FIRE COMMISSION REGULAR MEETING
MINUTES

Wednesday, October 9, 2019 – 9:00 a.m.
City Hall, 1 Dr. Carlton B. Goodlett Place, Room 416, San Francisco, California, 94102

The Video can be viewed by clicking this link:
https://sanfrancisco.granicus.com/MediaPlayer.php?view_id=180&clip_id=34487

President Nakajo called the meeting to order at 9:00 a.m.

1. ROLL CALL

Commission President	Stephen Nakajo	Present
Commission Vice President	Francee Covington	Present
Commissioner	Michael Hardeman	Present
Commissioner	Ken Cleaveland	Present
Commissioner	Joe Alioto Veronese	Present arrived 9:03
Chief of Department	Jeanine R. Nicholson	Present

Victor Wyrsch	Deputy Chief -- Operations
Sandy Tong	EMS
Dan DeCossio	Bureau of Fire Prevention
Khai Ali	Airport Division
Dawn DeWitt	Support Services
Michael Cochrane	Homeland Security
Joel Sato	Training Division
Natasha Parks	Health, Safety, and Wellness
Assistant Chiefs	
Rex Hale	Division 2
Steven Bokura	Division 3
Staff	
Mark Corso	Deputy Director of Finance
Olivia Scanlon	Communications and Outreach

2. PUBLIC COMMENT

There was no public comment.

3. APPROVAL OF THE MINUTES *[Discussion and possible action]*

Discussion and possible action to approve meeting minutes.

- Minutes from Regular Meeting on October 23, 2019.

Commissioner Cleaveland Moved to approve the above meeting Minutes. Commissioner Hardeman Seconded. Motion to approve above Minutes was unanimous.

There was no public comment.

The below item was taken out of order so that Chief Nicholson could give her report before her meeting with Mayor Breed.

4. MEMORANDUM OF UNDERSTANDING BETWEEN CITY COLLEGE OF SAN FRANCISCO AND THE SAN FRANCISCO FIRE DEPARTMENT *[Discussion and possible action]*

Discussion and possible action to approve a new five-year Memorandum of Understanding (MOU) between the Fire Department and City College of San Francisco.

Deputy Director Corso explained the MOU, which is a five-year MOU with City College of San Francisco which transitioned into City College course curriculum and resulted in actual City College credits for members going through the academy. He stated that the program has been very successful and as a result, both parties are looking at expanding the term and scope of the agreement going forward and while they are currently using the entry-level firefighter academy and probationary period, under the agreement, they are working with City college to expand the scope to a variety of other training and courses. He introduced retired Captain Jim Connors, who is the Department Chair of Administrative Justice in Fire Science, Dr. Edith Kaeuper, the Associate Vice Chancellor of instruction at City College and Monique Pascual, Director of Apprenticeship and Instructional Service Agreements.

VPC confirmed that there were no changes in language from the initial one-year MOU. She also confirmed that approximately $70,000.00 in revenue comes back to the Fire Department's Division of Training to be used for additional training classes, equipment and things of that sort.

Commissioner Cleaveland Moved to approve the MOU. Vice President Covington Seconded. Motion was unanimous.

There was no public comment.

5. UPDATE ON EMS-6 PROGRAM *[Discussion]*

Dr. Clement Yeh and Captain Simon Pang to provide an update on the EMS-6 Program.

President Nakajo welcomed Dr. Yeh and Captain Simon Pang. The provided an update regarding the EMS-6 program which has been very successful and helped many people in the city. They presented the attached PowerPoint presentation. https://sf-fire.org/sites/default/files/COMMISSION/Fire%20Commission%20Support%20Documents%202015/ems-6%20presention.pdf

Dr. Yeh gave a brief overview of the program, provided data and some de-identified patient stories to give a bit more perspective on the actual work his team does. He reminded the Commission that the program began in earnest back in January 2016 and this is a robust collaboration between multiple departments in the city, primarily, between the San Francisco Department of Public Health, the San Francisco Department of Homelessness in support of housing and the San Francisco Fire Department. He stated that as responders within the emergency care system, they represent the safety net which helps and serves different people in different ways. He added that with EMS-6, it is about meeting people where they're at, figuring out where the gaps are, where the unmet needs are and then motivating what they understand is the safety net to come and bring those folks out of a state where they require emergency response all the time and hopefully stabilize them. He also stated that when looking

at the absolute numbers and the impact on the community they have had with the program is that EMS-6 supports the existing emergency care system.

Chief Pang described a case study of a person that was homeless in San Francisco for nearly 20 years and could upend an emergency room with her disruptive behavior and shockingly sharp tongue. He stated that three years ago, he remembers being asked by her primary care doctor to talk her into going into hospice. She was gaunt, frail, with acute medical needs, and was at the end of life. Her 9-1-1 utilization was increasing In the first half of 2018, she had already surpassed her entire utilization of the year before and was on a pace to increase her utilization by 200 percent and with someone in her state, you cannot just tell them they have a room at a shelter because they will never get there. You must personally walk them through the door, check them in, escort them to their assigned bed, stay with them until they have a plate of food in front of them. They did this for her repeatedly and eventually, with the help of the shelter health team, she developed a routine and she stabilized, and she moved into her own apartment in June of last year. Since then, she has only utilized the ambulances twice. He added that the mission of EMS-6 is to help vulnerable people find the care they need. Someone becomes a frequent 9-1-1 utilizer because they need help. But an ambulance and an emergency room don't provide solutions to the root causes of their predicament. He stated that by connecting people to the system of care that best serves their needs, such as primary care, primary mental healthcare, shelter, or housing stabilization, they reduce the dependence on the 9-1-1 emergency system. The overarching reason for the success of EMS-6 is the team. Not everyone is suited for EMS-6. You have to be compassionate, patient, persuasive, and motivated to create change. Fortunately, the team of Captain April Sloan, acting Captain Brandon Chattum, Captain Michael Mason, and acting Captain Scott Eberhart have those attributes. They have also greatly benefited from the dedication of Medical Director, Dr. Yeh. He added that by March of 2020 they hope to be fully staffed at seven EMS captains all trained as community paramedics with operational hours from 6:00 a.m. until 2:00 a.m., seven days per week.

Captain April Sloan also presented a few case studies with good outcomes. One that she described was a man who was consistently directed to sobering centers and through many discussions, they discovered that he had some undiagnosed mental health issues related to the death of his mother. Shortly afterward, they observed a sharp spike in his unitization of emergency services and his risk-taking behavior. The relationship they had with him allowed him to confide in them that he was actually, in fact, suicidal and they worked with street medicine and placed him on a 51/50 hold where he received treatment and he entered residential detox treatment and transitioned over to a navigation center where he is awaiting housing. She described several other case studies.

The following questions answers and comments followed the presentation.

COMMISSIONER HARDEMAN: Thank you for your report. It seems like these few cases you identified can take care of the whole 19 percent, that success ratio. It's amazing that we allow this. It's crazy. I mean, as a society, somebody could take an ambulance 200 times, and we just don't care. I mean, basically, we care but it just goes on. Maybe after the 20th time you say we're going to have to keep you in here for a day or so, but we think that's not the way to treat people, but maybe in San Francisco, we'll probably continue this pattern, but maybe another city that ran into this problem would be a little more common sense and say 20 might be the limit in a year, and then we're going to just keep you in. And I'm sure some of the behavior was so bad that it should be considered criminal, and you could probably incarcerate him, but we don't do that either, but anyway, congratulations on your success. I think it's terrific. But it's just a sad case of spending so many resources on so few people. And hopefully, in a year we can get a report back from you on these particular cases and that's all worked out well, and it's paid dividends to everybody.

COMMISSIONER VERONESE: Thank you, Doctor, for your presentation, and captains, both of you for the hard work that you do. I know that you hosted me for a ride along one day. And I don't know if you remember this, but we spent a couple of hours with Rocco that day. He wasn't in a wheelchair. We got him to one of these -- I don't know if it wasn't a Sobering Center, it was more of a shelter if I remember it. But it was really interesting to meet him. I remember him specifically because he was a little old Italian dude and I got along well with him. A couple of questions. You know I'm a huge fan of what you guys do, and after we had our ride-along, I professed my love for this program. But I do have some criticisms, and it's not directed at you guys at all or this Department and the work that you guys are doing, but it's really towards other departments and why this type of program has to exist. And I'm a strong believer that this program exists because other departments are failing us. But that being said, I'm fully supportive of what you guys are doing, and you're doing God's work. A couple of quick questions. I'm curious as to I know that we had some new hires coming out of the last budget, and that just goes to show how good of a job that you guys are doing that the city is willing to throw more money at it. And I'm curious as to why each of the hires are captains. I wouldn't be doing my job if I didn't ask the obvious question as to why everybody that's being hired into this unit is a captain level person.

DR. YEH: I could give some input on that, and then, of course, I'll hand it over to Chief Pang. One of the important aspects of the design of the program is that we need people to interact as supervisors when they arrive on scene. And EMS-6 is, as the Department is, kind of an all-hazards response, so we need to have people who are capable. If we have a unit out there and there is a mass casualty incident or a working cardiac arrest, they are an additional resource that can respond. And then additionally, it helps to have the experience and guidance of having a supervisor to interact with crews, especially when it comes to coordinating a lot of care with a lot of different entities in there. So that's one piece that does lend itself to having someone in a supervisory position. Of course, there are many other benefits, and I think that if you look at other programs and other jurisdictions, there's a lot of different approaches to how you, you know, provide this service. You know, I think we saw the need for having a supervisory interaction and providing someone who can have that level of guidance and experience on there. And, Chief Pang, you want to add on?

CHIEF PANG: I could think of three reasons. Dr. Yeh mentioned the first two already. Because we are clinical supervisors for 9-1-1 medical emergencies, if we are in proximity to a call, we'll go on it. If we're the closest one to a cardiac arrest, we'll go. We feel that's our moral obligation, and we're fully loaded ALS rig. The other one Dr. Yeh mentioned is that I think it takes a supervisor on the scene of these calls when we're interacting with our own crews. Not only our own crews, but with members of law enforcement, because a lot of times, there's a lot of chaos on scene, and other city agencies don't want the scene to unfold the way we want it to go. So the fact that we are an officer in the Fire Department has a lot of weight. And that's very helpful. When we're trying to convince an officer of the police force that we really want someone to be placed on a hold, we feel they're greatly disabled, and we feel that they're a hazard to the community. But that officer doesn't want to do it. It helps tremendously to be a captain. The third one is that we interact with our clients, our patients, with our crews, with members of law enforcement, but also, with social workers, nurses, doctors, and also with agency directors. And it's just a little bit more -- of course, it's not an asymmetric relationship with an agency director, but if you're a captain in the Fire Department, it's more weighty than if you're not. And it's helped us tremendously.

COMMISSIONER VERONESE: Okay. Thank you. Fair enough. I think that the command of authority could be a good enough reason. It's good enough for me.

COMMISSIONER VERONESE: If you could expand on one topic that you just mentioned. You and I spoke about it when I did the ride along and I did some follow up work after the ride along in this regard, but if you could tell the rest of the commissioners, because they weren't

there that day when we spoke about it and saw the things that we saw, and perhaps, they've done ride alongs themselves. And if they haven't, I would highly encourage you all to do it. But if you could expand on the relationship that you guys have with the Police Department in regard to what you're talking about, the holds? Now, the holds, I'm assuming, you're referencing the Health and Safety Code, or the Welfare Institutions Code for a 51/50. Is that correct?

CHIEF PANG: Yes.

COMMISSIONER VERONESE: Okay. If you could start by kind of giving us an idea of what that means, first of all, and then what is that relationship between you and law enforcement and how does it come up in your job?

CHIEF PANG: Well, first of all, paramedics are not authorized to place people on a 51/50 hold. A 51/50 hold is for an individual who is either a potential harm to themselves or others, or who are unable to provide for food or clothing or shelter for themselves as a primary result of mental illness. The police and social workers, doctors, and psychiatrists can place those holds. Now, as you guys know from walking around in our city, there are a lot of people who are vulnerable and essentially gravely disabled on our streets that are still on our streets. And when we come upon them, there are times when we feel that something must be done. So the one route of placing someone on a hold would be special calling a police officer. And the police officers are very quick to place a hold for someone who is a potential harm to themselves or others. But the third one, being gravely disabled, is a very subtle thing. And the police officers are not the best, in my opinion, are not the best agency to do that. That's one reason why we now have psychiatrists, a psychiatrist, and a psychiatric nurse practitioner and the social worker who can write a hold with us. They have been extremely helpful to be at our side when we approach that individual and recognize that this person cannot care for themselves. So to address your question specifically, we have a very good relationship with the police, but at times, it seems that their mission is different than ours, and we can help the people that need help through the help of the behavioral help team of street medicine.

COMMISSIONER VERONESE: So I thank you for that explanation. And I think what's important for this commission to hear is that the police officer's job, is a criminal justice job. They're part of the criminal justice program. And I don't know, this is my opinion, but I assume that there are many people in this room that would agree that if somebody is unable to care for themselves or they're a danger to others because they have some mental instability, which is typically what it is, right? Then that's not law enforcement's job. We don't want those people in the criminal justice system. We want them in the public health system. Is that correct? Do you agree?

CHIEF PANG: In fact, I do. Yes. We don't want the unfortunate criminalization of someone who is mentally ill.

COMMISSIONER VERONESE: The trick question. No. I mean, it was -- that was a softball, but -- and then the other side to it is that the police officers don't have that medical experience, and especially captain, you know, captain EMS medical level experience to know or to be able to make a call that this person has some sort of disability or ailment that is threatening to their lives. They don't have the training for that; correct?

CHIEF PANG: I would say that you're correct.

COMMISSIONER VERONESE: Okay. And then the same is also probably true for psychiatric people that are with you. You mentioned that you had some psychiatric people that are part of your team there with the Department of Health. They don't have the training or the certifications to actually make a medical-related call; correct?

DR. YEH: Yeah. I would say, Commissioner Veronese, yeah, you bring up the exact challenge with a lot of our clients is the interaction of all of these things and trying to sort out what is possibly behavioral versus psychiatric versus medical. And sometimes I would say this is exactly why we collaborate on a multi-disciplinary level is because it takes all parties to be involved. You know, to the credit of our kind of behavioral health and street medicine collaborators and partners, they do have a lot of expertise in this area. But with that being said, you know, our clients are people that are really, really challenging. So it's not often, but there are times when, you know, there's not a consensus. We don't all agree on exactly what the underlying cause is. But, you know, I readily agree with your point that it can be very, very difficult to tell sometimes.

COMMISSIONER VERONESE: I think the point I'm making is that every single person that's a part of that team, whether it's a policeman or an EMS-6 captain, or a psychological person, or a HOT team person or whoever it is else that you guys interact with on a daily basis, every single one of those people brings some sort of specialty skill to the table. Otherwise, they'd be useless in that scenario. Right? They bring something special to that. And it's obvious that EMS-6 brings that medical part to it because that's what they're there for. And so I guess my question is, and Dr. Yeh, can you answer this question or, Chief, you can answer it, but would it be helpful for your job for EMS-6 captains to have the ability to 51/50 people? Is that a tool that you would like to have in your toolbox so that you could do it? Because I was a police officer back in my younger years, and I can tell you one thing, and you guys probably have that same exact experience, is that when a police officer shows up to a mental case, and the Fire Department shows up to the mental case, it's two entirely different reactions. And, in fact, we saw it when I rode with Captain Simon when that day was I think we were over behind the Federal building, and we were there to interact with an individual that was there. And the Police Department showed up. And the moment the Police Department showed up, that individual's attitude turned hostile. And that is not helpful for our ability to give the type of care and the type of resources that we need. Right? That happens out there. Am I wrong about that?

CHIEF PANG: Oh, it does indeed happen there.

DR. YEH: Absolutely. And this is a challenge. I want to get back to your -- your essential question about the nature of involuntary holds and how -- where that sits in terms of the toolbox that we see as EMS-6. I would say that taking away a person's ability to decide for themselves for their care, where they want to be, and that is not something to be undertaken lightly. And it's an immense challenge ethically, legally, even medically. And you mentioned things about the relationship and the client or patient's perception of who is responding and trying to help them. That is the relationship and trust that we establish with our clients is paramount. And so that's an obvious concern. Now, to directly get back to your question, I think that it's something that we undertake as a last resort. And we rely on the collaboration and ability to involuntarily detain folks when it's done in conjunction with law enforcement and behavioral health, and there can be an agreement about that, because one thing I do want to also stress is that, you know, a 51/50 72-hour involuntary detention is a means, but too often, we don't think about what has to happen after that. 72 hours is a short amount of time to figure out and rectify a situation that can be a life-long challenge for someone. And unless we actually have the back end figured out, I think we really, you know, should not be extremely, you know, too eager to involuntarily detain people unless we actually understand what the overall game plan is. So, you know, so to answer your question, it is something that we do rely on in very -- in situations of last resort, and we do it in conjunction with our law enforcement and behavioral health partners because that's really the only way that we can make these things stick and work. Going to somebody and then, you know, detaining them again and again and again and again is a very bad and disturbing cycle. So I think you would agree from your experience as a law enforcement officer.

COMMISSIONER VERONESE: Of course. And I think I hear you guys agreeing is that this is a tool that would be useful to you because adding the law enforcement element to that last resort, I mean, we're talking about last resort, but you guys are more qualified to know whether or not somebody is medically incapable or medically harming their own lives than any law enforcement branch is going to be able to do it. So I guess my question is very simple. Is it a tool -- currently, legislatively, you guys cannot do it. But if it were possible, is it a tool at last resort that you would like to have in your toolbox in those cases where you are more qualified than other people around you in medical cases to use?

CHIEF PANG: Let me try to answer that. So I think that if we could place a hold, we would do so effectively and judiciously. There are times when someone would benefit from a hold, and police are not available. One of our advanced clinicians are not available. Mobile crisis is not available. And in those situations, if we had the ability to do it ourselves, it would be helpful. But there are other considerations that are kind of tempering my enthusiasm for being able to place a hold. And one of them Dr. Yeh mentioned already, that it is such a serious matter that we would want a more collaborative decision-making approach when putting someone on a hold. So for example, it's like, well, law enforcement felt this way means we felt this way, a psychiatrist or social worker felt this way. And then that hold has more weight. If we placed the hold, then I would not want some advocate for people's rights to suddenly think we're the bad guy. We're taking people's rights away. That would be really challenging for us. And the other thing would be there's a benefit for having a psychiatrist placing the hold. And that is the psychiatrist has that relationship with the other physicians at psychiatric emergency or at the other hospitals. They could follow that patient through and lend their professional opinion in a way we could not. So that would be really the -- having a clinical -- a mental health professional write the hold is I think the best way to do it.

COMMISSIONER VERONESE: So when a 72-hour hold happens, and I know this because I've done it before as a police officer, that person is brought to a hospital by law, is required to be brought to an institution that is licensed by the state, and there are particular hospitals that have these licenses. Many of them in San Francisco do because they're at that level. And then immediately upon entrance, they are seen by a doctor who does an analysis themselves as to whether or not to waive off the hold to let that person go or to hold that person longer. So maybe you don't have the experience with it doing the holds themselves, but I think a little bit of training behind what it is that goes behind that and having -- and getting those relationships would be really helpful. But I get what you're saying, that -- my biggest worry when I brought this issue up was we have got a -- such a great reputation out there in the field, and this really is my concern, which is why I didn't push it, that do we want to tarnish that reputation when we think that somebody is so messed up that they, their lives are in danger, but it looks like we're taking them into custody? And -- and I go back and forth on that because I feel like the cops have the authority to do that, but this is not a criminal justice issue. These people shouldn't be in that system. Right? Because the moment a police officer writes a 51/50, there's a police report behind that, and then they're a part of that system. And they shouldn't be a part of that system if it's a medical issue, mental or medical issue. So I go back and forth on this thing. And I really would like you guys to have that ability, a tool in your toolbox if you absolutely need it when other people aren't around, and just for the "edumacation" of the rest of the commissioners, I spent about four months on this issue with the city attorney going over the 51/50 law, and I actually even wrote a resolution to come to this Commission, because the reality of it is that we can, as a Commission, and then it would then go to the Board of Supervisors, designate EMS-6 captains as a -- there's a specific term in the 51/50 code which is like an emergency task force or whatever, which it clearly is. It's a task force created to deal with a particular emergency. We could determine them to be under 51/50, and it would give them the ability as long as the hospital sanctioned it. I think EMSA sanctioned it. And so there is a resolution that has been written to do this if it's something that we want to think about. But I would really, I would push it if it came from you guys and the Chief, of course. It

would have to first go to the Chief. And I ran it by the former union bosses, Tom O'Connor, and he was okay with it at the time. And I actually even ran it by several supervisors who actually like the idea but it just didn't go anywhere. But my point is that if it's a tool that you guys really want, talk to the Chief about it, this commission has the ability to give that tool to you that would then go to the Board of Supervisors for approval. So I'll move on from that and let the others comment on it. It's a hot topic. It's a really kind of, it's a hot potato topic because the issues are so sensitive around it, but it pains me to see us walking over people on the streets of San Francisco, which we do on a daily basis, that clearly ave a mental disorder where they are harmful to people and themselves, for that matter. And we've seen incidents such as in North Beach with the knife-wielding lady, who everybody knows who that lady's name was, and you guys probably knew who that lady's name was because you dealt with her on a daily basis. Certainly, the police did. She had a mental health crisis. We see it occasionally. These are people that could have been helped by us, and I don't want to see us not helping people because we don't have the right tools. My only point. Quick question and potentially sensitive question for you is when we create a program like this, and we see that that program is effective, you guys are 19 percent reduction is amazing. I mean, those numbers are really, really, really good. And the city is throwing additional money at this issue or at your unit because they're seeing that you guys are an effective unit. And I guess my question is this, is that at a certain point, I don't want to create an inn constitution around a problem. Right? We do -- we do a really good job of that here in San Francisco is creating institutions around problems. And then it gets really hard to once you solve that problem, or once you come up with ideas to solve that problem, we're becoming really good to do away with that unit because it's no longer needed. Right? And so I wouldn't want to see that happen because I like the Fire Department getting money. But at a certain point, you guys are going to do your job so well that we're not going to have any frequent callers anymore. Right? So I would like to see this tran -- I know it's a pipe dream, but it could happen one day. But I'd like to see this program transition into maybe something else at a later date once we become so effective and the rest of the departments have actually stepped up where we don't have this need anymore. And so I'd like to maybe have the Department come up with some sort of plan, a 10-year plan of some kind of how we transition this unit into something else once we've solved the problem because solving the problem is the goal. Not creating another institution that the taxpayers are going to have to pay for around, you know, a problem that we're not going to solve because we're getting money for it every -- every year. I've seen city departments do it. I worked for welfare fraud back in the -- when I was in my 20's, I was a senior investigator for the Welfare Fraud Division, and I saw how that department didn't want us taking people off of welfare that weren't eligible for it because it meant less money for their department. I don't want to see that happen here. I want to see us do our job so well that we're no longer needed at some point but transition this unit into something that is going to be more effective. So I'd like -- I'd like you to have a pipe dream about what that looks like 10 years from now, a 10-year plan, so that we can transition into something that -- that because we've solved the problem and working towards actually solving that problem. My last question as Commissioner Hardeman had mentioned the touchy issue of at a certain point, how many, you know, calls becomes a crime? And I know there are more questions that you ask about that, and, you know, what's the mental capacity of this person? Is he doing it intentionally? And all that other stuff. But do you ever come across the incidents where people are just calling 9-1-1 to mess with us? Like I remember, I think you told me a story one time about a guy who called 9-1-1 because he needed help with his remote or something like that. But these are really people that just kind of are lonely. It turns out that guy was just a lonely guy and he liked having people around, and, you know, when you call 9-1-1, we're going to respond. Right? So how often do you see that in those types of calls in this type of unit? And what do we do about it?

CHIEF PANG: Well, first of all, I've been in the Fire Department for 24 years, and I do know that there are times when people maliciously activate emergency services. And it sure is irritating. But in the last nearly four years, our people that we've been working with, that has not been the case. It has not been malicious. It's, probably, it's entirely rooted in dysfunction,

disregulation, untreated mental illness, substance use disorder. One subset, because not all of our people are homeless. There's about 28 percent of our people annually that have residences that live in the Sunset, the Richmond, and they're maybe end of life and they need help. And so we help them too. It's a totally different set of tools. But we go over there and we do a needs assessment. We look at their house. We contact their primary care doctors. We call IHSS. We all APS. We -- we do a lot of things for them too. So fortunately for us, I don't think -- I can't think of a single person who has like been on our list that's been - if it has been malicious, their primary cause is mental illness substance use disorder.

COMMISSIONER VERONESE: And that's part of the job. I get it. Thank you so much, all three of you, for answering the questions. I know they were sensitive questions, tough questions, but, I mean, we're here to ask those questions. And if there's anything that we can do as a commission through your Chief, of course, to add tools to your toolbox to make your jobs more efficient and better, that's why we're here. So thank you all for your presentation.

DR. YEH: I want to say I just very much appreciate your offer, Commissioner Veronese, addressing the issues about involuntary holds and such. And I am very appreciative of your attention to this matter and efforts to coordinate. You know, one of the things we've really learned is that it is about the multi-agency coordination. I do not think that at this time that that's an overriding need for us to be able to independently do something. And I would also emphasize and reassure you and the rest of the Commission that it is something that we do undertake. It is something that we do undertake with our partners in collaboration, and I think that this is a good approach because of all of the reasons that were sort of specified. But I'm very appreciative of your attention about the matter. And we'll definitely take you up on that offer, issues that we need to have addressed. And we know that the commission is on our side, so much appreciative.

COMMISSIONER CLEAVELAND: Thank you, Mr. President. I'd like to pick up on some of Commissioner Veronese's comments dealing with the mentally ill. What percentage of your calls are mentally ill People Versus addicted people or whatnot?

CHIEF PANG: I actually thought that that would be your question, and I was looking in our internal data, and frankly, we don't have any internal data that measures that percentage. Of the individuals that are homeless, I'd say it's very high.

DR. YEH: And we don't have an exact number. I would sort of tell you that the rate among our highest users is very high. So people tend to have the combination of substance use disorders, mental illness, and medical challenges. And those three things together have, you know, caused people to require a lot of needs in the safety net. I do want to also just emphasize, though, that is not to say that the opposite is true, that people who do have behavioral health issues are automatically frequent users. So just sometimes we get confused about that, that distinction, but to be clear, again, many, many, the majority of clients that we are seeing on a highest user basis do have concombinate psychiatric and psychological challenges. The opposite is now true. All people who have behavioral health issues are not frequent users of 9-1-1. But we tend to see those people who have this combination of mental health challenges, substance use disorders, and medical comorbidities.

COMMISSIONER CLEAVELAND: So the people that you do request a 51/50 on through law enforcement, what percent of the people that you deal with are actually detained under 51/50?

CHIEF PANG: It's a great question, but we also don't have that number.

DR. YEH: Yeah. I don't think we have that data. I think one of the challenges is that, as I kind of alluded to before, a short-term involuntary hold it is exactly what it is. It's a short-term

involuntary hold. And the long-term challenges persist after that. If you put someone on an involuntary psychiatric hold and they clear, and in 72 hours can demonstrate that they have decision-making capabilities, we have no rights, nor should we, I think, for detaining them against their will. And if that happens many, many, many times again and again and again, then we have to look at some other possible solutions. And one of the cases that you heard about illustrates what that process is. It has to do with things like conservatorship. It has to do with things like long term stabilization. We try to do everything we can, as was mentioned before, to avoid those situations. But it is necessary sometimes.

COMMISSIONER CLEAVELAND: When they are detained and they're sent to a hospital, I assume, are they under lock and key?

CHIEF PANG: No. So in our city, someone who is placed on a hold can be transported there by a police unit if there are no other concomitant medical issues. Or an ambulance. And they could be taken to any of our receiving emergency rooms. And, frankly, each hospital handles them a little differently. Sometimes the emergency room doctor will assess the patient and release the patient and drop the hold if they feel that whatever conditions existed a few hours ago no longer exist. And other hospitals seem to wait until there's a psychiatrist that can assess the patient. Dr. Yeh, you probably have more insight than me.

DR. YEH: Yeah. I would say to directly answer your question about where patients go, I mean, we have one location. We have one psychiatric emergency location with psychiatric emergency services in San Francisco General. So people who do have sustained involuntary detention and require longer-term care ultimately do need to be transferred and to that location, if that's what your question was.

COMMISSIONER CLEAVELAND: If they're in for 72 hours, do they get over their alcoholism in 72 hours? I don't know. Does it take more than 72 hours to detox an alcoholic?

DR. YEH: Absolutely. And therein is the challenge is that you know, holding a person who may not want to go for an evaluation at that moment is a beginning. But then we have to go through the mechanisms to determine whether they can continue to decide that they wish to have treatment or not. And unfortunately, as all of us know, addiction is a really challenging issue. And not the least of it is people's willingness to engage in treatment. And, you know, being able to involuntarily detain a person is a pretty blunt instrument. But to your point, very infrequently are we able to address the long term substance use disorder problems within 72 hours. It's a very long path after that.

COMMISSIONER CLEAVELAND: So the percentage that you actually call for detention or call for a 51/50 is very small.

DR. YEH: Correct. Yes.

COMMISSIONER CLEAVELAND: What? Under 10 percent of the people of the calls are under five percent?

DR. YEH: I would say even less.

COMMISSIONER CLEAVELAND: Okay. So it's a very small percentage. So Commissioner Veronese's idea of giving you the authority to do a 51/50, would you see that percentage increasing?

DR. YEH: That's a good question. I don't know. To be completely honest, I don't know the answer to that. And I think that right now, it is a, thankfully, a rarity that we're doing that, but it's very memorable, obviously, and it has a real effect on the system when we have a person

who has to be involuntarily detained. And as Chief Pang mentioned, you know, we need to have the resources available to be able to do that. But what would the effect of us having that ability -- I do worry about that. And that is -- that's a very real –

COMMISSIONER CLEAVELAND: An image issue.

DR. YEH: Yes, yes. And I also think that you know, law enforcement, we rely on them a lot in these situations, particularly if a person who we are deciding needs to be detained disagrees with us and does not wish to be detained, does not wish to go to an involuntary treatment location. The last thing I want to do is create a dangerous situation.

COMMISSIONER CLEAVELAND: Well, I fully support the program. I think as Commissioner Veronese said, you need all the tools possible in your toolbox. I'm not sure what it legislatively means to give you the 51/50 authority, but I would support giving it to you because I know you would use it very judiciously. In terms of your being on the scene, you're not a 24/7 service at this point. Correct?

DR. YEH: That's correct.

COMMISSIONER CLEAVELAND: You're what? 18 hours?

CHIEF PANG: Very soon we will be at 6:00 a.m. until 2:00 a.m. seven days a week. Unfortunately, Captain Sloan has a bad ankle and is on modified duty at the moment, otherwise, we would be there. So half the week, we work from 6:00 a.m. until 2:00 a.m. And the other half of the week, we work noon until midnight. We are going to have reinforcements very soon. April will recover eventually. Plus, we still have three additional captains to be on-boarded, which we hope to do by March of 2020. And at that time, we will be 6:00 a.m. until 2:00 a.m. seven days a week. And at the high point of the day, we'll have four units on at the same time. So we're going to greatly increase our bandwidth, and we hope to demonstrate that we're going to increase our productivity equally.

COMMISSIONER CLEAVELAND: So you have the funding online to go to 6:00 a.m. to 2:00 a.m.?

CHIEF PANG: Correct. Yes. And we've chosen that because we've analyzed the numbers. The low point of frequent 9-1-1 utilization is between 2:00 and 6:00 a.m. And also, there are very few resources available between 2:00 and 6:00 a.m., so even if we got to somebody's side during those hours, we would just be minding them.
Just sitting with them. And most people don't want to Emote at 3:00 a.m. So we just don't think that's a good use of our resources. We think it's better to double up during peak hours.

COMMISSIONER CLEAVELAND: So you do have the funding in place to do it all but four hours of the day?

CHIEF PANG: Yes.

COMMISSIONER CLEAVELAND: In the early morning hours?

CHIEF PANG: Yes.

COMMISSIONER CLEAVELAND: That's in place? That funding is in place? Well, that's good to know. You talked about the Medicare support for EMS-6. Can you explain a little bit more about what's going on there?

DR. YEH: Certainly. So ours is a, I think a cutting edge program, and there are similar efforts to reform healthcare systems in other areas. And I think at long last, it's kind of got the attention of reimbursement reform and policy change. One of these large things has to do with the federal government as an innovations pilot initiating a program in which they would allow certain places to get reimbursement from Medicare for caring for Medicare beneficiaries in ways other than transporting them to the -- an acute care hospital. Let me back up and just, and sort of say from a healthcare economic standpoint, from Medicare, Medicare reimburses for transport to an acute care hospital. That is it.

COMMISSIONER CLEAVELAND: That's all they cover currently. And that's about 400 dollars a pop.

DR. YEH: That's correct. That's correct. So if we engage a client in their home, manage their medications, offer alternatives in a deferred appointment or determine that they can seek other care and then not bring them to the Emergency Department, we are not eligible for reimbursement currently by Medicare for those services rendered. And I think the federal government is realizing that that's a cost savings. It's also better patient care. So they're trying to incentivize that with programs such as the ET-3 program. Now, we have applied, as have many, many other places. The deadline was met, we submitted an application, but they kicked back the review so we probably won't know until sometime in the spring if they've chosen to extend us into the program.

COMMISSIONER CLEAVELAND: But if they do accept our program, it could be an additional source of revenue to support the program?

DR. YEH: Yes. That is correct. And the only thing I would temper that with a little bit is to recognize that that is specifically for Medicare beneficiaries. It doesn't necessarily reflect other payors within their system. And depending on which subgroups you're looking at, Medicare beneficiaries may not be a very large proportion of the clients that we're taking care of. So it would allow for a mechanism for funding. I think the bigger picture is that eventually, this means that the reimbursement policies change throughout. But for the time being, I wouldn't expect that there would be a massive influx of funding from that particular program.

COMMISSIONER CLEAVELAND: Thank you. Chief Pang, you mentioned the meth sobering center idea, which I, you know, I assume it's simply an idea at this point, and you're part of the task force, which I think is very important. What does that mean? What is a meth Sobering Center?

CHIEF PANG: Well, methamphetamine users stand out because they are very frequently behaviorally disruptive. So, you know, you take them to an emergency room and they blow the place up. They're shouting and screaming. And oftentimes, their medical needs are met. They are not in acute medical distress, but they are detoxing from the drug. And what do you do with that person? And we have a Sobering Center for people that use alcohol. It works very well. But we cannot just send them someone who is, you know, high on meth there because they will be disruptive. They will, you know, be bouncing off the walls. So the idea is to have an appropriate place that's safe, that has clinicians there to make sure that they stay safe, that they don't have any unmet medical needs where they can safely detox. And -- and also, while they're there, they can be referred to detox and treatment resources.

COMMISSIONER CLEAVELAND: Have you determined a site yet for this?

CHIEF PANG: Oh, no. That's far above my level of involvement. I went through four meetings and collaborated and gave my input about the challenges that we face, and now that

it's been brought up to the Health Department, the mayor, supervisors, and it's up for them to decide what comes next.

COMMISSIONER CLEAVELAND: Okay. Thank you very much. Well, I think I speak for the Commission when we say we all support what you're doing out there. We know it's a tough job every day, and you have to put your heart and soul into this program. It's the reality of our society these days, and we're trying to meet the needs as best we can.
So thank you for all that you do.

VICE PRESIDENT COVINGTON: Captain Sloan, do the members of your team have a list of questions that you pose to people that you help in the field?

CAPTAIN SLOAN: We do. It's called a biopsychosocial assessment. So we assess the social determinants, the medical determinants, the psychological factors that might be driving the 9-1-1 calls, and we try to identify the one factor that is and address it, whether it's an unmet medical need, shelter, connection to primary care.

VICE PRESIDENT COVINGTON: Do you have that list of questions with you?

CAPTAIN SLOAN: I don't.

VICE PRESIDENT COVINGTON: Can you give us a few examples?

CAPTAIN SLOAN: Sure. This is my field level. This is what I do. Hi. I say "Hi, I'm April. I see that you've been on the ambulance 10 times this month, and I work for the Fire Department, and I'd like to see what's going on. Can you tell me what's happening that you need to come to the Emergency Department so often?" And what can we do to help you with that? And it sort of flows from there. They might tell me that there's nothing wrong and they don't need help. And I come back another day and I try again. They might say, you know, my drinking is a little out of control. They might say that they're having an issue with their alcohol and I will direct them over to the Sobering Center so that they can leave the ED and go to a safe place. And I can go visit them at sobering and talk to them and see if they're interested in going over to detox. If they're not interested in detox, I tell them I'm still here to help them, and I'll get them to sobering every night. And I would prefer that they would go to sobering versus, you know, the hospital. And if possible, maybe you can get to sobering by yourself. Maybe you don't need to call an ambulance. You know exactly where it is. If it's an ongoing chronic medical issue, you know, I can connect them to street medicine because they're often with us too. They will get them over to the clinic and assess them and give them future appointments. A lot of times, we're managing their medications. And we might pick them up, or we might manage them, or we might check with them, "Hey, did you take that today?" So those kinds of things we're doing.

VICE PRESIDENT COVINGTON: So there is a lot of follow up that you do?

CAPTAIN SLOAN: There is a ton of follow up. Just because we have gotten somebody somewhere slightly stable, that actually becomes a lot more intensive because then that's the time to kind of reach out and really figure out what it is that they need to continue being stable.

VICE PRESIDENT COVINGTON: And are any questions asked regarding where they lived last?

CAPTAIN SLOAN: How long have you been homeless? You know, when were you last housed? Was it a safe environment? There -- we probably deal with a fair amount of people

that I would consider marginally housed. Maybe they get their check and they go spend a few days in an SRO or something like that, but then after that, they're back out on the street.

VICE PRESIDENT COVINGTON: Do you have any idea of the percentage of people who are homeless in San Francisco who were previously housed long term in San Francisco or people coming from other places?

CAPTAIN SLOAN: I don't have the statistics on that. I do know that evictions -- without supportive housing. And by supportive housing, I mean when a person is placed in housing, they're placed with a hotel or SRO that offers social work, on-site medical, that kind of thing. Their chances of sustaining it are fairly low because they still require the ongoing stabilizing care. And I don't know what number of people we have that come in from out of county or state to hear. Most of our clients are long term, homeless people.

VICE PRESIDENT COVINGTON: Thank you, Captain Sloan. So for you, a former captain, now Section Chief Pang, can you please tell us a little bit about the conservatorship task force? Can you tell us, if you know, when will the task force be presenting its findings and its recommendations?

CHIEF PANG: Well, we've only met once so far. And the workgroup, the Housing Conservatorship Workgroup, is that what you're referring to? We've only met once. And I think the next steps are going to be identifying people who are eligible for this conservatorship.

VICE PRESIDENT COVINGTON: People who are eligible to be under conservatorship, or people who are eligible to be trained as conservators?

CHIEF PANG: Oh, no. Eligible to be conserved under this new conservatorship law. So this conservatorship law first was signed into law by Governor Brown in late 2017. And it is a pilot program for three cities in the state, San Francisco, San Diego, and Los Angeles.

VICE PRESIDENT COVINGTON: So the three largest cities?

CHIEF PANG: Right. And it was crafted for a need that Senator Scott Wiener identified. Also with former Director Barbara Garcia, that there were some individuals who cannot take care of themselves and are dying on the street who don't want to be helped. We might meet them over and over again, and they will not take us up on our offers for housing. They won't do it. So what do we do with those people? And as it turns out that there's a small group that do not fit under current conservatorship laws, LPS conservatorship. So this is a new tool, which is called a housing conservatorship. And there are a lot of safeguards and protections to prevent people's rights from being abused. We don't have anybody yet that has been activated under this law. What has to happen is they have to have eight or more 51/50s in a rolling 12-month period. And they have to have been referred to AOT, Assisted Outpatient Treatment, if they are eligible for AOT, and they have to have been demonstrated not to have succeeded there. And they have to be -- they have to be given advanced notice that conservatorship is a possibility. They have to appear before a judge. They can plead their case with an attorney before the judge. And ultimately, it would be up to the judge. And there is a one-month preliminary period for them to stabilize. If they don't stabilize after one month, then they could be conserved for up to six months. And during that time, they would undergo detox and treatment. And they are guaranteed permanent supportive housing at the end of their conservatorship. So it's something which initially, two years ago, there was a lot of push back from advocacy groups, but the bill was amended and amended again. And now, I think there are still some reservations from civil rights advocacy groups. But I think that it's -- it's going to go forward, and I think -- I think it's going to show some benefit.

VICE PRESIDENT COVINGTON: Okay. Thank you. I also think it will show some benefit. You know, there are numerous models of conservatorship, you know, for the elderly who don't have a family close by and people want to make sure that someone is looking out for their interest and making medical care available to them on an as-needed base and all of that. So, you know, and scheduling and home care and that sort of thing. So there are a lot of different kinds of conservatorship. And I think that that's just another example of the kinds of things that can be done to help people who cannot help themselves. It's a very, very, very complex thing. I don't think any of us 20 years ago would have imagined that we would be where we are now with so many of our fellow Americans sleeping on the streets and there is this toxic soup of mind-changing drugs. It's not one kind of drug. I notice that there is an increasing number of heroin addicts in San Francisco now. I haven't seen a heroin addict for the longest time, but people are nodding out on the corners, and I'm like, oh, my goodness. You mean heroin is making a comeback? And it seems to be. You know? So you got the heroin, you got the meth, you got the -- it's just on and on. And each of these, including alcoholism, each of these dependencies has a different approach to even getting people to understand what you're trying to say to them. And so I admire the work that the team is doing and thank you so much for your willingness to do this. And it really heartened me to hear you say, Section Chief Pang, that our people have these kinds of issues, not those people, but our people because these are our people. You know? We are -- we're all human beings and we want the best for our fellow human beings. And it is not -- we are not a successful society. We're maybe the richest and the most powerful, and we are not a successful society when you walk out your door and you see people sleeping on the street in these numbers. So the -- the medical support and the 51/50 hold, I -- just transitioning to something else, I think that unless you lobby the Commission to have you have that ability, that I think it's best left to other people. I think the psychiatrist, you know, are powerful, powerful and brilliant people who are not just medical doctors but they specialize in this -- I mean, for years and years and years before you get a chance to be called yourself a psychiatrist. So they can prescribe the meds. You know, our -- our firefighters, our captains, our Chief of the Department can't write a prescription for someone. So we need to have that, that separation and -- and not slow down the process. You know, if this person needs to see a psychiatrist, then get them in there and let the psychiatrist make the determination on the 51/50 hold. Do you concur or --

DR. YEH: I do. I appreciate your comments, Commissioner, and I do also want to just say I absolutely -- none -- I would say none of our discussion about whether we have unmet needs is in any way supposed to be diminishing the ability for healthcare, like behavioral health professionals to make that assessment, because I think you bring up a really important point. I don't think it's just that they are professional colleagues with long term care. It's like they provide an assessment. They provide their mental health perspective. And that's really important down the road for sustaining conservatorship or long term holds or hospitalization, if that's what happens later on, so I completely agree. Thank you.

VICE PRESIDENT COVINGTON: Right. And that's what they do all day every day. They -- they just focus on that, what's going on with your brain, what's going on with your body, and how can we get the two to work in concert so that you are -- you feel as if you are a whole human being? Let's see. I'm mindful of the time, so I will hold any other questions that I have because our president might have one or two.

PRESIDENT NAKAJO: Thank you very much, Vice President Covington. Thank you very much for your presentation. I do have a few comments. I also wanted to express appreciation for this very important dialogue that occurred this morning all the way from Commissioner Veronese to Commissioner Cleaveland to the Vice President. And I know that Commissioner Hardeman is engaged with this as well. This has been a long discussion this morning. Very educational. It says update, briefing, but there's a lot of education and a reminder of circumstances as well. So much information that I had to keep on drifting back to the purpose of when we started this whole EMS-6. As our commissioner, that talked, and we were engaged

with this identification of frequent flyers. And engines and trucks were going to the streets and seeing these individuals repeatedly over and over again. Folks used to ask me besides the engine, how come there is an ambulance there as well? The same results occurred who picked up the member, whoever it was, of the public. I'm generalizing. Took him to the hospital, dropped him off. The hospital had to go into their mode. And basically, during basic circumstances, that person, individual, was discharged. And two hours later, that engine or truck would respond as well. I remember that because I went on the ride-along, specifically asked to be in the ride-along within the targeted districts to see for myself, and to see the attitude in terms of that workload that affected us, the Fire Department and our members. Engines and trucks responding too, ambulances responding too. And basically, we picked up our patients, did our job, dropped them off. So the EMS-6 to me was a mechanism, Dr. Yeh, that was introduced really early that I had to try to understand as well as the colleagues as to what is the purpose of this? And is the goal to decrease the frequent flyers within statistics and modes so that we can go ahead and do our task? And only because of EM-6, with the phenomenon of the homeless and the Health Department and all this that we have this over two-hour discussion on detail in terms of the information and the services that we, the Department, have inherited. It's a definition in terms of public service and what we do, but we serve the public. And we wouldn't have this kind of detailed discussion and these case studies if we didn't have EMS-6 with these examples in terms of our effect in terms of that. So to me, these case studies are very, very important. You know, sure, in the reduction of statistics in terms of the frequent flyers to the numbers, but part of the definition for me in our department is that we save folk's lives. We save the public's lives. You know, we respond, in suppression, we respond in terms of fire prevention. But we now have a definition. And some of these examples that you gave specifically talked about saving lives. So to me, this department has done a really intricate detailed work over these years that have identified all these multiple issues and how people care. And if anybody cares in this city and this department is members of the EMS-6 and this department that charges us to go out there. We know we need coordination between the alcohol center, the homeless center, navigation centers. We understand the parameters of team. And I'd rather have the coordination of a team that understands what we're dealing with so that we can try to do the job that we're entitled to do. So to myself as well, I see some great worth within the EMS-6. In some ways, we're drifting in terms of patient/client care. But in some other ways, the bottom line is that we get them on the rail so they can be part of society as well. And so I know, again, it's a very complex issue, but it's an issue that I am, the commissioner, greatly appreciative in terms of the work that you do. It's amazing kind of -- and, Dr. Yeh, Chief Section Pang, April, in terms of the team of three that has now grown and now are trying to be effective. It's a great thing. And I still see many things that have to be developed from that as well as we move down and try to be innovative in terms of caring for our citizens of San Francisco. And thank you for your report this morning, Dr. Yeh.

DR. YEH: Thank you, President Nakajo. I would say I agree. I'm very grateful. The Commission has always been fantastically supportive of this, the leadership of the Department. And I also would just want to point out that although the EMS-6 team spends all of our time working on this, specifically responding, it really -- we really depend on all the members of the Department, people who are out there running calls, responding, identifying when there are patients at risk and helping us care for them. Even just identification and supporting, it really -- this is a Department-wide effort. Although the EMS-6 team may be the, you know, at a focus, it's really something that relies on everyone who is responding and caring for people. So I completely agree with you in terms of the mission of saving lives, and I'm very grateful and thank you to the Commission for this discussion today.

PRESIDENT NAKAJO: Very, very appropriate, Doctor, in terms of that acknowledgment of the Department, the Chief, and the command force. You folks are the boots on the streets. You're the ones that are dealing with it in terms of San Francisco, and it's not easy, and we understand that. Thank you very much.

There was no public comment.

6 CHIEF OF DEPARTMENT'S REPORT *[Discussion]*

REPORT FROM CHIEF OF DEPARTMENT, JEANINE NICHOLSON

Report on current issues, activities and events within the Department since the Fire Commission meeting on April 24, 2019, including budget, academies, special events, communications and outreach to other government agencies and the public.

Chief Nicholson reported on activities since her last report.

Events and meetings, she attended during the reporting period:

- Station 50 and 51 visits.
- Town Hall at Station 49, that Mayor Breed also attended and is supportive of their needs. She added that there was good energy and morale in the room.
- Meeting with SFPD regarding the replacement of Dr. Father Green who has retired.
- Meeting with Dewayne Eckard regarding the Firefighters in Safety Education.
- In house meeting regarding special events.
- Budget 101 meeting with Mark Corso.
- Trip North to visit the members that were deployed on mutual aid to the Kinkade fire.
- A hearing regarding at the Board of Supervisors, where Supervisor Mar had a resolution pertaining to the Emergency Firefighting Water Supply.
- Phoenix Society Dinner.
- Veteran's Day parade. She thanked all members who attended that event.

There was no public comment.

REPORT FROM OPERATIONS, DEPUTY CHIEF VICTOR WYRSCH

Report on overall field operations, including greater alarm fires, Emergency Medical Services, Bureau of Fire Prevention & Investigation, and Airport Division.

Chief Wyrsch's report covered the month of October and is attached: https://sf-fire.org/sites/default/files/COMMISSION/Fire%20Commission%20Support%20Documents%202015/nov%20ops%20report.pdf

He stated they had one second alarm at 255 Vienna which he described in detail and stated it was a very good job by all the companies. He gave an update on the Strike Team that deployed for 9 days to responded to the Kinkade fire where they engaged in structure protection and fire extinguishment. Chief Wyrsch gave a shot out to Lt. Baxter for all his good work as well as Chief Cochrane and Lt. Balzarini with their work in conjunction with the Police Department academy, talking to the probationary academies, talking and explain to them what the Fire Department expects and needs from them at a fire scene. He touched on EMS, Fire Prevention, Airport Division, Homeland Security and the Training Division.

The following questions, answers, and comments were made:

COMMISSIONER CLEAVELAND: Thank you, Madam President. Thank you for your report, Chief Wyrsch. On behalf of the Commission, we would extend our condolences to the Worcester, Massachusetts Fire Department for their loss. I wondered if you could give me a quick update on the K-9 support program.

CHIEF WYRSCH: So the K-9 support program right now, we would like to add two more K-9 handlers. So we have a total of three right now that have applied. We have to do an interview process. We will have some members with the actual board that's coming out, the actual handlers that will give us the dogs, we're going to put them on our interview board,

CHIEF COCHRANE: The National Disaster Search Dog Foundation, they make the final application. So USAR Task Force 3 from Menlo is really who our three K-9 handlers work for. Acting Lieutenant Eli Thomas, Captain Miller, and Eddie Martinez do an outstanding job. They've been to hurricanes, and they're available locally. They're looking for more dogs. So we've had informational meetings, told them how basically difficult it is to take care of a dog. And we ran through that program, and now we're at the final stages for interviews.

COMMISSIONER CLEAVELAND: So you have the ability to have two, or you have two dogs currently?

CHIEF COCHRANE: We have two currently.

COMMISSIONER CLEAVELAND: I know that it's expensive. I mean, it's like $6,000 per dog in terms of buying a dog that's been trained properly.

CHIEF COCHRANE: So the National Disaster Search Dog Foundation provides the dog.

COMMISSIONER CLEAVELAND: Are we talking about search and rescue dogs here or are we talking about K-9 support dogs?

CHIEF COCHRANE: No, no, no. Search and rescue dogs.

CHIEF WYRSCH: Search and rescue dogs.

CHIEF COCHRANE: But we utilize them at Fort Funston. They've been to hurricanes.

COMMISSIONER CLEAVELAND: Right.

COMMISSIONER CLEAVELAND: Those are critically important. Absolutely. But I was referring to K-9 support dogs.

CHIEF COCHRANE: No. This is different. Sorry.

CHIEF WYRSCH: I used the word support because we're supporting this program, so sorry for the confusion. But right now, we have two. If we can pass up all three, we might be lending one of those handlers to Oakland. Oakland is in need of somebody, so that's a possibility we're looking into.

COMMISSIONER CLEAVELAND: So we're talking about mental health here. We're talking about K-9 support dogs for mental health, for PTSD. What's the status of that?

CHIEF OF DEPARTMENT NICHOLSON: I can speak to that. So our new Health and Safety Chief, Tasha Parks, is working on that program as well. She has a lot of things on her plate right now, but I know she's been in contact with the SPCA over that. So more to follow.

COMMISSIONER CLEAVELAND: Thank you, Chief.

COMMISSIONER VERONESE: Thanks, Chief Wyrsch. I really appreciate your report. And I want to stress on page 18, the Narcan report. More information is always better, so I appreciate the additional line there. It helps us understand. I did want to point out, though, that you did mention there's an 11 percent increase over this next month, which is a big number because if you like at it over the last year, it's actually almost a 300 percent increase. And so, and I know I mentioned this in the past, but now that we have this information, what are we doing with it? Have we notified the Department of Health that this is going on? Do they know what's going on? I just want to make sure that we're being the most effective use of the information that we're gathering because you're going to the trouble of gathering it. We might -- and it's good information. And we might as well send it off to all the people that need it or should have it. So I just want to make sure that that's happening. I know I saw this morning there was a press release by the Mayor's office that they've reached an agreement with the Board of Supervisors on the comprehensive mental health agreement, and I'm just curious for a future meeting as to what the Fire Department's participation in that would be.

CHIEF OF DEPARTMENT NICHOLSON: Yeah. I mean, in the mayor's department head meeting, we just had Dr. Anton Nigusse Bland talk about the mental health program. So I know our EMS-6 has been in contact with him, and I spoke with the doctor afterward, and he said he was going to get back in touch with Chief Pang on some further stuff in terms of what EMS-6 is doing around the behavioral health stuff and how we can work together.
So, yes, we're on board.

COMMISSIONER VERONESE: Great.

CHIEF OF DEPARTMENT NICHOLSON: And in terms of the statistics on -- or the data that we're collecting, we are absolutely using that data in conversations with DPH and in conversation with the mayor's budget office.

COMMISSIONER VERONESE: Fantastic. Great. Thank you, Chief, so much for that. And then just finally, I know that you know, we had the wildfires going on, and -- and we had a crew up there for a couple of weeks I think it was. Right, Chief? Or how long was that deployment?

CHIEF WYRSCH: Seven to 10 days. It was different for both. We had a couple of crews. So, excuse me, seven to nine days. Seven to nine days depending on which crew you were working on.

COMMISSIONER VERONESE: Okay. Maybe offline, and I don't know if the other commissioners are interested in this information. If so, online then in front of everybody. But maybe if we could get some more information on when the last time we looked at those lengths of deployments and whether or not they're appropriate in length. I mean, I'm sure you're constantly looking at this stuff. Right? But it seems to be that these fires are different than

they were before. They're certainly more intense and they're lasting longer. And I'm curious as to the length and the exposure, if we're looking at that and if we're adapting to it, if appropriate.

CHIEF WYRSCH: We are looking.

COMMISSIONER VERONESE: So offline would be fine. Thanks for your report, Chief.

COMMISSIONER HARDEMAN: Thank you, Madam President Covington. Yeah. Your report, you just don't want us to have any questions. You're getting real good. So detailed. But the one that's interesting is the Narcan. The other day, there was an article on it. The fentanyl use is dropping down significantly the amount of needles that are now found on the street. So there's one benefit to it, but the fentanyl use, except it's also the worst drug, supposedly, so that's not good news. The drones, I think Amazon, one of them was doing delivery now within the last couple weeks, so that's becoming pretty well accepted. And you're talking about the firefighter tragically passing in Massachusetts. And we had a guy hero named Buck Delventhal. I don't know how many of you -- when I became a Human Rights Commissioner in the 80's, and he was like my first go-to guy. And he is the smartest greatest guy. I mean, he always had an answer. If you didn't want to go all the way to the top to like Louise Rene or something or didn't want to talk Dennis Herrera, you go to Buck. He was like the guy that probably knew more than them, anyway. And everybody else, they would probably admit if you asked them. And he just passed away, but very tragically. He just, boom, went. It was very unexpected. But what a nice man and what a great, great person for the city, and always level with you. Gave you the straight scoop. And if you're a little confused about something or whatever, you wanted to push something to the edge, he'd always give you the best advice, so maybe we can remember Buck, Chief, also along with this. Thank you.

President Nakajo excused himself at 11:15 a.m. and Vice President Covington chaired the rest of the meeting.

There was no Public Comment.

7. FIRE COMMISSION MEETING CALENDAR 2020 ***[Discussion and possible action]***
Discussion and possible action to adopt the 2020 Fire Commission Regular Meeting calendar.

Commissioner Cleaveland Moved to approve the 2020 Fire Commission Meeting Calendar. Commissioner Hardeman Seconded. Motion to approve was unanimous. (4-0; Hardeman, Cleaveland, Covington, Veronese)

There was no public comment.

8. COMMISSION REPORT ***[Discussion]***
Report on Commission activities since last meeting on October 23, 2019.

Commissioner Hardeman stated he visited the Sacramento Regional Fire Museum, along with David Eberle and powerful people from the Police Department, Sheriff's Department and EMS.

There was no public comment.

9. AGENDA FOR NEXT AND FUTURE FIRE COMMISSION MEETINGS *[Discussion]*
Discussion regarding agenda for next and future Fire Commission meetings.

- Drone update

There was no public comment.

10. PUBLIC COMMENT ON ITEM 11
Public comment on all matters pertaining to Items 11(b), below, including public comment on whether to hold Items 11(b), in closed session.

There was no Public Comment.

11. POSSIBLE CLOSED SESSION REGARDING PERSONNEL MATTERS AND EXISTING PRE-LITIGATION

a. VOTE ON WHETHER TO CONDUCT ITEMS 11(b), IN CLOSED SESSION *[Action]*

The Commission may hear Item 11(b) regarding existing pre-litigation in closed session if it votes to invoke the attorney client privilege (Government Code § 54956.9; Administrative Code § 67.10(d))

Commissioner Cleaveland made a motion to conduct item 11(b) in Closed Session. Commissioner Veronese seconded, and the motion was unanimously approved. (4-0; Hardeman, Cleaveland, Covington, Veronese)

The Commission went into closed session at 11:30 a.m. and cleared the room.

b. CONFERENCE WITH LEGAL COUNSEL – EXISTING PRE-LITIGATION.
Conference with legal counsel to discuss and possibly approve settlement of existing pre-litigation Charge No. CA-2018-00027-20-G, Clinton Bailey v. City and County of San Francisco, filed with the Veterans' Employment & Training Service of the U.S. Department of Labor, in exchange for payment by the City of $49,076.68 pursuant to Government Code Section 54956.9(a), (c), (d), and Administrative Code Section 67.10(d)(1). ***[Action item]***

12. REPORT ON ANY ACTION TAKEN IN CLOSED SESSION *[Discussion and possible action]* as specified in California Government Code Section 54957.1(a) and San Francisco Administrative Code section 67.12(b).

13. VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL DISCUSSIONS HELD IN CLOSED SESSION, as specified in San Francisco Administrative Code Section 67.12(a). ***[Action]***

The Commission reconvened in Open Session at 11:49 a.m.

Commissioner Cleaveland Moved not to disclose discussions held in Closed Session. Commissioner Hardeman Seconded. The motion was unanimous. (4-0; Hardeman, Cleaveland, Covington, Veronese)

14. ADJOURNMENT Vice President Covington adjourned the meeting at 11:52 a.m. in the memory of Deputy City Attorney Buck Delventhal and Jason Menard of the Worcester Fire Department.