Introduction

The Abaris Group was asked to conduct an evaluation of the current ambulance franchise planning and input process as well as the performance metrics of the current ambulance franchise operation. The proposed ambulance franchise selection process was also reviewed in terms of timeframes and deliverables. The goal of this analysis is to evaluate the current status of the ambulance franchise and stakeholder input process and to make recommends on how to proceed with the new request for proposal (RFP) process.

Beginning in mid-December 2007, a number of focus groups and on-site interviews were conducted over a period of eight weeks. Representatives from the area fire departments, both basic life support (BLS) and advanced life support (ALS) providers, local hospitals, REDCOM, the EMS/fire dispatch provider, American Medical Response/Sonoma County Life Support (AMR/SLS), veriHealth, a BLS/ALS provider, and REACH, the air medical provider, were interviewed. Additional interviews were conducted with Bells Ambulance, the Coastal Valleys EMS Agency (the local EMS Agency or LEMSA), County Health Services and the County Administrator's Office as well as County Counsel. In addition, an Abaris Group consultant directly observed EMS operations in Sonoma County by riding along with the Santa Rosa Fire Department and Sonoma Life Support on January 14th and 15th and conducted some observation sessions of REDCOM dispatch operations.

In addition, a number of documents were reviewed, including Ambulance Franchise Planning Meeting minutes and support materials, all 1998 ambulance franchise RFP documents, the current franchise agreement and amendments, and RFPs used in recent years throughout California. Data was also requested, to the extent available, on response times and on other system performance parameters (e.g. financial).

Overview from Stakeholders

During the 1998-1999 RFP process, an extensive "visioning" process (called Future Search) was used to design the franchise. This process was facilitated by an outside expert. For many stakeholders, the process was very collaborative with consensus appearing to be reached on most franchise components. During recent interviews, some stakeholders felt that after that RFP process was completed important agreed-upon elements were eliminated from the franchise contract without wide stakeholder agreement. Most stakeholders offered that they now understand that fine tuning often occurs during the final contracting process.

In reviewing the LEMSA's current process, The Abaris Group concludes the process has been well organized and that information has been easily accessible to all interested stakeholders on the Coastal Valley EMS Agency website. Monthly "town-hall" style meetings have been conducted with several informational presentations related to EMS system design provided. The stated purpose of these meetings was to receive input from stakeholders regarding EMS features that could be included in a new ambulance franchise for Sonoma County. A project timeline was developed and posted on the LEMSA website. A matrix was also developed to track the progress of key issues identified during the project.

Summary of Stakeholder Comments on the Planning Process

The impression of some stakeholders interviewed was that although there have been processes for obtaining input, the input they provided was not being considered and important decisions regarding the content of the RFP were not being made or their status remained unclear. Initially, some stakeholders were under the impression that there would only be minor changes to the current franchise and that EMS operations in Sonoma County would basically remain as they are today.

The primary areas of concern expressed include the potential to add routine EMS transports (BLS ambulance services) to the franchise on an exclusive basis, the potential for eliminating the ALS/fire first-responder contract and the ambulance response time adjustment feature, the location of ALS ambulances during periods of peak demand, the lack of complete clinical quality control efforts by the ambulance provider, and the opportunity to review the full draft RFP document.

Additional opinions expressed by some stakeholders during interviews include:

- LEMSA staff was not objective and appeared to have some biases to AMR
- LEMSA staff undervalue the ALS first responder service
- ALS ambulances with limited or no availability during Level 0 or 1 system status (0-1 ambulance available)
- Limit franchise to 9-1-1 ALS calls only and not include interfacility BLS services
- LEMSA's prohibition against in-house fire-based ALS training
- AMR's limited CQI processes
- Lack of preceptors for fire paramedic interns
- Impact of franchise agreement on ambulance responses (e.g. lack of fixed 24-hour stations, minimal posting outside the core Santa Rosa area, move ups of Bells potentially affecting Bells' responses to non franchise zones).
- The addition of ALS resources in non-ALS first response zones.
- Lack of performance standards or requirements for ALS inter-facility transfers and inadequate LEMSA staff to monitor inter-facility transfers if there were performance standards.
- Hospitals' concern that AMR can not provide timely interfacility transfer of patients because franchise ambulances are busy with emergency 9-1-1 responses and transports.
- Surge capacity addressed in the RFP.
- System educational standards are poor and need upgrading (e.g. PALS, etc).

Ride-Along Observations

The Abaris Group participated in ride-alongs with Santa Rosa Fire Department and AMR/SLS. The personnel from both agencies interacted well on-scene and used a team approach to patient care. The interaction between the ambulance personnel and the hospital also appeared to be good. The ambulances and medical equipment appeared to be in good condition. The AMR/SLS supervisor responds to motor-vehicle collisions on a routine basis and was able to provide additional on-scene assistance to the crews.

It was noted that there were several calls related to alcohol, drugs, and homeless individuals. AMR/SLS units are frequently moved around the area to different posts. There appears to be minimal documentation requirements from the field units for hospital staff at the time of delivering patients to the hospitals.

Risk of Hospital Closure

Recently Sutter Medical Center of Santa Rosa announced they were going to continue to honor their Healthcare Access Agreement with the County of Sonoma, so the risk of that hospital closing has now diminished. However, hospitals in Sonoma County currently have adequate capacity to handle the demand for hospital services even if there were some fluctuations in hospital beds. In 2006, there were 692 licensed general acute care hospital beds at hospitals in the county after Sutter Warrack closed its inpatient units and ED, with a licensed bed occupancy rate of approximately 59.7 percent. Additionally, there were 82 licensed ED treatment stations in the county. With 131,905 ED visits, there were approximately 1,609 visits per treatment station in 2006. It is estimated that approximately 14,866 of these ED visits arrive by ambulance.

Additionally, in March 2008, Santa Rosa Memorial Hospital added 80 new medical/surgical beds. With this additional capacity, using 2006 utilization data, Sonoma County would have a licensed bed occupancy rate of 53.5 percent.

Sonoma County Hospitals
Hospital Capacity, 2006

	Licensed General Acute Care Beds	Discharges	Patient Days	Licensed Bed Occupancy Rate	ED Treatment Stations	ED Visits	Visits/ Treatment Station
Healdsburg District Hospital	34	565	1,799	14.5%	4	7,219	1,805
Kaiser Hospital Santa Rosa	117	8,932	31,582	74.0%	17	30,198	1,776
Palm Drive Hospital	37	1,051	4,201	31.1%	5	7,547	1,509
Petaluma Valley Hospital	60	3,159	12,865	58.7%	15	18,321	1,221
Santa Rosa Memorial Hospital - Montgomery	209	11,349	56,240	73.7%	19	33,560	1,766
Santa Rosa Memorial Hospital - Sotoyome	29	816	4,779	45.1%	0	-	-
Santa Rosa Memorial Hospital - Fulton	15	251	3,480	63.6%	0	-	-
Sonoma Valley Hospital	56	1,619	6,177	30.2%	5	8,072	1,614
Sutter Medical Center of Santa Rosa	135	6,170	28,102	57.0%	17	24,389	1,435
Sutter Warrack	63	343	1,597	6.9%	7	2,599	371
Total[1]	*692*	*34,255*	*150,822*	*59.7%*	*82*	*131,905*	*1,609*

Source: OSHPD Hospital Annual Financial Pivot Profile, 2006; Hospital Annual Utilization Pivot Profile, 2006; County of Sonoma Health Services, Public Health Division

[1] Note: Sutter Warrack excluded from total capacity as inpatient units and ED have closed

Study Conclusions

The Process

Some stakeholders say they were told only small "tweaks" would be made to the franchise. This position appears to be in conflict with other shareholders that desire to have a comprehensive visioning process similar to the process ten years ago. In addition, documentation of the input process, at least at the committee level, has been excellent. It suggests that a thoughtful and deliberate process has been followed by the LEMSA. However, the perception of most stakeholders is that this has not been the case and that closed meetings, documents circulated to small groups and statements made by LEMSA staff advocating for particular changes to the scope of the RFP were in fact the methods being used.

Most fire department stakeholders appear to want to have substantial involvement with the RFP process including reviewing all documents and sitting on the Selection Committee. This is due to distrust in the process. It appears additional trust has been gained in the last few months through collaboration with the Department, LEMSA staff and its consultant and the sharing of the proposed RFP elements. Completely sharing all RFP bidding documents would give an unfair advantage to a local bidder as they would have access to the complete bid package prior to their potential competitors. Having one or more local stakeholders sitting on the Selection Committee may give the appearance to an outside bidder that this stakeholder group(s) (e.g. fire departments) are controlling aspects of the RFP process and would suggest to potential bidders that the selection process would be biased.

There is an industry expectation that contracts that contemplate a ten-year term include a comprehensive review for potential improvements to the system. Such a review provides an important opportunity to improve the quality of ambulance services available to the community. The LEMSA has added three more stakeholder input meetings to the schedule and retained the services of The Abaris Group, a firm with industry experts, who will weigh in on the key components of the franchise and after receiving input, accelerate the development of the franchise tools.

It is The Abaris Group's opinion that the ambulance franchise RFP process should proceed ahead on the current timeframe to select and operationalize the next franchise holder by July 2009. A review of other potential parallel RFP processes in the state suggests some overlap but nothing that conflicts with the timing of Sonoma County's process. For example, San Mateo County was scheduled to release its ambulance RFP process in March 2008 with the process to be completed well in advance of their contract expiration deadline of July 2009. The City of San Diego ambulance RFP process is expected to start within a few months, missing their contract expiration deadline of July 2008. To mitigate the expiration of their current ambulance contract, they intend to extend their current contract on a month-by-month basis. The Solano County RFP will not start for another year and their deadline is July 2010 and thus not a factor for the Sonoma County RFP.

The Department and LEMSA have elected to proceed forward under the current timeframe. The alternative would be to delay the RFP process. Not conducting an RFP process is not a long-term option due to state regulations. Proceeding on the current schedule provides synergy with other County RFP processes. There has been recent out-of-state ambulance provider interest in at least one

other RFP process in California and that interest might extend to other regions as well. It should be noted that delaying the RFP process would also delay other important system improvements that The Abaris Group is recommending. These include rightsizing the response zones, better defining the data reporting requirements and establishing an AED/citizen CPR program, all of which are further described later in this report.

Even under the best of circumstances, not all elements in an RFP process will be included in the final contract due to a best-and-final negotiating process that the LEMSA is ethically and financially responsible to complete. This is due in part to cost and value considerations that cannot be ascertained prior to acceptance of the bids and partially from competitive proposals that include different approaches that must be valued by the LEMSA.

Shareholders commented on AMR's poor ambulance CQI processes. The current ambulance CQI process may be excellent and need more transparency or may need to be improved.

The Abaris Group recommends:

- The LEMSA should continue with their current input process (which included the three additional meetings from January to March 2008) by collecting additional stakeholder input on the RFP elements and then moving on to a RFP process. (Additional input on RFP elements has been received and the LEMSA is currently in the process of developing the RFP.)
- The LEMSA should initiate an RFP process consistent with the timeline in Appendix C with completion prior to the current contract expiration of July 2009.[1] (The LEMSA has initiated the RFP process consistent with the timeline set forth in the Appendix C.)
- The LEMSA should share the "elements" and not the full RFP documents to all stakeholders prior to the RFP process for the reasons stated above. (RFP elements were shared with the stakeholders at the March 2008 meeting.)
- The LEMSA should appoint all RFP proposal review committee members from outside the county, with members completely screened for bias or even the potential for perceived bias, and with at least one out-of-county fire representative.
- The LEMSA should ask AMR to completely document the last year of CQI work including topic areas, special studies and outcomes and ask The Abaris Group to evaluate their performance in this critical area.

Value of ALS First Responders

A review of ALS first responder service should not be threatening if the underlying justification for the service exists. The Abaris Group has reviewed the literature on the subject of ALS services in general (e.g. first response and ambulance based) and the literature is not clear on the subject of the

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[1] This recommendation is subject to the successful completion of the 90-day zone reallocation process recommended on page 8.

effectiveness of ALS services. More research on this subject is being done and will likely be published in the next few years.

Instead, The Abaris Group has analyzed the value of this service and how much leverage it provides against more expensive ambulance unit hours that the ambulance provider would incur without this coverage. Also, the community within the City of Santa Rosa has spoken on this subject (Measure O) and the value ALS first response services provides. AMR, by subcontracting directly with the City, is able to obtain more leverage of the ambulance unit hours due to the relaxed ambulance response standard when the ALS fire first response unit arrives on the scene. The ambulance franchise zone has also been able to reduce the ALS on-scene performance standard by a minute (as compared to other metro areas across the country) from an eight-minute community standard to a seven-minute standard and the community is to be commended for setting this high bar. In addition, ALS first response engines now move up and cover within the City and also respond outside the City if needed, both of which are commendable attributes and industry-leading concepts.

The LEMSA has expressed concern about skill decay with the ALS first responder staff based on low frequency use of key skills (e.g. intubation, etc.) It is within the LEMSA's jurisdiction to raise these concerns. However, the LEMSA has provided no data to support their concern.

Some fire and non-fire agencies (Sheriff Helicopter) have questioned the lack of revenue sharing under the current ambulance franchise (e.g. AMR/Santa Rosa contract). The contract between AMR and the City of Santa Rosa is not a "revenue-sharing" relationship. AMR is purchasing specific services from the City in order to reduce their ambulance unit hours and improve their actual performance. Thus, a specific set of "value-added" services are being provided under a business model agreed to by both parties.

The Abaris Group recommends that the next ambulance franchise contractor consider the following three characteristics prior to agreeing to any expansion of the ALS first response program: 1) Is there a clear documentation of "value-added" performance to the franchise?; 2) Is there a business plan to financially support the expansion?; and 3) Is the business and clinical skill set of the new ALS providers sustainable? Also, any additional subcontracting of services and franchise dollars should only be considered if there is additional marginal revenue to support such ventures from the ambulance franchise itself and does not put the ambulance franchise at financial risk.

The Abaris Group recommends:

- The current option of a Santa Rosa ALS first-response program should be left in the scope of the RFP as an option, subject to the ambulance contractor being able to successfully negotiate with the City of Santa Rosa.
- The ambulance contractor should not consider additional ALS engine programs without meeting the above three criterion and demonstrating that the franchise can support the additional funding.

Locations of Ambulances

There exist within the franchise three fixed ambulance locations. While these fixed ambulances may float during any 24-hour period, the ambulances are stationed at the fixed location when the ambulances are not needed elsewhere. Traditionally, performance-based franchises would not have "fixed" units because they may imply that the LEMSA warrants the sites as appropriate for meeting the performance standard. A fixed-station program is known in the industry as a "best-efforts" model (provider should use its best efforts to achieve performance with no guarantee they would be in compliance) rather than a "high-performance" model (provider must meet the performance standard and is free to choose its own unit hours and posts but guarantees their own performance). However, these fixed stations have stood the test of time relative to performance and also with respect to negotiated community concerns about access. As such, The Abaris Group does not recommend eliminating fixed stations. The LEMSA should require potential bidders separately cost-out fixed stations in the RFP. (Details of the actual current performance standard by region and by type of call are provided in Attachment A.)

Additionally, some fire departments advocated for the provider to redeploy ambulances/QRVs to rural areas when resources are low because they feel the ALS engines "cover" the central populated area and thus, in their opinion, the highest risk areas are in the rural periphery of the franchise. This is an ambulance franchise provider issue as it is within their discretion on how they deploy ambulances and the QRV.

The Abaris Group recommends:

- The ambulance franchise RFP maintains the option of the three current fixed-station locations.
- Continue to allow the ambulance provider to determine ambulance/QRV deployment.

Performance Standards

The Abaris Group reviewed the current performance standards as required in the contract. While there appeared to be robust performance data reporting early on in the franchise, this all changed with the new CAD dispatch software added about five years ago. The new CAD software was designed for fire departments and has a complex zone system that makes it nearly impossible to achieve any ambulance performance data reporting at the sub-zone levels (e.g. reporting for the equality zones contemplated in the original RFP).

The LEMSA and AMR/SLS have struggled with the ongoing challenges of the franchise performance data systems. To date reporting from AMR/SLS to the LEMSA at the franchise level has been inadequate and at the beginning of this analysis nearly one-and-a-half years old. Recently, the data reporting on overall system response times has been catching up and should be up-to-date (reporting for the last 30 days of service) within the next month or so. However, this catching up will only cover franchise-wide performance and not sub-zone performance.

Also, a mitigating factor is the limited number of complaints about long response times in the past few years. An early review of the nearly complete up-to-date franchise-wide data suggests performance

for the entire franchise on average is acceptable. However, data on subzone performance is still unavailable and will not be available until corrections to the zones described below are implemented.

There are many reasons the franchise is challenged with getting data scrubbed and produced in a reportable fashion. The current process requires a long and laborious download process that occurs monthly as the data is run through one of the County's servers. Each month's download to the County server takes approximately three days and if there are any glitches with the download, the process can be delayed for weeks. It takes another two to three weeks for AMR to scrub the data and deliver it to the LEMSA. It then takes the County staff another three days to look at the data and evaluate response-time exemptions allowing compliance with performance standards to be assessed.

AMR has indicated that a fix for the long download process would be in place within a month with new daily downloads being made. Despite improvements to the download process, the most significant challenge to achieving detailed performance data reporting is the multiple levels of zones. It is difficult to tie those zones to geographical markers and the complex array of performance standards that apply across a possible 1,000 permutations. This challenge needs to be addressed immediately as it will be difficult to market or describe the current zone system to a potential bidder. LEMSA staff indicate that a fix could be achieved, with all parties providing prioritized resources (County departments and AMR) within the next 90 days. On the date this report is issued, the LEMSA has implemented a Response Time Compliance Project to re-engineer response time zones.

Fire departments indicated concerns about the lack of an ongoing contract compliance committee which was in place early in the franchise period. The LEMSA correctly asserts that there is not enough data to support a stand-alone committee with only average franchise-wide response time data being available. However, additional challenges exist that that could be addressed by such a group (e.g. perceived lack of attendance at fire sponsored training, potential for a countywide backboard program, Level 0 status, etc). A franchise compliance committee might be the place for these issues to be addressed while the data collection process catches up.

The LEMSA expends significant resources reviewing requests for exemption, averaging 90 – 120 calls per month. This number is dropping as the LEMSA establishes firmer guidelines as to which calls qualify for an exemption. Despite the LEMSA efforts, however, the exemption process continues to be laborious and excessive for a franchise this size.

Fire Departments were also concerned about Level 0 status (no ambulances available). The Abaris Group notes there is no requirement for AMR to track Level 0 status, and thus it is difficult to track the volume of these events.

The Abaris Group also notes that there are quarterly and annual financial statement disclosures that are required in the contract with the County. Recently the County has engaged their compliance officer on this issue. In addition, AMR recently released 2007 financials to the County, putting them in compliance for that year.

Finally, Attachment A provides a matrix of performance parameters in the current contract and other proposed changes for the future RFP process.

The Abaris Group recommends:

- The LEMSA and AMR should work over the next 90 days on a collaborative and high-priority basis to reallocate and reengineer the franchise zones from the now very large and complex system to the approximately 30 zones that it is estimated should be achieved. (The LEMSA has already begun implementation of this recommendation.)
- Upon the conclusion of this zone re-engineering process, the LEMSA should insist on regional zone reporting 30 days from the completion of each calendar month.
- Key performance standards and reporting not currently included in the ambulance franchise (e.g. Level 0) should be added to the new RFP per Attachment A.
- Consider re-establishing the Contract Compliance Committee.
- Re-evaluate and tighten definitions on what is adjustable for late ambulance responses which should significantly reduce the LEMSA's time on this task.

Franchise Scope

A considerable amount of time was spent during the interviews on whether to franchise non-ALS ambulances (BLS ambulances including BLS interfacility transfers) within the franchise zone. The 9th Circuit Court of Appeals decision (RELS v County of Sonoma, 9th Circuit 190 Fed 3rd 949) clearly gives the LEMSA the authority to franchise all ambulance use (BLS and ALS) within a franchise zone. The LEMSA chose not to include BLS calls and BLS interfacility transfers in the franchise zone during the 1998-1999 RFP process as they were still in litigation over the above case. Any comment to suggest that no other local emergency medical services agency has included BLS ambulances into the franchise is incorrect with six other California counties having chosen to do that.

Using The Abaris Group assumptions, a simple calculation of potential marginal net revenue to the franchise was prepared assuming that the franchise would include BLS calls as follows:

Estimated Marginal Revenue BLS Calls Included in the Ambulance Franchise				
Total Estimated Annual ALS Transporst	Estimated Additional BLS Transports (estimated at 30% of ALS)	Estimated Average Charge	Estimated Average Collection Rate	Estimated Marginal Revenue to the Franchise
18,000	5,400	$ 950	50%	$ 2,565,000

Source: The Abaris Group

Using conservative calculations, The Abaris Group estimates that the marginal revenue opportunities available to the franchise zone contractor would be approximately $2.5 million not considering costs. Depending on how well the provider leverages resources (e.g. dedicated BLS units supported by ALS units at peak BLS call times), the net contribution of adding BLS calls to the franchise could be in the

range of $100,000 to $200,000. It would be a matter of negotiation as to how those funds would be used and the extent they could be used for new franchise program initiatives (e.g. AED program, Citizen CPR).

While there is some theoretical financial opportunity based on the above calculations and assumptions and some positive considerations identified through the SWOT analysis for adding BLS calls to the franchise (Attachment B) (e.g. attractiveness for bidders, additional financial stability, etc), these assumptions are not clearly developed from a refined data standpoint. There is also considerable opposition from other stakeholders including several of the hospitals, some of the fire chiefs and at least one BLS ambulance entity. The hospitals claim they would have eroding performance and financial leverage over the franchise BLS provider. The BLS provider is worried for its survival as well as the lack of surge potential during major emergencies.

On the concept of interfacility emergency transfers Critical Care Transfers (CCT) and Critical Care Transfers with Paramedic (CCT-P) is a different matter. The LEMSA now has input from County Counsel which provides that it is completely within the LEMSA's authority to include CCT and CCT-Paramedic (CCT-P) in the scope to be franchised for the RFP and will be doing such. I believe it is a proper inclusion as it is an emergency response (unlike routine basic ambulance interfacility transfers which we do not at this time recommend being franchised even though the LEMSA has that authority to do so as well) and the CCTs inclusion will likely enhance the overall franchise attractiveness to outside potential bidders. It is also the current practices standard in the franchise zone. The selected ambulance provider will be required to meet certain performance standards for responding for such CCT requests and will be required to have mutual-aid contracts with other providers should the contractor temporarily not be able to respond within the required response time standard. The County should commit to monitoring this aspect of the franchise contractor very carefully as routine failures to meet this portion of the scope of the RFP could put the contractor's entire contract at risk.

The Abaris Group recommends:

- BLS ambulance services and BLS interfacility transfers should not be included in the scope of this current franchise process.
- The LEMSA should study volume and impact of potentially adding BLS ambulance calls and interfacility transfers into any future franchise to include the potential financial impact to the franchise.
- CCT and CCT-P should be within the scope of the franchise zone with clearly defined performance standards and the requirement that if on any request, the response time parameter cannot be met, the franchise provider must notify an approved CCT mutual aid provider who will be required to respond within the performance timeframe standard stipulated.

Fee Schedule Adjustments

The County has a formal ambulance fee schedule adjustment process. Until recently, AMR had not submitted financials as required in the contract. Without historical financials being provided it is difficult to tie requests for a rate increase to actual cost or revenue assumptions. When the Board of

Supervisors approved the last rate increase it instructed the LEMSA staff to return with additional justification for the approved rate increase prior to the January 2009 adjustment.

The Abaris Group recommends:

- The Abaris Group should continue to review the supporting financial documents that AMR has supplied.
- The LEMSA should return to the Board with additional justification for the approved rate increase prior to the January 2009 adjustment.

Clinical Innovations

Since the landmark publication, *"Future of Emergency Care, Emergency Medical Services, at the Crossroads"* by the Institute of Medicine (IOM, 2006, The National Academies Press), the nation has been looking at the variations in prehospital care and the development of innovations. Amongst many criticisms of EMS delivery systems in the country is the IOM's strongly worded admonition concerning the lack of research on delivery systems and outcomes. Why is it, the IOM asked, that we have such divergent rates of cardiac arrest survival in this country when all the EMS providers use the same defibrillators and drugs? This key clinical topic will get more attention and analysis in the near future with the Centers for Disease Controls and Prevention's Cardiac Arrest Registry to Enhance Survival (CARES) program underway in Fulton County, Georgia. One cluster of best practices is scientifically known: when a significant percent of the public is trained in CPR and with the aid of quick access to automatic external defibrillators (AEDs) there is a substantial increase in the survival rate of sudden cardiac arrest. Seattle, Washington is credited with having one of the highest cardiac arrest survival rates in the country thanks to their very successful bystander CPR program coupled with an aggressive AED deployment program. Four additional communities in the country are exploring the impact of expanding this initiative nationwide (see: www.takeheartamerica.org).

While there are a number of clinical innovations in the current ambulance franchise (e.g. end-tidal CO2, 12-lead EKGs, etc) more needs to be done to assure Sonoma County residents have access to clinical programs commensurate with the size of the community and sophistication of its residents. Bystander CPR and aggressive AED deployment efforts need to be made a priority in the region and to the franchise.

Additional review is needed of REDCOMs dispatching policies. While Sonoma County is leading the way in stratifying dispatch of ambulances by Alpha, Bravo, Charlie and Delta calls, fire and ambulance resources are routinely sent with lights and sirens on all requests. This is complicated by the fact that the actual medical screening of calls occurs after the first-response resources are dispatched in order to meet dispatch performance standards. Fortunately, REDCOM's operations committee has agreed to study this issue. The current dispatch standards also have a complicated array of levels of the type ambulance response and expected performance for each call category making it difficult to monitor and deploy resources.

The Abaris Group recommends:

- LEMSA and Sonoma County Health Services, Public Health Division should establish, concurrent with the development of the ambulance franchise RFP, a Blue Ribbon Task Force to study and make recommendations on bystander CPR and an aggressive AED program for the county and on the additional scope and funding that may be needed (including through the ambulance franchise) to achieve a successful program.
- Encourage the REDCOM operations committee to study alternative first-response dispatch policies.
- Additionally study the current complicated dispatch level of equipment response (e.g. ALS vs BLS) and subsequent performance standards.

Proposed Timetable

A proposed timetable is supplied in Appendix C.

Attachment A - Sonoma County Ambulance Franchise *(not a complete list which is under development)*

Contract Item	Current Contract		Proposed Contract
▪ Definitions	A. Advanced Life Support B. Advanced Life Support Resource C. Ambulance or ambulance unit D. Basic Life Support E. Emergency Ambulance Service F. Response Time G. On scene H. Appropriate Unit for C & D level calls I. Appropriate Unit for B level calls J. ALS Transport Unit K. BLS Resource L. BLS Transport Unit M. Critical Care Transport N. Quick Response Vehicle		The Abaris Group would add: A. AED B. CCT C. CQI D. EMD E. First Responder F. ICS G. MCI H. Urban, suburban and rural areas
▪ General Responsibilities of Contractor	A. Personnel, Equipment and Materials Required B. In-Service Training Required C. EMS System Interaction 1. Development & implementation of "treat and release" &"alternative destination" programs 2. Development of a social service referral program 3. Expanded scope of practice treatment & equipment programs 4. First Responder, EMT-I, Paramedic, MICN, Base Hospital physician and dispatcher education and training, and ride-along programs 5. Disaster exercises and drills D. Equipment Maintenance E. Materials and Supplies F. Policies and Working Relations G. First Responder Relations		The Abaris Group would add: N. SSP O. First responder interfaces P. Staffing requirements Q. Mandatory key meeting participation R. Additional credentials (e.g. PEPP/PALS, PHTLS, ACLS, etc) as warranted S. Vehicle requirements T. ePCRs U. Funding of County supervision V. Funding of REDCOM W. Field supervision X. Safety and risk program Y. Clinical research and innovations Z. Public education AA. Search and rescue support BB. HAZMAT training

Contract Item	Current Contract		Proposed Contract
	H. Posting Locations I. Law Enforcement Relations J. Professional Conduct of Personnel K. Professional Equipment and Facilities L. Mutual Aid Agreements M. Reputation N. Training O. Quality Improvement P. Permits and Certifications Q. Implementation of EMS Agency Policies R. Financial Implications of Operations S. Data, Billing and Collection T. Paramedic Preceptors U. Reports to EMS Agency V. EMS Dispatch Center		
▪ Medical Control	A. Medical Control Authority B. Adherence to Medical Control Standards C. Compliance with Laws and Policies D. Contractor's Medical Director		Maintain with slight adjustments
▪ Scope of Service	A. General Provisions B. Alpha & Omega Calls C. Critical Care Transport Services D. Wheel Chair and Litter Van Services E. Standby & Special Events Coverage F. Swift Water Rescue Team members & Paramedic Cycling Response Team G. Health Fair demonstrations & other related events to promote EMS awareness & education H. First Aid & CPR training to community organizations		Maintain with slight adjustments, House and maintain strike team equipment (AST DASU)
▪ First Responder Coordination	A. Re-supply of First Responder units B. Implement & maintain First Responder orientation program C. Return of equipment & First responder		Maintain with slight adjustments. Add backboard and other equipment standardization and exchange program. Provide for dedicated/protected Sonoma County education and CQI staff.

Contract Item	Current Contract		Proposed Contract
	personnel D. Respond & standby for Haz Mat, fire and law enforcement when requested E. Provide a First Responder defibrillation program, training, and oversight F. Internal continuing education programs open to First Responder personnel G. Assist the EMS Agency with evaluation & implementation of expanded scope programs for Paramedics, EMT-Is & First Responder personnel		
▪ Dispatch Services	A. EMD program & emergency ambulance dispatch services provided by & operated by the Contractor 1. Provide personnel to operate EMS Dispatch Center as Secondary PSAP 2. Specific provisions to operate Dispatch Center negotiable in separate agreement 3. Provide & maintain CAD system 4. Equipment needed to maintain continuation of services during periods of disruption from normal operations 5. Provide EMS dispatch operations consistent with EMD protocols and operations approved by the EMS Agency 6. EMD certification required & background checks as required by EMS Agency 7. Ensure & maintain certification & training of Emergency Medical Dispatchers 8. Provide all emergent & non-emergent dispatching of franchise units 9. Provide emergent dispatch services for all permitted emergency ambulance providers within the county (for a fee) 10. Posting of units & resources in		Agree to a management services agreement to operate the REDCOM dispatch center on a cost recovery basis as is the practice today.

Contract Item	Current Contract		Proposed Contract
	accordance with SSM plan 11. Provide for a mechanism for tracking & maintaining the status of Contractor's units & resources via MDT & AVL 12. Responsibility for oversight & management of the EMS dispatch function/positions, as well as physical space allocated 13. Provide tracking & maintain the status of emergency ambulances & ALS resources that contract for dispatch services 14. Provide coordinated dispatch of the EMS Agency's Critical Incident Stress Management team 15. Provide dispatching of in-county & regional EMS aircraft 16. Establish a system, approved by EMS Agency, to provide backup dispatch services B. Dispatch operation to be supervised, monitored & subjected to policies & procedures established by EMS Agency C. Provide EMD countywide if requested by other county PSAPs, in exchange for county space & communications infrastructure D. Participate in the ongoing development & implementation of countywide consolidation of public safety dispatch services E. Discuss & negotiate impact & costs if county PSAP & Communications Center is relocated F. Adapt to changes & work with EMS Agency to meet future needs of EMS system evolution & the corresponding dispatch component		
▪ Helicopter Air Ambulance Services	County reserves the right to allow helicopter air ambulance services by a provider other than the Contractor		Maintain

Contract Item	Current Contract		Proposed Contract
▪ Service Area and Response Zones	A. Service Area Defined – map attachment of Franchise service Area and 6 individual "zones" B. Response Compliance Zones – Population density based for urban, semi-rural, rural (Attachment 2)		Substantially adjust the service zones to limit the number of variations to 20 to 30 zones, maintain the integrity of the urban, suburban and rural approach but provide or a much more manageable performance systems. Add language that the contracted provider should be willing to negotiate in good faith the addition of other service areas to their contract should a community unexpectantly loose their EMS services.
▪ Conditions of RFP and Contractor Proposal	Includes terms and conditions stated in 1998 RFP and Contractor's response to RFP dated January 8, 1999		Maintain
▪ Personnel	A. Personnel Required – necessary personnel to provide ALS, emergency ambulance services B. Key Personnel – agreement awarded based on qualifications of Contractor and Key personnel C. Supervisory Personnel System – establish a supervisory system with personnel in sufficient numbers to provide field evaluation of Contractor's personnel D. Field Evaluation – provide Field Training Officers E. Emergency Vehicle Operations Course- field personnel shall complete Emergency Vehicle Operations Course F. Certification and Licensure of Personnel – personnel appropriately certified, accredited and licensed G. Maintain records and data pertaining to certifications, licenses and other credentials and make them available H. Wages and Benefits – adhere to wage and benefits in accordance with labor agreements I. Employee Handbook – develop and maintain J. Administrative Representative – provide an administrative representative to County fire and police organizations		Add additional credentials as listed above. Revised stress management program (e.g. resiliency based) Maintenance of incumbent workforce to be added. Priority for locally needed preceptor slots.

Contract Item	Current Contract		Proposed Contract
	K. EMS Incident Forms – furnish an approved EMS Incident Report Form for use by personnel and provide to EMS Agency L. Equipment Failure Reports – furnish employees with approved Equipment Failure Report Forms M. Competency and Conduct – personnel shall be competent and hold appropriate permits, licenses and certificates N. Knowledge of EMS – personnel shall be knowledgeable and cooperate in the provision of EMS O. Infectious Disease Exposure – provide testing and counseling services to all employees P. Employee Assistance Program – provide employees an EAP Q. Occupational Health Services – maintain an in-house program R. Immunization and Testing Program – provide for employees S. Injury Prevention and Treatment Program – maintain for employees T. Hiring Standards and Practices – maintain a program U. Peer Counseling – maintain a peer support program and participate in the regional CISM team V. Maintain employee services above and notify EMS Agency of any changes		
▪ Rights and Responsibilities of Field Personnel	A. Linkage between field personnel and medical director B. Linkage applies to regulations of vehicles, on-board equipment and collection and recording of primary data C. Contractor encouraged to employ its own		Maintain

Contract Item	Current Contract		Proposed Contract
	methods and techniques to produce the required performance reliability and efficiency		
▪ Response Time Standards	A. Overall response time performance under this agreement is intended to ensure that CONTRACTOR responds to and arrives at each incident with an appropriate resource; Pertains to call in the Franchise Service Area; Response Time Clock for a "Resource Unit" may be stopped by a first responder, QRV, or ambulance; Response Time Clock for an "ALS Resource Unit" may be stopped by an ALS first responder, QRV, or ambulance; Response Time Clock for a "Transport Unit" may be stopped only by an ambulance B. respond to all requests for service that have been triaged as Bravo responses with a BLS or ALS resource and/or ambulance in accordance with the standards set forth below C. respond to all requests for service that have been triaged as Charlie or Delta responses with an ALS resource and/or ambulance in accordance with the standards set forth below D. Response time performance calculation - Response times are measured and calculated on a monthly basis for each response compliance zone within each of the six individual Franchise Service Area zones. E. The response time standards as measured for each response compliance zone within each of the six zones in the Franchise Service Area shall be as follows: 1. The response time for the ALS Resource on calls prioritized as either Charlie or Delta responses shall be as follows:		Substantially adjust the service zones to limit the number of variations to 20 to 30 zones, maintain the integrity of the urban, suburban and rural approach but provide County to establish and provider to participate with multiple disciplined stakeholders on a compliance oversight committee. Consider streamlining Alpha, Beta, Charlie and Delta – ALS versus BLS call levels Continue to permit a direct contract between the current ALS fire first responder Allow the contractor to consider future opportunities to subcontract with new ALS first responders subject to the conditions of a business plan, clinical efficacy and long term sustainability. Add CCT performance standards with mutual aid backup. Remove Alpha, Bravo, Charlie, Delta performance standards and substitute with the priority of call standard (Code 2 and Code 3) with no BLS responses permitted.

Contract Item	Current Contract		Proposed Contract
	a) Urban - 90% of all calls in 7:00 minutes or less b) Semi-Rural - 90% of all call in 14:00 minutes or less c) Rural - 90% of all calls in 29:00 minutes or less 2. The response time for the ALS Transport Unit on call prioritized as Delta responses shall be as follows: a) Urban 90% - of all calls in 11:00 minutes or less b) Semi-rural 90% of all calls in 18:00 minutes or less c) Rural 90% - of all calls in 33:00 minutes or less 3. The response time for the ALS Transport Unit on all calls prioritized as Charlie responses shall be as follows: a) Urban 90% - of all calls in 20:00 minutes or less b) Semi-Rural - 90% of all calls in 35:00 minutes or less c) Rural - 90% of all calls in 45:00 minutes or less 4. The response time for BLS Resource on calls prioritized as Bravo responses shall be as follows: a) Urban – 90% of all calls in 15:00 minutes or less b) Semi-Rural – 90& of all calls in 30:00 minutes or less c) Rural – 90& of all calls in 45:00 minutes or less 5. The response time for BLS Transport Unit on calls prioritized as Bravo responses shall be		

Contract Item	Current Contract		Proposed Contract
	as follows: a) Urban – 90% of all calls in 20:00 minutes or less b) Semi-Rural – 90% in 35:00 minutes or less c) Rural – 90% of all calls in 45:00 minutes or less 6. All Alpha and Omega transfer service within 30 minutes of the scheduled arrival time 7. Response time standards for Alpha and Omega may be waived by EMS Agency during unexpected and unavoidable system overload 8. Equipment failure, dispatch error, or lack of LAS or BLS resource/ambulance is not a reason for response time exemption F. Document and report to County monthly all calls in excess of the 90% standard		
▪ System Status Management	A. Operate service to equalize response time performance throughout the various jurisdictions B. Develop and submit a SSM plan to County C. Develop and maintain a SSM Committee with County representative and meet on regular basis D. Any change to SSM that reduces number of units must be approved by EMS Agency E. Submit SSM plan annually to EMS Agency F. Maximum Unit-Hour Utilization rate not to exceed .50 without approval of EMS Agency G. Adhere to initial plan first 3 months H. SSM plan to specify locations of ALS resources, ambulances, post location, or dispatching procedures, and identify the number and location of vehicles to be deployed 24/7 for Bravo, Charlie and Delta		Maintain with only slight adjustments. Bid to include 133% or resources at peak load.

Contract Item	Current Contract		Proposed Contract
	responses		
▪ Staffing of Ambulance Response Units	A. ALS ambulance minimum of 1 paramedic and 1 EMT-I B. ALS Resource minimum 1 paramedic with all ALS equipment C. BLS ambulance at least 2 EMT-I personnel D. BLS resource at least 1 EMT-I E. All QRVs at least 1 paramedic F. Ensure 100% of all responses for Delta, Charlie or Bravo call are handled by appropriate resource and ambulance in accordance with EMD protocols		Maintain with only slight adjustments No BLS ambulance 9-1-1 responses
▪ Vehicles, Equipment and Maintenance	A. Minimum number of ambulances at 133% of vehicles required for peak load of the SSM plan; Meet federal and California standards B. Staffed and equipped in accordance with state law and EMS Agency policies C. EMS Agency will assist in waivers for QRVs D. Maintain vehicle replacement program and replace based on mileage or when 6 years service E. Adhere to preventative maintenance program, equipment replacement schedule and reporting system as described in Contractor's response to RFP F. Interior height requirement G. Approved markings H. Meet state and County standards, maintain 133% peak load for supplies and equipment I. Provide for restocking of drugs and supplies J. Register vehicles with County as legal owner K. Equip vehicles with emergency alerting devices and 2 way radios L. Equip vehicles with cell phone or equivalent equipment to communicate with base stations		Maintain with only slight adjustments. Bid to include all new fleet. Fully document preventative maintenance program including listing specific maintenance staffing or methodologies and PM thresholds.

Contract Item	Current Contract		Proposed Contract
	and receiving facilities M. Alphanumeric pagers required for recall of off-duty personnel N. Response and transport units equipped with MDT and AVL O. Provide for maintenance of vehicles, equipment and facilities P. Contractor responsible for maintenance of County owned communications equipment Q. Assist COUNTY with implementation and debugging of new EMS equipment, including computerized communications and data systems and software which may be placed in service over the period of this Agreement.		
▪ Disaster, Multi-Casualty and Instant Response	A. Develop and implement a plan for the immediate recall of personnel B. To the extent that CONTRACTOR may have resources available, CONTRACTOR shall respond to requests from neighboring jurisdictions and ambulance providers for instant aid that require a Code 3 (lights and siren) response. C. Provided for an approved disaster plans and protocols, commit such resources as are necessary and appropriate, given the nature of the disaster; Exempted from response time performance requirements, including late run deductions, until notified by the EMS Agency that disaster assistance may be terminated; Personnel shall perform in accordance with local disaster protocol's established by that community D. Use best efforts to provide local Charlie, Delta and Bravo coverage, and may suspend, with EMS Agency's approval, Alpha or Omega		Maintain with only slight adjustments

Contract Item	Current Contract		Proposed Contract
	transport work as necessary, informing persons requesting such Alpha or Omega service of the reason for temporary suspension. E. Determine its direct marginal costs incurred in the course of rendering this disaster assistance, and shall present such cost statement to the EMS Agency for review and possible reimbursement F. Normal (i.e., not disaster related) multi-casualty incident calls rendered by CONTRACTOR shall be performed in accordance with approved "move up and cover" agreements		
▪ Specific Provisions	A. User Fees 1. Rate Schedule a) Effective date b) No discounts 2. Rate Adjustment a) Determined by County BOS as shown in Attachment b) Negotiated adjustment based on operational cost increases c) HCFA (now CMS) meet and confer clause d) Rate adjustment process e) Rate adjustment based on extraordinary circumstances 3. Rate adjustment based on Medicare adjustments 4. Rate adjustments finalized in Attachments to this agreement B. On-Scene Collections – not allowed C. Billing and Collections 1. Compliance with laws and regulations 2. Billing staff requirements		Establish an automatic annual medical COLA and then a formalized process for any rate increases above that. Maintain other provisions with only slight modification. Levied fines to be deposited in an EMS system benefit account to be used for communityo-approved initiatives (e.g. education, AEDs, etc)

Contract Item	Current Contract		Proposed Contract
	3. Maintain billing and collections system requirements (subsections a. – m.) D. Billing Procedures 1. Obtaining billing information (billing procedures subsections a. – d.) 2. Compassionate Care Allowance 3. EMS Agency request for Compassionate Care Allowance 4. Maintain policies and procedures for billing and collections 5. Develop and maintain plan for user payment schedules E. Response to billing and payment inquires		
▪ Contract Management/Monitoring Fee	Annual fee to County to cover County's costs set by the County		Maintain with only slight adjustments
▪ Data Collection and Reporting Requirements	A. Maintain data collection and reporting system (specified in subsections 1 – 3) B. Annual reports based on GAAP C. Maintain records, reports and data (specified in subsections 1 -8) D. Changes in Practices and Procedures E. Ownership of data (specified in subsections 1 – 3)		Maintain with only slight adjustments
▪ Liquidated Damages	A. Relative to late runs and other failures to meet required standards B. Liquidated damages for ALS resource performance 1. Failure to meet 90% response time standard - $100/tenth less than 90% 2. ALS resource fails to arrive at Charlie or Delta within maximum time - $5.00 per excess minute; Calls referred to mutual aid agencies will be included C. Liquidated Damages for Delta Transport Ambulance Performance - Transport		Maintain. Fines would increase substantially to market rates ($300 per every one tenth of one percent over the standard, $500 per Level 0/event > once per month, $2,000 for a BLS referral for an ALS call, etc). Create an enterprise fund for fine deposit to be used to benefit approved clinical initiatives and innovations. Carefully scrutinize and then publish a defined exception list.

Contract Item	Current Contract		Proposed Contract
	ambulance fails to arrive at a Delta response within the maximum time - $5.00 per excess minute D. Liquidated Damages for Charlie Transport Ambulance Performance – Charlie responses - $5.00 per excess minute E. Liquidated Damages for Emergency Bravo Resource Unit Performance 1. Failure to meet monthly 90% standard - $100/tenth less than 90% 2. BLS resource fails to arrive on Bravo call within the maximum specified time - $5.00 per excess minute F. Liquidated Damages for Bravo Transport Ambulance Performance – failure to arrive within the maximum time specified - $5.00 per excess minute G. Multiple Units/Breakdowns 1. If a unit breaks down at the scene, the response time is measured when the additional unit is requested until it arrives. Penalty assessment shall be consistent with unit response requirements as listed above. 2. If a unit breaks down en route to the scene, the response time is measured from the original time of request of the first unit until the replacement unit arrives. Liquidated damages assessment shall be consistent with unit response requirements as listed above. 3. If a unit breaks down on the way to the hospital with a patient on-board - $500.00 H. Waiver of Liquidated Damages/Grievances – County reserves right to exclude certain calls; Grievance procedure will be developed I. Data Reporting Assessment – failure to		

Contract Item	Current Contract		Proposed Contract
	provide information - $10.00 for each item of information J. Exceptions – county may grant exceptions to response time requirements K. Payment of Liquidated Damages – within 30 days of receipt of written notice		
▪ Compliance	Policies, procedures, medical director, etc.		
▪ Most Favored Customer	A. No transfer or assignment equal to or greater than 50% B. Loss of contract in future bids means loss of all business covered in agreement C. May not enter into agreements which extend past date of agreement D. "Factors of Production" devoted exclusively to this agreement E. Not prohibited from outside work related ALS or medical transportation F. May use County logo		Maintain with only slight adjustments
▪ Restriction of Services to Chronic Abusers	A. May name chronic abusers and with Medical Director approval deny service B. Dry runs, chronic abusers considered for financial impact to do business		Maintain with only slight adjustments
▪ Audits and Inspections	A. Standard language for observing operations and records review B. County's right to observe and inspect operations C. Observation and records inspections extended to authorized County representatives		Maintain with only slight adjustments. Reconfirm financial reporting requirements.
▪ General Responsibilities and Duties of County	A. Conduct competitive bid process B. Review, reserving right to approve or disapprove reasonable rates and charges C. Provide for system medical control/Medical Director D. Provide for and maintain EMS		Maintain with only slight adjustments

Contract Item	Current Contract		Proposed Contract
	communications system E. Reserve the right to review and approve or disapprove equipment lease/sublease arrangements F. In the event of default, taking over and managing all operations		
▪ General Provisions	Term of agreement and renewal provisions 1. Initial term 2. Renewal and extension 3. End term provisions (specified in subsections 1 – 7)		Maintain with only slight adjustments
▪ Dispute and Grievances	A. Monitoring of operation B. Monthly performance reports C. Disputes and grievances D. Minor Breach of Agreement E. Appeal to EMS Agency Director F. Final decisions and liquidated damages		Maintain with only slight adjustments
▪ Major Breach and Takeover Provisions	A. Major Breach Definitions (described in subsections 1 – 6) B. Notice to Contractor C. Major breach not resolved notification process D. Major breach determined to be minor E. Board of Supervisor's Hearing (process defined in subsections 1 and 2) F. Expedited Hearing Process G. Notice of default H. Declaration of Public health Officer I. Emergency Takeover J. Equipment and Vehicles K. Payment by County (for rent of facilities, vehicles etc.) L. Takeover Cooperation Described in subsections 1 – 4		Maintain with only slight adjustments
▪ Dispute Resolution	A. Mediation of Disputes 1. Fees		Maintain with only slight adjustments

Contract Item	Current Contract		Proposed Contract
	2. Discovery 3. Confidentiality 4. Enforcement B. Dispute Resolution/Arbitration (process specified in subsection 1 – 6)		
▪ Performance Security	A. Contractor agrees to performance security B. Amount specified in Attachment 5		Maintain with only slight adjustments to security amount subject to current market.
▪ Insurance Required	A. Maintain required insurance (specified in subsections 1 – standard requirements) B. Documentation C. Obligations not limited by Insurance D. Material breach for lack of insurance coverage		Limits to be reviewed with County Risk Management
▪ Compensation to Contractor	A. As compensation for the services, equipment, and materials furnished under this Agreement, CONTRACTOR shall receive the following as full compensation: 1. Market rights as specified 2. Use of communications infrastructure 3. Income from fee for service billing and other reimbursement B. Exclusive provider language		Maintain with only slight adjustments
▪ Rights and Remedies Not Waived	Standard language		Maintain with only slight adjustments
▪ Entire Agreement; Amendements; Interpretations; Venue Notices	Standard language		Maintain with only slight adjustments
▪ Force Majeure	Standard language		Maintain with only slight adjustments
▪ Independent Contractor	Standard language		Maintain with only slight adjustments
▪ Partial Invalidity	Standard language		Maintain with only slight adjustments
▪ Hold Harmless	Standard language		Maintain with only slight adjustments
▪ Prevention of Implementation	Standard language		Maintain with only slight adjustments
▪ Non-Discrimination	Standard language		Maintain with only slight adjustments
▪ Non-Transferable Agreement	Standard language		Maintain with only slight adjustments
▪ Section Headings and Table of Content	Standard language		Maintain with only slight adjustments
▪ Cooperation	Standard language		Maintain with only slight adjustments

Contract Item	Current Contract		Proposed Contract
▪ Term	Five years with two two-year extensions		Initial five years with a two- and three-year extension at the County's discretion based on superior performance.
▪ Accreditation	n/a		CASS or other equivalent County-approved entity accreditation within the first five years of the contract.

Sonoma County Ambulance Franchise BLS Call Inclusion into the Ambulance Franchise SWOT Analysis	
Strengths: ▪ Adds to attractiveness of the RFP from outside bidders ▪ Helps with franchise financing (more marginal funding available to the franchise) ▪ Maybe able to provide marginal programs for new programs (e.g. AED, Citizen CPR, etc) ▪ Helps with franchise financial stability during future uncertain times ▪ Could encourage other BLS entities to bid	Weaknesses: ▪ There does not appear to be significant performance concerns with current BLS providers ▪ Significant concerns from some hospitals about future performance ▪ Potential for predatory pricing in a non competitive BLS market ▪ Limits ambulance resources/redundancy during episodes of surge
Opportunities: ▪ Could encourage other BLS entities to bid ▪ Would allow the County to set and monitor performance standards for BLS providers ▪ Would likely add ALS ambulance resources to the system status plan	Threats: ▪ Threatens the livelihood of at least one BLS provider ▪ Could threaten the ability of AMR to meet its national contract with Kaiser (if a provider other than AMR were chosen) ▪ Potential lawsuits from several parties

Attachment C – Proposed Ambulance Franchise Timeframe

The proposed timetable for the ambulance franchise is as follows:

Event	Date
Announcement of RFP	June 16, 2008
Bid Document Available	June 17, 2008
Deadline for Written Questions	July 3, 2008
Proposer's Conference	July 11, 2008
Letter of Intent Due	July 31, 2008
Proposals Due	September 18, 2008 – 4:00 pm
Review of Credentials/Proposals	September 19 – 20, 2008
Recommendations Made by the Evaluation Committee to the DHS/Coastal Valley EMS Agency	October 17, 2008
Notice Given by the DHS/Coastal Valley EMS Agency of the Apparent Successful Proposal	October 31, 2008
Last Day to Protest Apparent Successful Proposer	November 6, 2008
Contract Recommendations to the Board of Supervisors	November 25, 2008
Contract Approval by the Board of Supervisors	December 9, 2008
Negotiation of Contract	December 2008 – January 2009
Implementation	July 1, 2009 (or sooner)