Dispatch Operations Advisory Group
Regular Meeting
Agenda

March 28, 2024 – 1:00 pm

Santa Rosa Training Tower
2126 West College Ave
Santa Rosa, CA

I. Call to Order

II. Approval of the Agenda

III. Approval of the DOAG Minutes

a) Minutes for January 11, 2024, Special Meeting Minutes – Discussion and action to approve – Spencer Andreis

IV. Public Comment Period

In this time period, anyone may address the DOAG regarding any subject over which the DOAG has jurisdiction, but which is not on today's agenda. Individuals will be limited to a three-minute presentation. Members of the public will be given the opportunity to address the DOAG regarding items on the agenda at the time that the agenda item is taken up by the DOAG.

IV. New Business

a.) New call type for prescribed burn (pile and broadcast burning). This would support position task books by having an incident number, and potentially display an icon in the proper location in PulsePoint (which informs residents) and Tablet Command throughout the duration of the burn – Marshall Turbeville
b.) Victor 1 and Victor 2 designated for vegetation management projects including roadside vegetation management traffic control and prescribed burns – Marshall Turbeville
c.) We may have the possibility install a repeater on Shellenger Road in Cloverdale. This site has a GMRS repeater that provides "great" coverage. I am starting discussions to see if a Victor repeater (probably not Victor 6), be put there for use similar to how Victor 6 is used in other parts of the county. Part of my discussion will be to determine licensing and feasibility- Marshall Turbeville

d.) SOP 6 Update - Special ops would like to make the following recommendation: - Mike Stornetta - We would like to number our jet skis as follows: Ski 3 (station 3), Ski 7 (station 7) Ski 9 (station 9), Ski 10 (station 10) - Ken Reese

This is important due to the fact that in the 75 series, we no longer have any 4's left. And if we need to change one, we want to change all for consistency.

e.) Amendments to policies 13, 25, 28 & 40 - Spencer Andreis

VI. Old Business

a.) Tiered Response Update – James Salvante

VII. Work Group Reports/ Sub Committees

Work Groups developing dispatch implementation recommendations will present reports to the DOAG. The DOAG may take action on information contained in the reports.

- Dispatch Steering Committee (EMD or EFD topics) – Evonne Stevens
- Radio – Control 2-4 replacement – Evonne Stevens
- SOP- Training
- CAD /Back –up
- SMART

VIII. Announcement Items from the Membership

Conduct a roundtable of members

Next Meeting May 23, 2024, at 1300

Adjournment:

Dispatch Operations Advisory Group
Regular Meeting
Agenda

Special Meeting

January 11, 2024 – 10:00 AM

Santa Rosa Training Tower
2126 West College Ave
Santa Rosa, CA

Present:
Spencer Andreis – Chair – Sonoma Valley Fire
Shepley Schroth - Cary – Vice Chair Gold Ridge
Travers Collins – Santa Rosa Fire
James Salvante – Costal Valley EMS
Ron Busch - SCY
Scott Melendy – CalFire

Others Present:
Brenda Bacigalupi – REDCOM Administration Assistant
Evonne Stevens – REDCOM Executive Director - Remote
Ken Reese – REDCOM Communications Manager
Nick Barber – REDCOM System Administrator
Sean Lacy – Sonoma Valley
Darrin DeCarli – Gold Ridge Fire
Monica Vanoni – REDCOM
Jeff Veliquette – Rancho Adobe
Jeff Schach – Petaluma
Jack Thomas - SRS
Mark Heine - SCFD
Brian Crabb – Healdsburg
Darrell Kopriva – REDCOM
Peter Goyhenetche – SLS
Matt Windrem – SCFD
Stephen Dalporto – 1401
Meagan Horeczko – REDCOM

Remote:
Evonne Stevens – REDCOM Executive Director
Dr. Mark Luoto - County EMS Medical Director

I. **Call to Order** Made by Spencer Andreis @ 10:03am

II. **Approval of the Agenda** Motion to approve Agenda made by Traver Collins, Second James Salvante – Discussion – No further Comments – Approved unanimously.

III. **Approval of the DOAG Minutes**

IV. **Minutes for November 28, 2023, Meeting Minutes – Discussion and action to approve – Spencer Andreis** Motion to approve Agenda made by Ron Busch, Second Travers Collins – Discussion – No further Comments – Approved unanimously.

IV. **Public Comment Period**

In this time period, anyone may address the DOAG regarding any subject over which the DOAG has jurisdiction, but which is not on today's agenda. Individuals will be limited to a three-minute presentation. Members of the public will be given the opportunity to address the DOAG regarding items on the agenda at the time that the agenda item is taken up by the DOAG.

None

V. **New Business**

a) Ambulance Posting SOP – Spencer Andreis – I actually put this on here with the new posting schedule I thought it would be favorable for the agencies in the County to have it visible. We have never done that. We did not do it with SLS, so given that we have a change. I figured that would be the best platform to get that new posting schematic politicized in viewable. Any discussion from the group.

Ron Busch – Is it posted already?

Spencer Andreis – No with the new EOA with the Board of Sonoma County they have changed the posting to different post locations, numbering schemes, and such different from what SLS did.

Ron Busch – We are going to send out the posting locations on a map so everyone can see them.

James Salvante – Spencer are you looking for something that is public facing? Is that the idea.

Spencer Andreis - Well again, just somewhere it is memorialized if anybody in the County can go, and I figured our SOPs would be a great place for it. Just a good reference point. I know Chief Heine alluded yesterday that they are going to also put it on their website so more the merrier.

James Salvante – I think that is a great idea.

Spencer Andreis - Any objections, any discussion.

Matt Windrem - I just ask are you looking for just the post locations or the actual like system status which units will be posted.

Spencer Andreis – No, just the numbering scheme. If Meg 992 said you got to go to post 12. They will have a reference point, or you know a Life West unit again just knowledge is power. We have never had it and I figured that this would be an opportune time to.

Mark Heine - Spencer, we will get it posted on the SCFD EMS web page. We just had a staff briefing yesterday on this. We are going to start getting all source stuff up there for everybody. The idea is from my perspective is to create a one stop shop anybody in the system go to and see the locations or whatever other source material that they want to see. We will prioritize that. If you are in the field or in the office, you can pull it up.

Spencer Andreis – Ok, are you suggesting that in lieu of the REDCOM website or in conjunction.

Mark Heine – No, just to saturate them.

Spencer Andreis - Ok.

Jack Thomas – Are you going to have like a map of those locations?

Mark Heine - Ron has been working with GIS. GSI is taking the EOA1 service boundary maps that we have had and operated for a while. Putting big blue dots on the post locations.

Jack Thomas – That would be very helpful.

Spencer Andreis – Any further discussion? Ok, hearing none looking for a motion.

James Salvante – What is the motion?

Spencer Andreis – The motion will be adding the new Sonoma County Fire Posting schedule as a new SOP.

Shepley Schroth - Cary - I have one question. I do not know how much work it will intel can it also be visible on the Table Command map. Would that be a facility, or would that be beyond and as things change in the future would that sound unreasonable.

Spencer Andrei s- Yes, we could push it as a file, and that way it could be just on the desktop of each so those that are in the MDM we could push it out to everybody that is in the MDM and addition too.

Ron Busch – It will be adjusted as needed.

Spencer Andreis – Right.

Shepley Schroth – Cary – I asked that question would it be a workload associated but we live in table command.

Spencer Andries – Yes, it is a great idea looking for a motion.

Motion to approve Ambulance Posting SOP made by James Salvante, Second Shepley Schroth – Cary – Discussion – No further Comments – Approved unanimously.

b) Station recommends vs unit – Ken Reese - Goldbridge came to me with an idea with some of their volunteer companies. That rather than recommending a bunch of resources from an agency that may or may not go to a call or we do not know what type of resources they have the had a suggestion. We have temporary put this in place. Basically, what we are doing is we are recommending the station rather than a unit. Rather than 5581, 5563,5540 whatever. We are actually just recommending the station and just saying station 55 Medic 576 Medical Aid blah blah blah and dispatching. They take what they want, or they do not take anything at all because they do not know. What we are kind of looking at, is to see whether anybody has any heartburn with that. Something that we brought up many many moons ago under Fort Ross. They decided to create Unit IDs and constantly recommend that Unit ID that really does not exist rather than using the station. You know doing that just saying you know in some cases you might say Station 55, Station 52, 5481 structure fire not only would it help to cut that down but the thought process in the long term is what we to do going forward as we start running out of engine numbers. Whether we are going to go to a three-character engine number or something like that or whether we can just start doing some of these agencies and just fake station recommendations.

Spence Andrei s- I think it is very applicable to the rural stations for sure. You know more so in Shepley's jurisdiction. I support it.

Ken Reese – I do not know if it needs to be moralized in SOP anywhere.

Spencer Andreis – I am sure there is some language along the lines but again I could be wrong with how recommends work or verbiage potentially on the dispatching side of units. I am not sure. That may have to be amended but we will have to drove into that and probably bring it back to next meeting to clean that up with what we find.

Ken Reese - As it stands that that seems to be working for Camp Mecker.

Darrin DeCarlie - Quick question, for a single unit response Medical Aid it seems like it is working. Structure Fire multiple response not just from those agencies, how would that work?

Ken Reese – It could be, I mean you could start getting to a place where those single station departments like Cazadero rather than verbalizing, we are saying 655. There was a time way back in the green net days where you verbalized the agency. It was Rincon Valley Station 2, Rincon Valley Station 4 structure fire. That is the kind of stuff you verbalized rather than the 4-digit identifier. It is kind of morphed over the years into this, it might be something that you start looking at and playing with and seeing how it ends up working over a period of time. We can start with Gold Ridge volunteer stations and see how it all plays out.

Travers Collins – What about request that come in through dispatch for say, that you are requesting 2 water tenders, a specific piece of apparatus. Will those go out as a specific request?

Ken Reese – I think those will go out a 4-digit identifier.

Ron Busch - You will still need to have those status still available in CAD.

Ken Resse – I think for the individual departments for their actual recommends, but when it comes to AD HOCing and mutual aid and stuff like that. It is probably the closest resource type threes water tenders, type ones, whatever, still need to utilize the 4-digit identifier.

Travers Collins - My only trepidation would be you know punch out and you cannot use any other department and they say ok we are going to respond, and they feel more comfortable, or they take it the wrong piece of apparatus to the incident. Then you are assuming or maybe it does not get caught on the dispatch side. They response without the appropriate resources. Then it is causing a clunky delay, or you know something along those lines. That would be my only fear.

Brain Crabb - Are we looking to go county wide with this or is this opt in.

Ken Reese – It really kind of started with Camp Mecker. Camp Mecker is basically wanted to get a general tone and they were just going to take whatever they took if anybody staffing. The same thing could probably play out like for Fort Ross there is another really good example. Right now, as you see you are getting Station 55 and 5481 get a recommendation. That is the agreement that they got. Monte Rio pretty much going to everything. They are taking whatever they are going to take. If it is a grass fire probably going to take the Type 3, if it is a regular call, they might take the Medical Aid or might take a Rescue or Type 1.

Darren DeCarlie - That will take some stations discipline. Request for Type 1, I do not feel comfortable taking that one I will take the Type 6. That is not appropriately right.

Travers Collins – I just fear with the volunteer companies and Darren and Shepley can speak to this. Not a lot of the volunteers might not have a Class B. They may have you know volunteers responding they can drive that apparatus. They take whatever they can take knowing that they got toned. Then they are on the road and through the chaos of that first 5 minutes of getting people in route. Ok, Gold Ridge responded, Camp Mecker respond wherever they are off the board. Incident command says Where are my other tenders, and my other Type 3 that I requested. I have this pickup truck showing upper or a squad or whatever that may be. Those could be isolated incidents that we can address as they come up.

Shepley Schroth - Cary - Are use is primarily going to be for Camp Mecker, Fort Ross, and Valley Ford. Where we have a redundancy of resources going anyhow. What it is doing now is when is the Unit ID it does not come up on there probably will never come up on there that then the dispatcher has to re-tone or ask do I re-tone and this way it kind of alleviates that issue and that was the thought process. It also shortens the dispatch and that was that was the motivation. As far as the other concern of if it is a specific apparatus, you are wanting the Water Tender from Valley Ford station then it is going to be dispatched as that. That is our kind of our issue to deal with. If they are not responding right.

Travers Collins - It does not affect us in the city, but it does and that is why I yield to that.

Shepley Schroth - Cary - It is a valid concern; we will take care of that.

Ken Reese - To put another spin on to that. Those agencies are like when we make recommendations to the CAD for mutual aid resources. They are not carded as a mutual aid resource in in the system. They do not get pulled unless it is a last resort. When we are pulling in county and then county strike team closets 5 Water Tenders stuff like that. It has an attribute on it and then those guys alternately end up getting skipped unless it is really kind of a last-ditch effort to get people.

Spencer Andreis - Well I think at this point we will investigate the S policy side of it then bring it back our next meeting and formally adopt any amendments to that reflect this.

Ken Reese - Ok

Spencer Andreis – Just to let everyone know that Evonne and Dr. Luoto have joined via zoom. Dr. Luoto has some time constraints, so we are going to skip item C and move into item D which is the 72nd rule acceptance with tiered response. Turning it over to you Evonne.

c) For SOP consideration - New Agency, SCYA MED1-9, 510-599, Agency BELL, Unit ID BELL1-3 for FOS -Ken Reese – Ken Reese – It is just a formality. It is just to throw that

into the agency list and memorialize the numbering sequence. Sonoma County Fire District EMS which we created a new agency called SCYA kind of goes along with the number plates like we have for all the other ambulance providers. They are going to have Supervisors Unit Medic 1-9. They are going to have a Medic and/or BLS 510 and 599 and Bells whatever is transpiring there. They want to have something for having a Field Supervisor identifier so we said Bell 1-3 should they ever need to expand other administration and things like that. I just wanted to make sure it got on here for consideration.

Spencer Andreis - How would like the supervisor to be announced on dispatch. I know like today it is SLS 4 or SLS 5.

Ken Reese - Like we do right now. We have Life West 1.

Spencer Andreis – It would be like Sonoma County 1 or something like that.

Matt Windrem – It would be MED not MEDIC. MED1, MED2, MED4. The 1-9 would be Supervisors and Managers for that. We are concerned obviously about somebody getting confused that it is an ambulance call side not a supervisors call side.

Spencer Andreis – Thank you for the clarification. Any discussion.

Scott Westrope – Is there an opportunity to compass the Cloverdale unit as well even though they may come and be used. There is a Sonoma County North MEDIC6 I think.

Nick Barber – It is actually SCN6.

Scott Westrope – Then never mind.

Peter Goyhenetche - Just one quick thought on the MED1-MED9. I could potentially default that I am thinking if say I am working MEDIC Engine 1 and I hear Med 1. I might think that I have heard myself being called or vice a versa. Perhaps maybe just a recommendation is call them MED Sup 1 and MED Sup 9. It is kind of a practice that we do over in Napa County prevent the sups from being over there being confused with that the City Fire Squads. Just kind of an idea to toss out.

Jack Thomas – The numbering of the ambulances are going to be MEDIC 510 – 579 and BLS 580 through….

Matt Windrem - We will share that out. There is the Medic Units are 510-519. Then they go up. They are numbered 24 hours units are 510s, 12 hours days are in the 20's and 12-hour nights are 30s. Special event things in there and the BLS are at the higher end 580 and up.

Jack Thoams – They are supposed to start like at 580. That would be great to get that list out.

Mark Heine – They are all placards. They are interchangeable placards.

Spencer Andreis – Does that sound reasonable Matt. MED Sup1 or something along those lines.

Matt Windrem – Yes.

Spencer Andreis – Ready for a motion.

Motion to approve made by Ron Busch Second James Salvante – Discussion – No further Comments – Approved unanimously.

d) 70 second rule acceptance with Tiered response call procedure changes EMD & EFD – Evonne Stevens – Evonne Stevens – Hi everybody, I am joining remotely because I have COVID. I wanted to bring this up because with the possibility of the Tiered Response starting on Tuesday, we will need to look at our 70 second compliance restraint for when we pick up 911s to the dispatch point. With the Tiered Response, we will need to get to a determinant through the EMD or EMD process before we can create an event in our CAD and dispatch it out to our responders. Currently we do have a 70 second rule and we have some exceptions that we currently apply to that such as language line translation, cell phone callers, third party callers etc... To proceed with the Tiered Response, we will need to have an exception for that 70 second compliance for all calls that we use EMD and EFD process on if we are going to use the Tiered Response for the county, because it will take longer to complete the call interrogation for these calls. Keep in mind there are ECHO level calls which are the most time sensitive and that include things like Code Blue, Choking and Process, patients within affecting breathing etc... also on the Fire side you know imminent Life Hazards, Structure Fires those should be discovered during Case Entry and those will still be dispatched in under 70 seconds as long as those are discovered and the caller gives us the information that we need during the beginning of our call interrogation. The other calls that would be able to do within the 70 seconds are callers where we do not have someone on the line such as LAF or like CHP calls with no transfer. I think it is important moving forward that we do have a time compliance. I am suggesting in lieu of the 70 seconds we do an exemption for possibly three months. Take some data on how long the interrogation is taking for the calls that we have reached a determinant on that are not in the exceptions already such as the language line that I have mentioned. Then pull the data on that and then create a new benchmark for the dispatch of those calls. I would like to open that up for discussion to the DOAG today. Thank you.

Travers Collins – Evonne just for clarification the ask is for a three-month period to extend the 70 second Call Taking processing for three months until data is collected?

Evonne Stevens – That is correct.

Travers Collins - I have concerns with it and I am trying to take myself out of the Santa Rosa factor on the equation in general. I think it is unfortunate that this is coming up right now and we talked about it at OPS yesterday and to ken's point you guys have done a

great job in trying to ascertain what that delay is going to be, and you know with making more phone calls and trying to you know go through this process to see what that gap is going to be. It is my feeling that I think that we need to instead of going through this three-month period where we are not knowing how long that is actually going to take with the end user being our citizen and whoever is calling to get care. I think that we have to look at keeping the Co Response in place until you we have a factual information on what this delay is going to be. My concern is if I am taking the Santa Rosa component out of it and just looking at it with the end user being our citizen is that delay in getting the right resource there in a timely fashion.

Dr. Mark Luoto - I am wondering how we came to the 70 second rule decision is there a standard, is that the standard. How did we get to 70 seconds as the dispatch time standard.

Travers Collins- It is national standard.

Ken Reese - Just to a point of that it is now FPA 12.1 is now 90 seconds. It changed 2019 or 2017 somewhere around there. It is actually a 90 second, we just have never changed it. We have always been able to 70 second requirement but more to the point. The problem with that is never going to know how long the real processing time is until we actually do it. Like I was saying in the OPS, I can sit and run scenarios and go ask somebody a question and they answer it and click click click click and I can get through it in 50,60,70 seconds. Until you actually talk to real caller, and you are asking the same question five times which happens all the time, all day long. You are really never going to know of what that call processing time on average is going to be until you actually are physically doing EMD with real people to determine the level of getting the call created.

Ron Busch - If the process does not change. Are you able to review old calls and listen to the recordings and run reports through ProQA to see how long that time is and have some case data from previous callers.

Spencer Andreis – Why can you not look at the old calls on see on this type of call we got to the determine this benchmark.

Ken Reese - Actually you probably could do that. You can mark when the send actually occurred from the time the call was created until you know when the ProQA Case number is assigned because that is calculable until the determinant is added which is also calculable. You could probably figure out that call process in factor get really close.

Shepley Schroth - Cary - I suspect with this change dispatchers not that you can change the questions you asked or speed up the process all that much but currently. I do not think getting to a determinant as emphasized as it will be with this in place, and I think you will see that that you will actually get to the determinant lot quicker potentially.

James Salvante – To your point Evonne on that calls that are higher acuity, we are not talking about delay there because that is going to be fast. In general, we are looking at the lower acuity ones we are delaying in a dispatch until we get to a determinate. I like the

idea about trying it and then having a really clear process for looking at exceptions. Can we flag them as Sentinel events if somebody says hey this this took a long time to get to determine it and then determine it was wrong. I think that retrospective analysis is going to be sort of tough, especially in a timely manner.

Mark Heine - The overall goal is to get the right unit responding to the call in the correct mode, right. That is really what the goal is to give the dispatchers a little time to process the call and send the right unit whether it be Code 2 or Code 3. I think the higher acuity calls are going to go out immediately. Like you and I were talking if it was a Structure Fire that does not slow anything down it is going to get launched right there if it be shortness of breath, they are going to launch it there immediately, correct me if I am wrong. It is more of the less acute ALPHA, BRAVO, CHARLIE.

Shepley Schroth - Cary – I have always said it is worth reading the cards and understand the process. I think we all mostly do. I think calls that matter, you get to the determinate within 30 seconds, if you asked the question “tell me exactly what happened”, my dad's not breathing. Ok, now 9 ECHO 1 off goes the tones. It is really that simple. Not to oversimplify what you all do, but it is that simple. Then the less acute calls, what happened? I tripped. What part of your body? My ankle. Ok that well probably an ALPHA call inappropriate. Any other part of your body hurts? No, just my ankle. Ok, how far did you fall? I fell from ground level. ALPHA call.

James Salvante – In that process right there it just saved somebody an ALS response.

Shepley Schroth - Cary - It saved an engine that might be close to ALS going. It saved a BLS unit when appropriate. To me, it makes perfect sense. You just have to trust the EMD process.

Travers Collins - I am all for trusting the process. My fear is that we do not even know what that number is right now. We have look at all aspects of it. We need to know what that number is. For calls from the City of Santa Rosa you are not going to get an engine response or an ambulance response until that card gets flushed out. You go down that and make that determine on whether it is going to be BLS or ALS an Engine response. That delay could potentially hinder the end users which is our patient at getting anybody on scene for that incident. Am I missing a mark there is that factually.

Darrell Kopriva - The only thing that automatically goes is the ECHO. DELTAS do not automatically go until we find the determinant. Which are sick patients. We are going to have to delay the patient. The second thing is there is going to be really no change to our mode of what we are doing now to be pressured and always going to get quicker, it is not. It comes down to RP. We have difficult RPs getting that information pulled out of that RP where there anywhere and it is not all of them calm and trying to calm them down and get them reeled in to get that information It happens on the majority of calls. That affects that time. That has to be put into consideration too. It is not the dispatchers can be quicker because now we are in Tiered Response that it is not going to be a factor.

James Salvante - I know that when we talked. When we looked at the various determinants, one thing that again I am not a Dispatch person so probably most people. I

do know that we look at things like the override cases and those were not going to be included. The idea being that the dispatcher, if they are having trouble getting information or having a bad feeling and there is the ability that agency for the dispatcher can say cannot get to determine on this. That is the understanding of the why the overrides were not included for that reason. So, the dispatchers would always be able to step in and just say no we need to send the ALS.

Evonne Stevens – That is correct. Another thing about the cards that are designed to find those high acuity calls more quickly than the lower acuity calls. If you are dealing with the caller with chest pain no it does not happen form case entry but when you ask the questions as they are designed and in order those priority symptoms such as altered level of consciousness, is the patient clammy, do they have a cardiac history are at the top of the list of questions that we do ask. As soon as we hit a priority symptom it will trigger that Delta event and put that event into pending. A couple of things that were brought up that are standing out to me. Most of the time, you know from the data that Ken and I have looked at. They are being breached in about 90 seconds to 100 seconds for a lot of those calls. If the national standard is 90 seconds and we have that 10 second pre alert time I think that when we get to breaking down this data you are going to see that those high equity calls are going out much faster and the lower acuity calls tend to have more questions and more delving in while they look for priority symptoms and may take a little bit longer but those are typically your fall cards. Sometimes your other cards that have less of a high acuity and less of a time constraint on that patient care that is my two cents.

Spencer Andreis - The national standard being at 90 seconds. This is nationally being done. I am guessing there is a lot of data out there predominantly on the East Coast. There is a methodology behind that number. It just sounds as though we have not updated that through time.

Jeff Schach - I initially have the same concerns as TC did, about the value of the delay of the end response. After talking with Chad, it was pretty good knowledge. He could not be here today. I think I have a better understanding to where you have the most critical are not going to be delayed. The more than 70 seconds are going to be the ones that are taking more questions, because they are less critical, and it made me feel better about going right to what is being recommended, going through the full EMD process. Another thing to do like about it, is there is going to be less radio traffic and because less units going out Code 3 and then it is EMD to Code 2 and then there is a hey a units stop Code 2 and confirmation of that. If units are initially going out as a Code 2 call and maybe it took a little longer to get there from here but that is ok because it is still less critical call makes it a little radio traffic. Maybe we are not even sending an engine to it or obviously an ALS ambulance potentially. I totally understand and appreciate TC's concerns, and I had the same ones. I still kind of do, but I after getting a little more deep into it I feel like the calls were talking about are not the ones that are the most concerned about.

Travers Collins - I get the change. It is like in NFPA you guys are doing an awesome job. I want to hear from the dispatchers on their thoughts on this process. You guys are doing a great job of meeting that 70 second mark. I understand there is an adjustment in NFPA but, are we looking at it with the wrong lens. Are we looking at it on how to extend that time to get more time than EMD process, which is whether we want to admit it or not

having a negative effect on the end user. Am I getting that that care in the appropriate amount of time. Are we looking at the wrong lens. That is why I brought up Co-Response because if during this three-month phase when we are looking at these numbers and looking at how long it is taking our dispatchers to get the calls out. What is the hindrance and I know there is an operational concern but of having that Co-Response during that time so there is no laps or extension on getting units to the scene and appropriate time. I want to hear from the dispatchers. I want to hear what they have to say and what their concerns are. I can read on their face they have something they want to say, and I think this is the form that they can do that.

Monica Vanoni - Obviously, we did not find out the Tired Response being on this until two days ago. I have not talked to everybody. We did come up with some questions. It had been mentioned before and we just did not know that it was going to try to be rolled out at the same time as everything else going on right now. That is our main concern. We now have a new EOA, EOA Provider, new unit numbers, new posting locations and posting numbers. We had radio issues last night that we did not know about that could happen. REDCOM died and all manual paging dies with REDCOM when it dies. That is a whole new issue and now we are going to be changing our entire Call Taking method the entire process. I just talked to Darrell about it, one of my main things that is very very much automatic to calm a caller even with an ALPHA level response that can be major freak out moment. Yesterday I had one, it was an absent seizure, and she was in tears. My main thing is I have got the call accepted. I have got help on the way. Alright ma'am I just need to ask you a few questions, help is already coming to you. It is not delaying anything; these questions are to help the responders as they come. I am going to have to break my own habit of doing that. because now I cannot say that because it is on a recorded line. It can be pulled that is my liability that is me lying to somebody. I do not have anybody yet because I have to go through questions first. I started in the field so for me it is a major. I do not like not having people on the road already. It is all about patience care. I want to get care to these people if we can reduce them going Code 3 absolutely. How many times have we had a caller, mom just will not answer me, she is awake, her eyes are open, looks like she is breathing, she is fine. It is maybe an ALPHA or BRAVO level response, and you get on scene, start a 20-minute timer for a Code Blue. RPs range and what they know. From absolutely freak out they know nothing just get them here. There are lot of uncooperative callers, and it has got worse. Some of our written ones is when we are mid EMD called, multiple 911 coming in. We could put callers on hold all the time. Sometimes we only have one Call Taker because other people are doing things during the day, or I have a radio in my ear while trying to take a call dealing with radio traffic trying to deal with an RP. How is that going to change for us. What is the Protocol for putting people on hold without it reaching a determinant. It was mentioned the 32 BRAVO but if I am on another card and I just have not reached the determinant and I go back and put it in his 32 BRAVO as mentioned now I am getting enough non-compliant call because we are graded and that is a job requirement for us. We have too many calls that are graded down as non-compliant we can lose our jobs. How is that going to change on being graded for ACE. If the if the answer to that question is to defer to the dispatcher and use your judgment call that is putting liability on me now. With resent cases across the country of families suing dispatches for you know liability issues or you know negligence mainly. What is my protections for that negligence or liability for being like this caller is fine I am going to put

you on hold, I will be back to you in a minute, mom dies, they sue, why was there no help there. That is our liability that I am not willing to take.

Evonne Stevens - Can I step in for a minute Monica? Pulling the caller on hold is the next item on the agenda. I do not want to skip over and ahead. I do want to say with that being said, what I am proposing is creating a call for that caller we are putting on hold. Like we do right now, putting the caller on hold and created at end of Case Entry keeping that policy the same and then getting back to that call and completing that triage which would not affect our ACE in anyway. It is already what we are currently doing. I am a little surprised that we are saying that we have not talked about Tried Response or that we are doing Tried Response. I know we have been talking about it on the floor for at least 6 months. I am not sure where the gap is and understanding that we would be doing dispatch to determinant. I know we have had talked about Tired Response for a really long time and it has been clear that we would have to get to the determinant to be able to dispatch those units appropriately and stop and go from Co-Response to Tered Response.

Meagan Horeczko - We did talk about Tired Response, but we never really had a hard date to when it was going to be rolled out and we found out the 16th.

Evonne Stevens - We still do not know. It could be the potentially be the 16th. That is why it is part of this meeting today.

Monica Vanoni - Another one that we had written down was the un-cooperative caller that flat out refuses to answer questions. What are we going to do with that. Are we going to just send for the 70 seconds. Like I said it was mentioned the 32 BRAVO entering in what is the 32 BRAVO is just completely unknown situation. Again, with the ACE Accreditation if we send that to get people out and then they finally put out another RP on the answers questions we are going back to another card to try to find that determinant again, if that call gets pulled, we are now non-compliant.

Evonne Stevens – No, we would be complaint, because that is new information and that would require a shunt. We can always shunt and recalibrate.

James Salvante - We are not doing BRAVOs right? We may have one or two. I think that a particular one that you mentioned.

Monica Vanoni - The 32 BRAVO is an unknown situation.

James Salvante – We are talking about the Tiered Response quotation We kept it almost exclusively ALPHAs and maybe we treat them as ALPHAs. It is not all the calls that are going out this Co-Response.

Monica Vanoni - There is another issue we are having is the absolute disconnects. Like we have said. We have been told well it is potential thing. Now we have heard from multiple people it is going to happen on the 16th. Which is why we are all here. That is just not a good idea. We have a lot of questions and again you are mentioning the ALPHAs and the OMEGAs which has never been brought up. We do not have any information on

what it is going to be, what it is going to included anything. This is new to dispatch we do not have any parameters. We do not have any potential; this is how it might work. We are going in blind, and it is less than a week away.

Meagan Horeczko – We are not saying we do not want it. We just have questions and concerns. That we wanted to bring up and if this is where the County wants to go. We are all for it but, we need the resources in order to do it correctly and having it all done on the same day. Which I am sure we will get to that. All we are just asking is for a little bit more time.

Brain Crabb- I think everybody is looking for a little bit of training. Also, one of my calming and reassurance tactics is to tell people. Hey, they are on the way, on the way right now. I know it is going to feel a little weird for a lot of us to kind of have to change something. There is a lot of changes right now. I think everyone is looking for a little bit more like hey here is what you can say if you do not have something on the way, but we do not want to get ourselves in trouble or anything like that. Something I want to mention from the conversation earlier. In terms of looking back at data to kind of create those benchmarks that we have. I know how my how my conversations go with callers once I have already sent units. It is a little bit more; I give them some time; I know people are on the way. I will give this sometime some questions I will not press them as hard. I do wonder how I am going to start with pressing callers to get more data to get that answer. I feel like my customer service level is going to go down. I do not know how much. I do not know how to adjust that to get to that determination. I do not know how I am going to be with my callers. I will be a little difficult to compare that send based on the determinate that we use and under the current system. I know I am much more conversational under the current system once I have units on the way.

Shepley Schroth - Cary – That is what I meant by if you understand the end of determinant that it is so critical. Your language, style is going to change. That is why you might see a small increase to getting to the determinant, not significant to your point Darrell but if you know to get help on the way you have to get to that determinate. Your mannerisms and your language that really are kind of off script will not happen as much. It has been a while is help on the way part of the script or not at all.

Monica Vanoni – Not until the end. We use it as a calming tactic because we are aloud to. It brings the caller anxiety levels down and really get them more into a headspace to actually listen and answer the questions.

Shepley Schroth – Cary - I need you to answer this question so I can get help on the way.

Darrell Kopriva - Usually for an example - Are they awake and breathing as I select the card. We have help on the way. I am going to ask you a few more questions as help is coming that seems to calm 90% of my calls down. If I do not that.

Monica Vanoni - What the statement you mentioned that is going to potentially raising the anxiety on the caller side. I never really realized how freaked out people were calling 911 until I was 911. You do not see it in the field because we were already talked him off with their anxiety ledge. If we do not have some of these calming techniques that we can use

now, we are going to have to come up in our own heads ways to try to bring them down without mentioning people are on the way, because you cannot promise something that is not already happening.

James Salvante - I do not think this is certainly happening with Tired Response. You are part of a disciple that is nationwide. Are there best practices for calming people that are not related to promising that there is help on the way. That sending everybody all at once immediately is not something that my systems is expensive. It is hard to support, and it is also not necessarily the best piece of resources, but I can see exactly what you are talking about. Being able to say; do not worry I am not asking you useless question there is somebody coming. Are there alternatives that are known in your industry with other centers.

Jasmine Mitchell - I can speak to that James, only having come from San Francisco where we had Tried Response forever. There are certainly work arounds it is not the ones that REDCOM is use too. It is going to take time to implement that into our Call Taking. We all know that Tried Response has certain responses. Are there work around's, absolutely. You know instead of saying I have help on the way, you need to listen to me. You just switch back to. We need this information to help you, I need this information so I can give it to the responders. Does not promise that we have someone on the way. It is those reassuring statements that we just have to now learn. For me, still being a Call Taker at REDCOM. I have to learn it all over again. Like Shepley was saying, usually you can get to the determinant even though there are times where you know it is a bad connection, a panicked caller. I had one caller tell me it is not an emergency put my mom just died. Coming from a different perspective whether it is a Hospice patient or what have you. Trying to get through each individual caller is our job and it definitely affects every single call, so you know putting all of these different tactics to use now it is a lot that we are asking from them. We know that we can do it and that we are all on the same page and wanting to get the service to the County. Those are all things that we will have to develop with in the center with practice.

Evonne Stevens - Would having the ability to create a MED event for those callers that you feel are taking too long or are difficult. We can always hit MED send the event and then continue on for those callers that we feel are difficult having that fail safe. It would not change our EMD scores. If you are really having that big of a hard of a time. I do not think anybody in this room would want to delay patient care based on that. I think that would be a good override to use sparingly and those true calls where there are difficult RP we are not getting to where we need to get, and we know they are feeling the delay and that is starting to increase anxiety. Just making MED on those and then looking back on it and I think that is an option that we could maybe explore, and it makes sense. Tiered Response, although it is a big change, and it sounds scary it is progress. It means sending these calls the right way, on time, to the right people not having to reduce people to Code 2 or yell oh, that is an ALPHA or that is a BRAVO. The way the Tired Response will work is the Codes that have been approved and the determinants that have been approved will go into CAD and it will create the correct recommend for the REDCOM Dispatcher. You as the Call Taker are not going to have to worry about oh, is this the Tiered Response call or is it not the Tiered Response call because there are some ALPHAs, BRAVOs that have been taken out of that including the overrides. If you are hearing something and you do not like

it, you do not have the right answer for it but you want to override that because you think it needs the correct response you will have that ability to do that and those will not be part of the Tiered Response. There are specific calls that we looked at when we were creating these events that we decided were going to be a good candidate for the Tiered Response and those were looked at with another agency Fresno which has a very very large, large area of people that they serve. They have been doing this very successfully for several years. We looked at what calls that they were using this on and what their decisions were and we mostly followed what their Codes were because looking at it soundly with KT and myself having the background of being QA for IAED for myself at least 15 years and knowing how the system works and knowing which calls are little bit empty sometimes and those calls end up you know maybe going a little higher than we suspect even though it followed all the way through to an ALPHA, we took those out. If we are finding codes or calls that we feel are having a bad outcome I think as dispatchers, you guys should be able to have the input and to be communicating these things and pulling those calls out. Like James said finding those and we can investigate those and look at maybe those are calls if we want to take out of the Tiered Response or maybe that particular disposition should be removed, or maybe more should be added. I think we are not going to be able to get to the place where we can move forward and be a responsive system that sends the correct units right on time at the right level for the patients that makes a better citizen where we do not have people driving around Code 3 that do not need to be going Code 3. We have ALS units available for the Code Blue because we did not send them on somebody who has a cut finger or something like that because we sent the right units the right way. We are not going to be able to move forward without taking those steps. The first step is the hardest step and that leads to progress in my opinion.

Dr. Mark Luoto – Evonne said pretty much everything I want to say. To the Dispatchers you guys are crucial with this. We are not going to make this successfully happen without you guys getting comfortable with it. I think in the beginning you are going to have the ability to say I do not feel comfortable at this second. I am speaking as someone that does not know that much about Dispatch. I have been there a couple of times. I do think you especially in the beginning after other Prague to say I cannot fully without sending someone right now. I think that will probably happen a fair amount of time in the beginning. What Evonne said before. We need your feedback about what is working and what is not. Your feedback is going to be crucial for determining is this determinant appropriate for Tiered Response or do we to take it out of Tiered Response for whatever time being. I think you have to have the prerogative initially to say no I do not feel comfortable. I am just going to send. I do not want it to be that I am glad there is a workaround so that you are not getting faulted for doing something that your gut at the moment tells you. We all get feedback on what works or does not, but you know I am hoping it is accurate. That when you do that override you are not going to be punished when you are scoring that would not.

Meagan Horeczko - Speaking for me too. I think having that ability to just say you know what this is not working, or this call is on cooperative sending it as a MED and knowing that we are not going to get a non-compliant or that call. In addition, we are going to have that support from the field. If the field is going and they are like, why are we going Code 3 and all I have time to put in the notes is leg pain or something as not having the field units doing that. There is something with this call that I just I need you to go Code 3 and as we

get that information coming in. You can downgrade it with what you believe would be or you can continue as you want. I think having that as a failsafe for us for when we first start. We are not against Tiered Response. We are not saying we are against it. We are just saying we need more tools and a little bit more training on it. Like Jeff was saying what are some of the techniques we can use when we are on the phone. That is what we are kind of looking for is having more of those things in our back pocket. We know it is going to be hard you are going to tell us not to do something that we have been trained to do. We are not against it. I think it is great. Sometimes you know when they are going on this call Code 3. This person just hit their toe. I would like to be able to send their appropriate units at you know Code 2 or Code 3. We are not saying we are against. We are just saying we need more tools in our tool belt in order to make sure this rolls out smoothly as it can because it is going to be a huge change. This is just a quarter of us here from our dispatch center.

Brian Crabb - I think everyone is just looking for a little bit of extra training as we are going through this. I think for Evonne and Jasmine and Jasmine has been through it. Maybe just daily check-ins 10 minutes here. Hey, come in and if you have been Call Taking, how is it going? Are you having problems? Strategies about how to go from, talking with Darrell he has been with REDCOM 18 years and 8 years for me. We are talking years and years. I can just close my eyes and not even look at the cards and do the whole thing. Some of the nomenclature and things that we say day-to-day that is really hard to just break it and then go to something different. I think some of that extra training day-to-day with our call takers would be really beneficial for us as we move forward.

Jasmine Mitchell – That is why we are pushing for the 3-month period of data collection. That is a really good amount of time for the Dispatcher to learn how to start putting these new practices into place. Like Brian was saying reciting these in your sleep after a while because we do not have to say it or remember it if we are saying it constantly. It does not take that practice and it does take that time to get to that level.

Evonne Stevens - Also using the Protocols as they were designed. I will go back to our training on EMD and EFD. We were trained to use the cards as we are asking to use them right now. They are designed to be used in a Tired Response fashion. If we are following the prompts and where they are asking for customer service and when they are telling us to stay help for the way. Then we have already the tools in front of us. We just need to remember not to promise the help has already been sent if we have not got to that determinate point. Saying something like, I am just getting a little bit more information to get the responders started or not mentioning that. Just say, you know I really appreciate your help and cooperation to get through these calls. If you are really not getting what you need, again I am not asking you to do the override at that point. I would say start that as a MED, use that tool like we normally do. Just classically starting it as a MED and then complete your triage and when you do that if it is a Co-Response, and it needs a downgrade that will come up to the REDCOM Dispatcher and we could sort that out. If you really get to that point where you have to send it and you are taking too much time and you are really concerned. I would say started as a MED and then we can downgrade that as appropriate once you get that further information and then we could do a cancellation on the ALS unit if that is appropriate. You know the ALS transport unit because it actually needs a BLS transport unit or something like that and that would not affect your score as

you are still just using the cards as design it does not affect your EMD triage at all. It just going and hitting that accept button like we used to and then it will change the event to the right event type when you get to the point of this disposition set. Like it does now normally it will send the BLS response into queue. It is going to send that other call up into queue so they will see that new determinant and understand it needs to be downgraded.

James Salvante – Evonne, I have a question for you just to know we all have a lot of meetings to go to. I know that we are all in for sort of a very regular weekly check in once we start Tired Response. How would REDCOM feel about putting a Dispatcher/ line person in that group with the Qi group with us. We are looking at having that be agency staff. medical director, representatives from the agencies that are that are participating, First Response, Transport providers with this Phase 2. I think we are absolutely going to include REDCOM leadership but maybe it would be very helpful to have somebody from the line participating and be able to just stay connected. We think that quality improvement is everybody's job. You are going to see things at your level that we may not see otherwise.

Evonne Stevens - I think that is a great idea. I really do. I think the dispatchers need to have more of a voice. We have the forum to be able to give their opinion on what works and what does not and what does not feel right. I think that is a fantastic idea and I would love to see that happen. The other thing that was mentioned by Brian is having that the presence of a supervisor. I am not sure if you saw the message that was sent out yesterday by Jasmine but definitely for the first week or, so we are going to try to have additional presents on the floor from managers. Jasmine is a que; I am a queue. We are trying to get a shadow dispatcher for the REDCOM Dispatcher to help with the new posting a Tiered Response so there is two of you making those decisions together and expanding that training. I plan on being in Dispatcher lot. Resting up from COVID and hopefully I will be back on Monday. I plan on spending at least 12-hour days for the next week or two on the floor helping and being totally present for you guys as much as possible. I have been a Dispatcher for 18 years on the floor and I very much understand EMD and EFD.I was a queue for many years and still am a queue. I would love to be there to support you guys. I do not mind sitting and putting on the headset take calls with you and seeing exactly what you are going through. I do it all the time. I am more than happy to be there supporting you guys and jump in and make sure that this process goes well.

Darrell Kopriva - You have heard some of the Dispatchers concerns. You know what is coming in. We know this change is coming. The majority of the Dispatchers just want to suggest to the committee that this be delayed a week or two. Just so we can get all this major EOA changes inflow. The new radio system inflow and then bring in the Tired Response then work on that and make that flow. That is what we are requesting just separate them a little bit not all of them in one day.

Travers Collins - That kind goes back to my original statement. There is a lot, we all know this. Sonoma County Medic. They have done a great job at troubleshooting it and making sure we do not have any blind spots. They are going to happen we all know that. This is a huge change and to alleviate that stress off the dispatchers and not go off subjective information of you know we hope this is going to work. I do not think even the data collection piece of it is going to be pertinent because it is going to be a huge overhaul of

the system. Is that data that we are getting at the change in our EOA provider going to be accurate data. I will take it farther than Darrell's two weeks and say hey in that first three months run it out even further. We talk about that three-month period of collecting that data and seeing what it looks like that Call Processing time so (A) That dispatch can get the additional training. (B) Their stress is alleviated as we do a huge change within the system, and we can get factual information to make our system efficient and effective.

Evonne Stevens – If we are not changing the call process that we are doing right now for the first three months. It would be no different than the data if we looked at the data from the last three months. If we are not changing the way we call take it all. We are not doing the Tiered Response the call takers would be using the same process which is right now. "What is the address of the emergency," What is the phone number you are calling from," "Tell me exactly what happened" boom event created. The data would not change at all. change at all.

Travers Collins - I understand that, Evonne. What I was tying it to was the change in the EOA provider. That is something that is not happening now. We are dealing with AMR who has a finite number of ambulances on the streets as opposed to a more robust system with more ambulances ALS, BLS that is a huge change in the system. The data from the last three months would not be applicable to what we are going to be facing moving forward. That was my point, sorry.

Evonne Stevens - I apologize, I did not catch it that way, thank you.

Mark Heine – Just a few things that just would like to share from the new providers perspective, I guess. I place a huge amount of value on this conversation this is hypercritical. I know I am certainly coming into this, and my team is coming into this wanting to address this as a one team, one mission aspect of it. That is REDCOM Dispatcher, Field Providers, Supervisors, other Agency is served in the EOA1, whoever that maybe. There is a huge value in hearing from our end users as far as I am concerned which our Dispatchers on the frontlines. Tired Response is another one of the big changes coming to Sonoma County. We are talking about a series of big changes here as part of this transition process that is accruing on Monday. It has been talking about for a long time. I am heartbroken to hear that there are Dispatcher that were somehow left in the dark. I cannot fathom how that happen, but it clearly did. Here is the crux of the situation. The entire system is being deployed on Monday is built around the use of this Tired Response proposal this first Phase and approach. It is not possible to change that in the next 3 and a quarter days before the first units being deploy on Monday afternoon. Everything from posting locations, drawdown plans, protocols, dispatches to staffing to apparatus to our shift scheduling is all built around that. I get it, it is a ****** situation, but that is where we are at. I would encourage us, if possible, to try to work hard and figure out what systems we can jointly put in place between now and then that would ensure our end customers are receiving the proper level of care in all aspects and if there is a way to do that, that is what needs to be our goal. If that is an absolute hard no physical way, can we get there. I am not sure what that looks like in the next 72- 96 hours. We are going to have to go back and figure out what massive changes need to be made. I am here to be the supporter. I hear this loud and clear. All the components of the EMS system have got to be in place for this to be successful. My question to the team in the room right now is 1.) Can

we agree that we need to try to see if there is a mechanism to get to yes to support this Monday night at midnight. 2.) If so, what does that mechanism and what does that look like and what support can we bring as the field provider in junction with Evonne and her Leadership team for all of you that are in dispatch.

Travers Collins – How much of an impact is it going to be if we are talking about the call process getting units on the road right. If Monica takes a call and both units get launched. This is totally planning, it out. Both units get start to respond she gets through the process and 20-30 seconds in she determines this is a BLS call this is a BLS unit drops that ALS unit they are back in service. Engines are responding BLS ambulance are responding the ALS unit is available. Everything is good. She has gotten through that EMD process, and the units are still available is that a huge impact.

Mark Heine – The answer is I just do not know. It makes me very apprehensive because all of our analytics went into posting and drawdown plans based on comprehensive data where calls are occurring, concentrations, time of day, day of week and all kinds of stuff for both our BLS 911 units and our ALS 911 units. It is possible that there is little impact, it is possible that there is great impact on drawing two rigs on geographical zone at the same time. I just do not know.

Darrell Kopriva – Giving the things we discussed earlier with. If I do not feel right sending it out as a medical. If this goes into effect on Monday -Tuesday with all the other change overs. Dispatch the best you can. We are going to have to do this, if you do not feel right send it have help going and then we will figure it out. The whole Tired Response is not going to be 100% at that point. Hairs on the back stand up, I do not feel, send it what impact would that have on the system.

Mark Heine - I 100,000% support that. I am not here nor and my team has clear direction on this we are not here to second guess anybody. I understand behind your back no no that should have been BLS. If you are not comfortable, air on the side of the patient that is what the whole system should be about. Please air on the side patient. We have trained our folks on our on boarding academies to that and they are not double questioning that. If that is where the team wants to go that sounds to be a pretty hypocritical component right now to make this successful. We will make sure on Monday we pull all though crews together and reiterate that message loud and clear. I know you have to be armed with that capability. You have to be able to make discussion on the fly like all the field people do and you have to know that we have your back to do that. I do not want to speak for Evonne, you know it will work for me. We are not here to jump on you for any of those discussions I will support those discussion 100%.

Jasn-min Mitchell - With the representation that we do have here today from Dispatch. I think that we are apprehensive of the changes that are coming obviously.

Mark Heine – Of course, so am I.

Jasmine Mitchell – This is very similar to getting a new CAD. You are learning a completely new system, and it is not that we cannot get this done next week. It is just a lot all at once. That is what we as Dispatchers are feeling the pressure. I know Darrell is

asking for a week or two. I do not want to speak for you Darrell, but you know we are prepared to rip the band aid off. It is going to be a lot of work right up front. We are going to have to figure out work arounds as the problems come up. We do not have a clear path and a clear map. This is the answer to every problem because we do not even know what the problems are going to be encountering. Those are things as REDCOM that we are coming together now to be prepared for, not to figure out because we do not know what it is at this moment sitting here. I do not want to speak for all Dispatchers.

Mark Heine – It would never be fair for me to ask you to rip the band aid and not have your back and wanting to put the band aid back. You had to have a trauma dressing on the dash right in front of you. ☺

Darrell Kopriva - In REDCOM history that you have not been here for Kenny knows we have down some rip the band aid off and went down a rabbit hole. ☺

Mark Heine – The other component for me to is this Tiered Response is just a sliver of this piece of it. This is a lot of all new change and some of this we are going to get into it 24 hours and you are going to say this piece does not work, by the way your posting location sucks, and we are totally open to that. I mean we tried to build it analytically does not mean we always get it right. We want to be able to have that ongoing feedback with everybody does not matter who the player is. I totally get there is a lot of change it was not signed to be a lot of immediate change. Somewhere along the line something happened process wise. I hear that loud clear and you did not get that, and I am sorry about that. I do not know why that happened, but it happened. It was not designed to be that way, so we will figure it out. I will work with you to figure that out. There is certainly no attention for me to sit in judgment of judgment decision you all have to make that I do not have the expertise to make. I get and I used to work as at a Tired Response Dispatch center, so I totally get it.

Brain Crabb - REDCOM operates at a high level all the time. We care a lot about what the field units are thinking. We think a lot about a call we do not want to screw the filed units over if they come back to us with negative things that weighs on us. We want to do better for them. I think the message that needs to go out all the line staff is patience. It would be really hard if were self-critical of ourselves with this change and then they hear it from maybe an engine calling up and saying, “hey what is going on.”

Mark Heine – We cannot guarantee that will not happen. The peace I own in this for you listening to this conversation and the piece we that I own for you is on two fronts. As we move forward in the system deployment not to create a situation that this ever occurs again right everybody has got to be fully in the loop from day one and the second piece is not to be the tyrant about you know how that goes so, we will get the message out to all of our field ambulance personnel. We will share it out as message through County Fire Chiefs today too. I think that would be healthy to the Police Chief who served in the EOA as well. Just let them know everything is not going to be prefect. I think it is. I know it is not. Things are going to happen that we did not think about before. I am sure you guys are going to come back to us on Tuesday or Wednesday and go maybe this piece of Tired Response is more comfortable. I thought it was going to be this piece it is not going to

work, and we need to fix this. That is when me and Evonne can sit down and figure out what that means and James and all the other stakeholders.

Ken Reese - Would it be helpful from those standpoints because you are trying to build the ambulance response around that BLS piece. We have situational thing where we created it as medical aid. We do not know whether it is a BLS. Would it be wise or permissible in the instances of EOA1 where there is ALS First Responder such as you know District 248 and the City of Santa Rosa. Dispatch the BLS ambulance along with the ALS ambulance. What do you do when you create the call up front and you get down to the BLS level once you do know it is BLS level call drop, and they have ALS ambulance back into the system. We could change the response plans to send both BLS and ALS ambulance on any call that is created just as a generic medical aid.

Mark Heine - I think that is a potential good outcome. I would rather reverse engineer it though. The folks dispatching have to tell me whether this is something that is comfortable or not. Let us try to implement the way it is designed and if that is quickly not working then we can reverse engineer the other way That gives me a little time to figure out how to build that piece. I have to sit down with my Medic counter parts and figure out how to build that piece. I think a good point Kenny raised, I just completely blanked on myself. We have worked very closely with Dr. Luoto because at the end of the day he is the one that is got to say this is what he is comfortable with or not. It is only going to be running in the area that is served by ALS Engine Company. We are really only talking about Santa Rosa and our stations that are in Santa Rosa basically. I think it is a small relatively small cross section even though it accounts for about 83% of the call volume. I get that impact; I am not trying to belittle it all. I hear that piece of it as well. This at least would allow us now to go back at a planning level and go, let us put a Plan B in place the case next week this is not working.

James Salvante - Evonne, can I ask. You talked about the Call Processing times 70 second and 90 seconds. How quickly do you have data on how it is going. This week are average is 78 seconds.

Evonne Stevens - We have first watch set up right now at the 70 second. Anything that goes over 70 seconds. We look at each day with the supervisor and talk to the dispatcher for feedback on that. We could change the way we look at those 70 second processes open up those calls and see exactly what happened on that. Then work with Kenny on the ones that are going over to see exactly what happened there. It would be a little bit more work, but if we are you know we are looking in a 90-day period of checking that data weekly. I think it is something I am willing to take on. I am sure Keeny would help me with the data collection on that. To take a measure of where we are really are something is alarming, we can certainly bring that back up in our weekly meeting.

Mark Heine – I think from a patient care standpoint because we have to keep that. That is the goal, patient care, patient outcome all that is hypercritical. These are calls that there is always going to be a paramedic on the scene. That First Responder engine company is going to be there so when the units do arrive there is going to be ALS on the scene to help with that ultimate determinant for transport need. We should feel good about that from a patient treatment standpoint, patient assessment standpoint. This is going to be a good

sort of technically I guess phase two for Tired Response to figure out whether that piece works. If that works where would Dr. Luoto like to go from there and maybe that is all that ever works, it may be that it can be expanded. I do not know; time will tell, and experience will tell. To go back to Chief Collins original concern, additional call processing time. Yes of course that is a concern it absolutely is. I do not have data for that other than just say my personal experience in a Tired Response system for many years. These were not high acuity calls, and you will get the oddball "oh my goodness the fall victim was a Code" yeah those things do happen from time to time. Fortunately, they are extremely low statistically and there will be an ALS responder on the scene. I feel like we are with a lot of the concerns there are entirely valid. We have tried to take as many mitigating measures and put those in place as possible to reduce risk.

Dr. Mark Luoto – I appreciate everything that has been said. I do think it makes sense to relax that 70 second standard. In fact, we probably need to look at is that an appropriate standard any longer given that the national standards 90 seconds clearly. I think we have to promise ourselves we are going to be looking at this on a weekly basis looking at the times as we go through this initial period. On an ongoing basis we want to see how those high acuity calls the ECHO and DELTA calls. How long it takes to send them on an ongoing basis as well. I think we need that three-month relaxation I have full confidence in in Ken and Evonne to give us the data on a weekly basis that we should be looking at in our committed. I really want to support having an online dispatcher if possible if they can fit it in to be part of that committee.

Stephen Dalporto – I would just say whatever decisions this REDCOM Board makes should be for the end user for the patients care. In my opinion from Santa Rosa Firefighters side, it does not seem to be the ultimate goal. Like James said, it is pricey to run an ALS on the unit without the Tired Response. That gives me concern that money was the main driver behind it. I am sure there is other reason. I am not calling you out on just that. That is one thing I heard. Whatever is going to be best for the people that are paying the taxes in this County should be the only thing we force on. If it is 90 seconds now sounds great but if it is working at 70 seconds and the Dispatchers are doing a good job getting us in an ambulance and out the door in 70 seconds. If they are comfortable with it that certainly up to their Labor Group stick with those kinds of things. Then listen to the Labor Groups. All of the Firefighters on the line are having a concern the ones that are in the Tired Response system now are having concerns and the Dispatchers having a concern. This came up in the meeting which happened back in November, December at the DOAG. There has been nothing but concerns since then. Yet, there is still more changes that are getting presented as we are getting closer and closer to the end date. What is going to come next on Saturday. Hey, we have one more thing to implement to make it easier for this new system. Let us make sure that your system works, let us make sure the ambulance system works. It is a whole new contractor coming in after 20 years and we want to keep implementing all these things along with it. Let's focus all of our attention to make sure the new ambulance provider is up to speed, and it is going to run well and then if that is working great cool, now let's move to the Tired Response make sure that is working well and perform best for the patients on the ground. You always say there is these one offs. I ran a call yesterday for a shoulder pain that is all that was told to the dispatcher. They did not hear anything different on that call. We get there and the guy with the full bleed was completely out, full strokes symptoms. Dispatchers cannot make a

difference on that because they are only getting information that is told to them by the RP and in the new system this would have been a BLS call. We would have showed up and then (1) either Santa Rosa would have had to ride with them in with this Ambulance and that would have been a single event this just happen two days ago, or we would have to wait an extra 15 minutes ALS resource. We keep making these changes and these things. We do not even know if the first step is going to work well yet. We all want to; we all want everything to work as well. as we do. We all support new system. We wanted it to be as successful as possible. We all fought for it on the union side for it go this way. Let us take the steps necessary in the correct order to make sure it works. So that one off does not cost someone to die in the line or one of our Medics to be held liable for a mistake that was made or the Dispatchers to feel terrible because something went wrong in the dispatch process, and they were not able to get the right people out. We are just doing everything at once to support the system that is not the people on the ground. We are supporting the overall entity, the Chiefs, Leaders of the organizations and not the people that are either the citizens or the people in the Labor Groups that are running the calls. Maybe that is the most frustrating thing. You heard nothing but concerns from the Labor Groups but yet nothing is really changed to make it better. Well, this is what we are doing. We got to do it this way. Maybe that is the plan, but we are the ones running it. We are the ones on the ground doing the work. They are the ones taking the calls and having all these concerns. Everything I have heard so far has just been rebutting the concerns that have come up and that is a hard step to take when the buy-in has to come from the people doing the work. I have not felt it from my Labor Group. I am just speaking for the Santa Rosa not the overall. I certainly hear their concerns.

Dr. Mark Luoto - I appreciate what you said. I think that I am certainly someone who has been in my home 45 years of being a physician have been a patient advocate, but you know the ugly part about money is without a margin there is not a mission. We cannot run a system effectively unless it is responsibility cost effective. For instance, the reason why I think AMR pushed so hard to get the Tired Response is that there was a paramedic shortage and that is real, and they could not actually provide the care. I think this is a way of making an effective system that is also cost effective which is very important and giving your point about this person that had a stroke. It is pretty clear that we want all of our stroke patients to get ALS First Response and transport but there is nothing in the field that you are going to do for a stroke victim except get them to the hospital quickly. If an BLS ambulance is there and they have a stroke victim. Then they have the capacity to take them immediately Code 3 if ALS is not quickly there because there is not going to be any change in the patient condition. If that patient arrests, cardiac arrest is basically initially a BLS process they have everything they can do the BLS portion of chronic risk management is the most important part. That example you showed of a patient with shoulder pain. If that person had gotten A LS inadvertently it is going to be rare. If they do not have ALS coming there then they should get right to the hospital. We allow them to do that and that is not going to harm the patient all they need is quick transport. There is nothing that an ALS person does to help stroke but get them to the EE quickly. There is a lot of good safety even in a BLS person even BLS rig getting there. That is documented in lots of studies to show that what they need is to get to transport to the hospital quickly. No care in the fields can help a stroke victim.

Stephen Dalporto – I appreciate that Dr. Luoto. That was just a one incident that I was on that call the other day. I certainly agree that is the easy transport you know there is downstream effects that too as well right that takes the Santa Rosa Engine out of service for however long it is but so be it still. We are more than happy to ride in, and we have done it on plenty of calls before. The new ambulance service was sold on to everybody on pull over profits. If there are any profits, then that no should go back into the system. That was one of the fights we had and that how we had to sell it to our Council Members, Supervisors. That all the money was going to go back into the system. I certainly agree everyone needs to get paid and you know we fight for that on the Labor side for fair wages and everything. The income that supposedly was coming in before should be going into the system that you know that should keep the highest level of care on the ground at all times and that is just my opinion of course.

James Salvante - I think I started it with the money comments let me be clear. I think that sometimes this gets taken out of context when I talk about it. You know I am not part of any with the organizations that make any money off of this the only money coming to County is coming from Oversite. This is not about maximize for profit for anybody or providing money to any agency or organization. The thing about cost when I comment on it is that the cost in the system ends up with the people that are end users and patients. You mentioned one part of it is taxes right but not billing that is the real question. If Sonoma County Fire District has to put a bunch of extra ALS units that goes beyond what they bid, they are going to come back to the county for a rate increase to pay for that. That rate increase is going to be felt by the end users. People that are uninsured or underinsured, not the medical patients that have the great cap or the Medicare patients for the folks that are self-made. Those people are going to pay a higher cost. It is not just the cost of whether you got ALS or BLS. It is the total cost of readiness of that system being able to operate. That gets factored into every part of the ambulance bill. That is why we see bills sometimes excess $4000 or $5000. That hurts are people. That hurts people that are chronically underinsured. Keeping costs down is part of good patient care. It does not do any good to show up for low acuity call for the huge ambulance bill to put somebody in collections or in some sort of financial impact. Those people are not going to want to call 911 and tell their friends do not call 911 because it is going to kill you and it is going to break you. Then we have people that are not taking advantage of the system that we are trying to build because they are concerned about that cost. That is going to always be a factor, but we need to do what we can to minimize it and to send the appropriate resources that are cost effective not just the best for the patient but also the best for their financial situations as well. That is my take on this I just wanted you to know. Coming from the cost. It is not about making anybody any money it is really about what is best for their financial situation.

Stephen Dalporto - I am not well versed on all this but if there is already going be more BLS ambulance on the road now with the new contract and you know the billing thing is almost equal. How does that savings fall back to the citizens. Maybe I am missing something.

James Salvante – The overall cost of the of this system is what gets factored into the ambulance bill. You might get billed more because there was medication or something. The base cost what it cost to put an ambulance on the road, cost of unit hours is between

the provider and the subcontractor all of that factor in the base rate. If you have to have extra paramedics because you are being required by the county to have ALS and you think that you can do just fine with the BLS for low acuity calls. There are going have to increase their rates higher for medics to pay for premium pay. If that is necessary because of patient care, then absolutely. Just to say all this system has to be all ALS because it has to be ALS unless there is a specific benefit because we do not want to do that. We wanted to be evidence based and that is why we are with Tired Response, and we are supporting as the LEMSA. Good for the business.

Trivers Collins - This goes to Evonne's point right. I agree with you. That change is scary, and system change and everyone getting this out now. The original motion is to look at extending our Call Processing time during a period. I think everybody is kind of getting out their fears for the Tired Response system that is coming. We all support it, I get it, but I think we need to go back to with the original ask was from Evonne on the Call Processing time. My only concerns were the extra work and stress that is going to be put on the Dispatchers during a time of huge change. I just wanted to get that out to the group. For Captain Dalporto's point about the stroke victim and just for your reference Dr. Luoto, on an incident like that there is still going to be an ALS unit on scene. They are still going to have a response from the City of Santa rosa and in our incorporated areas. There will still be a paramedic on the scene with that call that will be going into the hospital with the ambulance. If it is a BLS ambulance and it is assembled event and those will be critiqued so just to give you kind of a background on how that would be processed on the street. I think we need to just get back to the original motion about the 70 second rule acceptance with Tired Response.

Spencer Andreis - The original motion was to give a 90-day exemption to collect data and then come back in and truly whatever the recommendation would go to the Board for formal adoptions out of this committee's purview for setting that.

Scott Westrope - I would make that motion, but I want to include the things that we have discussed with what we have heard from the Dispatcher regarding that Med send option as well as kind of separate but also equally important. That there is a lot of grace given to Dispatchers and everybody through this period of message book by the Fire Chiefs and others. If there are any additional asks, I think we need to hear if Jasmine or Evonne have additional tools that we could give to the dispatchers to ease this process.

James Salvante - Can we put in that that motion inclusion on the QI committee representative from line staff as well.

Scott Westrope – Yes.

Shepley Schroth - Cary - Motion for 70 second rule acceptance for Tired Response called procedure change with addition of the MED but to be able to send the call for override with Med send along with the inclusion of Field Personnel and Dispatchers in the QI oversight committee's process.

Motion to approve made by Shepley Schroth – Cary, Second James Salvante - Discussion – No further Comments – Approved unanimously.

Scott Melendy - Is there any like any time limit if you go over a certain amount of time that would trigger an override or an abort of some sort. Where the caller is kind of working on getting that sermon code kind of tunneled in on getting that information and not realizing it has been now 100 seconds, 120 seconds to where that would trigger the override and get the response going.

Jasmine Mitchell - Not at this time. It is up to the individual Dispatcher to accept the call. There is no flag that comes up to say hey you been talking to this person for 15 minutes.

Darrell Kopriva - There is one thing 2 1/2 minutes. I have seen a window pop up.

Monica Vanoni – That is if we are not active on EMD and if you are not moving anything it comes up in 3 minutes if you have case open.

Jasmine Mitchell - You have to open EMD or EFD for that to come up but not on our actual CAD which you know always performance.

Mark Heine – I can ask a question for the Dispatchers real quick. Would it be help for if we had somebody our shop in dispatch Monday night, Tuesday not to second guess, double check, or any of those things, but to buffer any issues that may occurred or any negative feedback that might come in somehow from the field unit. I want to make sure you guys are supported. If that is support tool, I would be happy to provide it. If you do not want it or do not need then I am good with that.

Darrell Kopriva – If we had someone available that would have been good, but we had a Battalion of available incase any issues arose.

Mark Heine – One of things we are going to do in our shop. We are going to have our department Operations Center USC activated at our EMS Headquarters in Santa Rosa just to provide support for our field crews and everybody else. We will give you a direct number in there there is any issues make one phone call and we will jump on it for you.

Jack Thomas – Mark, I did throw out as being part of the determinants group for us and Dr. Luoto and Evonne and everybody that I would go up there as well and hang out.

Mark Heine - I hope everybody feels good about this conversation. I do not want anybody to feel bad. This is why we are so effective in this County on what we do. We can have these kinds of conversations and as stuff comes up that you think about after this meeting is over today, push it out and let us address it with you let us try to help everybody work through it.

Brian Crabb – I just wanted to let everyone know that there are two separate front half day shift and night shifts and then the back half, day shifts and night shifts employees. You are going to have new people learning it on the front half and then a few days later you are going to have a whole new group of people on the back half.

e) Call acceptance procedures Medical 911 put on hold during call surges – Evonne Stevens – Evonne Stevens – Other big one for Tired Response. We kind of talk about couple minutes ago when our dispatchers had legitimate concerns about what happens when we have not got to our determinant, and we need to answer another call. We generally try to have two call takers in the center. We also have the backup of the least busy person on the Control Channel picking up a phone call when that is necessary. Sometimes we just get a surge of calls, and we have a really high standard in our center. I pretty much call it the three-ring rule. If we hear that emergency call ring more than three times it creates a level of anxiety for people. Somebody has got to pick up that phone. Currently what our process is, is we get to the sent portion of the call asking the first three questions for both EMD and EFD and that is 'What is the address of the emergency" What is the phone number you are calling from" "Tell me exactly what happened" based on the information we can send. Our current policy for hold, is we have to get all the way through that and then find out how many patients there are, if the patient is awake and breathing and their age and then we can now put that caller on hold. With Tired Response we will not have call created in some circumstances before we have to answer another call because no one else is able to answer that phone and it is on you to answer that call. What I need to do is. I want to keep the Case Entry completion as our policy for everybody because I think it is absolutely vital that we find out if the patient is awake and breathing. Between that point if we have to put that caller on hold, again we are going to have to have an override where we are sending an event. I want to put out to the group. What event are we going to send. Some of these are going to be you know applicable for the BLS Tiered Response in the EOA1 and would typically send a BLS transport unit with the ALS engine. In these cases what kind of event is my Dispatcher going to create while they are having to put that caller on hold. Of course, their priority would be to get back to that caller and complete triage as soon as possible. Sometimes we are able to do that pretty quickly and there are other times where another call comes in like a structure fire or we have multiple callers calling in because many people are seeing something as we just get a really big surge of many calls. If we are not able to get to that. We want to make sure that the correct response is going to this event. I do not want to have a situation where we put a caller on hold, and we do not have an event created. Again, we are talking about this creating the MED override. I am trying to address now. I just want to hear the opinion of the group and the DOAG and Dr. Luoto on what type of event we should create in that circumstance again our goal would be to get that call triage as soon as possible get back on the line as soon as possible but there will be cases where we will not be able to get back on the line. That is why it is so vital we create that event before ever putting someone on hold.

Dr. Mark Luoto - Can I ask a question Evonne.

Evonne Stevens – Sure.

Dr. Mark Luoto - Just so I can put this into perspective. Can you estimate how often someone has to be put on hold in a 24-hour period. Can you give me a rough estimate.

Evonne Stevens – I am not working the floor as frequently as someone like say Monica who is pretty prolific call taker on day shift. Monica, you wanted to speak to that.

Monica Vanoni - Midday, on busy days I can put 10-12 callers on hold. Just depending on what kind of call taking we have. If we are up staff, which unfortunately it does not happen as often now. If we only have two call takers and it is a really busy day like where SLS is up in the 150 to 180 call range, we can each put 10-12 callers on hold easily. That is 20-30 between the two of us.

Evonne Stevens - More specifically Monica. How many calls are you having to put on hold before you get to that send determine. You could still have the whole PAI/ PDI portion of the call.

Monica Vanoni - Just out of case entries probably 2 to 3 a day.

Meagan Horeczko - It is hard, because right now it is slower. You know with storms not necessarily coming in recently, but I mean you taken fire season are lines are ringing constantly.

Monica Vanoni – There has been times where you know we only have 6 lines that we can a lot to people on hold before my call bank is full. We have hit that quite a few times on storm days. It is just getting the address, location if it is hazardous condition just send it. I have to put you on hold go to the next one. I do not even open ProQA at that point because we are so busy. On a normal daily basis maybe one or two before right at the end of case entry.

Evonne Stevens – Thank you, Monica.

Shepley Schroth - Cary - What is asked on this line.

Evonne Stevens – I am just trying to determine what the DOAG and Dr. Luoto what kind of event you would like us to create. Should we just go ahead and create a regular Medical Aid as we have been. That sends the ALS transport unit with the ALS or Fire Engine that is not ALS as we have been doing or if we have not had priority symptoms mentioned do you guys want to take the leap and make a BLS Co Response call on those calls where we have not had a priority symptom mention. I just wanted to set some direction for my Dispatcher so they know what to do when we do come down to this Tiered Response happening and they know they have to put this caller on hold what kind of call do I need to create so I can answer this next line and get back to this as soon as I can.

Spencer Andrie s- I think we air on the side of caution. You created as a MED ALS and then downgrade once to get the caller back on the line and that determines that.

James Salvante – I would support that.

Travers Collins – 100%

Dr. Mark Luoto – Agree with this totally.

Evonne Stevens – That is my ask.

Spencer Andreis – There you have it.

Dr. Mark Luoto – It has to make sense to the Dispatchers.

Meagan Horeczko - Yes it senses. I also have a question. A lot of times we get calls from PD man down calls. Where we never even get a caller. I mean that is another thing that needs to be addressed. You can look at the data, but it is very significant call volume with the man down. We do not get a call from there.

Traver Collins - I think that it would fall in line here.

Jeff Schach – Anything that is not EMD should air on the side of caution. The only time we should be sending BLS only is if it has been EMD properly and gone to that whole process.

Spencer Andreis – Looking for a motion for the Amended call acceptance procedures.

Motion to approve made by James Salvante, Second Ron Busch - Discussion – No further Comments – Approved unanimously.

f) Instruction asking large facilities to bring stable patients to meet responders at entrance – Evonne Stevens – Evonne Stevens – One of our Fire Chiefs suggested with the resurgence of COVID patients and the potential for to rapidly spread inside of large care facilities. To avoid unnecessary exposure for the First Responders we could evoke an instruction to have stable patients asked to be brought to the facility entrance. We did something similar when we were using protocols 36 during the COVID surge and with the DOAG approval I think we could add this as an acceptable protocol enhancement. IAED to of course to not score down on this instruction and this would potentially protect our crews and limit the spread of COVID and other infectious diseases that are kind of running rapid inside of these large facilities. I wanted to open that up for discussion at Chief Costa suggestion. That we would invoke instruction like this again only in large facilities where we have at least stable patients probably the ALAPHA/BRAVO type of patients or somebody needs to go in for catheter or those lower acuity calls. Certainly not anybody that is, and you know CHARLIE level or even some BRAVOs.

   Travers Collins – In theory it makes sense speaking for Santa Rosa. I know like Petaluma has 1115B. They have some medium sized care facilities. My only concerned and this is from the Santa Rosa side would be. A lot of our facilities are huge, so knowing what exit they are going be bringing the patient too. I can see a little bit of maybe clunkiness in regards to the time which the staff is potentially taking the patient out of the room and then our crews getting on scene. We have a pretty short response time into those areas and then tracking that patient down. If it is a BLS call, and they are saying they are going to go to whatever entry or exit way and then we meet them there and it is not imperative that we go in the facility, and we can wait for them I think it is fine.

Spencer Andrei s- We did it for close to two years and I have never heard anything negative only positives.

James Salvante – I do not recall of any issues when it was done for COVID. I am just sort of thinking through what might be the standard. Are we in a place or not with COVID risk that it is a tradeoff between going directly where the patient is taking over care versus having them transferred to wheelchair or something and then moved and then transferring again. I really have not had a chance to think about this. Mark, have you had an opportunity to think through this.

Dr. Mark Luoto – I am working in facilities, and I think you know we are back masking all patients and all providers. I do think the risk is very low. I saw four COVID patients yesterday and I am not worried. I am protected I am wearing surgical mask. I know that in the State there were like a lot of miscues when they were trying to get people to bring to the front. I do not know how much hassle that is for the facilities or what it means. I think the risk to us as providers is very low going into facilities right now. We are all seeing COVID patients it has certainly got much less. There is still a lot of elders who are risk for you know badness with COVID but most of us (I am an elder) most of us have a very low risk if we are masked. If you really want to be careful going into a facility wear a N95 mask. I think your chances of contracting COVID are close to zero personally.

Darreel Kopriva – A few concerns with the dispatchers on this topic about moving stable patients. Yes, we have done it in the past, but it was hyper specific to COVID only. Concerns about this could be construed across the board not just COVID or facility with mass COVID in it. For any stable patient where the Dispatcher you have instruction is going against EMD which states, “We have the patient most comfortable position and wait for help to arrive” or as for medical for trauma being “Do not move the patient unless it is absolutely necessary tell them to be still” and that goes for stable or unstable.

James Salvante - That is what it speaks to my concern about medical practice.

Spencer Andries – I think to is also letting the facilities have a voice if we are going to implement a big change like this permanently. It is a change of working conditions practice for them all as well. I would almost like to see some buy in or support and/or concerns.

James Salvante - You know how those places tend to be staffed.

Spencer Andries - Exactly, if they called 911 and Dispatches is instructing them and potentially taking their staff away from another patient needs and such to accommodate one. I just see that if we are going to permanently implement this need to reach out. I do not know if there is a stakeholder group associated.

James Salvante – We have the EMCC coming up this month. We do not get great representation from the skilled nursing assisted living kind of places where this would applicable. The hospital reps are there that is about it. Maybe even our providers that have better relationships with places. You know your facilities and how would they feel about that.
Spencer Andreis - or could we do it exactly specifically to facilities and the agencies would go out and do their do their own outreach get the buy in and or not and potentially. I do not know if we can hard code that CAD where you get a call at this facility that hardly get enacted versus another, you know I'm saying.

Travers Collins – It is a request from the facility right. Hey, do you have the ability to get this patient to this area. It is a request if they cannot do, they cannot do it. To your point follow up with that facility. We ran into this with pick up and put backs. If someone has fallen out of bed an Engine response. They are not injured they just need help back in bed. We do not do that. I can see the same thing going on these line. Hey, can you get the patient to the main entrance. No, we do not do that. We do not have the ability to or the staff to do. We are not trained to do that. It is a request right, that is what it is. It is asking me if you can get them to the place, so we do not have to enter the facility.

Evonne Stevens – That is very true and on the COVID side of things We did not get a lot of cooperation from many facilities. They just said they were not able to do it. We moved on to the rest of the PDIs. I do want to stop for one second and Dr. Luoto has his hand up and he is on limited time. I am going to give him an opportunity to speak on this before he has to step away.

Dr. Mark Luoto – I appreciate it. Yes, I think this is creating extra work and extra stuff. I personally do not think we are at risk going into these facilities. If you really want to be especially careful wear a N95 mask not just surgical mask. I think you are going to be safe. I do not think it is worth it personally. I just wanted to say thank you Evonne for getting a hold of him 5 minutes before the meeting. I appreciate being of this meeting it was an important meeting and I really appreciate it being here thank you everyone.

Evonne Stevens - Thank you for making it possible to come on here. I appreciate your attendance today Dr. Luoto it was very important.

Mark Heine Chief Schach do you have any feedback on that.

Jeff Schach – I have not talked to Chad about it. I understand the concerns, I understand the challenges. I am good either way and if we do not make that a holistic policy here within REDCOM that is something we have reach out to the facilities that we have concerns with and ask that that just be standard factor on their part and not be included in the Dispatchers procedures.

Spencer Andreis - That sounds to me or is everybody is good.

Spencer Andreis – Moving back to item C.

VI. Old Business

a.) Tiered Response Update – James Salvante Spencer Andreis – I do not think we need to talk about Tired Response. 😊

b.) Prepared Live update - Ken Reese – Ken Reese – The Prepared Live we brought the demo the product essentially for a refresher. We had a pretty small group of people on that particular day. Prepare Live is a free service unless you want additional pieces that go along with it. It basically is a free service. Where a Dispatcher can say, if I send you a code to your phone could you show me what you are seeing. Essentially, they can click on a link, open it up and you can get access to their camera. This is what the fire looks like, and you are putting it up on the CAD station. Prepared live is being used by PSAPs all over the US. Matter of fact our CAD vendor partnering with them and integrating that product into the CAD system, it is going to have the ability to become part of our system no matter what we are going to do in the near future. The free version is this simplistic thing. There is a paid tier one of the first paid tiers are you can create contacts. Let us say you have Duty Officers for REDCOM. I task them with showing me proof that you have company officers that are looking at a live feed of somebody showing something because I call BS, right. There is no Engine company CAD driving down the road that is going to be looking at you know these types of things. I could see maybe BC that is not responding but maybe BC that is not going to the call but wanting to watch. It does have the capability of having the contact sending that link to that Duty Officer so they can make an informed decision about how to automate a response, upgrade a wildland thing and a lot of it is going to be about wildland. Law Enforcement is using it for all whole different type of thing. One of the big concerns was HIPPA. We would have to use policy of not using those some sort of EMS event. The other piece of it is there some stuff that is trackable, was there an audit trail who can accessed that. Who was the particular caller. All of that stuff is there. At highest level of that product, it has translation and transcription services. Unfortunately, the translation pieces is one way. It goes in as what is called a SIP it goes into our 911 phone system and as they talk, you have that window open and as they talk it translates that into text for you. It does not do it back the other direction but there are those types of services that are there. There so the question was, there we several Chiefs that have come to us. Chief Akre and Chief Costa had come to us. These are great products that potentially could be using for a Dispatcher to gain better knowledge of a particular instance that is going on. Evonne and I were talking about potentially using this the free version of it and see where that goes. It that is something that say a maybe the REDCOM Duty Officers might want to be a part of that. We can explore the additional cost of having what they call the Responder mode of that which is a X amount dollars per year kind of scenario. The ask here is does the DOAG have any kind of heartburn with at least starting to use the free version of this and giving the Dispatchers that extra tool. I do not want to put at any money for something that we find is not ultimately something useful at the Dispatcher level. It is something that is available.

Spencer Andreis – I think it is a great idea. I think you guys can just get back to us on your experience and if it is a viable solution moving forward. Anybody else.

Shepley Schroth - Cary – Last time this came up I had strong feelings about the impact of the Dispatchers exposure to traumatic things more than just listening to people and ultimately, we are going to address all those issues the HIPPA, storing of the data their solutions so initially I was pretty reluctant to be supportive at no cost and exploring I think it is appropriate, but with those considerations.

Ken Reese - We already have a draft policy already written up which some of them we plagiarized from El Paso. El Paso is using it at the NTH degree translation at the whole Marianne. I sit on an Executive Board with the Director for El Paso from the CAD side of things. They are absolutely thrilled with it. The vendor is going to continue to provide me with the use cases and agencies that are actually truly using this from the fireside for First Responders and things of that nature. I have a hard time believing that an Engine Company Officer is looking at a video stream while they are driving down the road and trying to navigate the call. It remains to be seen. At least if we have the ability to start this as a free service it is worth it.

Shepley Schroth - Cary – The other part that I think should be excited is the Fire prevention investigation side. Really integrate that group into this as well so that they can utilize it, so it is not wasted. If we do have early video of the fire start it would be really helpful make sure that information is given to fire investigators.

Ken Reese - It is available at the physical CAD workstation, so you do not have to log on to any kind of 3rd party machine. It is also on the CIJS cloud it is a CLETS complaint piece of service. It is pretty secure, and the storage is good, and it is retrievable. There is whole good process for records requests and everything that goes along with that.

Shepley Schroth - Cary – Two comments really. One was back at the Dispatcher sided shop hearing today and the workload and how busy it is. Is that something that really would be useful or even useable and second piece is a having a little bit of concern with the earlier statement maybe it would allow the Duty Chief decisions upgrade decisions etc… remembering that is the Battalion Chiefs level responsibility so I just kind of breaking that community of command having with one person in charge etc… maybe some guidelines put in place on its use. Who is stepping in to make override calls etc.…

Ken Reese – The free version does not have the ability for anybody else but the Dispatcher to look at the instance and they can say this is the size of this, this is where it Is traveling so, they are giving good information for the responders that are going and if we find that that it is working and beneficial that we explore this $1500 a year or whatever the cost is for the responder version. Which gives the ability to create contacts and individual people so you could have all of the Battalion Chiefs listed in there. It is a one touch thing. It goes to their iPad, their phone whatever and they click the link, and they can make decisions at the agency level.

Jeff Veliquette - Who would be the person filming this so to speak.

Ken Reese - It would be the callers. I had a great kind of a use case. This would have been perfect. I listened to a dispatcher going back and forth with somebody for 15

minutes on the phone about where they were looking at this and going on and they were on the phone for about maybe it was 15 minutes, it sounded like it. I am sitting in my office. Would it not be great if I could just send them a link that they could open and show me where they are talking about on their phone, and you can blur things. You can control their phone. It is going to be a 911 caller.

Monica Vanoni - I think it will be similar to us using the current fire cameras right now. We can hear someone talking and trying to locate a smoke in general direction you are going to jump on it trying to get cameras.

Evonne Stevens - I just want to reiterate this strictly a fire tool and that it would be an additional tool for the dispatchers and the intent is not to create an additional workload for you guys. It would be a tool that you could use in cases where you feel like it would be valuable and not something you would be expected to use. There would be no discipline process if you did not use it. It would just be something to enhance your ability to give the First Responders a better look at better information about what is happening on the calls that we find difficult, or we are having a location issue, or you feel like they have got their eyes on something that is potentially going to be useful so at your discretion.

Spencer Andreis – Work Groups

VII. Work Group Reports/ Sub Committees

Work Groups developing dispatch implementation recommendations will present reports to the DOAG. The DOAG may take action on information contained in the reports.

- Dispatch Steering Committee (EMD or EFD topics) – Evonne Steves –

Brenda Bacigalupi – I forgot to remove.

Spencer Andreis – No worries. Evonne is there anything else you wanted to add on to the Steering Committee.

Evonne Stevens - Just that we would not be using this for medical. I do not want to place any trauma on the dispatchers at all or have them seek anything emotional this would be strictly for fire calls.

Spencer Andreis – Can you hear me, Evonne.

Evonne Steven – Yes.

Spencer Andreis - We are moving on to work groups Steering Committee.

Evonne Stevens - We covered that.

Spencer Andreis – Kenny do you want to do a quick update for us on Control 2.

Radio – Control 2 replacement – Ken Reese - Everything has been replaced with the exception of St. Helena and Oakridge. There is an access issue to get to Oakridge. Oakridge is not a big playing partner in that so much. St. Helena unfortunately was supposed to be done today. They had some all-out sick and then now they have to work in the shop and so that has not been done. There was a lot of radio testing that went on yesterday and places and people that could not talk on Control 2 before had the ability to talk on Control 2. That would include Gold Ridge from the station on portable and mobile and crystal clear as if they were in the room with you. Big props to the radio shop for getting all that stuff done. I mean technically you could probably go back to using Control 2, but I would be reluctant to anything too far north county would have some issues because St. Helena is not online. I think it is just probably best to leave things alone as it is right now and then hopefully when they bring that online tomorrow that we can flip everybody back over. If it is going to be a delay period of time that we probably should get folks back on with the exception of north county and just keep north county on Control 4 for now. That is where we are at and we will know more this afternoon.

Spencer Andreis – Thanks Ken.

Evonne Stevens – I have a little update as well Spencer. For the Control 4 side of the radio project. The Board of Supervisors had their meeting on the 9th. They did approve the grant to go through for us. I spoke with the folks from Daily Wells yesterday. They had pre-ordered the equipment for Control 4 to be shipped out on January 27 with the expectation of the Control 4 equipment to arrive at the radio shop for the first week of February so they can start working on getting Control 4 done potentially by the second week of February or maybe a little later than that depending on testing. We are going strong with that, and the equipment should be here less than a month.

Spencer Andreis – Great news thank you. Anything for SOP or training. We already talked about SOP anything for training.

- SOP- Training – Evonne Stevens - Nothing for training.
- CAD /Back –up – Nothing
- SMART – Doug is not here.

Spencer Andreis - Anything from Memebrship.

VIII. Announcement Items from the Membership

Conduct a roundtable of members

Mark Heine - As we roll this new process out on Monday. Everybody needs to just take a deep breath and let it roll a little bit. We have ambulances in place and start standing up at 1900 hours on the 15th and then it will progress from there to the next day. I think everybody has my personal and work cell phone. If you have any issues, please call us. We want to be collaborative. I understand that this is a huge paradigm shift for us right now. I know there is a lot of concern. Everybody in this room is a professional and

we will get through it. I think it is going to be a positive change for us it is just going to take a little bit of time. We do not know what we do not know. I appreciate everything that everybody is doing. The Dispatchers. Labor so it is all good. I think this is for a better system it is going to take us a little of time.

Ken Reese – Back on SMART. Doug announced yesterday that he is no longer going to be station liaison as of the end of the month. That will be transitioning over to Public Safety Chief for SMART.

Spencer Andreis - Hearing no additional announcements. Looking for a motion to adjourn.

Next Meeting March 28, 2024, at 1300

Adjournment: Motion to Adjourn made by Ron Busch, Second Shepley Schroth - Cary – Discussion - – No further Comments – Approved unanimously @ 12:18pm

REDWOOD DISPATCH COMMUNICATIONS AUTHORITY
STANDARD OPERATING POLICY

PROCEDURES FOR ELECTRICAL WIRES DOWN/ACKNOWLEDGEMENT BUTTON	Policy 25
Green denotes the most recent changes	
Page 1 of 1	Effective Date February 28, 2024
Approvals Spencer Andreis DOAG Chairperson	Evonne Stevens REDCOM Executive Director

25.0 PROCEDURES FOR ELECTRICAL WIRES DOWN/ACKNOWLEDGMENT BUTTON

25.1 Incidents involving electrical wires down pose an extraordinary life hazard to responding emergency personnel. Because of this, special procedures shall be followed on any call where it is reported or believed that electrical wires are down, or whenever field personnel report wires down.

25.1.1 The CRO shall announce to all responding units that "WIRES ARE REPORTED DOWN" and a roll call shall be made of all responding resources.

25.1.2 Responding resources shall acknowledge this message with "*UNIT DESIGNATOR* COPY WIRES DOWN or via there "Acknowledge Button"

25.1.3 The CRO shall document in CAD incident history the transmission of the wires down alert and unit acknowledgment.

25.1.4 The "Acknowledge Button"may also be utilized for Staging Events, Change Of Address or Reduction to Code 2/Upgrade to Code 3.

25.1.5 Should a unit equipped with Tablet Command not acknowledge the special message within (5) seconds, the CRO shall revert to a verbal announcement to the responding unit requesting acknowledgement.