January 26, 2016
Regular Meeting
EMS Ad Hoc Committee
Item #2b

Committee Findings & Recommendations
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To: Mono County Board of Supervisors

From: EMS Ad Hoc Committee

Date: 2/16/2016

Subject: Committee Findings & Recommendations

I. Committee Formation

The Mono County Board of Supervisors established a committee made up of subject matter experts to study and recommend a high quality, county wide, fiscally sustainable EMS model. On March 17, 2015 the Board approved the establishment of an Ad Hoc Emergency Medical Services Committee made up of members of the both the public and private sectors. The Committee was charged with the following goals:

i. Analyze current model and cost
ii. Gather information and expert input
iii. Develop options and one or more recommendations that will support a high quality, countywide, and fiscally sustainable model for the future of EMS

The Committee met twelve times over a six-month period. Each meeting lasted a minimum of three hours. A summary of presentations and information received and materials cited is located in section VI of this memo.

II. Executive Summary

The Committee determined that there were three plausible models for delivery of EMS services in Mono County that meet the goals established by the Board of Supervisors. These are:

(1) maintain existing system with modifications;

(2) integrate EMS with Fire Districts; and

(3) privatize EMS.

Of these three, the Committee determined that the existing system with modifications model is the preferred/recommended alternative. The other two models were deemed less desirable for reasons described in more detail below.

The Committee also concluded that the success of any of its recommendations depends highly on the execution of a structured implementation plan, including management and management practices, which is addressed in section V of this memo.

III. Background

A. Committee's Understanding of the Goals: "Fiscally Sustainable," "High Quality" and "Countywide"

Fiscally Sustainable

A fiscally sustainable EMS means one that responsibly minimizes and balances the county contribution from the general fund with support of other county services by maximizing other revenue streams and containing cost. Factors to consider:

1. Creating a 3 to 5-year master plan, including finances and general fund impact over time, with best projections and expense control to improve predictability.
2. Community education and involvement in planning, plan execution and continuing services.
3. Pursuing all potential revenue sources, e.g., taxes, grants, subsidies, revenue cycle management.
4. Pursuing all potential cost cutting and cost containment measures.
5. The need to balance service quality, countywide access and fiscal sustainability.

Note that the Board of Supervisors did not provide a specific dollar figure for achieving fiscal sustainability.

High Quality

High quality for Mono County EMS means a clearly defined, well -managed system that provides an integrated continuum of EMS care with flexibility considering regional population variance and risk assessment. Action items:

1. Meet ICEMA requirements, EMS industry benchmarks and applicable consensus standards, following measurable standards to meet objectives (e.g. response time, level of care, patient satisfaction).
2. Coordinate with other entities providing care, e.g. hospital, base station, public health, veterans affairs, other providers, including for patient follow-up, preventative health and community involvement.
3. Provide and empower well-trained, competent manager and staff operating under defined SOPs.

County Wide

A countywide EMS means clearly defined access to appropriate ALS services for all residents and visitors in all areas based on community needs, geographic region, population and accessibility. Action Items:

1. Conduct a needs assessment based on call volume projection and past and projected seasonal population variation and characteristics; and correlating adjustments to deployment models.
2. Utilize applicable benchmarks and consensus standards (e.g. response times).
3. Ensure coverage to under-served and non-served areas of the County.

B. Description of Existing System

The primary provider of ALS transportation services in Mono County is the County Paramedic Program. However, the EMS System does not involve one agency, but a multitude of agencies, to provide both ALS and BLS services across the County. These agencies may provide support services on either a paid, volunteer or mutual aid basis, subject to availability. The EMS System within Mono County consists of the Mono County EMS assisted by:

East Fork Fire & Paramedic Districts (provides mutual aid)
Mountain Warfare Training Center *(MWTC)* (provides mutual aid)
Symons Ambulance of Bishop
Fish Lake Ambulance of Nevada (serves Dyer)
Volunteer Fire Districts (most provide first responder without transport capability; Mammoth Fire, Chalfant, and White Mountain have transport capability)
Mono County Sheriff's Office (MCSO) Dispatch (provides 911 dispatch, no "Emergency Medical Dispatch")
Southern Mono Healthcare District (provides base station)
Search and Rescue Team (managed by MCSO)
Aircraft, fixed & rotary (upon request)

IV. Recommendation

A. Pursue the "Existing System with Modifications" Model

The Committee recommends that the Board of Supervisors maintain the essential features of the existing system, but implement modifications that are targeted at enhancing fiscal sustainability while maintaining quality and extending services countywide. The recommended modifications fall into the following categories, each set forth below.

Note that individual items listed below have not been analyzed to determine which may be implemented immediately, and which would be the subject of negotiations. They also have not been vetted for legal barriers. If any particular item is to be pursued by the County, then those questions need to be answered.

Modifications to Reduce Costs

1. ALS (Paramedic) and BLS (EMT-Basic) combination staffing or separate units
2. Consolidate stations combining Bridgeport station with Walker or June Lake
3. Eliminate scheduled overtime, would require reduced operations or increased employees
4. Cut hours/positions, again resulting in reduced operations daily or by location
5. Stop fearing negotiations, consider possible layoffs, loss of pay or benefits
6. 50/50 paramedic/EMT, current employee numbers have more Paramedics than EMT's
7. Management restructuring with reduced number of positions
8. Over Time for all shifts to be covered by an EMT-Basic with results similar to #2, #3, #4
9. One-man Paramedic Squads working with volunteer fire department ambulances
10. Consolidate stations during identified low call volume periods, again similar to #2, #3, #4
11. Alternative work schedules combining or in place of current 48 hours on with 96 hours off

12. Eliminate/consolidate management positions, consider program not under Health Dept.
13. Don't move Medic 7 to south county (Mammoth) during high call volume periods
14. Determine when overtime costs equal or exceed new hiring costs
15. Modify/increase benefit contributions of employees
16. Utilize Sleep Time Hours to be without or reduced pay for on duty crews
17. Hire non benefitted or otherwise lower costs part-time or seasonal staff
18. Shift Paramedic Program's direct oversight to the County Administrator's Office
19. Full time EMS Manager/Director who would cover Paramedic shifts as needed
20. Split a two paramedic staffed ambulance into two single paramedic ambulance of squad units
21. Consider encouraging early retirement for higher paid employees
22. Involve paramedics with county dispatching duties
23. Formalize agreements with outside providers who might provide service at no costs to County
24. Improve and correct deficiencies with record keeping and data management
25. Utilize long term Master Planning and three to five-year Strategic Planning processes

Modifications to Enhance Revenues

1. Actively and continuously seek various public and private Grant Funding
2. Calculate costs of doing business (stand-by and readiness) and seek recovery reimbursements
3. Seek private business contributions, Mammoth Mountain and other local or national firms
4. Put a Special Tax on the ballot for county wide or more local approval
5. Conduct more vigorous billing including increased rates to reflect industry standards
6. Special Tax Initiative for the communities currently having paramedic stations
7. Conduct pricing and rate analysis similar to #2 and #5
8. Mono County Hwy 6 Paramedic Station serving Bishop under contract with Inyo County
9. Resident Subscription Service with Care-Flight / REMSA helicopter from Reno NV
10. Increase the number of patient transports including those now done by Mammoth Hospital
11. Place a 1% Sales Tax Increase on the ballot for voter approval
12. Place a Special Tax or service Fee on the Ski Area lift tickets
13. Increase with voter approval the Transient Occupancy Tax to match other county's rates
14. Charge for response to car wrecks and Haz-Mat incidents regardless of patient transports
15. Charge the Sheriff's Department for calls to the jail in Bridgeport
16. Charge the federal Government for Mountain Warfare Training Center (housing) for service
17. Create and number of local county Paramedic Districts
18. Create and market Mono County EMS logo wear to increase awareness and utilization
19. Explore Medi-Cal Ground Emergency Medical Transportation reimbursement program
20. Identify and seek private or foundation donations and other fundraising opportunities
21. Negotiate with the Town of Mammoth for contributing to the Paramedic Program
22. Seek out and partner with other providers including East Fork FD, WMTC EMS, Symon's
23. Capture the Film Industry's need for onsite standby services through the permit process
24. Provide Cal EMA, the US Forest Service and Cal-FIRE with standby at their local fire camps
25. Train and provide Fire Line Medics for additional services to the agencies in #24
26. Utilize a Succession Planning Process to improve in house promotions in rank
27. Recruit / Develop a highly qualified and full time Paramedic Program Manager/ Director
28. Place Program under a new Mono Co. Cal-EMA Rescue Office of Emergency Management

B. Reasons Integration with Fire and Privatization Models Not Preferred

1. Integration of EMS with Fire Districts

Contemporary fire and EMS organizations are highly integrated in many EMS systems throughout emergency services in the US. The integration is generally founded on three considerations.

First, the majority of "fire" service calls are ems-related (typically in the 65%-85% range). In the most literal sense, EMS is the fire service with additional low-frequency/high complexity emergency response duties included (e.g., fire, rescue, hazmat, etc.).

Second, EMS readiness costs are high because they require sufficient staffing to keep total response times low in support of improved patient outcomes. In most cases an ambulance staffed with two providers (e.g., 2 paramedics, 1 paramedic and 1 EMT, or 2 EMT's) is sufficient based on the majority of EMS calls for service. While advanced life support (ALS) interventions have grown steadily since the 1970s to improve patient outcomes, some contemporary research is emerging that questions the superiority of ALS over Basic Life Support (BLS) levels of service[1]. However, two person staffing is the minimum for ambulances. Calls for service involving less frequent but more severe problems (e.g., heart attacks, respiratory problems, and trauma), or movement of patients in challenging settings (e.g., upper floors with stairwells, outdoor settings, vehicle extrications or other entrapments, etc.) require interventions at the ALS or BLS level needing more than one person, and leaving no one to drive the ambulance. Fire service personnel, full time and part-time/volunteer, can supplement the ambulance system staffing as needed without the ambulance system needing to carry the extra staffing as part of their readiness costs.

Third, fire services are generally very stable (full-time, combination, or volunteer) due to revenues primarily based on property taxes. Stability does ensure some level of service will almost always be available, but it also means changes are not very responsive. Because the profitability of EMS changes, primarily due to legislative changes effecting cost recovery, private sector interest in providing the service is, quite understandably, less stable. Fire services provide at least a baseline for EMS delivery during those times/conditions when profitability is scarce, which tends to keep the fire services close to EMS in either a supporting or primary role. Additionally, within each EMS delivery area there are geographic areas with higher call volumes and shorter turnaround times to hospitals. These generate higher ambulance UHU (unit/hour utilization) which means more transports (revenue) with less resource (expense). Each service area also has outlying areas with few calls and long turnaround times which generate lower ambulance UHU. It is common to have a public or private ambulance system be the primary care provider (i.e., first on scene) in the higher UHU areas, and for the fire service, which has historically been based on a travel time/distance static deployment model, arrive first on scene (with or without an ambulance for transport) in the lower UHU areas.

[1] "Outcomes of Basic Versus Advanced Life Support for Out-of-Hospital Medical Emergencies Outcomes of Basic Versus Advanced Life Support" (http://annals.org/article.aspx?articleid=2456124). The intent of this article, and the cited works within it, is not to advocate a given level of service, but to acknowledge that there is a scientifically based debate in progress about patient outcomes after receiving care in ALS and BLS systems.

To varying degrees, all three of these considerations are applicable to our situation in Mono County, and therefore the EMS/Fire integration model was evaluated. Following are the eleven primary considerations that emerged:

1. **Current inability to utilize Code of Federal Regulations Title 29, Subtitle B, Chapter V, Subchapter A, Part 553.201 Section 7(K) exemption to the Fair Labor Standard Act**[2]
    - This exemption allows certain government public safety workers to be placed on a schedule that expands the time frame to calculate overtime (e.g., fire service personnel working 24 hour shifts generally must work in excess of 56 hours/week before qualifying for overtime).
    - The paramedic program currently schedules its employees for a 56 hour work week, but pays them as if they are on a 40 hour work week with an additional 16 hours of overtime. Various 9th Circuit Court of Appeals decisions have severely restricted the applicability of the 7(k) exemption to employees with primary EMS functions.
    - One benefit of having the paramedics (and EMTs) qualifying for the 7(K) exemption would be the ability to avoid the 16 hours of overtime rate in each 24 hour shift.
    - Part 553.210 Fire Protection Activities reads:
        - As used in sections 7(k) and 13(b)(20) of the Act, the term "any employee * * * in fire protection activities" refers to "an employee, including a firefighter, paramedic, emergency medical technician, rescue worker, ambulance personnel, or hazardous materials worker, who—(1) is trained in fire suppression, has the legal authority and responsibility to engage in fire suppression, and is employed by a fire department of a municipality, county, fire district, or State; and (2) is engaged in the prevention, control, and extinguishment of fires or response to emergency situations where life, property, or the environment is at risk."
    - As the paramedics currently are not uniformly trained in fire suppression to any level, nor are employed by a public fire department, they do not meet the exemption requirements of "7(K)".
2. **Limit to the amount of integration without jeopardizing the EOA.**
    - It is the understanding of the Committee that, based on legal counsel interpretation, and testimony by Inland Counties Emergency Medical Services Authority (ICEMA) CEO Tom Lynch, transitioning the current paramedic program from the Mono County Department of Health and Human Services, to a County "Fire" Department which does not currently exist, would cross the threshold of protection for the current Exclusive Operating Area (EOA) agreements, and require the service areas to be opened for Request for Proposals (RFP).

[2] See http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=29:3.1.1.1.30#se29.3.553_1201

- This is not a disqualification of the fire integration model, but it does potentially generate a loss of current exclusivity enjoyed by the County in the provision of EMS.

3. **Possible issues to train current employees.**
   - The fire training, equipping, and maintenance of fire service skills to the existing workforce will require a considerable financial investment.
   - As the Committee was formed in response to fiscal unsustainability of the current program, it seems unlikely that the County would be willing or able to make such an investment in the short-term.
4. **Might not provide (existing) county wide benefit.**
   - As there are several different kinds of fire integration models, different levels of county wide benefit, as described in the Background Section of this report, will exist. Reduction or redeployment of resources may be perceived by residents as a loss of benefit depending on where they live.
5. **Squad deployment and transport times.**
   - One of the potential benefits of a version of fire integration involves changes to the type and location of vehicles in the system. For the same daily staffing expense, there could be three ambulances on duty, and two single responder "Squads" (i.e., non-transporting SUV's/Type 6, etc.) and unstaffed ambulances in strategic locations. During an emergency the Squad responds as does the closest fire department, driving an ambulance with two personnel.
   - The logistics for this kind of arrangement probably only works in the extreme North and South ends of the County (i.e., Walker/Coleville, and Chalfant/Benton/Paradise/Wheeler Crest). This is due to those areas having a potentially shorter turnaround time for transport. Volunteers coming to cover an ambulance call cannot reasonably be expected to be gone for hours due to relatively long transport distances.
   - Currently there are probably not sufficient EMT's with ambulance licensure, and general availability from primary work, to support this option.
6. **Diverse districts with varied standards, capabilities, philosophies, governing boards, lack of funding.**
   - Fire integration of county wide paramedics would require a uniformity among individual fire districts that may not currently exist.
7. **Difficult to Implement and Manage.**
   - Neither the paramedic program, nor the individual Districts, currently have the staff capacity to provide the administrative, training, and operational management to implement, or manage, a fire integration model.

- The District most likely to be able to provide such staff support resides with the Mammoth Lakes Fire Protection District. However, this integration was previously attempted from November 1985 until November 1991[3].
- The findings of the Committee in this respect, and several others, are remarkably similar to those identified by the Abaris Group, who consulted on the 1991 County of Mono Paramedic Program Business Plan (see footnote 4). While the program did return to the County from the Fire District, the draft of the plan had extensive fire integration intent[4], mostly focused on personnel management and local supervision of operations.

8. **Mono County Fire Chiefs Association.**
   - The Mono County Fire Chiefs Association (MCFCA) does not believe its' respective Districts have the capacity to provide the additional fire training, or get its' personnel to the additional EMT training, needed to support the fire integration model(s).
   - The MCFCA supports the "Existing System with Modifications" option.

9. **County has no authority over independent special districts (Fire Districts).**
   - The only way for the county wide fire integration model(s) to work is for there to be support from the respective fire districts, and the MCFCA representing those districts does not endorse this model because they do not believe they can logistically support it.
   - The Committee does not believe the County has any direct ability to assert authority over the districts to support this option.

10. **Political resistance.**
    - Nearly any change to the current system, and even inaction, will generate political resistance. However, until or unless the MCFCA believes there are conditions under which they have the capacity to support the model while retaining their autonomy, it is anticipated there would be strong political resistance to imposing this model.

11. **Currently unidentified funding source.**
    - The upfront and significant financial costs associated with this model have no identified funding source.

Based on these findings, the Committee does not support integration of EMS with fire.

The Committee also recognized that there are potential benefits to the fire-based model. These include:

- Increased levels and types of service
- Increased value resulting from same number of personnel performing additional functions

[3] County of Mono Paramedic Program Business Plan, Draft II (p.3); September 9, 1992.
[4] Ibid 4, pp. 16-17

- Potential for better Insurance Services Office (ISO) ratings

2. Privatization of EMS

On the surface, privatizing our EMS system seems like a very attractive option by which we can divest ourselves of the operating costs and liability of our EMS service. However, there are some problems with this approach that the Committee identified through study.

1) It is not known whether there is interest by private providers in serving Mono County. One way to identify whether such interest exists would be to issue a request for proposals (RFP)
2) The economics of EMS in Mono County do not support a for-profit operation without subsidy. The chief factors are that Mono County has a large service area combined with a small population. EMS in Mono County is a high cost, low volume, low reimbursement business.
3) We believe that pressure for profitability in the long-term will erode both the standard of care (Advanced Life Support) and the level of service (response time). This is because there are no obvious ways to raise revenues and, therefore, private enterprise will have to substantially cut expenses in order to make a profit. Reimbursements (revenues) are controlled by Medicare, MediCal, and private insurers. They have established reimbursement rates for ambulance rides irrespective of the cost of providing the service. Reimbursement rates of 50% for the actual cost of the ambulance ride are considered to be extremely high. That does not include the cost of establishing, equipping, training, and maintaining the service. The County does not have a 50% reimbursement rate and its receivables are close to 25% of program costs. This gap between revenues and cost does not go away with a private contractor.
4) Other counties have this same problem. They have had to subsidize the operations of their private contractors so that those contractors can make a profit. Not only have they had to provide a subsidy but in some cases private contractors have come back to the county later, mid contract, and demanded increased subsidies because they could not make a profit. They effectively leveraged the county by threatening to abandon the contract if the subsidy was not increased. We refer the reader to the report from Contra Costa County in our appendix. Perhaps more compelling than Contra Costa's experience, is our own. This has already happened to us (Mono County) back in the 1980s with the American Ambulance Company. Although we've lost the institutional memory of this experience, they abandoned the contract when Mono County could not provide a subsidy. The committee believes that privatizing our EMS program carries significant risk of unplanned future demands for public subsidies of private profits and of default by the contractor. We must point out that at that stage of the game, we will no longer have the capacity to take the service back in house.
5) In 2004, an Exclusive Operating Area (EOA) Plan for Mono County was adopted as authorized by the Emergency Medical Services Act (the EMS Act). This plan grants authority to Mono County EMS to exclusively serve designated regions of the County (essentially everything but the Tri-Valley area). By limiting competition, the EOA Plan limits further erosion of the revenue-raising potential. Normally the granting of such exclusive rights requires a competitive procurement process. However, because Mono County provided these services prior to the enactment the EMS Act, no competitive process was required. If the County decided that an entity other than it (i.e., a private or different public entity) should provide services in the exclusive areas of Mono County, then a competitive process would be required to select that provider. Thereafter, competitive processes would be required periodically. Mono County could not "re-enter" the field without successfully competing in an RFP process. It also means that ICEMA would have the final say over which proposal is accepted -- not Mono County. It is unclear if ICEMA will establish the specifications of

future contracts but it is clear that the County will lose some measure of control over EMS in Mono County but will still have to pay the subsidies.

Based on all of these factors. The Committee does not favor privatization of the entire Mono County EMS program. We think we are better off to work with the program we have and change it ourselves. We think there is room for cost control within the current system without compromising the Standard of Care or Quality of Service. Cost control ideas are presented elsewhere in this report. We also want to clarify that our current system includes relationships with other agencies within and outside of Mono County. These relationships could be expanded in the future if circumstances prove advantageous to the County, its residents, and visitors without losing either control of the quality of EMS in Mono County or giving up our capability to provide the service. It should be noted that there could be costs associated with expanding these relationships and those costs would be borne by the EMS budget.

We acknowledge that during the Committee's review of the private option, we were unable to gather any firm details about cost savings or potential service standards for a private EMS provider. We had one presentation from a private business but the feedback we received was very conceptual and lacked any specificity. Additional information could be acquired through further outreach and/or the issuance of a request for proposals.

Based on these findings, the Committee does not support the privatizing EMS in Mono County.

The Committee also recognized that there are potential benefits to the private model. These include:

- Potential for immediate short term cost savings
- Provider would be self contained with own management and administrative structure

V. Implementation

One of the guiding objectives given to the Committee was that its recommendations make the EMS system fiscally sustainable. In order to accomplish this, our recommendation includes suggestions in the areas of revenue enhancement, cost cutting / containment, and operational changes.

Going forward, any decisions made, should have a foundation in evidence based analysis and professional / industry best practices. These decisions will also require a “top down” commitment to the continued success of the EMS program.

This commitment should include policy level direction regarding the overall mission of the Paramedic Program including the most appropriate placement within the County organizational structure. It also requires strong management and administration involvement including committing to and establishing a realistic budget to fulfill the mission objectives. Another function of strong and proactive leadership will be obtaining the necessary “buy in” from the employees in carrying out potentially new and different assignments.

Develop and execute an implementation plan. The Committee recommends that the plan include:

- A master plan and integrated rolling 5-year strategic plan, including a budget/financial plan, operational/staffing plan and performance management plan

- Recruitment/development of a full-time EMS Program Manager, Deputy Director or Director
- Provide Program Manager, Deputy Director or Director with adequate compensation, training, authority, Board support and empowerment
- Give more responsibility and duties to Station Captains
- Revised and refined paramedic and EMT job descriptions
- Service levels and budget for commensurate staffing levels, equipment and training
- Annual adjustment of strategic service level goals to strategic projections (e.g., tax revenues, negotiated labor costs, roll-ups, etc.)
- Definition of performance measures and compare to actual performance
- Prudent MOU negotiations
- Assignment of staff, volunteers and/or consultants to complete final program design and implementation

VI. Sources of information

HELEN TO ADD LINKS TO EACH DOCUMENT

A. Presentations
    i. Tom Lynch, CEO – Inland Counties Emergency Medical Authority (ICEMA)
        1. State, Regional, and Local EMS Oversight
        2. Overview of EMS Trends
    ii. Dave Fogerson – Asst. Chief, East Fork Fire & Paramedic Districts
        1. Fire Perspective of Fire/EMS System Integration in Douglas County
    iii. Dr. Rick Johnson – Medical/Health Operational Area Coordinator
        1. Survey of County EMS Systems w/ Less Than 40,000 Population
    iv. Ray Ramirez – Asst. Chief, Ontario Fire Department
        1. Ground Emergency Medical Transportation/Intergovernmental Transfers Reimbursement
    v. Bob Rooks – Retired Division Chief, Mammoth Lakes Fire Department
        1. History of Mono County Paramedic Program
    vi. Judd Symons – Operations Manager, Symons Ambulance
        1. Private Perspective of EMS Delivery in Mono County
    vii. Dan Flynn – EMT, Mono County Paramedic Rescue Association
        1. Association Perspective of EMS Delivery in Mono County
    viii. Frank Frievalt – Fire Chief, Mammoth Lakes Fire Department
        1. Integrated Operational Response Scenarios

b. Professional Literature
    i. Previous Consultant Reports
        1. 1991 – The Abaris Group; Draft II County of Mono EMS/Paramedic Program Business Plan
        2. 2012 – Fitch & Associates; EMS Assessment
    ii. Pertinent articles – various sources
        1. Contra Costa County RFP

2. Articles describing challenges faced by Alameda and Santa Clara Counties

iii. Standards

1. National Fire Protection Association
2. American Ambulance Association
3. American Heart Association

iv. Mono County Emergency Medical Care Committee Annual Reports

c. Agreements

i. Mono-Inyo-San Bernardino Joint Powers Agreement
ii. Mono County Exclusive Operating Area
iii. Mono County Paramedic Association, Memorandum of Understanding

d. Current EMS System and Paramedic Program Review

i. Fiscal Analysis

1. Leslie Chapman – Chief Financial Officer
2. Ralph Lockhart – Private Sector Health Professional

ii. Legal Analysis

1. Stacey Simon – Mono County Counsel
