need to up our game in order to make sure that folks are feeling at least some type of urgency to go get themselves boosted. Are there any other groups like schools campaign we can do on this or even going to various kphaupbty groups we could try to get this word out?

There May be. maybe we could gather up a list of things, approaches that we have going currently.

2:32 PM This is the time to do it. and by time covid is hitting as we know the vaccine, even though after you get it, it takes at least 2-4 weeks to activate and work well against the bug. If it's too close the vaccine might be too late. So this is the time to get it. So let's not wait too late. If we could get the word out I would appreciate it.

I would say we have another opportunity to capture the public's attention when the bivalent booster for the youngest children becomes available, and so that s an opportunity. We will be taking to emphasize the importance for the people that listen to their local news will hear that message that way.

2:33 PM Sr bring your whole family over and get vaccinated to prepare for the winter, something like that would be and get for the winter, something like that would be great. You mentioned 5-11. Right now I think we still have an infant vaccine 6 months to 5 years. Are they still using the old vaccine?

That's correct.

All right.

The other question I have now is with mpox now -- do you see mpox considered an sti?

It's not being called an sti per s, but what we do know and see in our local data is that it is the -- the infections are among people who have had sexual contact with one another.

2:34 PM Okay. and if this were categorized sti is there an effect in terms of how we administer this?

Well, as far as problem mat particularly we do fold it into our h. I. V. And sexual health and harm reduction program. It's being olded into that program. As far as funding, the funding streams come in all sorts of different ways. And we have -- and there is now a -- late breaking news -- a small amount of funding that will come from the state to local health departments to address mpox.

2:35 PM I want to make should you we're aggressive to get these type of fundings because e ave almost 200 cases of pox in our county.

Yes. we are receiving funding from the state and their formula -- I can't remember all the variables, but basically it looks at the burden of disease that a county as experienced and reported as well as other underlying risks in the population where we know that the wrist ubg will continue. So we have received our undingri wil. So we have receis will continue. So we have receik will continue. So we have received our funding allocation -- we haven't received/ it but we received word that we will receive it and it's welcomed.

And do you think there is any other outreach that we need on the mpox information to the public?

I think as you know over time we've gradually expanded eligibility for who is eligible for the vaccine nd done that in concert with others in the region. And and the state has also expanded eligibility. I think at this point the partnerships that we have have been very productive and we continue -- we continue to do outreach and education and encourage people at risk to be vaccinated. I will say that the pace has slowed down, so as you remember, we certainly had

demand of fire outspacing supply early on and then it matched up and then we have more supply than demand and we're needing to do sort of higher touch and resource activities to reach people who need to be vaccinated but have not been vaccinated yet. We did quite a bit of work on barriers and what might be keeping people from being vaccinated and the thing that you might imagine, everything 40 didn't realize that I was at risk and needed to be vaccinated to, i'm worried about it for one reason or another, to i'm having difficulty getting to a site.

2:37 PM Great. that's all the questions I have. Thank you very much.

Thank you.

Thank you, Dr. Cody. I have a couple of observations then I want to pull you and Dr. Smith into a conversation about who is doing what in terms of providing the bivalent booster vaccinations. The first is, I think if covid's going to be with us for a while and appears that's the case based on all indicators, including your remarks, then maybe we need to move from hope willing or expecting people act with a sense of urgency to hoping they develop the habit of getting a booster when that's called for. That's little hard to do, I think, when water still learning as we go and when the booster formulation is changing, the timing is uncertain. But do you have thoughts about this becoming a hash it rather than a response to an urgent circumstance? I know for years every fall you and I would have a brief exchange where I was reminded once again about the importance of getting a regular flu shot. Thought?

2:38 PM Yeah, I think it's an excellent thought as to how to develop and instill a habit rather than being n a reactive mode to an emergency. It's difficult to stay in that reapbgtive mode for a long duration of time. One of the challenges I think is around a predicting the future and communicating an explanation. So, for example, how frequently will people need a booster. When they'resing about developing ha I object habit what would it need to look like? It May be that you get your booster along your flu shot or you May need to get one more frequently because of what's happening with evolution of the virus and variant becoming quite different than the variants that we have seen before. So that's a challenge, a surmountable one but a challenge.

2:40 PM I want to plant the seed of that or reinforce it if the seed has been planted. But I think we need to think about how we can stop the necessary reactive mode of lush muching from moment of crisis to moment of crisis and try to be a little bit more masters of our own destine 90 if such a thing is possible at this point. I want to express again the appreciation that my constituents and I have for the north county facility that's in the space in mountain view. Although I have to say what's interesting and source of some concern is that there seems to be a divide that there's a need to access it and it's quite close by and convenient. So i'm pressing on our organization to continue with public awareness ampaigns throughout the county, including folks in the north county or close proximity would find it convenient. I want to express my thanks to folks in the communication side of the pandemic response team. I understand that here's more in the works. But we hear from you repeatedly the concern about the lack of urgency. To which my reaction is always, well, if it's urgent, then eutz seems ought to be urgent that we're communicating to people that there is a resource available. I share that with you and Dr. Smith putting the resource out there and not backing that up with a robust communications and public affairs strategy I think not the best of all possible strategies. I'll let it go at that. Then the issue I want to spend time on with you and Dr. Smith on is thank you for the information about covid-19 vaccinations administered to santa clara residents sorted and segmented by healthcare provider. Dr. Cody, do you have easy access to that page by any chance. I want to give you a minute if you need it.

2:42 PM Let me see. this is, I believe, from the data presented at the last board of supervisors meeting.

2:43 PM Yeah. i'm not sure this works but that's the document i'm talking about. Dr. Smith, if you could let us know you're standing by as well that could be helpful to the conversation. Conversation.

Yes, i'm here and i'm trying to find the data myself.

I'll email it to you in case that helps.

I don't know if this is easier or harder than the old days when we just got up and handed it to somebody. But thank you for that. Pre covid. Tell me when.

I have it up, but my power point is not responding so that will be difficult to share with Dr. Smith, but i'll keep trying.

What we have 234 front of us or what we had in front of us a list of providers, retail pharmacies and kaiser permanente, our own santa clara healthcare and other entities in the county, the folks at palo alto medical foundation and healthcare entities outside of santa clara county and

what it indicates the estimated number of folks who are covered by each of these various providers and then the percentage of the county population that they serve and then the tphupbl of doses that they had a ministered of the booster and then the percentage of boosters that represents. Dr. Cody, i'm going to pick ne example because it's the one I have most experience with because it's my provider and that's the palo alto medical foundation which operates under the auspice of the charter health organization. There are 320,000 residents covered or served by the folks at sutter. 16. 5% of the population is the estimate of how much that represents. And then the number of bivalent doses that are administered is 29. Thank you for that. Now you're looking at the center of the screen here. 29019 and 3. 2%. So here's what i'm struck by and I want to precede my concern and critique and ask you to hold that steady if you can now. There are unold thousands of folks who have given of themselves over and over and over and over again at every one of these institutions and I know that from my first hand experience and experience from my constituents at the palo alto medical foundation at sutter. That said, organizationally, in terms of the corporate policy, i'm looking at what appears to be an indication that with 320,000 residents served, that fewer than 1% of that patient population -- that would be the third column -- 2919 doses have been administered. That's less than 1%. You all have repeatedly, both Dr. Smith and you, Dr. Cody, exhorted us and our constituents to understand the urgency and take the necessary steps. Here we are with data from the end of september, I think it's September 28th that says that this is a well establish organization with significant resources that has managed to get the becauseter out to less than 1%. And another way to look at this in terms of who is doing their share, is to say, 16 . % of the population in the county but only 3. 2% of the doses administered to date. What is the -- for give me, i'm rarely speechless. But weaves been at this for 2. 5 years and here we still are. What does it take to get everybody to step up and do their part, Dr. Cody and Dr. Smith

2:47 PM Well, I think this has been a constant struggle as we have talked about before, the health systems other than our system do not perceive themselves as participants in public health needs, and so they're content to let it be the public health system's problemful we pushed them, pushed them, pushed them, they continue to be reluctant to take over larger responsibilities. Some of hem have actually been traying to notify their patients, but none of them are actually performing at the same level that the county is but none of performing at the same level that the county is performing. Other than a legal compulsion I don't know how we could move ahead and get them to comply since they are private entities. We can't force them other than with legal threats.

2:49 PM Dr. Cody, thoughts?

Well, I would agree that this has been a challenge throughout the pandemic, and disappointing throughout the pandemic. I can only sur mice that it has to do with a financial dis dis incentive to do this and not to their advantage to scale it up. Certainly with the counties stepping up perhaps not a perceived urgency in providing the serve because others will carry the water.

2:50 PM Have you given any thought on how to give them notice step up?

To me it's a broad problem. whose responsibility is it to provide vaccine to the population? Is it the healthcare provider? Is it the public healthcare system? Is it the local governmental health department? I think it's the responsibility of the healthcare provider to provide a preventative service for their patient. So, i'm not sure that a health order in a single jurisdiction by a single health fficer for a single disease unnecessarily makes sense, that this is the best way to address what I think is a larger problem.

Can you understand my frustration, Dr. Cody, if we have empty office buildings and mask require pblt here in our own county and yet we have fewer than 1% of the healthcare providers patient population being administered a booster under those circumstances.

2:51 PM I absolutely share your frustration.

We're 2.5 years into this, Dr. Smith and Dr. Cody, and I think the public might understand the first 3-6 months of healthcare crisis, the pandemic that was in many ways unprecedented and is not unprecedented certainly unanticipated, but 2. 5 years in, I kind of think -- I think people really expect that we have this sorted out. Dr. Sphreutsdz does that mean that going forward it will of necessity be the policy of our county to provide vaccinations as needed to all 2 illion residents of the county, not withstanding the fact that our own client population or patient population is a relatively small fraction of that, maybe 15% or so?

2:52 PM A complex question. we exphrordz potential vehicles to try to apply pressure to the outside agencies and businesses. Some of this needs to be discussed legally in closed session, but suffice it to ay, that the most likely sin tphaur row is actually an ordinance on the local books.

Public health has something associated with it. I don't want to go into oo many details because this might be legal issue. Sadly because of the structure of our healthcare system, private providers have much discretion about how much of particular services they offer and they don't feel compelled to offer more han they already do.

2:53 PM Let me ask this question. for give me if we have county counsel. Mr. Press, are you with sed a?

Yes, i'm here.

Thanks, Mr. Press. nice to have you with us. Mr. Press and Dr. Smith, i'd like to ask for an off agenda confidential memo on the tools available to our county, whether that be the board or public health officer, to compel participation in a robust program of vaccination I would like to have a closed session if you deem that appropriate. Do I gather, Mr. Press, that is consistent with our own about how we might best proceed to have this conversation? I like to do things in an open and public fashion whenever possible, but if this is the only way we can have the conversation, then so be it it.

2:54 PM Yes. as you probably recalled from reluctant to discuss different strategic options in a public forum because we want the free tom to think out loud and discuss different options confidently. So whether it's confidential off agenda by itself or memo in conjunction with the closed session, either of those options i'm certainly comfortable with. Once we all land on something then we can implement that and srelt that publicly as we must.

2:55 PM Thank you. Dr. Smith and Mr. Press, I just want to make sure as a process matter, i'm about to make a motion directing the county counsel's office to provide such information on an off agenda memo and agendize this for our closed session. Is that sufficient to ensure that it will in fact land on a closed session agenda in the near future?

2:56 PM I think that's sufficient. county counsel develops the closed session agendas, but they are very responsive to the board, so I don't think you have a problem with that.

Dr. Smith?

I'll relay this to the county counsel forthwith and i'm not concerned this will make its way to closed session.

Okay. do I take that just to make sure we don't have a triple negative there. You're not concerned that it would not make its way, yes?

Correct. thank you.

Then i'll make that motion and ask supervisor lee for a second.

Are yes, i'll second it.

Thank you, I appreciate the courtesy, supervisor lee. We'll go to the public in a moment for comment, if any. Dr. Smith and Dr. Cody and Mr. Press, now we pulled you in the conversation, ordinarily I don't share my personal experience. I think it's important that all of us take a broader view. Have a slice of life, not take on undue importance or influence, but in this particular instance I was able to test out my theory by contacting the folks at the palo alto medical foundation center health and ask for an appointment for a booster and I was informed by very capable and professional call center staff person that, no, you cannot get a booster in palo alto. Fine, i'll go o mountain view. No there is nothing there. How about san carlos. No, nothing available there. That meant that I was then, Dr. Smith, in the position of saying, well, there's always scc free vax at our county website which is where I went and signed up at our north county site in mountain view. Have been through that process which was smooth and capable and professionally administered, which is what I heard repeatedly from my constituents. I want to be clear that i'm not saying that an isolated afternoon he can tkoetl experience is evidence. That he why I asked for the chart. When the chart says that one provider as an example has 16. 5% of the patients but delivered only 3. 2% of the vaccines that tells me that by a factor of 4 or 5 fold someone's not handling what I would call their fair share, and when, as I say, less than 1% of the patient population in that same provider's care has been administered a dosage by sutter. That tells me that we have a problem and even if you look at retail pharmacies, the number of doses there and just estimate that -- percentage of those folks who got a shot from a pharmacy is roughly equal it's very clear to Dr. Cody's earlier point, we're not getting it done. And I have made the case from the beginning that understanding the importance and need for outreach to folks who are vaccine hesitant or resistant that if we can make it easy, make it simple, be clear and concise in our direction to tpoegz who want to get the vaccine that's the path towards a quick adoption or quicker adoption t any folks who want to get t vaccine that's the path towards a quick adoption or quicker adoption at any rate. Ultimately I ended as an independent patient being a burden on

the healthcare system rather than being able to access the booster that you all have been recommending from my own provider. I'll stop there. But I just i'm hearing this story enough that I have to believe this is not isolated and that the data supplement ports the notion that it's not simply anecdotal, it's consistent with what the numbers show us. Dr. Sith, I see your hand is back up. Would you like to get back in?

3:00 PM First of all, you're not a burden to our health system and never would be. So i'm glad you got your shot. But secondly, the issue that you're describing that the committee is discussing at this point goes far deeper than merely vaccines. We are focussed on vaccines right now as we appropriately should be. But i'd like to point out that there are entities, which I won't name, with clinics in palo alto that currently have all f their primary care panels filled, which means that no new patient can be seen in primary clinic in palo alto if they're a member of the insurance system. It goes to point out the scarcity of resources even in one of the richest counties in the nation and also the focus that private corporations have on profitability rather than patient care. I'm extremely oncerned about it as it will negatively effect our constituents. It already has.

3:02 PM To be continued. we have a motion on the floor. Which by the way incorp praeutsz the receipt of the report. Let me see if we have someone standing in the cue.

One request to speak, Mr. Chair.

Let's go ahead and hear from that individual up to two minutes. Thank you for posting the time.

Ask victor, you'll have two minutes to speak and it timer will start when you begin victor, you minutes to speak and it timer will start when you begin speaking.

3:03 PM Thank you. since I heard supervisor simitian's comments i'm also a patient/client at palo alto medical foundation and, yes, they have some delays in get the vaccine out. Both my wife and myself almost instant usually got appointments at other local facilities and got our shots for both the flu and the ovid variant. We got those almost instantaneously. So the vaccines are available and they might not be there but locally and easy to get. And they're available at no cost. Then maybe to clear up something that I heard supervisor lee mention. I'm sorry to hear that you had a reaction or your Sunday was spent dealing with your vaccination. But i've had 5 vaccinations now for covid and had no reaction to any of them. So I think most people should understand this is smart and good thing to do and go get your vaccination. I was on for a different issue, the suicide prevention report but I have another meeting I have to attend. I'm going to make a quick comment before that before you get to it on the agenda. This has separate to do from the specific actions that our committee is taking and more to do with the whole history of the fact that we started in 2010 doing the work on suicide prevention. We're one of the first counties to do that and I think our successing becausee based on sustainability. When some people react to deaths and then put a committee together and then let it wane. So my final comment would be, keep supporting what we are doing. Because it's invaluable. And thank you and I have to go to a different meeting now.

3:05 PM That concludes our requests to speak.

That ings it back to you and me, supervisor lee. I'm going to call the roll in just a moment on the motion which is to receive the report and to direct county counsel and administration as indicated. His experience or his observation underscores the very point i'm trying to make, which is you can get the vaccine. So it's not that you can't get it. It's that some folks are not stepping up to deliver and that's putting a burden on others to step up and deliver, and that is the concern that I have and ere we are 2. 5 years later still struggling to wrestle that one to the ground. Supervisor lee, anything before I call the roll?

3:06 PM Yeah. just I want to supplement that. This past Saturday we had a day on the bay and received both the flu shot and covid bivalent shot. I want to give a shoutout to a few folks. Eileen steiner and j d who is account manager of the california department of public health and her team did a great job of administering a couple hundreds of vaccines for the covid shots and for the flu shot we had serena from primary care operations and kathryn timmons and her team. Of a wait and everybody who uch - wanted a shot, get a shot. That was great and is I wanted to give a public shout out.

Call the roll.

Advise chairperson lee.

Aye.

Chairperson simitian.

Aye. motion carries unanimously. I rook forward to following up on that one. Item number 7 mental health parity. Who is going to begin the presentation from the team here?

3:07 PM Yes, good afternoon Mr. Chair. Simitian and vice chair lee. I'm director for the county of santa clara health system and here with me is amy carta who will do the presentation on this particular item. But before I turn it over to her. I want to highlight a couple of things under your leadership the held and hospital committee has focussed on. As you know and the general public might know, our county declared behavioral health as a public health crisis. You have been receiving monthly reports from both the county executive as well as the behavioral health department. And parity is the foundational policy which we're all grappling with. You just talked about vaccines and private systems. Similarly in behavioral health it's both a foundational and aspirational issue for us. Suffering from a mental health - or substance abuse disorder should be treated fairly and equally like if it was any other healthcare or medical are problem, particularly by health insurers. 74% nearly 3 quarters of our residents in our community are actually covered by private health insurance and not necessarily medicare or medi-cal. As you heard from our behavioral health department in many cases medi-cal is the solution to many of the problems people encounter in other sectors. So what we are proposing here today beginning with item 7 is a very new approach. I don't think any other county is doing what we're proposing to do under your direction. One of them as amy will indicate is the development of an outreach education. What are the gaps and loops and patchworks that exist and why people can't find access to mental health and substance abuse services in our community. Item number 8 is an innovative pilot that builds on our local experience of having to deal with gaps in medical care to do that also for behavioral health and substance abuse services. You'll be hearing from laura our ceo from alley health plan which will be presenting recommendations relating to that. Particularly with people with moderate incomes not receiving services. And aoeutdz 'em 9 what we are doing working with our insurers so our employees have timely access. Without further adeu i'll turn it over to amy in terms of agenda itemwithout further adeu i'll t it over to amy in terms of agenda item 7.

3:10 PM Good afternoon, supervisors. it addresses the importance and need for mental health paeurtty. This addresses the first referral regarding options to improve mental health parity for county health. The written report details a series of bills on parity requirements and oversight and summarizes the patchwork of legislative and regulatory actions around parity. All of which are rooted on insurance. And combine the laws have a foundational it pact for those californians with coverage and mental health pact for those californians with coverage and mentalmpact for those californians with coverage and mental health diagnosis. There are many efforts underway in santa clara county to improve services and expand capacity to address behavioral health. In considering operations attention needs o be paid to aligning and not duplicating efforts. To identify the opportunities to improve parity a work group as formed which includes legal aid and behavioral health board and el camino and kaiser and momentum and alliance on mental illness. Consistent themes emerged pointing to policy and outreach and education especially n how to access care and services. Understanding rights to access care, the changes in recent laws and process to access medically necessary services. Resources and information to help assist the consumer and employers and where to go if additional assistance is needed. Through the work groups conversations it's become clear there are many barriers to achieving full parity. They fall into two categories, policy and education. To achieve meaningful progress changes are needed in the policy environment. We'll begin by identifying where there are gaps in the patchwork of parity laws and education campaign would enhance understanding regarding laws and regulations and help make it easier for care and services and resources. Specific information and resources would be developed nd outreach campaign. One-time funding from the mental health services act was recommended to support the education campaign and provide updates to the committee as it progresses. With that i'll say thank you and see if there are any questions.

3:12 PM Supervisor lee, i'll turn first to you.

3:13 PM Thank you, chair simitian. first of al, thank you very much for this very insightful report. I think the point has come up repeatedly through these discussions about the ability to get the word out, outreach and education. Do we have a timeline ever when this type of education outreach and campaign will begin?

At this point in time we don't. We will work on developing that and we'll bring that back to the committee.

Okay. and that's all I have for the time being. Thank you.

Thank you. supervisor lee's question mirrored my own. I want to thank you and I don't want this to be misunderstood. I want to thank you for the brevity of your report, because I think you crystallized a lot of information in a very brief period of title and essentially said there are two things that need to happen, better policies and real education and outreach. And so I think being realistic about how long policy change takes, that's going to be a while incoming and wand we hope we make more progress obviously. I guess to supervisor lee's point I gather from what you were saying not withstanding there needs to be policy improvement ate something that folks can only take advantage of if they know about it and how to take advantage of it. Is that what you're aying some

3:15 PM I believe so.

If I have a sense of urgency about this and my goal is to make sure that folks out in the community know at the earliest opportunity that they have a right to mental health services, particularly as santiago was pointing out, folks who are covered by private insurance and May have that right and not really fully be aware of it, is that the kind of campaign you're anticipating thinking about developing here at the county level?

We'll be working with our partners on the committee to develop the best messaging and the campaign. The providing information to individuals in terms of what the laws say and how they can access services are two very important components that we'll definitely dive into.

3:16 PM You talked about timeline and and basically too early to tell. But when should we be circling back, either if you or Mr. Sapblting a go could respond and say how are we doing? Is where are we and when are we going to be out there sharing this information?

We can share it by early spring. It keeps the current cadence of reporting going and looking at the report that we need to accomplish, that would seem to be a reasonable timeline.

If I have a greater sense of urgency is there any reason I shouldn't take out an ad in the local newspaper that says insist, you have a right to phrtsdz care coverage. Contact your insurer if need be and try to start the conversation that way? Some reason that's not -- I just -- as I say, I worry that time will roll by and pursuit of the perfect will be the cliched enemy of the good. Dr. Smith, I see you leaning in, I think.

3:17 PM Yes. there is nothing to stop you from doing that. Everyone should be aware that they have a right to mental health care in an equitable way obviously as amy described there are other ways around that for the provider. But everybody should know they have the right. If they don't have a provider willing to provide that kaur, they should find another provider.

3:18 PM We'll work through these issues with you all, ms. Carta and santiago and Dr. Smith. but again, I think the sense of urgency is quite real. And I know there are a lot of stressors in our organization but one way to reduce those would be to get private sector insurance providers to step up and do their -- address their legal obligations to provide care. Another thing I would say is that it seems to me that one way to move in the right direction is to mobilize patients and the families of folks who need and deserve and are entitled to this care through greater engagement by the public. So if that he what it takes, that's what it what it takes, that's what it ' what it takes, that's what it s what it takes, that's what it takes. I think we all had too much experience and the data s clear a lot of folks are not getting help to which they are legally entitled. All right. Let's see if we have anyone here to speak to this item, madam clerk.

3:19 PM No requests, Mr. Chair.

And supervisor lee, anything else or would you like to make a motion to receive the report?

Yes, so moved.

Motion by lee and seconded by simitian. Call the roll, please.

Vice chairperson lee.

Aye.

Chairperson simitian.

Theaye. that passes unanimously and i'll say thank you again and exhort whatever urgency we bring to the effort please. Phr sntiago, are you going to lead us into conversation number 8?

3:20 PM This is our ceo will be presenting.

Go right ahead.

Thank you so much. good afternoon. I'm going to speak about the primary axis program and how we'll leverage that to expand access to behavioral health. Just to go over where we are in terms of what we were doing a year ago. We are were talking about extending p cap which is

the primary care access plan and do a lot ore outreach and expand eligibility to 400% as this committee led and the board led and build a quality program that would increase funding for the clinics and reward access and quality and reimburse the clinics for recertification and align these with the uspf and include all the standardized codes and reimbursement and standardizing the copayments and other contractual areas. To give you some sense where he are today we did consolidate the operations across vhp and the health system so that was done by January of last year of this year. We have -- we did all our contracts with the chc's to include this expansion for pcap and working on our quality program and implementing epic as are the clinics so everyone is in full implementation. That will help a lot with the data sharing. And unable to access other insurance options and working with the clinics really to leverage all that epic data sharing to improof quality and care. As of course you are aware, there was a board referral requesting the creation of a pilot to subsidize outpatient mental health care at that non-profit clinics for the middle income and the ask was to identify residents for a program and how they could be served. So that is what we are bringing you today is our proposal for how to create that expansion. So we are proposing the leveraging of the pcap program because we have an existing infrastructure in terms of claims and value-based program and the problematic support and the community clinics and other providers under contract and we had those established work flows across the community health partnership as well as other stakeholders and a public familiarity that is growing with the pcap program and marketing materials and communication pathways into the community. So people really know the program and getting more familiar with it and we successfully expanded the 400% of fpl that was requested by the board this year. So we've got a good strong platform to now uild upon. And so, proposing an expansion, what we are stating is a full continuum of mental health care, including severe mental illness and outpatient substance abuse treatment for the low to middle income. And in-patient services are available through vmc which is the health access program at the hospital system. This would include pharmaceuticals through the vmc pharmacy and better health and here you see current behavioral health roviders that could be part of this contractual expansion that are already part of it or would be -- could be included in this expansion. We have gotten many of these under contract with dhp and we could expand this as well. So some of the considerations are: that the current program for pcap is up to 400% of fpl and the in-patient program side of the program at vmc goes up to 650% of fpl. We're proposing increasing pcap to 650% so it will align with that, that's one reason. The other is that it will align -- it will actually help with referrals and keeping continuity of care and post discharge care and expand -- if we're going to expand to this mental health piece then it makes it easier toe administer the program across the board rather than having different levels and given the cost of living in the county and salaries and what it means to middle income in santa clara county we think it makes sense to go 650% and introduce that complexity and ensure people are receiving the right care. Both nationally and locally they're impacted to an unprecedented degree. I'm sure you have seen many articles and featured reports and all sorts of media. There is a lack of providers. We're proposing to contract with our clinic partners and supplement with our private behavioral ealth net work to ensure patient access. Telehealth has been proven to increase access and patient satisfaction for behavioral health in particular and we definitely want to include the vhp tele health and we have md live currently and looking at other potential partners as well and behavioral health like telehealth for its convenience and privacy. So that's going to be part of the pcap expansion and looking at launching this in a phased approach in the first quarter of 2023. And estimating for the behavioral health side about a cost of approximately $1 million a year. That concludes my presentation. I'm happy to take questions.

3:26 PM Thank you. ms. Roses, my colleagues sometimes tease me about my frame of reference when I say, if somebody asked me about this how I would explain it. And if I were sifting through all that really helpful and good information to sort of sy, bottom line, here's what we got in the way of report back, the administration is now prepared to say, we have an existing pcap program that provides healthcare coverage for folks who are uninsured and we are now prepared to make that program available to a great substantially greater number of folks based on a higher income level. Yes?

3:27 PM That is correct.

And number 2, supervisor simitian, you and your colleagues on the board of supervisors have asked us to ensure that we can make mental health services available to the so-called missing middle in terms of income and we're now prepared to do just that using not only the existing pcap structure so we don't have spend as much time and energy ramping up but at the same higher income level to make sure it serves the so-called missing middle, yes?

That is correct.

3:28 PM I ught to say, good nws, since when we are struggling, I want us to confront that. I'll go back to santiago if I could pull him back on the screen for just a minute. Santiago when I talked to you in advance of today's meeting if I May say so, you seemed pretty proud of all msantiago when I talked t in advance of today's meeting if I May say so, you seemed pretty proud of all rsantiago when I talked to in advance of today's meeting if I May say so, you seemed pretty proud o. Santiago when I talked to you in advance of today's meeting if I May say so, you seemed pretty proud o santiago when I talked to you in advance of today' me t ting if I May say being a safety net for the very poor and most vulnerable. This is about really taking care of everyone and we pride ourselves of course for better health for all. We know that over the last two years has been very difficult for individuals and families as they've been isolated. The increased rates of anxiety and depression because of covid-19 and the he economic uncertainties has impacted everyone 6789 building on our strengths which is not only our talented staff and team of providers and caregivers, but then also the talent that we have and the willingness to go beyond what other counties are not to go quite frankly. In this particular case it's working with our partnerships to expand and be treating the patient not only as a whole person but also equally in terms of the dimensions of health. Meaning, the medical side as well as the mental health and other addictions. I think this is great breaking. You're both addressing the policy and some of the begans, even though that's difficult because a lot of the solutions but dealing with some on the ground issues in terms of real time access. The last point i'll make is that more than 60% -- and Dr. Smith will know the statistics -- more than 60% of the medications are issued by primary care doctors trying to deal with mental health conditions and substance abuse and I think this approach that ms. Roses saw in terms of bringing that together in a very integrated fashion is really taken us in the right direction.

3:30 PM Thank you for that. Dr. Smith, you want to get a word in edge wise here?

Well, I think that rene is captured a lot of it but i'm very proud of it too. I mean, we -- this ounty with the leadership of the board has made the commitment to provide service to not only the underserved but all of the individuals in our ommunity that are in the missing middle and can't get insurance for whatever reason and also those who qualify for covered california and this is an important step forward and we're hopeful that other counties will join in the effort. Ut's really a minimal amount of resources for a huge positive in the community to be able to provide behavioral health services. We think it's great step forward.

3:31 PM Let me also say on occasion made the observation it's one thing for individual board members or the entire board to say, hey, we have got a notion and a thought and we have a vision. So for everyone who takes these and makes them real I want to say thanks again.

3:32 PM Thank you.

Mrs. Roses and santiago and Dr. Smith i'm acutely aware of the fact that we can have a program in place but ult mountainly if there aren't any providers, just because there is a shortage in the field that is going to be a significant impediment to our efforts. 245's why I wanted to know what stepped we could take to provide the services. Let's check with my supervisor lee and s got any comments or but what amount of coverage that is expanded is truly amazing. It's the fact that we're going to a 650% ffpl which is significantly higher than 400 that we've been working pl which is significantly higher than 400 that we've been working with. The additional million dollars seems to be small compared to people we're helping. Where is the cost avings coming from? Additional coverage was small?

3:33 PM That s correct. we looked at utilization data and compared it across the lines of business and did a -- some forecasting to get to that amount. And if I would like at the pcap report that was part of the vhp monthly operations report you'll see pcap has dropped about 1800 individuals. Most likely because of the expansion of medi-cal as we had expected. Because there has been no recertification for medi-cal yet and recertification of the pcap members so we'll expect that we'll see pcap drop which is what we are seeing.

3:34 PM So exactly how does that readministrative co reduce administrative complexity?

If you think about it patient coming in for pcap it's 400% and we would say if you have behavioral health issue now your income makes it more available that's hard to message and it's hard to get in front of patients if thy assume they're not eligible. If half is covering the patient at 650% and now they need behavioral health it just becomes very disjointed if it's not clear that it's 650% across the board. How many people in that higher income racket are going to be eligible? It's hard to say. A lot of people have insurance. But it's still -- if for people in that

income bracket who don't have insurance it's a barrier to have different eligibility levels are for different types of care.

3:35 PM This is really exciting because I know my colleague always talks about the missing middle and this is exactly what we are talking about by increasing 650 fpl tat's covering the missing middle.

3:36 PM That's correct.

At this point that's all I have.

Thank you so much.

Rogers you'll have two minutes to speak and it timer will start as you begin speaking.

I wanted to commend the county health system for this program. It's really wonderful thinking back through the history of aca in this county programs for older couples ran in the rang of thousands of dollars per month. So getting 6 times the federal poverty level gets you about $108,000. If you're spending many thousands on living space and costs you thousands per month, before you look at deductibles that's significant. So that's fantastic to provide offering the accessibility of care and adding mental health is phenomenal. Talking to Dr. Smith's comments earlier about entities not providing services that they're contracted for, this is anecdotal information but I know a number of people in kaiser who find getting mental health care within the system is practically impossible. Aapartments are many weeks or months out in time. We all know that mental illness has a significant amount of urgency toin time. We all know that mental illness has a significant amount of urgency toout in time. We all know that mental illness has a significant amount of urgency tomonths out in time. We all know that mental illness has a significant amount of urgency toout in time. We all know that mental illness has a significant amount of urgency tomonths out in time. We all know that mental illness has a significant amount of urgency to it. Whether it's paid for by an employer or by medicare advantage or some other program entities. N directly by private - one thought I had in these larger discussions that was very effective I thought in early parts of the pandemic was dragging these entities to the board of supervisors to explain what they're data -- where their data was at and giving updates and working effectively with the testing in terms of who was providing it. There was an ordinance involved but I think just the fact of bringing them in to health and hospitals might be an interesting suggestion to get accountability and make them publicly. I know these cover so making wider awareness where there are gaps and particularly in kaiser's case they paid for them in advance. They made a ton of money when they were limiting the amount of services they were providing. So in any case thanks again for the county health system for taking leadership. These are great programs along with whole person care and the stuff that the stuff the state is taking on.

3:38 PM That concludes our request to speak.

3:39 PM There thank you very much. completelet me ask for a motion to receive the report.

So moved.

I will second. let's call the roll.

Vice chairperson lee.

Aye.

And chairperson simitian.

The aye. thank you very much. That takes us to the next item, item numberaye. Thank you very much. That takes us to the next item, item number 9. Who is going to be proud 50-twoing that report if

This was added to the board referral and we have rhonda schmidt from employee benefits.

Go right ahead.

Hello supervisor simitian and supervisor lee. I'm the employee benefits director and i'm happy to address any of your questions. Comments or questions.

3:40 PM Yeah, sure. the report talks about going to be produced to us in 2024. Our county is supposed to be taking a lead o. The May 9 on report highlight for improvement and I think it's certainly important that also be monitored close khreu. Is it possible to receive an off agenda report with the accurate data that helps us see how we're doing to comply with the parity laws? Is

I'm not certain wee be able to receive data from the health plans because they're still working with the department of managed healthcare regarding reporting requirements. But we can certainly ask them.

3:41 PM Yah, if you could just get back to us because I don't think we should wait a year and a half or

two years for something this important. Obviously mental health of our employees is so important and I think it's something that you could obtain early would be helpful. Thank you. And that's all I have, chair simitian.

Thank you, supervisor lee and my apologies for the lag time here. I'm trying to make sure we have no back chatter and means every time I unmute there is a little bit of a lag. Let me ask the clerk, do we have folks who would like to speak to this issue?

We do not, sir.

Well then, let me just ask, ms. Schmidt and the rest of the team, what would your best advice be to employees we hear from who say they have trouble accessing the services they nee need? Let's try it that way.

3:42 PM You said from the employees?

Yeah. I mean, I don't want to presume -- I can't presume to speak for supervisor chavez, but she raised this topic in the context f mental health parity and specifically for our employees. And I think wanted to be sure we pursued opportunities to make sure that folks are getting the services they need and are entitled to. So if we have employees in our organization who express concern about their ability to access those services, what advice would you suggest we give them?

3:43 PM Well, I would certainly be interested in being informed whenever that's the case so that I can address that issue with the health plan providers.

Okay. and going back to your earlier comments, tell us again how you feel the providers are doing in terms of understanding and responding to the obligation that is already there in their contracts?

My understanding is they do understand the requirements and are working owards compliance.

Okay. ms. schmidt not to put the weight of the world on your shoulders, but are you literally the person to hom folks should be referred if they feel like they can't get the services to which they are entitled and they feel they need?

No. I have a team, all the service center staff for each of the departments are available to address customer service concerns from the eployees.

3:44 PM I sk because I ant to ensure fidelity to the referral from supervisor chavez but also because I raised this issue in a referral of my own some months back in connection with mental health needs at vmc and public health in particular for folks who had been on the frontlines of the covid challenge. But as supervisor chavez's referral suggests and as I indicated as well, clearly it's a system wide responsibility. I see, Dr. Smith's and is up. let me take his comments at this time.

I just wanted to add a little bit to the issue of our employees and their insurance coverage. As you know, we really have three insurance providers that all of our employees have to choose from. One is vhp and I think you heard from them about their commitment to have mental health as a service that has parity with medical health. The other is health net. They also do a reasonably good job of providing mental health services, and they are ppo system so you have some discretion about where you go. The biggest concern I think would be kaiser, which is a third operator, as one of the speakers mentioned that I kaiser has limited mental health -- at this point limited mental health services available although there is a commitment from them to the state to improve that access and if any of our employees have problems with their health plans or their eligibility they should alk to employee benefits but there are -- there's a network of service enters throughout the county and then a central access point either by email or by phone, which can be gotten on the website in order to register complaints or change your program or deal with any other issues that are going on. And then just for completeness sake, the state department of managed healthcare also has regulatory control over all of the managed healthcare plans and the insurance Commissioner Has regulatory control over the insurance system. So, benefits can refer you to those if there is a specific situation.

3:47 PM There all right. let me confirm with the clerk once again we do not have speakers on this item.

; is that correct?, Mr. Chair.

All right. then motion by supervisor lee, please to receive.

So moved.

Seconded by simitian. please call the roll.

Vice chairperson lee.

Aye.

Chairperson simitian.

Aye. thank you very much and that takes us to item number 10 suicide prevention and let me just ask who would like to present here?

I'll be presenting. this is bruce director access on planned services, supervisor simitian and lee, i'll start the ball rolling. Before you is the annual report of the suicide prevention 2021 year. It is submitted on behalf of the santa clara county suicide prevention oversight committee and other its work groups and includes key findings and is major objectives and is next steps. I also want to take a moment o thank vick who couldn't be here for our presentation. He's been a strong leader over the years as we have developed the suicide prevention plan in our county and set the standard through out the state. With that i'd like to turn it over to michael who is the manager in the prevention services division and will lead you through our brief power point and answer any questions you might have on the substance of the report. Michael?

3:49 PM Thank you so much, bruce and thank you chairperson simitian and vice chairperson lee and thank you to all the participants and attendees for the opportunity to present this report. Can everyone see the report at this time? So as we see this is the suicide prevention annual report October of 2022. As we're getting started in here i'd like to take everyone through the logic model and outlining the objectives and making the connection between the objectives and the activities that the program provides on a daily basis. As you see here the ultimate goal of the program is to reduce and prevent suicide deaths within santa clara county. We attempt to operationalize this or achieve this as a program through these 5 outcome objectives. As I said i'll make a connection between the objectives and the activities that the program administers. The first one is to strengthen the suicide prevention and crisis response systems within the county on some of the activities that the program engages in in order to facilitate this. Are the schools or suicide prevention programs and county health outcome objective includes community helper and mental health trainings which are administered or provided by program staff. This is the series as it relates to mental health and suicide pre 50-sevening. They can text a crisis counselor if hey're in distress and third has to do with access to lethal means. Some of the activities that the program engages in include gun safety communications and ligature restriction efforts and at times possibly also media campaigns related to these two topics. Again this goes back to a lot of our media monitoring. The communication worker that monitors media reporting on suicide deaths to ensure the way they reported on these doesn't lead to condemnation or other spreading of suicide within the communities. And also there are safe messaging consultations and trainings to media reporting that are receptive to these consultations and trainings and then finally the attempt or the objective of creating community environments this is manifests through some of the work with used connect and the focus on increasing social/emotional learning in the school systems. These make the connection between the outcome objectives and the actedivities that are provided and cross cutting initiatives. Last year the substance abuse treatment and suicide prevention teams emerged. And so in some of these there is collaboration mong the data and evaluation, policy and implementation and cultural come pen 10:0-- competency as it relates to the two teams. Transitioning from some of the objectives and activities to reviewing some of the most recent ata we have available. I'll highlight quickly as we're transitioning to this slide. We do have the raw data for suicide deaths in the county from 2021 although due to the fact that the census has not been available we do not have rates from that data. You'll hear me talk about the data throughout the course of the presentation largely focussing on the most current raw data which is available with the caveat that rates are not available due to the limitations of the census. One thing we see is generally speaking over the past 5 years as it relates to suicide rate as we see there are increases sustained from 2017 to 2019. But then as it rerates to the raw numbers 2019 to 2021 there have been declines in these raw numbers. They have been slight decreases and again what we do know about rates even if there are slight decreases it might not translate so to a rapid reduction and rate. But it's worth highlighting the raw data is trending in the reduction ever total suicides within the county from 2019 to 2021. From 2020 to 2021 there was a decrease in females from 10. That was the decline of 10 deaths and fascinating as well the number of male deaths in the county due to suicide remains consistent and what we know nationally about sue sited is the rates for males were trending higher. The fact we didn't see an increase in the county is something noteworthy in addition to the fact we did see this overall reduction. Taking a look quickly at some data related to age, the number of deaths were older adults 65 plus. While the number of deaths for young adults 25-34 remain the same from 2020 to 2021. So, again, we're seeing just from the raw data from 021 there weren't increases so much in a lot of

these categories from age and genders and things that we think of as high risk. Just looking a little bit at the ethnic data from 2021 there is an increase 2 suicide deaths within the asian community 2020 to 2021 while in the black community there was a decrease of 4 suicide deaths from 2020 to 2021 from 5 to 1. So again we're seeing roadly here some of the reductions in raw numbers and also highlighting in the slide the number of deaths in which firearms were the method of suicide reduced. This is noteworthy because he know just from data and research the most frequently useuuttilized method is firearms or hanging. It's something that we would want to notate and we'll connect with later slides which talk about the programs outreach efforts and education efforts pertaining to firearms as well as hanging. We saw from some of the stressors this was reviewed by the medical examiner, the top stressors that were learned or known based upon review were unknown, intimacy, diagnosis, job and conflict. One thing to notate that the staff who did the review and analysis wanted to highlight in the ongoing conflict that did include bullying and included other sources of intser personal distress. So it's important just to make it known that this unknown category actually incapsulates interesting stressors that are worth knowing about and guiding more efforts moving forward. One thing that the program's particularly proud of in fiscal year '22 the program entered its 4th year with a partnership with school districts participating in s4sp. As you can see here from the chart in the 4th year, total of 17 districts with varying needs and technical assistance were reached and that reflects in those 4 years of the partnership more than 15,000 staff and students having been trained in various simulations. Cog neat tow who is a simulation that allows students to go through scenarios in which their peers might be in distress or experiencing suicidal ideation and allows them roll play and learns them skills and tools to adapt and report it and allows teachers and staff the ability to get simulations nd receive training in suicide prevention. You know, in 2020 to 2021, during the academic school year, even though the pandemic was in effect, cog neat tow training was rolled out online and even in the 2021 to 2022 school year, over 2000 school staff and approximately 1,000 students were trained in online cog neat tow modules. So again, a lot of really great outreach being done as it relates to training staff and students as well in suicide identification and prevention. And fiscal year '22 the team completed 51 consultations and trainings and social and emotional learning with 95 administrators and staff from 17 participating districts and finally, just highlighting quickly the youth connecting initiatives in palo alto and this is looking at evaluating outcomes and funding the program to ther cities. They hosted informal presentations and they trained other students as well as staff to be brave and had a call to action workshop development. Highlighting some of the programs effort as it relates to ligature safety and public awareness campaigns to support suicide prevention throughout the county, if fiscal year aoep '22 the communication work group planned and developed and implemented a comprehensive awareness he is campaign by offering safe firearm storage and it's to give knowledge about best practices for safe firearm use and gun storage and we see that public awareness campaign between you and the loaded gun can make a difference. We see this was other information gauged during attempting to increase safe firearm behavior and including use and storage practices among county participants. And it had a gun buy back effort and continues to do this working with other various steak holders throughout the county. The program also worked on addressing ligature safety. Based on suicide date that hangings were the most common ways of suicide and this is prevalent among youth who were of non white, racial and ethnic groups and a lot of communication focussed on hanging safety and two roundtables conducted on suggestions for prevention strategies and also a work group to focus on this topic. We see here that there was a brochure created focussed for family members and community providers in order to vied information about ligature means restriction and suicide prevention in the community for people at risk of engaging in suicide acts with ligatures. It was between the community connection psychological associates and various stakeholders. As we see here description was provided for those to review. But basically what the focus of this was on improving and supporting culturally competent suicide prevention management and the county's clinical services with behavioral health as initial sites. One of the most exciting successes that occurred in fiscal year '22, especially among men ambulatory and behavioral health within the greater health system was the initiation and group therapy offerings through health clinics. They handled high patient loads and buffer the transition process for patients awaiting connections to individual therapy. It improved access and actually increased retention in some instances. And enalso one thing to highlight was the team from community connection's psychological associates conducted a needs assessment with momentum at the end of fiscal year associates conducted a ne assessment with momentum at the end of fiscal year '21. And in 'tpwao they had a 6 month training series for 2 training series for 2 they had a

6 2 training 2 they had a 6 2 training series for suicide. They pled a number of lasting changes and they continue to revisit these monthly trainings in order to keep the topics of suicide prevention and culturally sensitive suicide prevention fresh in their teams' minds. I'll talk quickly about future directions. We'll continue as a program to sustain and grow our current efforts and especially going to focus on identifying or developing evidence-based evaluation methods of professional practices which allow or the measurement of services focussed on socio and emergency learning environments within school districts throughout the county of santa clara and continue to identify and implement joint efforts with the substance abuse prevention and raw data from 2021. Suicide deaths by overdose by drugging or poisoning increased by 3 from 2020 to 2021 within the county. And so again, as a result of this integration of these two teams they're going to continue to figure out and how we can do outreach and formulate program related strategies to focus on these deaths by overdose in these social/emotional learning environments and we'll continue the pursuit and analysis of suicide data and medical coroner examiner has a data dashboard which has made some of the process of obtaining the county death -- county suicide death data a little bit more and timely. It's a work in progress but we'll continue to pursue in a way that allows us to do it accurately and try to get it out as timely as possible. Please call 1-800-704-0900 and press 1. That's the most effective way I was asked to message or members of our community to access our crisis in suicide prevention. I want to thank everyone for the opportunity and ake any comments or questions.

4:05 PM Thank you very much. let me turn to supervisor lee and see if he has comments or questions to begin.

Yeah, thank you, chair simitian. Thank you for the very informational report regarding the various circumstances or this this very difficult topic. When we look at the data - and i'm trying to understand, we're looking at the different ethnic backgrounds, it looks like the pacific islanders have a ery high yearly suicide rate. Looking at slide 8 of the suicide data report. I'm trying to understand if there is anyway to find out the reason why and are we doing any type of intervention targeting the pacific islanders, and also as highlighted in page 30 of the annual report.

4:06 PM I want to thank you for your question, vice chair. Yes, thank you also for that attention to detail and noticing how that data visually comes off on page 8. There were 2 questions in there so one I wanted to directly mention is that in addition we do have a sub group who have an interventions work group and sub group focussed specifically on pacific islanders. So that sub group is in place. And then in addition to that, if I could say a little more. I have spoken to a community outreach specialist within the program and we are working -- the team is orking on trying to host an annual suicide prevention event starting in May of '23 where everything specifically is the pacific islander population. In addition to that we would like to, as a team, develop some type of survey so we can increase the data that we have on the population. Survey specifically for the population to learn more maybe about some of the stigma, barriers, those sorts of things. That's something that is in place and then the data from the survey will be used to create specific pacific islander resources and outreach. I could kind of speculate a little bit based on the new menu item of options and I don't want to do that,

4:08 PM Looking at the map also in terms of the location where these suicides are all occurring in the county, there appears to be a higher concentration in the south county and parts of san jose including central southern and eastern regions. Are we targeting some of these areas?

Yes, thank you. I was presenting on this data in the past two months or so, and somebody else had highlighted that. I appreciate the data is coming to the attention of people's eyes and so let me respond kind of broadly. The program's efforts are data informed. So the program's going to tailor their whether it's campaigns and outreach or trainings and other activities based on a wide selection of data. We're always going to aim to capture the needs of specific groups whether it's race, ethnicity, age, gender. Using these variables to guide campaigns or outreach effort, we do reach folks who live in these areas, especially if you're using the broader awareness campaign and also continue was was referenced but I think it's important to highlight we support he south county gun buy back event and participated in one of the most recent ones in north county and planning on participating in south county later this year. Some of the things we're doing is providing gun locks and information that kind of stuff. And then actually more specifically some of the examples of the specific intervention efforts include bill wilson center has a response increased sun port. Team and program, it's following community losses and whenever that occurs they're more than able and willing to do that. And training and peer support and other staff in kreut call management stress management and those are deployed across parts of south county and eastern regions of san jose. It's focussed on students

and might warrant referral and that early identification and early intervention model so that's in the regions that you are describing. We host south county trainings for santa clara providers from south county so we are trying to provide skills and tools to the staff doing the work on the ground. Then we also -- there's a south county task force mental health committee which includes members from previous work groups whether it's intervention or oversight so there are numbers down there and they're also engaged in this work group and stuff trying to improve access in mental health for youth and also our community outreach specialist is tabled at morgan hill. I don't want to presume but I believe they've done that before and the outreach will continue and then our programs trainings on mental health as well as suicide prevention which has provided community solution. I haven't worked out in community health and when I did community solutions was a large organization. So the fact we're engaged with them is providing our trainings for suicide and mental health is a positive.

4:12 PM Okay, great. thank you very much.

Can thank you, supervisor lee and let me just ask, is the decrease in suicide among women statically significant in a way that allows us to conclude there is good news there beyond the one time drop or are the numbers not significantly large to provide that statistical certainty?

4:13 PM I'll take this if you like to add anything feel free. I have to remain as program manager I would love to correlate some of our activities to that. But the reality of it is we don't have the ability to draw a correlation there yet. And more information and more data would need to be researched.

I would aree. it's hard to say whether it's a positive trend or not. But it's going to take a longer term.

4:14 PM Next question, there was passing reference to the w csycs program, and I thought you widening to other cities. Could you tell us more about that. I's an activity in my district that attracted my interest and attention. I'm going to say that's something I need to do more research on and I would feel uncomfortable offering an answer to that because that's my transparent respectful answer there.

Thank you that. nothing wrong with saying you don't know enough to give an answer. Why don't we ask for an off agenda report. Some time in the next month or 2.

4:15 PM Of course. we'll get back to you in a month. If I were to ask you sifting through all this what should we be doing in the future to hopefully make progression sounds to me like keep doing what we are doing along the lines of what he said which is stay on it and don't let our foot off the gas. Is that a fair summary?

>>absolutely. anything particular you wish we had the ability to do more of? Or you thinking paying particularly good dividends in terms of suicide prevention?

4:16 PM One thing I would quickly say is we -- the more act to analyze data the better we'll be able to inform our efforts. Any time we're improving our data collection or analysis system, we're going to be able to do ore effectively targeted outreach and notice trends as they develop as they were highlighting and demographic data. As we improve our data collection and analysis things will improve. I know this is probably an answer that you hear frequently. But the more staff we have to provide outreach and reduce stigma and have peer mentors telling their stories and increase access, that's something else that's going to improve otcomes. Within the community. I could probably keep going just off the cuff but those are well thought out things in response.

4:17 PM Thank you. any member of the public cued up

No requests, Mr. Chair.

Supervisor lee, can I get a motion to receive the report?

So moved.

All right. we'll say thank you to the whole team as I ay second that motion and let's call the roll.

Vice chairperson lee.

Aye.

And chairperson simitian.

Aye. carries unanimously. Thank you again. Gentleman and thank you to your teams and please pass that along. That I believe takes us to item 13 the update from the directors since we made items 11 and 12 consent calendar item ep items.

4:18 PM Good s.

Good afternoon. address parted of my report most of the updates are related to the legislative

approvals that happen and signatures by the governor related to this legislative year. We do have ms. Keli brooks here in case you have any specific questions to bills or budget actions by the governor and how they might impact locally. That will conclude my report before you let me know how you want to proceed.

>>well, just to note that that the legislation to permit a broader distribution program for surplus medication which you know is near and dear to my heart was signed by the governor if I am reading my notes corrtly. This is the bill that senator becker carried at our request. So thank you for that. Why don't we ask at our next meeting this have committee we get some thoughts from the administration, santiago and others on what that additional flexibility permits in the way of expansion of the program. Is that a clear enough request, santiago?

4:20 PM Yes, absolutely. we'll incorporate it for our next agenda. Thanks to ms. Brooks. Anything on this piece of the report if

No thank you.

From thank you again. and we have a report from the public health officer but we have received the report and unless that public health officer wants to share anything else at this time.

Dr. Cody has stepped away for another meeting s.

? without objection, supervisor lee, i'll move on to item 13c, which is a verbal report from the chief executive officer vmc. Mr. Lorenz I think I saw your cube somewhere on my screen. Anything additional you'd ike to share?

4:21 PM Supervisor simitian and supervisor lee, I wanted to share with you the three hospitals continue to have a very high census in terms of patient patients as we look forward to the winter months and flu season we want to make sure we build our capacity in terms of additional beds needed going forward. During our last meeting we talked about the demand on the system. So we are operationally looking forward to the coming months to ensure that we can better serve the community. Our ability to repatriate we would ant in our system has been challenging. But we are looking to build additional capacity going into the winter months.

4:22 PM Mr. Lorenz, we can all recall the initial concern about flattening the curve on covid and making sure we had the surge capacity if and when it was needed. We thankfully are not in that position where that's the case at the moment. Are you feeling kflt if and when things took an unexpected turn that the ability to surge is something that you all could respond to successfully? The need to surge if it happened?

>>i do. I think our system has the ability to flex and redirect resources to ensure we're meeting the highest priorities in terms of need.

4:23 PM Supervisor lee, anything more?

Yeah, Mr. Lorenz. the question is regarding as you said the census is starting to pick-up and we're concerned with the winter mnths. One of the questions is usage of er and how the numbers are so high ight now and I was talking to some of the doctors yesterday and they were alking about how if we hire more doctors at the community clinics they believe that would alleviate a lot of the need of people going to the e. R. What do you think of that type of strategy in terms of getting more doctors hired there and potentially given slightly higher rate for these doctors so that they are not only attracted to work with us

4:24 PM And thank you. it is a multifaceted program and expanding care is key. It's also important that urgent care centers are critically important to deal with same day access issues. In other parts of the county as well. It is a multifaceted etd problem whereby, increasing access from an outpatient standpoint is a means to reduce the demand on the ed.

4:25 PM I think the investment actually in the long run will save money. And also provide better care access because as we know the e. D. Wait time often exceeds an hour or two hours depending on the day. And urpblgt encounter care a lot of less serious issues being dealt with, number one. And actually it's quite profitable because the way we get aid I believe is per head comingone. And actually it's quite profitable because the way we get paid I believe is per head cominumber one. And actually it's qu profitable because t for our community as a whole. Do you agree?

4:26 PM Yes, I would absolutely agree with those comments.

Okay, great, thank you. if you could let us know what type of plans in place in terms of hiring more medical professionals to allow more appointmentings being covered among weekends and is being covered am weekends and whatnot. Either way we appreciate it.

Waoelt include hat in our next operation's report.

4:27 PM Thank you.

I've been in public healthcare since the 1990's and there is obviously a lot of truth in terms of expanding primary care and urgent care and alternative ways and more cost effective. The I have experienced even with a 40% increase in access or very specific increase it doesn't save mney. And even when we had compression of hospitals and reduction of hospitals and is even some closer of hospitals in different communities, somehow or another healthcare expenditures go up. I think it's still the right thing to do and provide timely access to care and prevent problems from becoming even bigger problems. But the dynamics is such that quite frankly healthcare expenditures in america continue to increase in and is of course we need to continue to provide the care in all settings whether it's acute or sub acute or outpatient.

4:28 PM Thank you very much.

And now 13 d.

Good afternoon. you do have our written report. I think the one area I would like to highlight for the public is that our county 2023 mental health services act annual update plan is posted as well as our three year plan. It is posted until October 26th. So encouraging the public or anyone interested in being able to weigh in on that plan to please do so.

4:29 PM Only thing I would add too today is an e please stay on public awareness and making that system as close to 100% as any human system can be. We knew when this came online that it would be a big lift. And it wouldn't be as simple as flicking a switch. But I want you to exhort you to stay on it and I think for those of us who work in this field it's easy to think hat everybody knows and I won't put my colleague too much on the spot but i'm guessing supervisor lee won't smile when I say, everybody doesn't know. This is a new tool, new vehicle and it's going to take time for it to become fully appreciate and understood and imbedded in people's awareness. Supervisor lee, I see you leaning in.

4:30 PM Yes. I can't say it better than you. I assume you want to encourage our staff to get the word out there we'll move on to item 13 e swrally health plan. Weva health plan. L health plan. L health plan. Ey health plan. We have anything you'd like to add?

4:31 PM We are over 211,000 members. our medi-cal is up to 157,000. We have seen a drop in pcap as I mentioned earlier. Open enrollment begins November 1st. You saw some of the new branding in the deck that I used earlier. You'll be seeing that everywhere as we start to push out. And though are my updates. Thank you.

I have nothing further. supervisor lee, you okay if we go on to the next item. That takes us to item 13f. Emergency medical services. Anything you'd like to add? You know where i'll go in a minute.

Good afternoon, supervisors. jackie with ems and we are hree months with a provider as far as being non compliant as well as partial for may. Provide err is currently trying to configure staffing with their labor. In order to become a lit more progressive and competitive in the whole labor force. However, they will be receiving second letter from us in collaboration with our county counsel to reinforce their continued non compliance. Our first responders are responding well and you'll be receiving a report as far as our updates on 2024. This is the fifth month consecutive we have had call volume in access of 8,275 plus per month. Last month in addition we had an accessibly bypass numbers. You do not have the ambulance off load times as there wasn't time to gather all of that data. You also have the domestic violence report. But i'm sure you have comments you'd like to share regarding compliance. Compliance.

4:33 PM Mindful of the hour i'll ask that you come back and -- I shouldn't give a nod here to Dr. Miller as well. good to see you. With clearly articulated pathway towards compliance. I've been raising this issue over the last few months. I know you've been ttentive to it as well. I hear you that the vendor knows that they're not in compliance, but after three months this is now a trend and not a blip and we have to address it before it becomes an even more deeply established trend. And i'll just ask that you come back with a work plan, if you will, for achieving compliance. Dr. Smith can I ask that the larger administration make a role in making that happen?

4:34 PM We surely will.

Thank you. supervisor lee anything else on this item?

No, thank you. thank you Dr. Miller and thank you. That takes us to 13g custody health. Dr. Day, are you with us? should there you are. I have no questions.

4:35 PM Yes, I just want to ask if we could update some of the slides we have regarding the vaccination of our population in both mainly the fully vaccinated and partially vaccinated as we know. We

changed those nomenclature once we started the boosters and now we would like to see if we could get an update and find out how many of those all have received the by variant vaccination.

4:36 PM Good afternoon. services manager for custody health. We'll provide that as part of our report next month.

Great.

With the new action vaccine now I just got it myself and I think it would be good to offer that on a scale so those who are in our system understand that this is something that's needed and the first two shots is really i'll say the words basically lapsed. Out dated because tgiving the living conditions the risk is higher. Especially for those who are older.

4:37 PM Thank you, supervisor. absolutely.

All right. forgive me I asked if you had anything else ask didn't give you an opportunity to share it. Anything else?

Nothing additional. thank you, Mr. Chair.

Hank you very much.

That takes us to the final subset 13h. It's a report on federal health policy and budget landscape. Mr. What would you like to share with us today?

I ave a brief report today since congress is out of session but there are a couple of points to make. First of all, the federal government is funded through December 16th as a result of the continuing resolution which was passed last month. The house and senate will come back on November 14th for a lame duck session. At a minimum during this lame duck, there will be an omnibus aprop operations package approved that will fund the government for the remainder of the fiscal year and no way doesn't happen not only is there not an incentive for either party to shut down the government during the lame duck but a number of ear marks this package and several billion dollars worth how much else that gets unwill depend on what happens in the election. This lame uck the last opportunity for democrats to act before republicans take control of both houses or even one house. One what incentive will the republicans have to cooperate if they take care of one house or both. So election results will determine the potential for other actions. There are number of health issues that could be acted on during the lame duck session. There's the issue of covid funding. There's the administration $22 billion request for covid funding that was not acted on earlier. It's still pending. That's for vaccines and testing and little public interest in supporting that. It takes bipartisan support to get that done. There are issues like the cap on insulin cost for the commercial plans, insulin costs under medicare were capped in the inflation reduction act at $35 a month and effort under way, bipartisan effort to get that commercial -- to get that insulin cap pplied to commercial plans, whether that happens or not in the lame duck we don't know. There are medicare cuts that are pending based on sequestration. Democrats and republicans always found a way to efer those cuts and they'll probably do it again. We talked about the bipartisan pandemic preparedness package that senators burr and murray put together to deal with future pandemics. It could surface during the lame duck. Election results will determine how ambitious and contentious the lame duck is and we'll have greater clarity after November 8th but one last point I want to make about the political environment on healthcare and it relates to the house republicans what they put out in the way of a platform about two weeks ago. Kevin mc carthy released something called the commitment to america document. Which is his version of what newt begin gingrich to outline the policy positions are and achieve longer, healthier gingrich policy positions are and achieve longer, healthier lives. You see the difference on prescription drug reform. Republicans are opposed to what the democrats did in giving medicare the power to negotiate prescription drug prices and is referenced the democratic plan eliminating life saving rugs and is there's a point of difference there. But there's one area of bipartisan agreement that's also worth noting and that involves telemedicine and telehealth. Republicans like it as to democrats. They want to see that continue and expanded. But the most significant part of this report which is really an omission which I want to highlight involves the affordable care act. There is no reference to it. No reference to repealing it and no reference to damaging it or weakening it. It's not mentioned at all. And it's a now clear that republicans at least in terms f their national policy thinking have given up on their long term goal of getting rid of the aca and none of the republicans none of them are talking about the affordable care act. This is the first time since 2012 that's been the case. The fundamental push to repeal it is over. And that's the last observation I wanted to share and happy to take any questions you might have.

4:43 PM You saved the best for the last. I have no additional questions. I should just sunshine the fact, supervisor lee, that I have him to share with us some is additional thinking on the medicare advantage program and the aco reach program 00, which the accountable care organization reach and this generated controversy in some quarters and I thought it might be helpful to our committee to hear back from him about what thatcontroversy in some quarters and I thought it might be helpful to our committee to hear back from him about what that debate so we'll hear from that at the next meeting. Any last comments or questions, Mr. Lee?

4:44 PM Thank you chair and thank you for the report. From the little I could gather in terms of the key points, saoeplt to me that despite all the fights between the parties and whatnot and dc, looks like affordable care act as least for now is not in dispute right now of being fought over in the near term. Is that correct?

4:45 PM That is correct. the republicans are basically saying in their platform and in their various campaigns they are goning to prioritize repealing the aca. Having failed they have given that up.

Okay, great. that's one. Second thing is a lot of times the party and 99 kwrort like to use the budget as a way to drag things m like to use the budget as a way a like to use the budget as a way to drag things j like t the budget as a way to drag thino like to use the budget as a way to drag thinr like to use the budget as a way to drag thin like to use the budget as a way to drag thinty like to use the budget as a way to drag things out. You're saying everything looks hunky dory for now and the former president trump trying to lay blame on the republican currently in office for not creating more problems to cause the government to shut down. But right now, as you can see, looks like there won't be such problems that we should worry about.

4:46 PM That's correct for this budget cycle december. If we have a divided budget tomorrow the potential for a shut down is real. In the current lame duck there is no incentive do that.

There great. all right. And election is coming up soon and by the time we talk again we probably would figure out clearly what happened to the November election. You mentioned something about the commitment with america?

Yes.

You mentioned this similar to the contract on america --

4:47 PM It was contract with america, I believe it was called that newt gingrich called and I don't understand the platform. Are they saying we should not lower the cost of drugs?

There are 135 life saving drugs over the next decades they're projecting we'll lose access to by having the federal government cut down on the profitability of the farm suitable industry. The argument really is you squeeze the pharmaceutical industry you give customers lower cost drugs but you limit them to increase new cures. There will be some is impact there. They thought it might involve a few dozen drugs. I don't know where the 35 number comes from. But in the scheme of things, that's the balancing act how much you squeeze and how much impact that has on research and how much short term benefit consumers receive. That's their argument.

4:48 PM And as a patent attorney working with many insrepters of various areas, including pharmaceuticals I can guarantee you that is one of the biggest bs arguments i've ever said.

I appreciate that response. and I will quote you perhaps to others on that point.

Please do.

Okay. well that's a term of art I wasn't expecting to hear today. Conversation about the legal and the healthcare environments. Supervisor lee, are we good to turn to the public at this point if there are any folks cued up.

4:49 PM Please do. thank you.

Let me ask the clerk do we have any members in the cue to speak on item 13?

We do not, Mr. Chair.

All right. let me confirm with the clerk I believe we have completed today agenda. Is that correct?

That is correct.

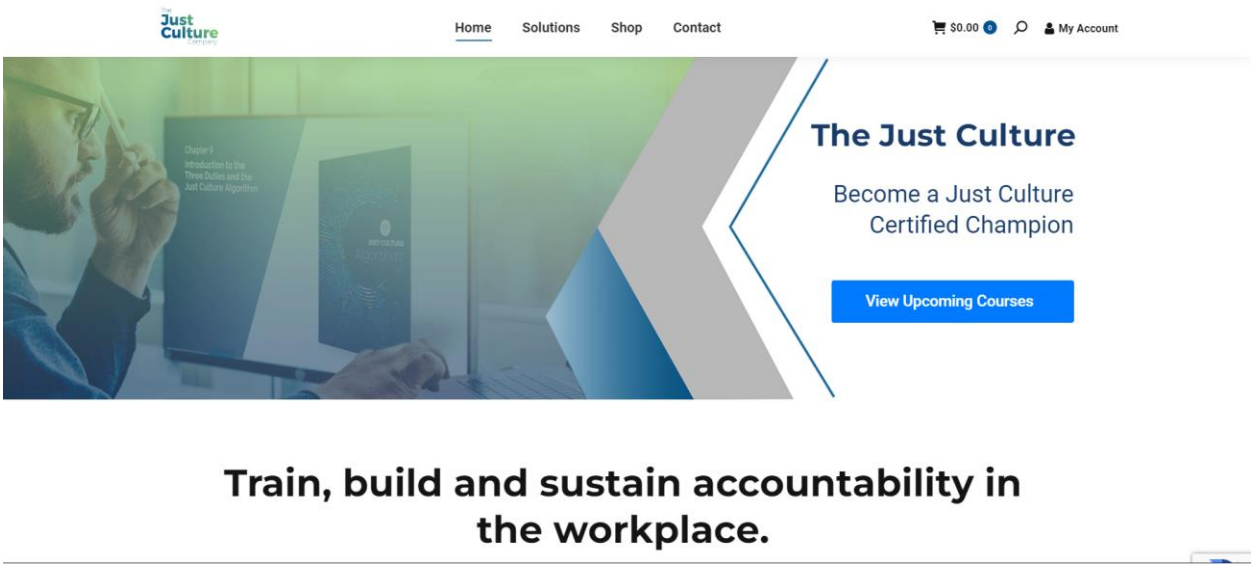
All right. then all that remains is for me to say, having completed our agenda today, we will adjourn today's meeting pursuant to our next regularly-scheduled meeting which is November 9th at 2:00 p. M. And it is still expected that that will be by virtual tele conference. Thank you to all who participated today and thank you

4:50 PM | *Recording was Paused*

The Just Culture Company

[The Just Culture Company – The Learning Resource for Just Culture Proficiency](www.justculture.com)

www.justculture.com



Our CEO, David Marx

Pioneering safety and improvement programs for NASA, nuclear power, patient safety, and beyond, David Marx is widely seen as the father of Just Culture. David and his firm Outcome Engenuity, LLC. administer the Just Culture Company, a resource for organizations across industries who strive to create accountable, safety supportive cultures using his internationally recognized model of Just Culture and The Just Culture Algorithm™.

2. American Medical Response West's Response to District's Protest (Nov. 10, 2022)

FOLEY

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CLIENT/MATTER NUMBER
027013-0127

November 10, 2022

Via Email (list below) and Hand-Delivery

Phung Loman
Chief Procurement Officer
General Services Department
Purchasing Division
County of Santa Barbara
260 North San Antonio Road
Santa Barbara, California 93110
Ploman@countyofsb.org

Re: American Medical Response West's Response to Santa Barbara County Fire Protection District's Protest (RFP 8010001)

Dear Ms. Loman:

On July 13, 2022, the County of Santa Barbara Department of Public Health, which is the local EMS agency for Santa Barbara County (the "LEMSA"), issued a request for proposals to allow the LEMSA to award the contract for the Exclusive Ambulance Services Provider for the Santa Barbara County Exclusive Operating Area ("RFP") to the successful bidder. On or about October 3, 2022, two providers bid on the RFP: the Santa Barbara County Fire Protection District ("County Fire") and American Medical Response West ("AMR"). The five (5) independent evaluators who reviewed the bids scored AMR 317.75 points higher than County Fire out of a total of 2300 points available – AMR 2,077.75 to County Fire 1,760. On November 4, 2022, County Fire filed its bid protest ("Protest"). AMR timely provides this brief response as allowed by the RFP.[1]

[1] Pursuant to Section 2.10(H) of the RFP, this response is due November 11, 2022, thus it is timely filed. For the sake of brevity, we address only a subset of the errors in the County Fire bid protest. Our lack of response on a particular argument in this letter should not be construed as a concession as to the merits of an unaddressed point.

I. Overview

AMR is an experienced ambulance provider that has faithfully served the County and its citizens for many years. For decades, AMR has provided similar services in more than 20 counties in California and currently operates approximately 1,000 ground ambulances per day. In California, AMR provides approximately 980,000 annual 911 ambulance transports and provides approximately 29,000 ambulance transports annually in Santa Barbara County. In contrast, County Fire operates only three ambulances, has never run a county-wide ambulance transport system, provides approximately 730 annual 911 ambulance transports a year, and outside of occasional mutual aid has never operated outside of its limited footprint of U.C. Santa Barbara, Vandenberg Village, and New Cuyama. The five independent evaluators here recognized the difference in experience, capabilities and the quality of the bids and awarded AMR 317.75 points more than County Fire received. AMR is the better-suited provider and was awarded the contract. None of County Fire's arguments in its Protest is persuasive or legally valid.

II. The Panel of Five Independent Evaluators

The County's General Services Department in consultation with the LEMSA and its third-party industry consultant, Fitch & Associates, assembled an expert panel of five independent evaluators upon whom they can rely when determining whom to contract with to operate the EMS system in the County. Each of the five persons chosen offered a separate but valuable perspective. Dr. Justin Fairless is an experienced emergency department Medical Director from Texas with extensive experience with EMS systems. Steven Fellows is a retired Chief Operating Officer for a Santa Barbara County based hospital, Cottage Health, with multiple years working in other hospital systems. Chief Steve Smith is a retired fire chief from Las Vegas, Nevada with experience regarding response time compliance and implementation of ALS services by a fire department. Richard Schomp is the Chief Operating Officer for a Florida-based private ambulance company and a retired firefighter. Lastly, Lawanda Lyons-Pruitt is a local representative of the NAACP and retired Chief Investigator for the Santa Barbara County Public Defender's Office with years of community experience focused on promoting justice, fairness, equality and equity in public systems. They had the benefit

of an independent financial analysis performed by Kevin Harper, CPA.[2] Mr. Harper examined each bidder's proposal, analyzed whether the bid met the four minimum qualifications outlined in the RFP and performed a fiscal review of the recent audit results and payer rates. He concluded that AMR and County Fire both met the minimum financial qualifications, the audit results, and the payer rates.

A Health & Safety Section 1797.224 competitive bid process, such as the one employed here, must be fair, unbiased and free from an appearance of favoritism and bias. *See Advanced Real Estate Services, Inc. v. Superior Court* (2011) 196 Cal.App.4th 338, 353 (sale of a fairgrounds was stopped due to failures in the bid protest procedures, relying on *Schram*); *Schram Construction, Inc. v. Regents of University of California* (2010) 187 Cal.App.4th 1040, 1059 (University must put affirmative safeguards in place to prevent bias and other arbitrary factors from influencing the bid selection). Further, a reviewing Court when ruling upon a bid protest will examine whether the public entity's actions were "arbitrary, capricious, entirely lacking in evidentiary support, or inconsistent with proper procedure." *Schram*, 187 Cal.App.4th at 1052. However, deviations from "strict adherence" to competitive bidding standards receive "close judicial scrutiny." *Id.*

To date[3], the RFP process has implemented numerous safeguards to ensure fairness, objectivity and to remove bias from the process considering County Fire and the County have the same governing board. The RFP had a mandatory bidders' conference, the RFP allowed bidders to ask questions, the RFP had oral presentations, the RFP[4] had an objective scoring matrix, and the RFP had independent expert evaluators. *See generally* RFP at Section 2.7. The process followed here with its prestigious panel of five

[2] County Fire contends that there was no financial analysis completed. Given Mr. Harper's review, this assertion is without merit.

[3] The County's early release of AMR's bid, which included its innovative approaches, e.g. nurse navigation and patient elopement project, to its competitor – County Fire - is inconsistent with the usual practice followed in most counties in light of the California Supreme Court opinion in *Michaelis, Montanari & Johnson v. Superior Court* (2006) 38 Cal.4th 1065, 1067 (public disclosure of such bids on public contracts properly may await conclusion of the agency's negotiation process, occurring before the agency's recommendation is finally approved by the awarding authority). The early release of AMR's bid will present problems later if the County asks the bidders to rebid this RFP.

[4] The RFP included thirty (30) scored categories adding up to 460 points. This scoring was designed to ensure "apples to apples" scoring amongst bidders and utilizing five independent evaluators provided protections from one scorer having too much influence on scoring.

independent reviewing experts should stand up to any close judicial scrutiny because the RFP was well-designed and well-executed to date with the benefit of a well-credentialed panel of independent evaluators. Accordingly, the judgment reached by these experts deserves respect and should receive appropriate deference. The independence and depth of experience of the review panel chosen here is the type of affirmative safeguard that the court in *Schram* mandated public entities utilize in bid processes. Having done so, the County can comfortably rely on and defer to this independent expert panel's fairness, thoroughness and judgment in analyzing the bids here.

III. AMR Met the "Minimum Qualifications" of the RFP

County Fire argues that AMR's proposal failed to establish AMR's minimum qualifications because "AMR failed to identify recent noncompliance, and, thus, the panel should have scored this requirement [in Section 2.9] with a 'fail' and discontinued consideration of AMR's proposal." (Protest at p.2). This argument is unsound. AMR is the most qualified provider in the United States, and its bid demonstrated that it more than met the minimum qualifications. The RFP required each bidder to demonstrate that the bidder has a "stable track record" of rendering all types of ambulance services at "levels of clinical quality and response time reliability **substantially equivalent** to the services required under this procurement." (RFP Section 2.9)(emphasis added). For purposes of establishing minimum qualifications, AMR focused on its decades of experience running the system in this County. AMR easily passed this "pass/fail" test. AMR included information about other counties simply to show AMR's breadth and depth in running other EMS systems. For the past five years, AMR has responded to several million 911 calls for service in California. Its relevant experience vastly exceeds the minimum called for by the RFP. County Fire tries to read out of the RFP the "substantially equivalent" language, which a reviewing court would not do. AMR had some minor contractual deviations in another county – Santa Clara County – related to lingering COVID-19 challenges. The October 12, 2022 meeting in Santa Clara that County Fire focuses on in its Protest occurred **after** AMR submitted its bid here on October 3, 2022. These isolated events in a different county did not disqualify AMR as a bidder because AMR demonstrated that it has rendered all types of required ambulance services in a sustained manner in Santa Barbara County – the jurisdiction AMR relied upon to meet the test. In fact, AMR has consistently met response times in

Santa Barbara even during COVID. AMR easily met all minimum qualifications and "passed" this minimum qualifications standard.[5]

IV. There Is No Kickback in the AMR Bid

County Fire argues in its Protest that AMR's bid should be rejected because AMR offered a kickback to the County in violation of the "Medicare and Medi-Cal Anti-Kickback Statute." County Fire's argument is legally without merit. AMR has not offered a kickback to the County. AMR indicated that if some possible federal funding ("PPIGT") were to become available at some undefined point during the life of the contract, AMR would explore with the LEMSA a potential method for accessing the funds. AMR did not offer to pay any remuneration to the County in violation of the Anti-Kickback Statute ("AKS"). Instead, AMR – as the County's anticipated partner in providing ambulance services – indicated its willingness to have a conversation about the funding to see if the EMS system could secure it in the future. AMR expressly noted in its Proposal that any potential funding was subject to all legal requirements and approvals, *i.e.*, "[i]n accordance with applicable federal and state laws and necessary approvals." *See* AMR proposal at pp. 95-96. This negates the principal element of intent under the Anti-Kickback Statute. Additionally, if funding were secured, the monies would benefit the EMS system. County Fire does not appear to understand the legal aspects of the federal AKS. The author's lay opinion should be disregarded because it lacks any legal validity.[6]

V. The Scoring Arguments Lack Merit

County Fire posits two scoring arguments. It asserts that the independent panel's scoring of sections 4.2 and 4.10 was defective, and "thus the entire AMR Proposal should be considered non-responsive." As the panel of independent evaluators correctly recognized, AMR thoroughly and sufficiently documented its clinical innovations throughout its proposal and in Attachment 04. This attachment included a sampling of

[5] This test was not intended to be a high bar to entry otherwise County Fire would not have passed given that it has only three ambulances and has no experience operating a high performance EMS system across an entire county like that contemplated in this RFP. It is a pass/fail test that examines basic qualifications not ideal qualifications.

[6] It is unclear whether County Fire consulted with an attorney regarding its unsupported AKS argument. There is no lawyer copied on the Protest, and there is no reference to any consultation with any lawyer about the possible application of the AKS to the facts here.

AMR's clinical and EMS research activities; these included publications in peer-reviewed journals, grant proposals and multi-site research studies. Attachment 04 shows detailed examples as recommended in the RFP. It also agreed to embrace the scorecard system that the LEMSA may implement. There is no need to adjust the scoring of these two sections; AMR met the requirements of the RFP, and the County is not empowered here to apply its own interpretation or discretion to rescore these sections that were scored by the independent expert evaluators. *See generally, Konica Business Machines USA, Inc. v. Regents of the University of California* (1988) 206 Cal.App.3d 449, 456-57 (strict adherence to the RFP is required when the award is a standard competitive contract).

VI. Other Miscellaneous Arguments Lack Merit

County Fire includes a grab bag of various minor arguments that hold no merit. None of them invalidates the RFP, and none of them is supported by substantial evidence of any error that would overrule the judgment of the independent expert evaluators. None of these arguments is going to concern a reviewing court. AMR here addresses the main ones: (1) County Fire objects to AMR's language about its fleet of ambulances. AMR submitted the required evidence that it can stand up the required fleet of ambulances prior to the beginning of the contract. The panel awarded points accordingly. (2) County Fire objects to AMR's use of the phrase "Just Culture." "Just Culture" is the intellectual property of another company, and AMR has a contractual right to use those words and logos in its RFP. (3) County Fire objects to AMR's use of the phrase "Lead CCT-P." County Fire misread the page; the exclusive icon is referring to the overall/entire clinical integration with CALSTAR, not the Lead CCT-P position. (4) Lastly, in preparing its bid on the RFP, AMR attached an incorrectly color-coded map at page 103 (the map contained a graphical typo with San Luis Obispo County colored blue instead of red). The textual description was correct (page 107) -- AMR provided an accurate list in the text of communities it serves with ground ambulance services, air ambulances services. AMR apologizes for this inadvertent map error. It should be noted, however, that AMR does provide mutual aid in San Luis Obispo County. If requested, AMR can also demonstrate why the other objections in County Fire's grab bag of objections should be disregarded.

VII. Conclusion

Thank you for the opportunity to respond to County Fire's Protest. To date, it appears that the County and its consultants have endeavored to run an objective and fair RFP process. Respectfully, County Fire's Protest should be denied, and AMR is prepared to move forward with the County contract. If you have any questions or wish to meet with us, we are available at your convenience.

Very truly yours,

/s/ Pamela L. Johnston

Pamela L. Johnston

cc: Rachel Van Mullem, County Counsel
rvanmull@countyofsb.org
Brian Pettit, Deputy County Counsel
bpettit@countyofsb.org
Nick Clay, EMS Agency Director
nclay@sbcphd.org
Mark Hartwig, Fire Chief / Fire Warden
Santa Barbara County Fire Protection District
mhartwig@countyofsb.org
AMR Law Department

3. District's Supplemental Information in Support of Formal Protest (Nov. 23, 2022)

Fire Department

"Serving the community since 1926"

HEADQUARTERS

4410 Cathedral Oaks Road
Santa Barbara, CA 93110-1042
(805) 681-5500 FAX: (805) 681-5563

Mark A. Hartwig
Fire Chief
County Fire Warden

Rob Heckman
Deputy Fire Chief
Administration

Anthony Stornetta
Deputy Fire Chief
Operations

Wednesday, November 23, 2022

VIA EMAIL AND U.S. MAIL

Phung Loman
Chief Procurement Officer
General Services Department
Purchasing Division
County of Santa Barbara
260 N. San Antonio Rd.

AND

American Medical Response West (AMR)
Mike Sanders, Regional Director
240 R. Highway 246, Ste. 300,
Buellton, CA 93427

The name and address of the Protesting party and its relationship to the responding RFP:
Protestor: Santa Barbara County Fire Protection District (RFP 8010001 Respondent)
Representative: Fire Chief/Fire Warden Mark A. Hartwig
Address: 4410 Cathedral Oaks Road
Santa Barbara, CA 93110
805-896-6400

Identification of the proposed contract/project: Formal Protest by Santa Barbara County Fire Protection District in Response to Notice of Intent to Award County of Santa Barbara RFP No. 8010001 (Emergency Ambulance Services) to American Medical Response, Inc. (AMR)

Supplemental Information In Support of November 4, 2022, Formal Protest in Response to County of Santa Barbara RFP No. 8010001 (Emergency Ambulance Services)

In light of new information becoming available related to AMR's contract and compliance within Sonoma County, we are requesting that this additional information and attachments be included to supplement the information and documents in our initial

protest, submitted on November 4, 2022, to the County of Santa Barbara RFP No. 8010001 (Emergency Ambulance Services).

Per the County's RFP protest instructions (Page 26, Section H), additional information provided by a protestor is contemplated and "Any written submissions after the initial filing shall, at the LEMSA's discretion, be limited to information that was not, and could not have been, known at the time of the filing of the Protest."

The below information and attachments were not available to the Santa Barbara County Fire Protection District at the time of the November 4, 2022, RFP Protest deadline. The Santa Barbara County Fire Protection District became aware of the Sonoma County contract and compliance matter on November 21, 2022. The letter dated October 14, 2022 from AMR to the County of Sonoma was not publically posted by Sonoma County and therefore could not have been known at the time of our protest.

The County Fire Protest, dated November 4, 2022, asserts that "AMR is false and misleading as to RFP Section 2.9 Minimum Qualifications because AMR failed to identify recent noncompliance and, thus, the panel should have scored this requirement with a "fail" and discontinued consideration of AMR's proposal." Not only did AMR cite within their proposal a contract with Santa Clara County (AMR Proposal Page 108) to establish its minimum qualifications in their proposal they also cited their contract with Sonoma County (AMR Proposal Page 110) as proof of "…a stable track record of rendering emergency, nonemergency, and urgent ambulance services…", meeting minimum qualifications in Santa Barbara County. AMR included Sonoma and Santa Clara Counties as evidence of performance BUT chose to omit the ongoing contract dispute, including AMR's assertion it no longer needs to comply with performance requirements with Sonoma County (and non-compliance in Santa Clara County). AMR does not have a stable track record of providing agreed-upon services in Santa Clara County or Sonoma County and AMR's citation to these jurisdictions is false and misleading and must be rejected.

On November 18, 2022, Counsel for the Sonoma County Department of Health Services responded to a notification provided by AMR to the County of Sonoma Board of Supervisors regarding their contract (dated October 14, 2022). As evidenced by correspondence between Sonoma County and AMR, AMR claims bad faith on behalf of the County and unilaterally asserts that the terms of the contract (e.g. response time and financial remuneration) no longer apply to AMR, essentially terminating their agreement with Sonoma County and advising that they will continue to provide services only under a "best effort" service commitment, not the required reponse times in the contract. AMR also includes a demand that first responder payments and performance penalties be returned to AMR, dating back to 2020, indicating that performance penalties have been assessed in the past under the contract. The dates of the correspondence and the timeline included within them demonstrate that AMR knew of the dispute before their bid submission and/or their presentation in Santa Barbara County.

Furthermore, as stated in AMR's letter to Sonoma County (Attachment 1), dated October 14, 2022, AMR asserts that they have not been under contract with Sonoma County since 2020. However, AMR characterizes Sonoma County as a client and proof of a stable track record (AMR Proposal Page 110), which these documents provide evidence is false.

In Sonoma County's response to AMR, the County "understands that the ambulance industry has faced unprecedented and substantial challenges in the last few years, including but not limited to supply chain disruptions and difficulty recruiting and retaining licensed and certified EMS personnel" and makes it clear that AMR has also not complied with requests for response time data ("To the extent that AMR is struggling with contract compliance due to these challenges…Among other things, AMR must immediately submit past-due final response time compliance reporting for August and September 2022 by December 1, 2022 and comply with the annual contract audit for fiscal years 2020-2022. Failure to do so would constitute a breach of the Agreement.").

We believe that AMR's unilateral move to vacate their existing agreement with Sonoma County and not comply with any performance requirements from the contract (in addition to demanding payment from from the County) eliminates them as a "qualified bidder" under the current procurement.

Thank you for accepting this new information that was not, and could not have been, known at the time our protest was filed.

DocuSigned by:
643A84E63CDE490...

Mark A. Hartwig
Fire Chief / Fire Warden

ATTACHMENTS

Attachment 1
AMR Letter, dated 10/14/22 - Notice that Emergency Ground Ambulance Services in Exclusive Operating Area #1 Between County of Sonoma and American Medical Response West dated December 31, 2008 as amended from time-to-time (collectively, "Agreement"), Ended on June 30, 2020

Attachment 2
Sonoma County Response, dated 11/18/22 - Re: Emergency Ground Ambulance Services in Exclusive Operating Area 1

Attachment 1

October 14, 2022

Tina Rivera
Director
Department of Health Services
County of Sonoma
1450 Neotomas Avenue, Suite 200
Santa Rosa, CA 95405
tina.rivera@sonoma-county.org
Via Email and Overnight Courier

Bryan Cleaver
Regional EMS Administrator
Coastal Valleys EMS Agency
195 Concourse Blvd., Suite B
Santa Rosa, CA 95403
Bryan.Cleaver@sonoma-county.org
Via Email and Overnight Courier

Board of Supervisors
County of Sonoma
575 Administration Drive
Room 100 A
Santa Rosa, CA 95403
Via Email Only

Sonoma County Counsel's Officer
County of Sonoma
Attn: Deputy County Counsel for Health Services
575 Administration Drive, Room 105
Santa Rosa, CA 95403-2881
Via Email and Overnight Courier

Re: Notice that Emergency Ground Ambulance Services in Exclusive Operating Area #1 Between County of Sonoma and American Medical Response West dated December 31, 2008 as amended from time-to-time (collectively, "Agreement"), Ended on June 30, 2020

Honorable Board of Supervisors, Director Rivera and Administrator Cleaver:

American Medical Response West ("AMR"), and its predecessor companies have been proudly caring for the citizens of the County of Sonoma for over 30 years without any cost to the County of Sonoma (the "County") and without county subsidy or any taxation to any of the communities we serve. Working together with the County and local public safety agencies, we have positively impacted thousands of lives with exceptional emergency medical care. Under our exclusive Agreement with the County, AMR currently provides services in Exclusive Operating Area #1 ("EOA 1"), where AMR responds to over 35,000 calls annually.

Attached is a letter from the State of California Emergency Medical Services Authority ("EMSA") dated June 17, 2022 declaring that the Agreement is non-exclusive. *See* June 17, 2022 EMSA Letter attached as Exhibit 1. This loss of exclusivity fundamentally undermines the material term of the Agreement and eviscerates the Fourth Amendment to the Agreement effective July 1, 2022. Specifically, Coastal Valley EMS Agency ("CVEMSA") and the County's actions have caused the County to lose exclusivity, and both entities have failed to cure this issue with EMSA. As a result, the terms and conditions of the Agreement are no longer in effect and AMR is no longer operating under the terms of the Agreement.

Notwithstanding, AMR will continue to provide emergency medical services as it has done over the decades while the County's request for proposal process ("RFP") continues. To be clear, AMR is no longer under contract to the County, and all terms of the Agreement, including, but not limited to, first responder fees and performance requirements have ceased and any payments should immediately be returned to AMR.

Attachment 1

In support of our decision, we have provided a brief and high level timeline below.

- In December of 2008 the County and AMR entered into the Agreement for emergency ground ambulance service in EOA 1, with an initial term of July 1, 2009 to June 30, 2014, and provided an option for two (2) extension periods with good performance, which we were awarded both times, for a total maximum of 10 years, concluding June 30, 2019.

- In March of 2017, AMR was notified that before an RFP for EOA 1 would be released the County desired to complete an ambulance ordinance revision process. In April of 2018, the County postponed the EOA 1 RFP and AMR was asked to sign a three-year extension that was set to expire June 30, 2022. This extension to the old Agreement of 2009 and its standards has resulted in instability to the system due to the delay of changing antiquated practices and implementing EMS system enhancements and innovation needed to improve the system. This instability has caused inefficient resource utilization and significant recruitment and retention problems, which have only been exacerbated by the global COVID-19 pandemic.

- On February 4, 2022, we were again approached by County Public Health to sign an extension in lieu of submitting a RFP response. While AMR was fully prepared to respond to the RFP and meet the March 1, 2022 RFP deadline, AMR was informed that the County would not be able to finish the competitive RFP process due to a potential bidder complaining about supply chain issues and its ability to procure ambulances. While not in AMR's best interests, we agreed to a 18-month extension of the Agreement with some provisions we believed would help enhance the system inefficiencies and improve instability, which included the implementation of a tiered response ("Tiered Response") system for a more effective use of resources and a rate increase to support employee wage adjustments.

- On February 17, 2022, the County settled litigation with Sonoma County Fire District and the California Fire Chiefs Association, Inc. related to EOA 2 ("EOA 2 Settlement"). EOA 2 is an agreement between the County and Bell's Ambulance – not AMR. Yet, the EOA 2 Settlement would only be effective if the County postponed the RFP for EOA 1. *See* EOA 2 Settlement dated February 18, 2022. In other words, the County settled an unrelated case involving EOA 2 by using EOA 1 as leverage. Again, Sonoma County Fire District presumably benefitted because it was unprepared for a March 1st RFP deadline for EOA 1.

- On February 18, 2022, AMR and the County attorney signed the first Fourth Amendment to the Agreement and the County Director of Health Services signed on February 22, 2022. *See* first Fourth Amendment to Agreement. The County did not inform AMR about its EOA 2 Settlement until after AMR signed the first Fourth Amendment to the Agreement. Despite material agreement on the terms of the first Fourth Amendment to the Agreement, the County Board refused to ratify the first Fourth Amendment and then later the County forced AMR to change the first Fourth Amendment.

- On February 18, 2022, the County cancelled the RFP for EOA 1 to meet the EOA 2 Settlement requirements.

- In May 2022 during the County Board meeting, we were ordered to make changes to our agreed upon February 2022 first Fourth Amendment as it relates to the implementation of Tiered Response.

Attachment 1

Tiered Response is industry standard and matches the right ambulance resource to the right call. Since that time, the County has been unable to make any material progress with Tiered Response. This is largely due to efforts from fire departments to obfuscate and delay through an unnecessary process of 18 meetings. Tiered Response could have been implemented almost immediately as the EMS industry has done in other areas including, in both public and private provider systems. The failure to implement Tiered Response on July 1, 2022 or earlier has compounded the system instabilities resulting in over 4,000 missed opportunities to keep advanced life support resources available in the 911 system to respond to high acuity patients in the need of life-saving services.

- On June 7, 2022, AMR signed the second Fourth Amendment to the Agreement.
- On June 13, 2022, the County knew there was no exclusivity and sent a letter to EMSA. Specifically, the County Director of Health Services requested an extension of the exclusivity for EOA 1.
- On June 16, 2022, the County signed the second Fourth Amendment to the Agreement acknowledging exclusivity for EOA 1.
- On June 17, 2022, the County received the EMSA letter that states, "[t]he exclusivity for Sonoma County EMS Sub-Area #1 expired on June 30, 2020."
- Since June 30, 2022 and despite a lack of exclusivity, AMR has paid over $330,000 in first responder and County oversight fees.
- As of October 14, 2022, the County has failed to cure the June 17th loss of exclusivity – over 100 days.

The County approached AMR on multiple occasions regarding an extension to the Agreement and we put the interests of the community first. The County seemingly forced the extensions to allow the local fire department to better compete against AMR in the future RFP. The local fire department has limited or no comparable experiences running a complex and large system such as EOA 1, with only a few ambulances and it has no comparable experiences in the intricacies of third-party billing. These delays and the fundamental changes to the RFP caused the County to lose exclusivity and caused the Agreement to end.

The County has made repeated changes to its draft RFP to ostensibly favor the local fire department and ease credentialing requirements in the RFP. These decisions were made over the services that have been provided and proven by AMR for more than three decades. In essence, the County has actively advocated and supported the fire department's ability to "compete" against us, abandoning its role to be a fair arbiter in the procurement process and influencing what is intended to be an equitable and competitive process as required by California law – §1797.224. Given the above, the County has abandoned its obligations under the Agreement and abandoned its obligations under the California EMS Act which necessitated our decision today. We are fully prepared to protect our legal interests under the California EMS Act and our former Agreement.

Attachment 1

Please feel free to contact our Region Director, KT McNulty (KT.McNulty@gmr.net) or me. **Again, even though this was forced upon us, AMR will not abandon our Sonoma County community and will continue to provide the services and excellent patient-focused care that the community knows and expects. Our dedicated union clinicians live and work in the County. We are prepared to protect their interests and our interests in order to continue providing our excellent services for years to come.**

Sincerely,

AMERICAN MEDICAL RESPONSE WEST

Sean Russell
President Pacific Region
916.921.4000
Sean.russell@gmr.net

Enc: Exhibit 1 - June 17, 2022 EMSA Letter

Cc: Susan Gorin, District 1 (Susan.Gorin@sonoma-county.org)
David Rabbitt, District 2 (David.Rabbitt@sonoma-county.org)
Chris Coursey, District 3 (district3@sonoma-county.org)
James Gore, District 4 (district4@sonoma-county.org)
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Nicole Henricksen, AMR Vice President
KT McNulty, AMR Regional Director
Law Department, AMR
Pamela Johnston, Foley & Lardner, LLP (pjohnston@foley.com)

Attachment 1

June 17, 2022

Tina Rivera
Department of Health Services
Coastal Valleys EMS Agency
195 Concourse Blvd., Ste. B
Santa Rosa, CA 95403

Dear Ms. Rivera,

The Emergency Medical Services (EMS) Authority has received and reviewed the Sonoma County Department of Health Service's June 13, 2022, request for extension of the exclusivity for Sonoma EOA #1. The EMS Authority does not have authorization in statute or regulation to issue extensions to EMS areas or sub-areas determined exclusive by competitive process as outlined in Health and Safety Code Section 1797.224. While the EMS Authority understands there have been many situations that could affect the local EMS agency's ability to conduct a competitive process, we are unable to approve your request for extension.

The exclusivity for Sonoma County EMS Sub-Area #1 expired on June 30, 2020. The EMS Authority recognizes Sonoma County EMS Sub-Area #1 as non-exclusive. In order for Coastal Valley EMS Agency to designate this sub-area as exclusive under HSC 1797.224, a new approved competitive process will need to be conducted.

If you have any questions, please contact Angela Wise, Assistant Chief of EMS Systems Division at (916) 431-3708.

Sincerely,

Elizabeth Basnett
Acting Director
Emergency Medical Services Authority

cc: Bryan Cleaver, Administrator, Coastal Valleys EMS Agency

Attachment 2

HOOPER, LUNDY & BOOKMAN, P.C.

HEALTH CARE LAWYERS & ADVISORS
101 MONTGOMERY STREET, 11TH FLOOR
SAN FRANCISCO, CALIFORNIA 94104
TELEPHONE (415) 875-8500
FACSIMILE (415) 986-2157
WEB SITE: WWW.HEALTH-LAW.COM

WRITER'S DIRECT DIAL NUMBER:
(415) 875-8497

WRITER'S E-MAIL ADDRESS:
JKEARNEY@HEALTH-LAW.COM

OFFICES ALSO LOCATED IN
LOS ANGELES
SAN DIEGO
WASHINGTON, D.C.
BOSTON
DENVER

November 18, 2022

VIA EMAIL AND U.S. MAIL

Sean Russell
Region President
American Medical Response
930 South A Street
Santa Rosa, CA 95404
sean.russell@gmr.net

Re: Emergency Ground Ambulance Services in Exclusive Operating Area 1

Dear Mr. Russell:

The Department of Health Services (DHS) is in receipt of your October 14, 2022 letter, which unilaterally asserts that the Fourth Emergency Ground Ambulance Services in Exclusive Operating Area #1 Between County of Sonoma and American Medical Response West dated December 31, 2008 as amended from time-to-time (collectively, "Agreement"), Ended on June 30, 2020" (the Notice Letter).

DHS disputes both your conclusion that the Agreement has ceased to exist and your recitation of the background facts in your letter; DHS's position is that the Agreement is lawful and enforceable. The Agreement does not allow AMR to unilaterally terminate, and the Agreement remains in effect.

DHS's mission is to protect the health and well-being of individuals and the community by ensuring the availability of the highest quality emergency medical services within a coordinated local emergency response system and delivered in an equitable manner. While DHS appreciates AMR's stated desire to keep doing business in the County and your corresponding commitment to remain in EOA-1, your unilateral rejection of the Agreement puts our residents at risk. This is not an outcome that DHS can allow.

That said, DHS understands that the ambulance industry has faced unprecedented and substantial challenges in the last few years, including but not limited to supply chain disruptions and difficulty recruiting and retaining licensed and certified EMS personnel. DHS believes that it has shown itself to be a willing partner to work collaboratively to address these challenges.

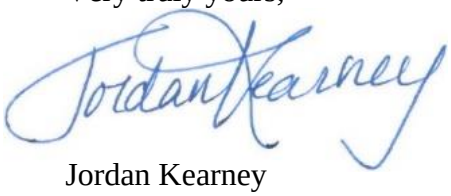
Attachment 2

To the extent that AMR is struggling with contract compliance due to these challenges, and AMR wishes to approach the County to seek a reasonable solution to address those factors, then AMR must utilize the mandatory dispute resolution provisions contained with the Agreement (Sec. 11).

Although DHS is willing to discuss your concerns through the appropriate processes, in the interim, AMR must continue to comply with its obligations under the Agreement. Among other things, AMR must immediately submit past-due final response time compliance reporting for August and September 2022 by December 1, 2022 and comply with the annual contract audit for fiscal years 2020-2022. Failure to do so would constitute a breach of the Agreement.

DHS would like to discuss appropriate next steps on a call with you. Please reach out to me at jkearney@health-law.com to facilitate this conversation.

Very truly yours,



Jordan Kearney

JCK

cc: Pamela Johnston, Foley & Lardner, LLP, pjohnston@foley.com
Walt Landen, Deputy General Counsel, walt.landen@gmr.net
KT McNulty, AMR Regional Director, kt.mcnulty@gmr.net
Nicole Henricksen, AMR Vice President, nicole.henricksen@gmr.net
Law Department, AMR
Tina Rivera, Director, Department of Health Services, tina.rivera@sonoma-county.org
Adam Radtke, Esq., Deputy County Counsel, adam.radtke@sonoma-county.org

4. American Medical Response West's Supplemental Response to District's Supplemental Information (Nov. 29, 2022)

FOLEY
FOLEY & LARDNER LLP

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CLIENT/MATTER NUMBER
027013-0127

November 29, 2022

Via Email (list below) and Hand-Delivery

Phung Loman
Chief Procurement Officer
General Services Department
Purchasing Division
County of Santa Barbara
260 North San Antonio Road
Santa Barbara, California 93110
Ploman@countyofsb.org

Re: American Medical Response West's Supplemental Reply to Santa Barbara County Fire Protection District's Supplement (RFP 8010001)

Dear Ms. Loman:

On November 4, 2022, County Fire filed its bid protest ("Protest"). On November 10, 2022, AMR timely provided its response as allowed by the RFP. On November 23, 2022, County Fire submitted a supplement to its Protest ("Supplement"). AMR now submits this reply to County Fire's Supplement ("Supplemental Reply").

Under Section 2.10(H) of the RFP, County Fire was required to submit all of its bases for its protest within five (5) business days of the award. The RFP only permits late submissions by County Fire if it can demonstrate that the new information "was not, and could not have been, known at the time of the filing of the Protest." County Fire asserts in its Supplement that it "became aware of the Sonoma County contract and compliance matter on November 21, 2022." County Fire, however, did not explain ***why*** it could not have known about the Sonoma County contractual events before it submitted its Protest on November 4. AMR's dispute with Sonoma County has been a matter of public record since October 14, 2022, and as explained below the California Emergency Medical Services Authority ("State EMSA") letter has been a public record since June 17, 2022. The Procurement Officer is authorized to deny consideration of this late submission by County Fire given the RFP's standard.

FOLEY

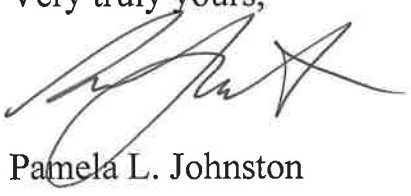
FOLEY & LARDNER LLP

If the Procurement Officer decides to consider the Supplement, the Procurement Officer should find that the Sonoma matter is irrelevant to the award of the Santa Barbara RFP to AMR. AMR has a bona fide dispute with Sonoma County arising from the State EMSA's denial in June 2022 of Sonoma County's request to extend AMR's exclusive contract. Specifically, on June 17, 2022, Sonoma County received a letter from the State EMSA that stated that "[t]he exclusivity for Sonoma County EMS Sub-Area #1 expired on June 30, 2020." Sonoma County and AMR are working through this dispute occasioned by the State EMSA's decision, and AMR continues to serve Sonoma County with high quality emergency medical services as it has done for decades. The Sonoma dispute has no bearing on AMR's ability to serve the people of Santa Barbara. Further, the Sonoma dispute has no bearing on the scoring of the five (5) independent evaluators who reviewed the bids and scored AMR 317.75 points higher than County Fire. County Fire's argument should be overruled.

Building upon 52 years of service, AMR looks forward to continuing to provide the level of service the County has come to depend upon from AMR, as was recognized overwhelmingly by the five independent evaluators. Because Santa Barbara County faces continued challenges related to wildfires, flooding and serious incidents, the County will continue to have well-prepared teams to serve its citizens and visitors. AMR looks forward to continuing to work with its partners in the fire service in the provision of excellent emergency medical services, and collaborating with all stakeholders to enhance the overall system as put forward in our response, to include the launch of a centralized fire and EMS dispatch center.

AMR is prepared to move forward with the County contract. If you have any questions or wish to meet with us, we are available at your convenience.

Very truly yours,



Pamela L. Johnston

cc: Rachel Van Mullem, County Counsel
rvanmull@countyofsb.org
Brian Pettit, Deputy County Counsel
bpettit@countyofsb.org
Nick Clay, EMS Agency Director
nclay@sbcphd.org
Mark Hartwig, Fire Chief / Fire Warden
Santa Barbara County Fire Protection District
mhartwig@countyofsb.org
Mike Sanders, AMR Region Director
AMR Law Department

5. RFP Protest Purchasing Agent Decision Letter (Dec. 14, 2022)

one COUNTY one FUTURE

GENERAL SERVICES DEPARTMENT

Janette D. Pell, Director
Lynne Dible, Assistant Director, CFO
Skip Grey, Assistant Director, Real Estate & Fleet
Andre Monostori, Assistant Director, ICT
Patrick Zuroske, Assistant Director, Capital & Facilities-Maintenance

December 14, 2022

Mark A. Hartwig
Fire Chief/Fire Warden
Santa Barbara County Fire Protection District
4410 Cathedral Oaks Road
Santa Barbara, CA 93100-1042

Re: Bid RFP #8010001 - GS Purchasing-Services: Exclusive Ambulance Services Provider for the Santa Barbara County Exclusive Operating Area ("RFP")

Dear Mr. Hartwig:

Thank you for submitting the protest letter dated Friday, November 4, 2022 and supplemental information to the protest dated Wednesday, November 23, 2022. Below are responses to the Santa Barbara County Fire Protection District ("District") protest and supplemental information.

District Reason 1: False and Misleading as to RFP Minimum Qualifications.

District states "AMR [American Medical Response West] Proposal is False and Misleading as to RFP Section 2.9 Minimum Qualifications because AMR failed to identify recent noncompliance and, thus, the panel should have scored this requirement with a "fail" and discontinued consideration of AMR's proposal." (Protest, p. 2) District specifically refers to RFP section 2.9.B. (Protest, p. 2.)

County of Santa Barbara Response to District Reason 1:

Denied.

RFP section 2.9.B states "LEMSA shall entertain proposals only from organizations demonstrating fiscal stability and prudence, as well as a stable track record of rendering emergency, non-emergency, and urgent ambulance services at levels of clinical quality and response time reliability substantially equivalent to the services required under this procurement. Therefore, all interested Proposers are required to meet minimum qualifications as a part of their RFP response. Proposers' credentials will be evaluated … to demonstrate each Proposer's ability to perform if awarded the Contract. Credentials … will be scored on a pass/fail basis." Nothing in RFP section 2.9, including subsection 2.9.B, required proposers to disclose non-compliance issues.

RFP section 2.11.A states "[t]his section includes the criteria that will be considered in scoring the Proposals …. [and] …. The matrix that will be used in the Proposal review process is outlined below. The total points that can be awarded for each area are identified." The Proposal Review Panel scored both proposals as a "pass" for RFP section 2.9 in accordance with Proposal Evaluation Criteria set forth in RFP section 2.11.

Per RFP section 2.10.G.iii. statements challenging the judgment of the Review Panel shall not be considered as valid protests.

District Reason 2: Failure to Comply with RFP Proposal Evaluation Criteria.

District states "AMR Proposal Is Nonresponsive to sections 4.2 and 4.10 of the RFP and thus the entire AMR Proposal should be considered non-responsive (RFP page 30), and the contract awarded to the District. The proposers were not accorded fair and equal consideration in the evaluation process because the bids were not evaluated in accordance with the stated Proposal Evaluation Criteria." (Protest, p. 3.)

In regards to RFP section 4.2 District states "Appendix 10 to the RFP is entitled "Sample Proposal Evaluation Criteria Explained" and contains questions intended to guide the Proposal Review Panel ("PRP") in evaluating the various sections of the proposals. For Section 4.2, Appendix 10 provides evaluators with the following guidance: *Has the Proposer fully outlined what data/metrics it will collect and how it will be used to improve the clinical practice within the EMS system?" (Protest p. 4.)* District continues "AMR failed "to "fully outline" the data/metrics AMR will collect or how such data will be used to improve clinical practice within the EMS system. Because it fails to provide the information requested in Section 2.1 of the RFP, the Proposal is nonresponsive and cannot be accepted by County." (Protest, p. 5.)

In regards to RFP section 4.10 District states that AMR failed to identify 7 elements listed under RFP section 4.10 and concludes "[t]he AMR Proposal, therefore, fails to fully respond to the instructions in Section 4.10 of the RFP, should have thus been scored as unsatisfactory by 3+ reviewers, and the entire AMR Proposal should be deemed non-responsive. (RFP page 30.)" (Protest, p. 5-7.)

County of Santa Barbara Response to District Reason 2:

Denied.

RFP section 2.1 titled "Performance-Based Contract" states "[t]his RFP is designed to result in the award of a performance-based Contract (also referred to herein as Agreement). Contractor's failure to achieve the performance standards set forth in the RFP and resulting Contract will result in the assessment of liquidated damages, as set forth herein, and may result in the LEMSA's termination of the Contract. The essential areas where performance must be achieved include: …[includes 10 bullet points]. The Agreement is not a level-of-effort agreement. The successful Proposer must employ whatever level of effort is necessary to achieve the clinical, response time, customer satisfaction, quality improvement, and other performance results required by the EMS System Specifications." Nothing required proposers to link all information to RFP section 2.1, nor does the section indicate it is the definition of "fully outlined."

Appendix 10 is titled "Sample". Nothing in the RFP required proposers to specifically respond to the questions in Appendix 10.

RFP section 2.11.A states "[t]his section includes the criteria that will be considered in scoring the Proposals …. [and] …. The matrix that will be used in the Proposal review process is outlined below. The total points that can be awarded for each area are identified." The Proposal Review Panel scored both proposals for sections 4.2 and 4.10 in accordance with Proposal Evaluation Criteria set forth in RFP section 2.11.

Per RFP section 2.10.G.iii. statements challenging the judgment of the Review Panel shall not be considered as valid protests.

District Reason 3: Possible Violation of the Medicare and Medi-Cal Anti-Kickback.

District states "County Must Reject The AMR Proposal And Refuse To Contract With AMR Because The Proposal Appears To Offer To Allow The County To Access PPIGT Funding In Violation Of The Medicare and Medi-Cal Anti-Kickback Statute (AKS)." (Protest, p. 9.)

County of Santa Barbara Response to District Reason 3:

Denied.

The County of Santa Barbara accepts AMR's response as a valid rebuttal.

District Reason 4: Additional False or Misleading Statements.

District states "The AMR Proposal should be rejected because it contains additional significant false or misleading statements. As per the County of Santa Barbara RFP No. 8010001, Section 2.5 False or Misleading Statements, "Responses which contain false or misleading statements, or which provide references which do not support an attribute or condition claimed by the Proposer, must be rejected, subject to the County's ability to waive minor irregularities." (Protest, p. 11.)

County of Santa Barbara Response to District Reason 4:

Denied.

The County of Santa Barbara accepts AMR's response as a valid rebuttal.

District Reason 5: Failure to Consider Economic Benefits to County.

District states "Santa Barbara County Code of Ordinances, Article VI, Section 2-40(d) for competitive bidding requires fiscal statements. Cost is always a factor when the County purchases on behalf of the taxpayer and failure to require this information in soliciting and evaluating bids harms the County and is inconsistent with the County Code." (Protest, p.12.)

County of Santa Barbara Response to District Reason 5:

Denied.

The County of Santa Barbara does not agree with the District's application of County Code section 2-40(d).

The County of Santa Barbara does not agree with the District's application of County Code section 2-41(a).

RFP section 2.11.A states "[t]his section includes the criteria that will be considered in scoring the Proposals …. [and] …. The matrix that will be used in the Proposal review process is outlined below. The total points that can be awarded for each area are identified." The Proposal Review Panel scored both proposals as a "pass" for the Financial Assessment in accordance with Proposal Evaluation Criteria set forth in RFP section 2.11.

Per RFP section 2.10.G.iii. statements challenging the judgment of the Review Panel shall not be considered as valid protests.

District Reason 6: Failure to Comply with RFP Proposal Instruction (Page 19 of RFP).

District states "AMR's Proposal did not comply with the RFP rigorous proposal instructions (RFP 2.8 Proposal Instruction, Pg 19); therefore, the AMR Proposal should be considered nonresponsive, rejected, and the contract awarded to the District." (Protest, p. 13.)

County of Santa Barbara Response to District Reason 6:

Denied.

RFP section 2.11.A states "[t]his section includes the criteria that will be considered in scoring the Proposals …. [and] …. The matrix that will be used in the Proposal review process is outlined below.

The total points that can be awarded for each area are identified." The Proposal Review Panel scored both proposals as a "pass" for section 2.8 in accordance with Proposal Evaluation Criteria set forth in RFP section 2.11.

Per RFP section 2.10.G.iii. statements challenging the judgment of the Review Panel shall not be considered as valid protests.

District Supplemental Information: False and Misleading as to RFP Minimum Qualifications.

District states "AMR is false and misleading as to RFP Section 2.9 Minimum Qualifications because AMR failed to identify recent noncompliance and, thus, the panel should have scored this requirement with a "fail" and discontinued consideration of AMR's proposal." (Supp. Info., p. 2.) District specifically refers to RFP section 2.9.B. (Supp. Info., p. 2.)

County of Santa Barbara Response to Supplemental Information:

Denied.

RFP section 2.9.B states "LEMSA shall entertain proposals only from organizations demonstrating fiscal stability and prudence, as well as a stable track record of rendering emergency, non-emergency, and urgent ambulance services at levels of clinical quality and response time reliability substantially equivalent to the services required under this procurement. Therefore, all interested Proposers are required to meet minimum qualifications as a part of their RFP response. Proposers' credentials will be evaluated … to demonstrate each Proposer's ability to perform if awarded the Contract. Credentials … will be scored on a pass/fail basis." Nothing in RFP section 2.9, including subsection 2.9.B, required proposers to disclose non-compliance issues.

RFP section 2.11.A states "[t]his section includes the criteria that will be considered in scoring the Proposals …. [and] …. The matrix that will be used in the Proposal review process is outlined below. The total points that can be awarded for each area are identified." The Proposal Review Panel scored both proposals as a "pass" for RFP section 2.9 in accordance with Proposal Evaluation Criteria set forth in RFP section 2.11.

Per RFP section 2.10.G.iii. statements challenging the judgment of the Review Panel shall not be considered as valid protests.

Thank you for the time and effort you and the Santa Barbara County Fire Protection District expended in responding to the Request for Proposal.

Sincerely,

Phung Loman

Phung Loman
Chief Procurement Officer (Purchasing Agent)
General Services Department
Purchasing Division

cc:

American Medical Response West (AMR)
Mike Sanders, Regional Director
Mike.sanders@gmr.net

Pamela L. Johnston

Attorney for American Medical Response West (AMR)
pjohnston@foley.com

Rachel Van Mullem
Santa Barbara County Counsel
rvanmull@countyofsb.org

Brian Pettit
Santa Barbara Deputy County Counsel
bpettit@countyofsb.org

Nick Clay
EMS Agency Director
nclay@sbcphd.org

6. Original Proof of email submission of District's Formal Protest in Response to Notice of Intent to Award County of Santa Barbara RFP No. 8010001 (Nov. 4, 2022)

From:	Stockton, Courtney on behalf of Hartwig, Mark
To:	Loman, Phung; Mike.sanders@gmr.net
Bcc:	Hartwig, Mark; Jorgensen, Shawna
Subject:	Formal Protest by Santa Barbara County Fire District in Response to Notice of Intent to Award County of Santa Barbara RFP No. 8010001
Date:	Friday, November 4, 2022 4:52:00 PM
Attachments:	Formal Protest by Santa Barbara County Fire District in Response to Notice of Intent to Award County of Santa Barbara RFP No. 8010001.pdf

Ms. Loman and Mr. Sanders,

Attached to this email is a Formal Protest by Santa Barbra County Fire District in Response to the Notice of Intent to Award County of Santa Barbara RFP No. 8010001 (Emergency Ambulance Services) to American Medical Response, Inc. (AMR).

This Formal Protest is in reference to RFP #8010001 - GS Purchasing-Services: Exclusive Ambulance Services Provider for the Santa Barbara County Exclusive Operating Area.

All documents located are at the following publicly accessible website link:
https://www.publicpurchase.com/gems/bid/bidView?bidId=160135&sso=5db6362b733a422577f0eda029f0423c

Thank you,

Mark Hartwig
Fire Chief / Fire Warden
Santa Barbara County Fire Department