City of Anaheim
OFFICE OF THE CITY MANAGER

September 11, 2012

The Honorable Thomas J. Borris
Presiding Judge
Orange County Superior Court
700 Civic Center Drive West
Santa Ana, CA 92701

Honorable Presiding Judge Borris,

The City of Anaheim appreciates the time and effort the Grand Jury spent on the development of their report on "Emergency Medical Responses in Orange County." The City Council has reviewed the report and authorized the attached response to the findings and conclusions noted in the report. We take very seriously the role that local government has in the protection of life and property for the residents and visitors we serve in the City and surrounding area. The City values the opportunity to respond to the report and share our perspective on the history of EMS in our county, and to provide a response to each of the issues outlined by the Grand Jury in their report.

If the City of Anaheim can provide additional information, or clarification of our response, please don't hesitate to call me.

Respectfully,

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Response to Findings and Conclusions

Finding #1

Fire departments that once primarily responded to calls for fire emergencies now have become emergency medical response departments primarily responding to medical emergencies. This evolution has occurred since the onset of "9-1-1" call where all emergency calls are received at one place.

The City of Anaheim wholly disagrees with this finding.

We disagree with Finding #1 based upon two key points. The first, not only Anaheim Fire and Rescue, but the entire fire service has evolved to an All Hazard emergency response agency. Today the fire service must prepare, prevent, and respond to a myriad of emergencies. This is a result of recent incidents that have re-defined the responsibilities of the fire service. While it is true that the majority of calls are for medical related incidents, the fire service still must be prepared to handle the variety of emergencies that arise daily in all of our communities With resources strategically located throughout the community the fire service is trained and equipped to provide emergency services in a timely manner and should not be discounted when evaluating the services that are provided to our community.

Secondly, to understand the importance that fire based EMS has, one must understand how we have taken on such an important role. The fact that the fire service in this county is a key component of pre-hospital care was not by accident, but by design. In fact, the emergency medical services (EMS) system in this county has always been viewed as a system, with coordination and collaboration by all emergency medical services stakeholders. It requires coordinated efforts, system resources, trained personnel, communication and equipment to safely and effectively respond and care for the emergency needs of a community. It is important to understand that the fire service and EMS have developed in parallel with such scientific research, both adapting and changing as new information became available. As researchers, physicians and healthcare providers have gained understanding and knowledge, and technology has developed, we incorporated each into field application of pre-hospital emergent care to positively impact patient outcomes. To say that fire service has become medical response departments since the onset of 9-1-1 is to minimize the complexity and growth of the Orange County EMS system over the last three decades.

Since its origin, the Anaheim Fire Department has embraced the call to respond to those in need, and has played an integral role in the history of Orange County EMS, preserving life, health and property; long before the advent of 9-1-1. The Anaheim Fire Department has evolved, adapted and changed as our history below reveals.

Pre-hospital care and rescue techniques were primitive at best, outside of wartime. It was the experience and lessons learned in Korea and Vietnam with the use of Mobile Medical Surgical Hospitals (MASH) that set the stage for paramedic pre-hospital care to emerge. Educated personnel, equipment and medical direction were lacking in most areas of the United States until the late 1960's. In fact, the first noted ambulance service was a covered horse-drawn cart, later replaced by mortician-operated ambulances. The high costs and rising demand for services eventually forced many businesses to abandon their work in EMS. Fire departments absorbed the responsibility in collaboration with local ambulance services. Eventually, the demand for emergency medical services outweighed what most urban settings could manage. The increased EMS demand made way for the development of municipal services (Brady 2000).

The 1966 publication, "Accidental Death and Disability: The Neglected Disease of Modern Society" by the National Academy of Sciences, the National Resource Council identified deficiencies in pre-hospital care and proposed ideas for improvements in a civilian system approach to the care of the trauma patient using physician staffed ambulances (Brady 2000).

The publication also proposed ideas for accident prevention, emergency first aid, and medical communications, in collaboration with hospitals who would care for the trauma patient. The council prepared guidelines for the development of an EMS system. The publication, often referred to as the "White Paper" helped to establish future initiatives.

The National Safety Act is one example of such an initiative, passed by Congress in 1966. The Safety Act charged the Department of Transportation (DOT) with the responsibility to create minimum standards for the treatment of accident victims. The Highway Safety Act distributed millions in grant funds between 1968 and 1979 to assist states in the development of EMS systems, emergency services education, and advanced life support (ALS) pilot programs. Their efforts created the national standard curricula for all levels of the emergency medical technicians (EMT) (Brady 2000).

Recognizing the high number of deaths from cardiac arrest and trauma; research studies were conducted by physicians to reduce the morbidity and mortality for these patients. Doctors from around the world were identifying solutions, but it was Dr. Frank Pantridge in Belfast, Northern Ireland who published the first scientific study in 1966 defining a Mobile Coronary Care Unit (MCCU). Dr. Pantridge's ideas were emulated in the United States (EMS Museum).

In the late 1960's, after noting the value of mobile coronary care programs in existence; expert physicians in Los Angeles County developed their own MCCU program. In collaboration with a local hospital, they created a "hospital coronary care unit on wheels". Around this, the same expert physicians proposed a Los Angeles paramedic training program. The Los Angeles Board of Supervisors in concert with key stakeholders within the medical community arrived at the

conclusion that fire personnel could best be trained as paramedics. A registered nurse responded with the paramedics because of California laws at the time (Los Angeles County EMSA).

On July 14, 1970, the Wedworth-Townsend Paramedic Act was passed. The Act was signed into law, and California became the first state to adopt legislation defining "certification" for paramedics to provide advanced medical life support.

In 1972, the Warren 9-1-1 Emergency Assistance Act was passed which established the number "9-1-1" as the universal emergency phone number. The Act encouraged the local government to develop and improve emergency communication procedures and to facilitate quick response from police, fire and medical personnel for any person seeking emergency assistance. The Act would not be imposed until 1985.

In 1973, Congress passed the Emergency Medical Services Act (EMSS Act). The Act allocated millions of federal grant funding for special projects, research and the development of regional trauma care services. Fifteen core components of the EMS system were identified. EMS system participants had to incorporate the fifteen components to be eligible for funding. The Act was amended in 1976 and again in 1979 to include the addition of two major components.

The lack of trauma and transport service was noted early on in Orange County. In March of 1944, the Mayor for the City of Anaheim signed and approved Resolution No. 1369, noting the unnecessary death and disability that was occurring in the North Orange County area. Because of population boom and traffic increase on North Orange County highways, a great number of traffic accidents were noted. Ambulance service was not available to the citizens in North Orange County, especially in the un-incorporated areas. The result was an increase in wait times for accident victims waiting to leave the scene to receive definitive care at the hospital. Ambulance service was available centrally in Santa Ana. The City Council of the City of Anaheim requested that the Board of Supervisors of Orange County take immediate steps to establish ambulance service in North Orange County.

In the late 1960's, Los Angeles County was not alone in their challenge to provide a systematic approach to EMS implementation. In 1968, the Orange County Board of Supervisors appointed a committee called the Emergency Medical Care Committee (EMCC). The committee was comprised of 11 appointed members with background in healthcare and emergency response. They included:

- County Health Officer
- County Director of Communications and Transportation
- Sheriff
- California Highway Patrol Captain

- California County Medical Association (OCMA), 3 physicians
- American Red Cross
- County Fire Warden
- Comprehensive Health Planning Council
- Police Chief's Association
- Fire Chief's Association County
- Hospitals in Orange County

They initially were tasked with review of the ambulance services operating within the county, emergency medical care offered within the county, and first-aid practices in the county. Resolution No. 72-238 authorized re-appointment of the EMCC and further authorized the committee for responsibility for planning and organizing all aspects emergency medical care needed to protect public welfare (Board Actions). The OC fire service naturally took on a leadership role in development of a comprehensive EMS system. The committee was utilized in an advisory capacity and regularly made recommendations to the board which resulted in such actions as:

- Resolution No. 71-1107 designated the County Health Officer as the certifying authority for paramedic training and paramedics.
- In 1973, Orange County implemented its first paramedic training program.
- An emergency communications system was implemented.
- Paramedic Receiving Center Criteria developed for hospital categorization to care for general emergencies.
- Development of Base Station Hospitals who had medical control authority.

EMCC realized that in order to prevent death and disability, a coordinated systematic approach beginning with field triage, field resuscitation, and rapid transport to definitive specialty centers was needed for the emergency patient.

The following were Board Actions or Resolutions filed in Orange County:

> In July, 18, 1972 - Resolution No. 72-818, approved the execution of the first Orange County Mobile Intensive Care Training Program at the Orange County Medical Center

(OCMC). The medical center was later purchased by the University of California at Irvine Medical Center.

On September 13th, 1973 - Resolution No. 73-263, the County Health Officer is appointed the certifying authority for the mobile intensive care nurses (MIC).

January 15th, 1974 - Board Action authorized the signing of Base Station agreements with Huntington Inter-Community Hospital, St. Jude Hospital, and Mission Community Hospital as part of a County-wide Mobile Intensive Care Program. Later, four other hospitals would enjoy base station status.

March 12th, 1974 - Board Action approved to increase training capacity for Mobile Intensive Care Paramedics at the Orange County Medical Center.

April 23rd, 1974 - Resolution No. 74-587, Board Action to endorse the submission of an application for the development of a County-wide Mobile Intensive Care Paramedic Program.

Recognizing the need to establish a comprehensive emergency medical system in Orange County, in 1976 the Board of Supervisors designated and financed the Office of Emergency Medical Services (OEMS) to create a regional comprehensive emergency medical services system. System stakeholders included EMS provider agencies, the medical community, local health system agencies, and the public and educational institutions (Emergency Medical Services Plan for Orange County December, 1978).

On April 1, 1977, the first Emergency Medical Services Grant Proposal was submitted to the Department of Health Education and Welfare for the planning and feasibility of a Regional Emergency Medical Services System for Orange County, California. An HEW/EMS grant was secured in July of 1977. Following the guidelines set by the EMSS Act, Orange County would set out to incorporate the fifteen EMS components into their emergency response plan (Emergency Medical Services Plan for Orange County December, 1978).

Over the next year a number of accomplishments were noted. Resource inventory for each staffing category identified, training levels assigned, thirty-two emergency medical technician – paramedics (EMT-P) and ninety-eight EMT-Ps recertified, planning for training programs were completed for emergency department nurses, critical care nurses, physicians, mobile intensive care nurses and mobile intensive care physicians, an ambulance radio grant was secured, county ambulance ordinance were developed and adopted by the Board of Supervisors, an EMS medical director was hired and eight physician experts consultants hired under contract. Critical care plans and treatment protocols were developed and hospital transfer agreements were established (Emergency Medical Services Plan for Orange County December, 1978).

In Orange County, communications were funded through a DOT/OTS Grant for the purchase and installation of radios in all OC operated ambulances. The radios provided the necessary link between the BLS and ALS system. Communication was an integral component identified by the EMSS Act. While Orange County's ALS communication at that time was excellent, they identified that a third component; a coordinated dispatch system, was needed. Fifty-five different telephone numbers existed for access to EMS through police and fire agencies. While the State of California was applying pressure on local agencies to incorporate a universal phone number, funding deficiencies, equipment challenges, and conflict in State legislation would slow the achievement. A 9-1-1 system for the Orange County area would not be realized until 1985. Until that time, the OEMS encouraged the fire chiefs to develop a joint powers agreement for a coordinated dispatch system. Huntington Beach, Fountain Valley, Seal Beach, Westminster along with Garden Grove and Orange already had coordinated dispatch systems (Emergency Medical Services Plan for Orange County December, 1978).

In 1977, well before the implementation of 9-1-1 in Orange County, there were 2,341 firefighters trained to the level of first responders. Of those, 2,107 were trained to the basic first aid level and 100% had CPR training. Additionally, 1,194 were trained to the EMT-A level (ambulance) – the national standard. The Orange County Fire Chiefs agreed to train 100% of all firefighters to the EMT-A level within a 2 years period. A number of local training programs were available. Additionally, there were 259 certified paramedics in Orange County. The local health officer designated the University of California at Irvine Medical Center (UCIMC) as the official paramedic training center. A Paramedic Master Plan was developed by the Board of Supervisors. The plan identified coverage, number of units and expected response times. The plan also identified the need to maintain competency through ongoing training and education. Of the sixteen listed paramedic units providing services in Orange County, fifteen of the agencies were fire department based while only one; Santa Ana-Tustin Community Hospital was a combination unit. There were twenty-two ambulance service providers (Emergency Medical Services Plan for Orange County December, 1978).

The 1978 Orange County Emergency Medical Services Plan states:

> *"In Orange County, the fire services are responsible for providing first response to medical emergencies when requested. The fire departments are also responsible for responding a heavy rescue vehicle to emergencies involving trapped victims. At present, these fire services are capable of responding to 90% of all medical emergencies within four minutes. Transportation in most cases provided by private ambulance companies. In critical cases, the paramedics accompany the patient in the ambulance. These patients are transported to the nearest Paramedic Receiving Center" (Emergency Medical Services Plan for Orange County, page 80, December, 1978).*

In 1978, Orange County Emergency Medical Service submitted its Emergency Medical Services Plan to the State in December of 1978.

In 1980, the California Emergency Medical Services System and the Pre-Hospital Emergency Medical Care Personnel Act established the California Emergency Medical Services Authority (EMSA). The law mandated state responsibility for emergency medical services by designation of a local EMS agency. The local agency (LEMSA) would be responsible to regulate, monitor, plan and coordinate pre-hospital emergency medical services, hospital emergency programs and the development of designations standards for hospitals receiving EMS patients.

The California Health and Safety Code, Division 2.5, Chapter 4, recognized the considerable investment local city governments and fire services had on the development, implementation and collaboration of an emergency medical services system. Section 1797.201 allowed for the continued administration of EMS services for those cities or fire districts who had established services prior to June 1, 1980, or until such time as the agency assigned administrative responsibility to the LEMSA. The City of Anaheim has not assigned administrative responsibility to the LEMSA and continues to exercise the right to maintain local control over its pre-hospital emergency medical services program.

In 1980, Orange County became the first regionalized, organized trauma system in the state. In 1982 the Orange County Board of Supervisors designated the Heath Care Agency as the local EMS Agency (LEMSA) (healthdisasteroc.org 2012).

On December 16th, 1975, during a City Council Meeting, Anaheim Fire Chief James Riley reported on a new agreement request by Anaheim Memorial Hospital. The new agreement was an outgrowth from a proposal submitted by Anaheim Memorial Hospital in April of 1974. In the proposal, one paramedic unit would be provided, housed at Anaheim Memorial Hospital, and controlled by the Anaheim Fire Department Communication Center. The unit was complemented with a paramedic-trained nurse who would normally be on duty in the emergency department. The Anaheim Fire Department responded, on average to 170 medical aid calls per month, with 100 of those calls requiring paramedic services.

The evolution of the fire service into the provision of EMS was not solely a result of the application of 911 as the emergency call number, but rather the early vision of the Board of supervisors, city elected officials, and Fire Chiefs as to the importance of the quality provision of EMS in Orange County. Today, we can note that an integrated EMS system is what has been achieved.

Finding #2

As the fire departments evolved into emergency medical departments, the model for operating the fire department has not radically changed. The fire departments have simply absorbed the emergency medical responses into their departments under their old "fire response" model.

The City of Anaheim wholly disagrees with this finding.

Anaheim Fire and Rescue has embraced the call to respond to those in need and has played an integral role in growth and expansion of Orange County emergency medical services system. In fact, in can be argued that the fire service has resources in place to provide the most cost effective and efficient form of EMS. Medical services were not absorbed, rather paramedic services were created due to this strategic deployment of resources. Anaheim Fire and Rescue has evolved, adapted and changed over the last 40 years to respond and care for the emergency needs of the growing community. Just as technical advances have allowed our fire department to respond with better tools and equipment on fire and technical rescue calls, Anaheim EMTs and paramedics respond to its communities needs with increased knowledge and skills on medical emergencies. Anaheim Fire and Rescue today is a multi-disciplinary, all-risk, all-hazard public safety department responding to and performing medical emergencies, hazardous materials response, special and technical rescue, fire prevention and code enforcement, public education, disaster preparedness and Homeland Security. Anaheim Fire and Rescue is able to respond to emergency situations quickly in a fiscally responsible manner due to strategically placed fire stations throughout the city. This strategic placement is enhanced by automatic aid, mutual aid, and JPA agreements with neighboring communities.

To state that emergency medical response was simply absorbed into the department's "old fire response model" is not accurate. There have been many evolutions to the staffing, distribution of resources, and various deployment configurations utilized since the inception of EMS in Orange County. One example is Emergency Medical Dispatching; whereas; calls are screened and medical instructions are provided while the appropriate resources are dispatched. Evaluating and measuring the fire service will continue to occur as the demand for pre-hospital care evolves and places subsequent new demands for service upon the system. As an all hazard response agency, the department must be able to respond effectively to a variety of emergency incidents. To efficiently do so, while still being effective in the delivery of service, the department utilizes firefighters who are trained in multiple disciplines. While the department still deploys its resources from geographically placed fire stations within our city, the equipment, staffing, technology, and skill set required of our personnel are much different than the "old fire response model" referenced in this finding.

Finding #3

Economic recessions have forced local fire department boards of directors and city councils to re-evaluate their models for providing fire and emergency medical responses. While this brings to the fore issues of staffing, response times, public safety, training, consolidations, union rules and privatization of their various services, it also spotlights the model used for all emergency responses.

The City of Anaheim agrees with this finding.

- In a very short period of time, many factors have come into play to create the shift we are experiencing and witnessing today. The economic downturn has hit many cities and counties very hard. The rising cost of pensions and health care costs, coupled with reduced revenue, have forced many communities to reduce services and re-engineer their operations to meet this new budget reality. The City of Anaheim has done that. The city is cognizant that this re-engineering and re-tooling must occur, and that the current service delivery models must be evaluated as we anticipate the services that will need to be provided in the future.

- The city has undertaken an outside study on consolidation of services and is in the process of evaluating our fire department through a comprehensive evaluation process of self assessment and peer review by the Commission on Fire Accreditation International (CFAI). The CFAI Accreditation Program is a comprehensive self-assessment and evaluation model that enables fire and emergency service organizations to examine past, current, and future service levels and performance and compare them to industry best practices. This process leads to improved service delivery by helping fire departments to:

    - Determine community risk and safety needs
    - Evaluate the performance of the department
    - Establish a method for achieving continuous organizational improvement

This comprehensive self-assessment process helps promotes excellence and encourages quality improvement by enabling local fire and EMS agencies to:

- Engage elected officials and the public that they have a defined mission and supporting objectives that are appropriate for the jurisdictions they serve
- Promote performance management in all functions of the department
- Provide a detailed evaluation of the services they provide to the community
- Identify areas of strength and weakness within the department

- Create methods or systems for addressing deficiencies while building upon current organizational success
- Encourage professional growth for both the department and its personnel
- Provide a forum for the communication of organizational priorities to the elected officials and the public
- Create a mechanism for developing strategic and program action plans

The accreditation model includes performance evaluation on ten categories of importance found to be critical for the fire and life safety profession today:

- Assessment and Planning
- Essential Resources
- External Systems Relations
- Financial Resources
- Goals and Objectives
- Governance and Administration
- Human Resources
- Physical Resources
- Programs
- Training and Competency

Each category includes a measure or index called a performance indicator. In the current edition, there are over 250 which the department must evaluate its performance. This results in identifying strengths and weakness in all aspects of the organizations business which are addressed in the development of a department strategic plan. Once the department has concluded this self evaluation process, a peer team will visit the agency and evaluate the credibility of the agency, validate the assessment, and write a report to the commission with a recommendation to Accredit, Defer, or Deny accreditation status. As with education and health care, accreditation is important element in defining organizational credibility for the public. It should be no different for the services provided at the local government level. Public Safety is one of the core services provided by the City of Anaheim, therefore it is essential that were ensure to the public that we have evaluated our service delivery based upon industry best practice. Therefore, the department has undertaken this effort to evaluate every aspect of the organization, and to begin to institutionalize a quality improvement mindset into our department culture.

Recommendation #1

The city fire departments and the Orange County Fire Authority should engage independent private consultants to re-evaluate their models for providing response for both fire and medical emergencies. These re-evaluations should include the strengths, weaknesses, opportunities and threats of current models and alternative models. This re-evaluation should be accomplished by July, 2013. (See F1, F2 & F3).

The City of Anaheim agrees with this recommendation.

In the summer of 2010, the cities of Anaheim, Fullerton and Orange agreed to move forward jointly with an independent consultant evaluation to explore the feasibility of a fire services consolidation, merger or contract for service partnership among the three cities. Citygate Associates was selected to conduct the study.

Citygate provided an analysis on key findings, recommendations, and conclusions. The analysis focuses on the background information of the services provided by each city, the merger cost and shared cost formula impacts. Options for how to share governance were presented, along with the shared deployment opportunities that exist if some type of merger of services were to occur. Collectively, the three agency staffs and Citygate all agreed that sub-regional fire service consolidation is a worthy goal. If done correctly, it can produce a fully consolidated, right-sized multi-city fire agency that provides the best long-term alternatives for efficiency and effectiveness in the fire service delivery, while maintaining local city control through a traditional city manager form of government structure that allows for the input of the agencies involved. As the Citygate feasibility summary report pointed out, the feasible objectives will take some time to achieve over a series of incremental steps. As with any merger and/or consolidation, there are always significant issues to overcome, which include different labor contracts, methods of operation, overlap or gaps in fire station deployment, differing support staff functions, and administrative processes. To achieve a shared services objective, the three partners recommended beginning the process by merging specific lines of administrative services that will provide a foundation for a mutual merging of the agencies in the future. All of the following themes can be developed in parallel. Cost sharing and governance can be accomplished by contract or an expanded Joint Powers Authority relationship. The recommendations included in the regionalization report provided to Council in January of 2012 included:

1. Look at The Region Rather Than City Borders When Building Future Fire Stations: A recommendation included in Citygate's report is to collectively plan fire station facilities. It was noted in the deployment analysis, in which multiple deployment scenarios were analyzed using two computer modeling systems, that opportunities exist to improve service delivery by relocating fire stations and constructing new facilities so that travel times can be reduced. This will improve the ability to deliver an effective response force of 15 firefighters in eight minutes travel time or less within the three-agency jurisdictional boundary. Such changes can be done with existing staffing levels but will require capital investments over time in each city. These changes will take time to accomplish, and are an achievable goal given

the already merged dispatch function, whether or not a merger and/or consolidation of any service is pursued.

2. Standardize the Oversight of Emergency Medical Services:
Emergency Medical Service (EMS) accounts for over 80% of the calls that are responded to by each agency. Therefore, EMS training and clinical oversight functions must be made available to ensure a high quality of paramedic service. The combining of EMS training and the exploration of using a common service delivery model would be an advantage to all the agencies. The use of a common EMS service delivery system would be accomplished in conjunction with the re-deployment of other field resources as noted in the report and as such, would occur at some point in the future.

3. Conduct Employee Training as One Agency:
There are three agencies that belong to the North Net Joint Powers Authority– Anaheim, Orange and Garden Grove. It would be beneficial to include the City of Fullerton in that agreement, as well as to provide for a collective training process for the three agencies, that would include a shared response gap coverage plan when companies go to the training center for hands-on field training. This is an issue that each agency struggles with, but collectively we could provide a better, more cost-effective system and improve the ability to increase annual training hours.

4. Use a Regional Model for The Delivery of Support Services Such as Fleet Maintenance and Purchasing
An opportunity exists to combine our fleet maintenance to provide for the specialized training and certifications that are required to work on fire apparatus. This would give the agencies the necessary depth of resources to provide a higher level of service in fleet maintenance than exists today, including the opportunity to potentially have field mechanics that would respond to stations to evaluate whether a piece of apparatus needs to be taken out of service and/or if it can be fixed at the station.

Jointly the agencies can provide a universal warehousing of common parts that are needed for replacement of fire apparatus, tools and protective equipment. A depth of maintenance personnel and supply personnel would decrease the amount of down time for our equipment when it breaks down. This is an issue that is faced by each organization, and collective improvements could be made in this area.

An opportunity also exists to consolidate the type of equipment and the purchasing of apparatus and smaller firefighting tools and equipment. As the agencies begin to standardize their operations, a consolidated purchasing effort has the potential to save money with more volume purchases, decrease down time and maintain desired customer service levels. This will ultimately have a positive impact when conducting field operations together.

5. Merge and Standardize Fire Prevention and Hazardous Materials Regulation Activities:

   The merging of administrative teams in the area of fire prevention, life safety inspections and hazardous materials regulation, is a line of service that warrants consideration for consolidation between the three agencies. Areas of expertise exist within each department that, when combined, would make for a more robust organization. Combining this operation would also provide a higher level of collective expertise affording the opportunity to become more effective in the delivery of those services and more cost efficient as redundant positions could be eliminated. In addition, a unified application of code adoption and regulatory enforcement between the three cities would be beneficial to the development and building industry that often work in each jurisdiction.

   As the CityGate report pointed out, there are significant long-term opportunities for fire station re-configuration and/or deployment innovation. These steps can occur without a partial or full merger. An administrative merger would be beneficial for all three parties. Until the total compensation differences between the agencies can be made smaller, an Anaheim-Orange administrative merger may the best place to start. Alternatively, the three agencies can merge one line of administrative services at a time, using either a JPA or contract-for-service model. The agencies' most understaffed and near-term needs for improvement are in the areas of training and paramedic clinical oversight and training. A merger of services in these areas would be both feasible and beneficial for all three agencies, in spite of the compensation differences between some job classifications.

Ultimately, a North Orange County Fire entity comprised of the cities that lie within that geographic area is feasible and can occur in phases, over time, as issues such as compensation differences can be worked to closure. Concerns regarding the merging of services often revolve around two main points, cost and control. Each city in this study has distinct ownership of their fire service, and is reluctant to give up their ability to ultimately own and manage that service. With that said, every city is also faced with the reality of escalating cost, an individual lack of resources and the challenge of being able to sustain what they currently have into the future. The consolidation of services with other cities in North Orange County if done correctly, can provide the level of local control necessary through a governing Joint Powers Agreement (JPA) that includes representation of all cities involved, transparency, by retaining the identity of stations and equipment by each city, and by merging of staff over time to reduce the redundancy that exist with multiple fire chiefs, deputy chiefs, training staff and other support level personnel. A combined effort would help to streamline the administrative overhead and allow for the savings realized from the merging of service to be used for such things as capital investment into new and existing stations, the training center, increased funding for training classes and employee education. Ultimately, the impact on the community, if done correctly, would be increased depth of field resources who are trained and equipped under one standardized operational procedure. This would provide a better long term ability to sustain the current level of service due to the anticipated escalating cost in this

area, and would still provide for the level of ownership to each city in respect to the fire and emergency medical services delivered in their respective communities.

Recommendation #2

Suggested alternative models should be included forming a unified Emergency Response Department that included fire and medical, separating the fire response from the medical response, privatizing the emergency medical response, etc, (See F3).

The City of Anaheim partially disagrees with this recommendation.

The City of Anaheim agrees that a review of the current delivery model is warranted. As previously stated, prior to the publication of the Grand Jury Report, Anaheim Fire and Rescue has undertaken a full review of its operations, including the engagement of an outside consultant to review the opportunity to consolidate services with two adjacent cities. We are continuing to explore those opportunities and are working toward implementing the recommendations included in that report. At this time, the City has no desire to separate fire from emergency medical response, and is not in agreement that privatizing emergency medical response will provide improved service to our citizens. While the City of Anaheim agrees that every aspect of government should be evaluated for efficiency, creating a new Emergency Response Department, separating fire and EMS, is contrary to trends and recommendations of consolidation. Creating a new department for an area already served may add redundancy, decrease efficiency, reduce local control, and add a layer of government oversight. In addition, at this time the City has no desire to contract for fire services with the Orange County Fire Authority, yet is open to dialog with our surrounding cities on partnership opportunities.

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