



2018 APR 12 PM 4:15

OFFICE OF THE
SECRETARY

MURIEL BOWSER
MAYOR

APR 12 2018

The Honorable Phil Mendelson
Chairman, Council of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Avenue, NW, Suite 504
Washington, DC 20004

Dear Chairman Mendelson:

Enclosed for Council review, please find the "Emergency Medical Services Transport Contract Authority Quarterly Report (October – December 2017)" for the first quarter of Fiscal Year 2018.

Under D.C. Code § 5-401, the Fire and Emergency Medical Services Department (FEMS) may contract with third parties to provide supplemental pre-hospital medical care and transportation to persons requiring Basic Life Support. FEMS and the Office of Unified Communications are required under the statute to provide a quarterly report to the Council regarding third party contractor operations. Further, each third-party contractor that enters into a contract pursuant to this authority is required to provide a quarterly report to the Department and to the Council regarding the contractor's operations.

If you have any questions, please contact Amy Mauro, Fire and Emergency Medical Services, at 202-673-3320 or Kelly Brown, Office of Unified Communications, at 202-730-0524.

Sincerely,

A handwritten signature in black ink, appearing to read "Muriel Bowser".

Muriel Bowser

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Muriel Bowser, Mayor



Emergency Medical Services Transport Contract Authority
Quarterly Report (October – December 2017)

February 9, 2018

As part of the “Fiscal Year 2017 Budget Support Act of 2016,” Mayor Bowser proposed and the Council approved the “Emergency Medical Services Transport Contract Authority Amendment Act of 2016.”¹

Under D.C. Code § 5-401, the Fire and Emergency Medical Services Department (FEMS) may contract with third parties to provide supplemental pre-hospital medical care and transportation to persons requiring Basic Life Support. FEMS and the Office of Unified Communications (OUC) are required under the statute to provide a quarterly report to the Council regarding third party contractor operations. Further, each third-party contractor that enters into a contract pursuant to this authority is required to provide a quarterly report to FEMS and the Council regarding the contractor’s operations (see attached).

The responses contained in this report are based on the best available data for the first quarter of Fiscal Year 2018, between the dates of October 1, 2017 and December 31, 2017.

If you have any questions, please contact Amy Mauro, Fire and Emergency Medical Services, at 202-673-3320 or Kelly Brown, Office of Unified Communications, at 202-730-0524.

A. Fire and Emergency Medical Services Department

1. *Activity by the Department to educate the public on the proper use of emergency requests for service.*

FEMS is in the final stretch of working with its government and non-governmental partners to launch the Nurse Triage Line (NTL) in late March 2018. As we have previously reported, the goals of this initiative are to improve patients’ health outcomes and to preserve FEMS resources for those patients with life threatening injuries and illnesses. It should also free up beds in crowded hospital emergency

¹ D.C. Code §5-401 (D.C. Act 21-488) (effective October 8, 2016).

departments, which will benefit all critically ill emergency patients. The District has the highest per capita EMS call volume in the nation. Our high non-emergency call volume strains the Department's resources for emergencies.

After the launch of the program, callers to 911 with non-emergency injuries or illnesses may be transferred to a nurse. The nurse will ask the caller questions and assess his or her symptoms so that the nurse can refer the caller to the most appropriate non-emergency medical care available, most likely a community clinic or urgent care clinic in the caller's neighborhood. Medicaid and DC Healthcare Alliance enrollees will be provided with free transportation to and from the clinic.

By recommendation of Office of Contracting and Procurement, the Department has modified its contract with American Medical Response (AMR) so that AMR will serve as the vendor for the NTL. AMR is developing the technology infrastructure, and providing nurse staffing for the line. We have worked with the District's Medicaid managed care organizations and the Department of Health Care Finance to provide bidirectional same day nonemergency medical transportation (NEMT) for NTL triaged callers who have been referred to an appropriate non-emergency health care site.

FEMS has worked closely with our Federally Qualified Health Centers (FQHCs) and the urgent care clinics in the District to assure that there is capacity at each site. We are building the specific site capacity for each of our clinical sites into our NTL system algorithm.

Additionally, the Department is working with the Lab@DC within the Executive Office of the Mayor in order to scientifically evaluate the nurse triage line intervention for low acuity, or non-emergency, callers. This collaboration will also research effective methods for engaging and educating the public about alternative avenues to fast, safe, and effective care.

FEMS is also finalizing its public education campaign, including branding, for the implementation of the nurse triage line. This campaign will be rolled out in the days and weeks leading up to the launch. FEMS is developing literature, public service announcements, and other communications strategies that will be used to educate the public on the rollout. FEMS leadership will also initiate aggressive media outreach and participate in community meetings.

2. The number of employees hired after the contract award and their residency.

FEMS continues to aggressively recruit and hire firefighter EMTs and firefighter paramedics to fully staff our units.

A recruit class of 18 firefighter paramedics is currently in progress (began in October of 2017 and is scheduled to graduate in April of 2018). In addition, two Firefighter/EMT recruit classes are currently in session. Class #381 has 30 recruits (began in September of 2017 and scheduled to graduate in March of 2018) and Class #383 has 24 recruits (began in November of 2017 and scheduled to graduate in May of 2018). Our Cadet class #20 of 18 Firefighter/EMT candidates is also currently in session (began at the Training Academy in August of 2017 and scheduled to graduate in July of 2018).

3. *Evaluation of pre-hospital medical care and transportation fees considering the reasonableness of the fees, the public interest, and the persons required to pay the fee.*

The Department’s ambulance fees and charges are described by 29 DCMR § 567.1. Such fees and charges have not changed, or otherwise been modified, since January 1, 2009. Currently, there are no plans to propose changes or other modifications to this fee structure.

4. *The number of ambulances added to the Department's frontline and reserve fleet after the date of the contract award, including whether added ambulances replace or supplement the current fleet.*

The Department did not receive any new ambulances during the first quarter of Fiscal Year 2018, however, we will receive seven new ambulances in the remaining months of the fiscal year.

5. *The number of emergency medical services personnel training hours provided.*

During the first quarter of Fiscal Year 2018, the Department delivered a total of 35,469 EMS training hours (detailed in the table below).

EMS Training Hours Delivered from October 1, 2017 through December 31, 2017

Class	Number of participants	Hours per class	Total
Advanced Cardiovascular Life Support for the Experienced Provider (ACLS EP)	6	8	48
Advanced Cardiovascular Life Support (ACLS) Refresher	10	8	80
Advanced Medical Life Support (AMLS) Refresher	18	16	288
Company Based Education	7	1	7
Emergency Medical Technician Course	67	310	12,760*
Geriatric Education for EMS Providers (GEMS)	34	8	272
Handtevy Pediatric Code	583	4	2,332
LGBTQ Cultural Competency	1,439	2	2,878
Module 02: Trauma & Excited Delirium Syndrome	6	4	24
Module 3: Cardiovascular and Respiratory Emergencies	12	4	48
Module 04: Altered Mental Status	64	4	256
Module 5: Wellness and Cardiac Arrest	6	4	24
Module 07: Unusual Emergencies & Operational Concerns	1,270	4	5,080
Paramedic Grand Rounds: Cardiac Arrest	201	4	804
Pediatric Advanced Life Support (PALS) (Refresher)	74	8	592

Pediatric Education for Prehospital Providers (PEPP)	44	16	704
Pediatric Clinical Rotations at Children's National Medical Center	24	8	192
Prehospital Trauma Life Support (PHTLS)	34	16	544
SafetyPad Training	42	0.5	21
Various Asynchronous Distance Learning Modules (Target Safety Courses)	8,060	Variable	8,515
TOTAL			35,469

*Only the training hours completed within the date range of this report are indicated.

6. The number of patients who used the Department's transport services twice or more within the reporting period, including the number of times the patient used transport services during the previous 12 months.

This data is reported using ambulance billing information. For the reporting period (12/1/2016 to 11/30/2017), ambulance billing data indicated 106,845 patient transports were completed by FEMS and AMR ambulances. Of these transport cases, 104,345 involved patients that could be uniquely identified by full name and birthdate. The remaining 2,500 (or less than 3% of cases) could not be uniquely identified and were excluded from analysis. Because many high volume user (HVU) patients are often transported by both FEMS and AMR, the number of individual patients and transports reported separately in the FEMS and AMR tables (below) do not add up to the combined patients and transports reported in the uppermost table.

During the last **twelve month** period (December, 2016 to November, 2017), for patients transported two or more times, **14,406 (or 22%) of patients** accounted for **52,503 (or 50%) of all patient transports**:

# of Transports	# of Patients	% of Patients	# of Total Transports	% of Total Transports
1	51,842	78%	51,842	50%
2 or more	14,406	22%	52,503	50%
TOTAL	66,248	100%	104,345	100%

During the last **twelve month** period (December, 2016 to November, 2017), for patients transported two or more times, **6,775 (or 18%) of patients** accounted for **20,986 (or 40%) of all patient transports** completed by **FEMS ambulances**:

# of Transports	# of Patients	% of Patients	# of Total Transports	% of Total Transports
1	31,605	82%	31,605	60%
2 or more	6,775	18%	20,986	40%
TOTAL	38,380	100%	52,591	100%

During the last **twelve month** period (December, 2016 to November, 2017), for patients transported two or more times, **6,413 (or 18%) of patients** accounted for **21,930 (or 42%) of all patient transports** completed by **AMR ambulances**:

# of Transports	# of Patients	% of Patients	# of Total Transports	% of Total Transports
1	29,824	82%	29,824	58%
2 or more	6,413	18%	21,930	42%
TOTAL	36,237	100%	51,754	100%

B. Office of Unified Communications

1. *The number of calls dispatched and the average dispatch time.*

OUC Calls for Service and Dispatch Times			
	# of Calls Dispatched	Average Dispatch Times (seconds)	Average Call Processing + Dispatch Times (seconds)
Oct 2017	13,738	32	135
Nov 2017	12,524	29	131
Dec 2017	12,956	30	137

2. *The average time within which the Department and the third-party contractor's ambulances reported arriving at a healthcare facility with a patient and returning to service.*

Average Hospital Offload Times (minutes)		
	DC FEMS	Third Party
Oct 2017	41:18	40:08
Nov 2017	41:05	39:04
Dec 2017	41:26	41:16

These numbers show that FEMS average offload times were an average of three (3) minutes lower than during the previous reporting period, while the third party provider time remained steady. The Department continues to monitor and work on decreasing Department hospital "drop" times.

In May 2016, the Department enhanced its supervision and tracking of hospital drop times at a per transport unit level. Since that time, this data is regularly shared with supervisors throughout the chain of command. Our field supervisors and the Office of the Medical Director are in continuous communication with hospital emergency department personnel about patient transfer wait times, both to troubleshoot issues as they arise in real time, and to discuss how to work together to better address this issue system-wide.

3. *The protocol to reroute non-emergency calls.*

As reported in the last quarterly report, OUC continues to collaborate with FEMS to implement strategies to address the misuse of 911, including public engagement, public service announcements, and website updating. OUC also works with FEMS Medical Director Dr. Robert Holman and the Integrated Healthcare Collaborative to identify alternative transport options and to roll out the Nurse Triage Line.

In addition, OUC's Community Action Team spearheads several of the agency's public education campaign initiatives and participates in community meetings across the District on the topic of the appropriate use of 911 services. The OUC is also moving forward on initializing newly enhanced features of the SMART 911 program and meeting regularly with target populations, focus groups and super users to create a greater awareness of the benefits of registration in the program.

4. *The average time between the on-scene arrival of the third-party contractor's ambulance and the time the third-party contractor is at the patient's side.*

The OUC is unable to provide data regarding the time difference between the arrival of the third party transport unit on the scene and its employee's arrival to the patient's side. This information is not captured in CAD and is the sole property of the third party. Accordingly, attached is a responsive report generated by AMR.

Emergency Medical Services Transport Contract Authority
Quarterly Report (October – December 2017)

Appendix A

American Medical Response, Inc.

Quarterly Performance Report



Quarterly Performance Report

Provided To:

Council of the District of Columbia

and

DC Fire & Emergency Medical Services

October 1 – December 31, 2017

Transports Performed

- * 13,386 patient transports were performed by American Medical Response (AMR) from October 1st through December 31st of 2017.
- * AMR responded to a total of 15,195 requests for service during this period, averaging 169 requests daily.
- * Average Response Time by Month:
 - October: 8 minutes, 10 seconds
 - November: 7 minutes, 52 seconds
 - December: 7 minutes, 52 seconds
- * AMR met each patient at the location of the incident and transported to the closest available hospital, or as directed by DC FEMS.

Transports Performed

<u>Hospital Name</u>	<u>Transports</u>	<u>Drop Off Time</u>
Children's National Medical Center	629	31:11
United Medical Center	2,077	41:27
Howard University Hospital	1,977	45:13
Holy Cross Hospital	22	43:34
George Washington Hospital	2,179	40:20
Georgetown Hospital	212	34:01
VA Medical Center	302	33:49
Sibley Hospital	430	34:44
Prince Georges Medical Center	703	51:57
Providence Hospital	1,623	40:22
Washington Adventist Hospital	63	36:29
Washington Hospital Center	2,783	37:15

Note: Drop off time is average time in minutes. Hospitals with less than 10 transports not represented.

Ambulance and Shift Information

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Current # of Shifts	30	38	35	35	35	40	33
# and Length of Shifts	6 – 8hr 9 - 9hr 4 - 10hr 8 - 12hr 3 – 18hr	10 – 8hr 10 - 9hr 3 - 10hr 12 - 12hr 3 – 18hr	10 – 8hr 9 - 9hr 4 - 10hr 12- 12hr	9 – 8hr 14 - 9hr 3 - 10hr 12 - 12hr 1- 14hr	8 – 8hr 14 - 9hr 3 - 10hr 9 - 12hr 1 – 14hr	8 – 8hr 16 - 9hr 3 - 10hr 9 -12hr 1- 14hr 3 -18hr	7 – 8hr 12 - 9hr 4 - 10hr 7 - 12hr 3- 18hr
Peak # of Ambulances Deployed	17	26	27	25	24	27	19

Average at Scene to At Patient Time*

* Approximate Times from Patient Care Reports

October	November	December
2:25	2:38	2:19

Personnel Data

* 267 Total Persons Employed in the Division

* 24% are District Residents

- **NOTE:** We are continuing to develop our in-house EMT program. Our goal of an inaugural class in Q1 of 2018 will be difficult to achieve due to some unexpected, external administrative challenges. We are continuing to work closely with DC DOH and have also begun exploring the possibility of partnering with an educational institution to help mitigate these challenges.

* 40% are Women

* 48% Minority Represented



Quarterly Performance Report

Provided To:

Council of the District of Columbia

and

DC Fire & Emergency Medical Services

January 1 – March 31, 2018

Transports Performed

- * 12,573 patient transports were performed by American Medical Response (AMR) from January 1st through March 31st of 2018.
- * AMR responded to a total of 14,494 requests for service during this period, averaging 161 requests daily.
- * Average Response Time by Month:
 - January: 8 minutes, 21 seconds
 - February: 8 minutes, 24 seconds
 - March: 8 minutes, 24 seconds
- * AMR met each patient at the location of the incident and transported to the closest available hospital, or as directed by DC FEMS.

Transports Performed

<u>Hospital Name</u>	<u>Transports</u>	<u>Drop Off Time</u>
Children's National Medical Center	597	34:44
United Medical Center	2,203	43:35
Howard University Hospital	1,755	52:17
Children's @ United Medical Center	342	33:34
George Washington Hospital	2,042	42:56
Georgetown Hospital	230	39:57
VA Medical Center	243	37:02
Sibley Hospital	384	35:59
Prince George's Medical Center	61	45:48
Providence Hospital	1,975	42:14
Washington Adventist Hospital	12	1:24:30
Washington Hospital Center	2,852	39:07

Note: Drop off time is average time in minutes. Hospitals with less than 10 transports not represented.

Ambulance and Shift Information

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Current # of Shifts	30	38	35	35	35	40	33
# and Length of Shifts	6 – 8hr 9 - 9hr 4 - 10hr 8 - 12hr 3 – 18hr	10 – 8hr 10 - 9hr 3 - 10hr 12 - 12hr 3 – 18hr	10 – 8hr 9 - 9hr 4 - 10hr 12- 12hr	9 – 8hr 14 - 9hr 3 - 10hr 12 - 12hr 1- 14hr	8 – 8hr 14 - 9hr 3 - 10hr 9 - 12hr 1 – 14hr	8 – 8hr 16 - 9hr 3 - 10hr 9 -12hr 1- 14hr 3 -18hr	7 – 8hr 12 - 9hr 4 - 10hr 7 - 12hr 3- 18hr
Peak # of Ambulances Deployed	17	26	27	25	24	27	19

Average at Scene to At Patient Time*

* Approximate Times from Patient Care Reports

January	February	March
1:50	1:45	1:45

Personnel Data

* 201 Total Persons Employed in the Division

* 24% are District Residents

- **NOTE:** We are continuing to develop our in-house EMT program. We are continuing to work closely with DC DOH and have also begun exploring the possibility of partnering with an educational institution to help mitigate these challenges.

* 39% are Women

* 50% Minority Represented



2018 AUG 21 PM 12:15

OFFICE OF THE
SECURITY

MURIEL BOWSER
MAYOR

AUG 21 2018

The Honorable Phil Mendelson
Chairman, Council of the District of Columbia
John A. Wilson Building
1350 Pennsylvania, NW, Suite 504
Washington, DC 20004

Dear Chairman Mendelson:

Enclosed for Council review, please find the “Emergency Medical Services Transport Contract Authority Second Annual Report (April 2017 – March 2018),” as required by the “Emergency Medical Services Transport Contract Authority Amendment Act of 2016.”

This report evaluates performance under the contract and includes the following information: (1) The impact on the Department's unit availability; (2) The impact on the Department's fleet, including the ability to conduct preventative maintenance and the number of operational and reserve units available; (3) The impact on the Department's training schedule; (4) The impact on the Department's response times and quality of patient care; (5) An assessment of the number of units, the number of personnel, the amount of training, and associated costs required to provide pre-hospital medical care and transportation without the use of third parties; and (6) Recommendations for implementing any additional units, personnel, and training. The responses contained in this annual report are based on the best available data between the dates of April 1, 2017 and March 31, 2018.

In our first annual report in 2017, we reported on the positive impact that our contract with American Medical Response (AMR) has had in each of the above areas. We are pleased to report that this progress has continued in the second year of implementation.

The implementation of the AMR contract has significantly improved the Department's unit availability. Starting from June 3, 2016 the Department had 11 or more transport units available over 90 percent of the time every week except for one week in July 2017 when the District experienced a severe heat wave. During some weeks, this measure was achieved 100 percent of the time. This was an extraordinary achievement. The launch of the AMR contract, as well as the addition of new ambulances to our Department's fleet, has had a positive impact on the Department's ability to conduct preventive maintenance.

The Department continues to prioritize both the quality of instruction and maximizing the quantity of training hours in all disciplines for members. During the second year of the AMR contract, the Department continued to deliver the types of EMS training reported on in last year's report, including regular modular recertification training, Paramedic Grand Rounds, and partnerships with universities and other outside organizations, including the National Fire Academy.

Since launching just over two years ago, the AMR contract has improved the response time of the Department's ambulances. Prior to implementation, average response of the first arriving FEMS transport unit to higher priority (ALS) EMS calls exceeded seven minutes. After implementation, average response times for FEMS transport units were reduced by almost one minute.

Perhaps most importantly, the Department continues to see progress in the area of patient care quality. Our cardiac arrest survival rates have increased for the fourth year in a row. The District is now at or above the national average in five out of seven Utstein categories, tracked by the national Cardiac Arrest Registry to Enhance Survival (CARES) database.

The second year of the AMR contract has supported the Department's efforts to improve the delivery of pre-hospital medical care to the visitors and residents of the District. We look forward to working with the Council, AMR, the Office of Unified Communications, our employees, our two labor unions, and the community to continue to build on this progress.

Sincerely,

A handwritten signature in black ink, appearing to read "Muriel Bowser". The signature is fluid and cursive, with a large initial "M" and "B".

Muriel Bowser



Government of the District of Columbia
Fire and Emergency Medical Services Department



Muriel Bowser
Mayor

Gregory M. Dean
Fire & EMS Chief

Emergency Medical Services Transport Contract Authority
Second Annual Report (April 2017 – March 2018)

July 10, 2018

As part of the "Fiscal Year 2017 Budget Support Act of 2016," Mayor Bowser proposed and the Council approved the "Emergency Medical Services Transport Contract Authority Amendment Act of 2016."

Under D.C. Code §5-401, the Fire and Emergency Medical Services Department (FEMS) may contract with third parties to provide supplemental pre-hospital medical care and transportation to persons requiring Basic Life Support (BLS). FEMS is required under the statute to provide an annual report to the Council regarding third party contractor operations.

This report evaluates performance under the contract and includes the following information: (1) The impact on the Department's unit availability; (2) The impact on the Department's fleet, including the ability to conduct preventative maintenance and the number of operational and reserve units available; (3) The impact on the Department's training schedule; (4) The impact on the Department's response times and quality of patient care; (5) An assessment of the number of units, the number of personnel, the amount of training, and associated costs required to provide pre-hospital medical care and transportation without the use of third parties; and (6) Recommendations for implementing any additional units, personnel, and training. The responses contained in this annual report are based on the best available data between the dates of April 1, 2017 and March 31, 2018.

In our first annual report in 2017, we reported on the positive impact that our contract with American Medical Response (AMR) has had in each of the above areas. We are pleased to report that this progress has continued in the second year of implementation. Above all else, the contract has enabled us to continue to improve patient care and service to the residents and visitors of the District of Columbia.

(1) The impact on the Department's unit availability.

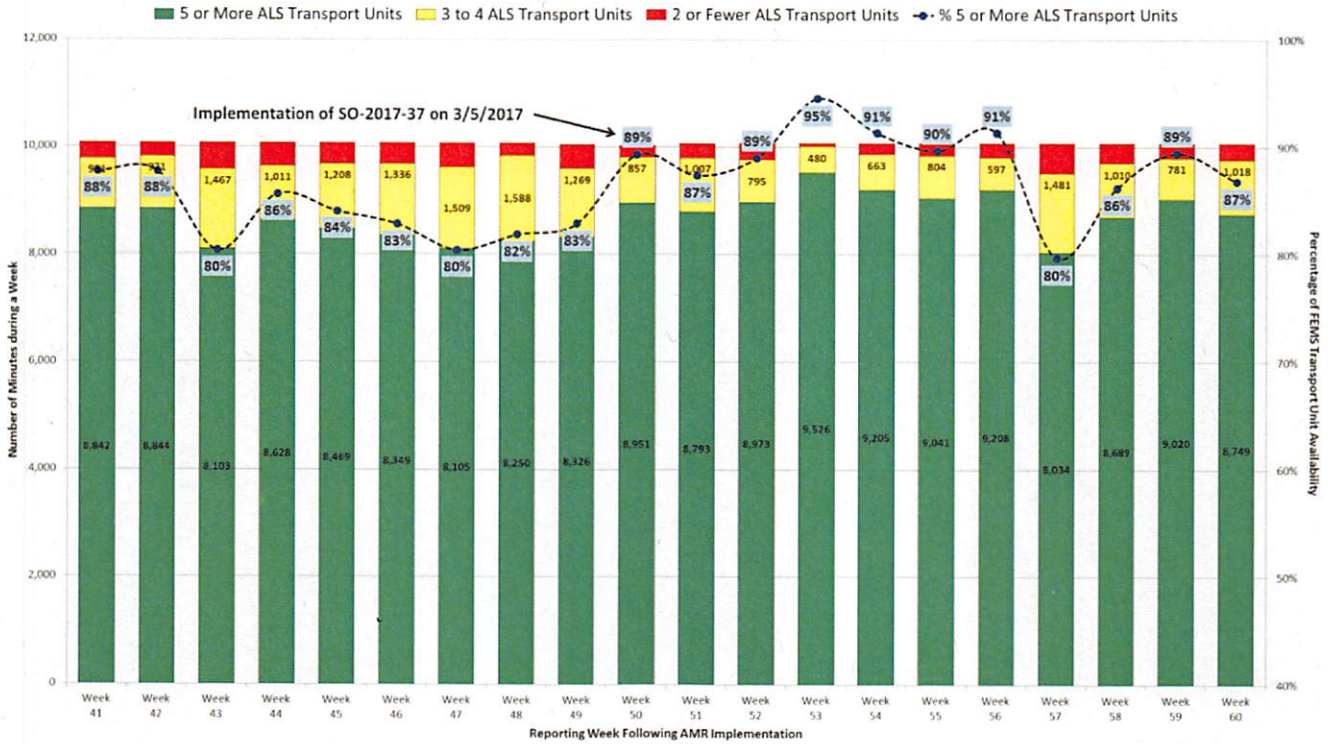
The implementation of the AMR contract has significantly improved the Department's unit availability. Starting from June 3, 2016 the Department had 11 or more transport units available over 90 percent of the time every week except for one week in July 2017 when the District experienced a severe heat wave. During some weeks, this measure was achieved 100 percent of the time. This was an extraordinary achievement.

Since then, the conversion of three BLS units to Medic Units has improved ALS unit availability without a significant impact on the Department's overall BLS availability. The following data shows the impact of the conversion of three BLS units to medic units on ALS unit availability. We have seventeen medic units. The green portion of each column counts the minutes during a week when five or more medic units were available. The yellow portion counts the minutes when three to four were available, and the red

portion counts the minutes when two or fewer were available. The dashed line shows the availability percentage of five or more medic units (“critical availability”). This data shows the improvement in medic unit availability after the Department converted three BLS units to medic units in March 2017.

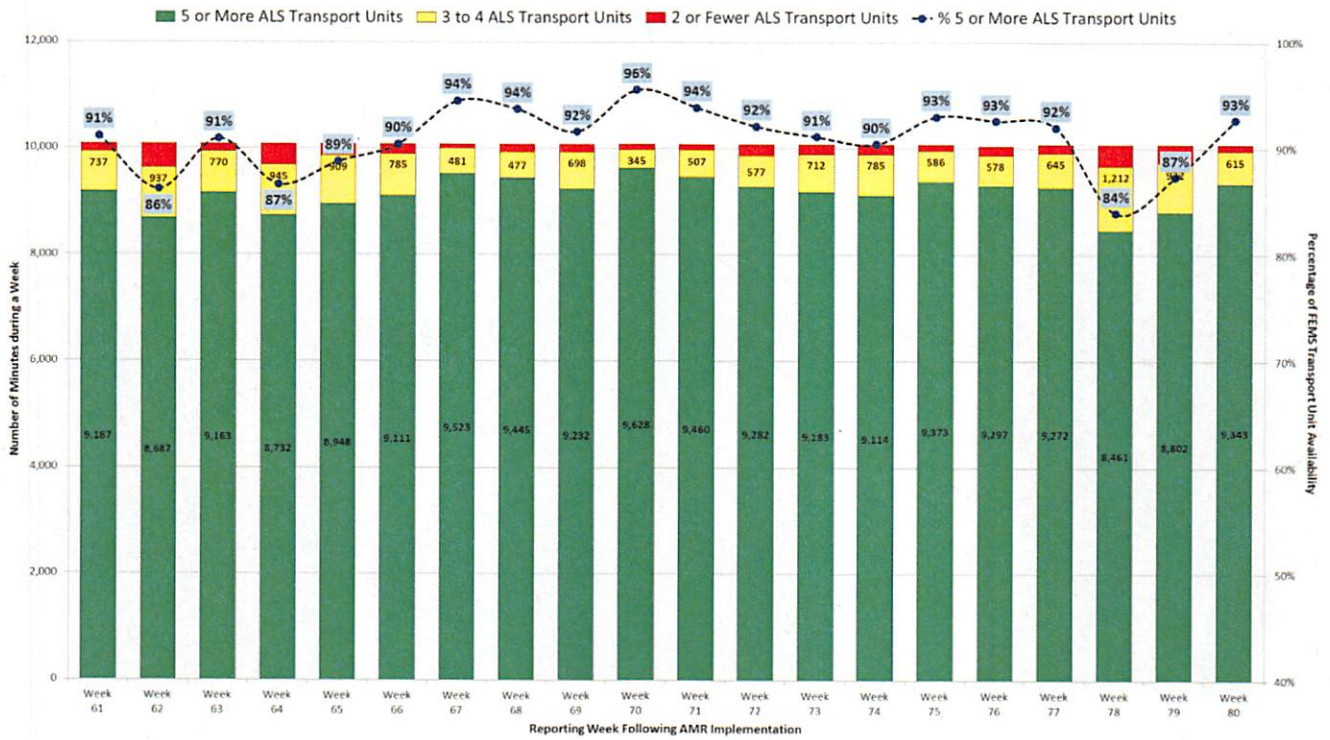
FEMS ALS Transport Unit Availability (by Minutes of the Day During the Week)

01/02/2017 (Week 41) to 05/22/2017 (Week 60) Following AMR Implementation



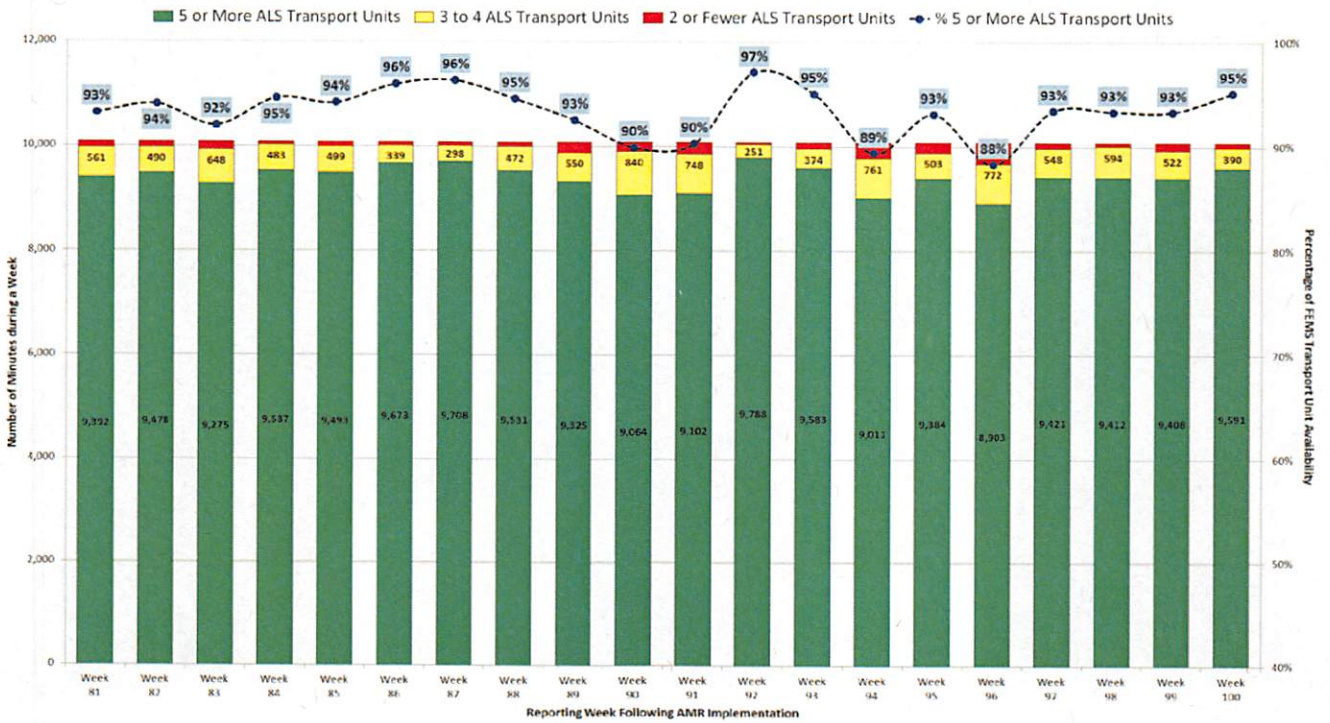
FEMS ALS Transport Unit Availability (by Minutes of the Day During the Week)

05/22/2017 (Week 61) to 10/09/2017 (Week 80) Following AMR Implementation



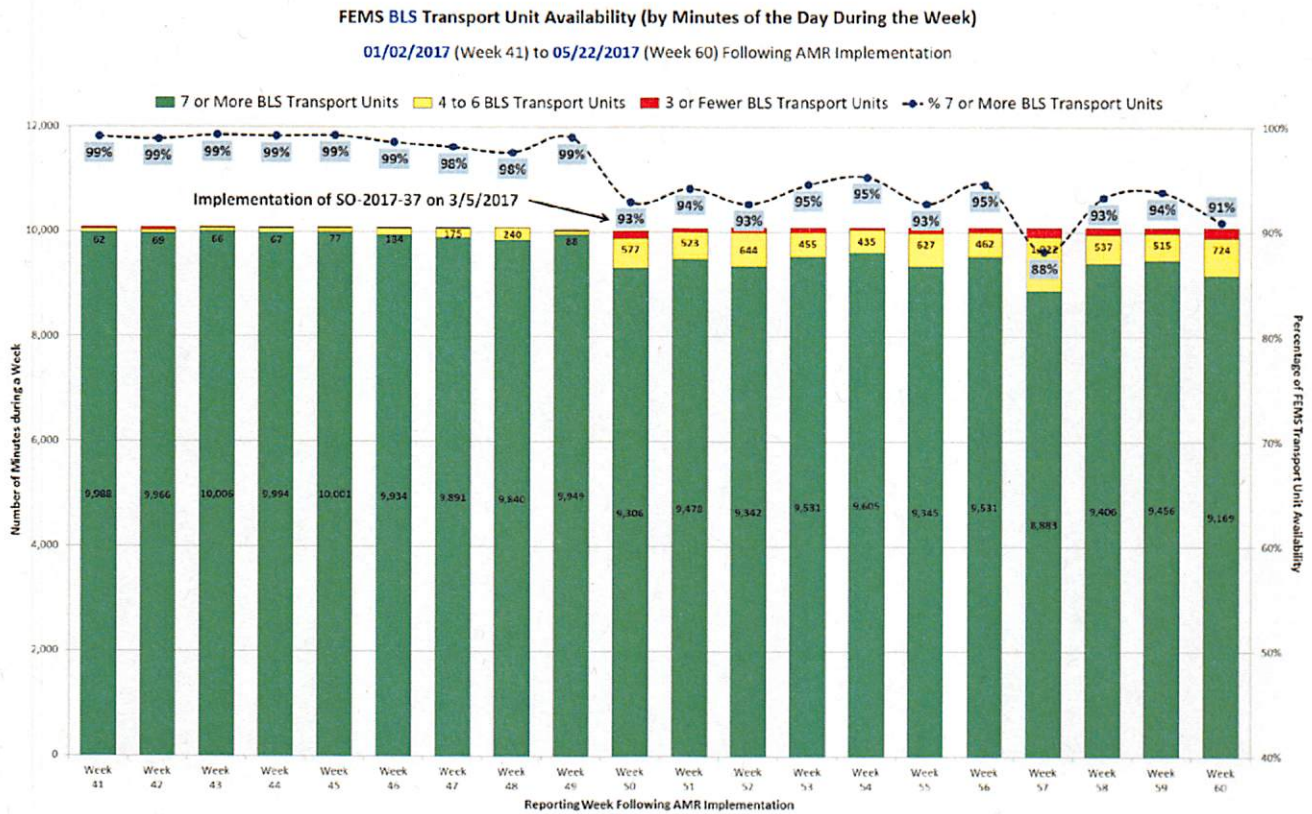
FEMS ALS Transport Unit Availability (by Minutes of the Day During the Week)

10/09/2017 (Week 81) to 02/26/2018 (Week 100) Following AMR Implementation



The following data show the impact of the conversion of three BLS units to Medic Units on BLS unit availability. After the conversion of the three BLS units in March 2017, BLS unit availability dipped in the following weeks but stabilized after implementation, and remained over ninety percent for all units throughout the summer. It rebounded back to pre-March levels in the latter part of 2017.

While BLS unit availability decreased slightly in the spring of 2017, overall unit availability remained strong, while our unit availability for our most critical patients improved.



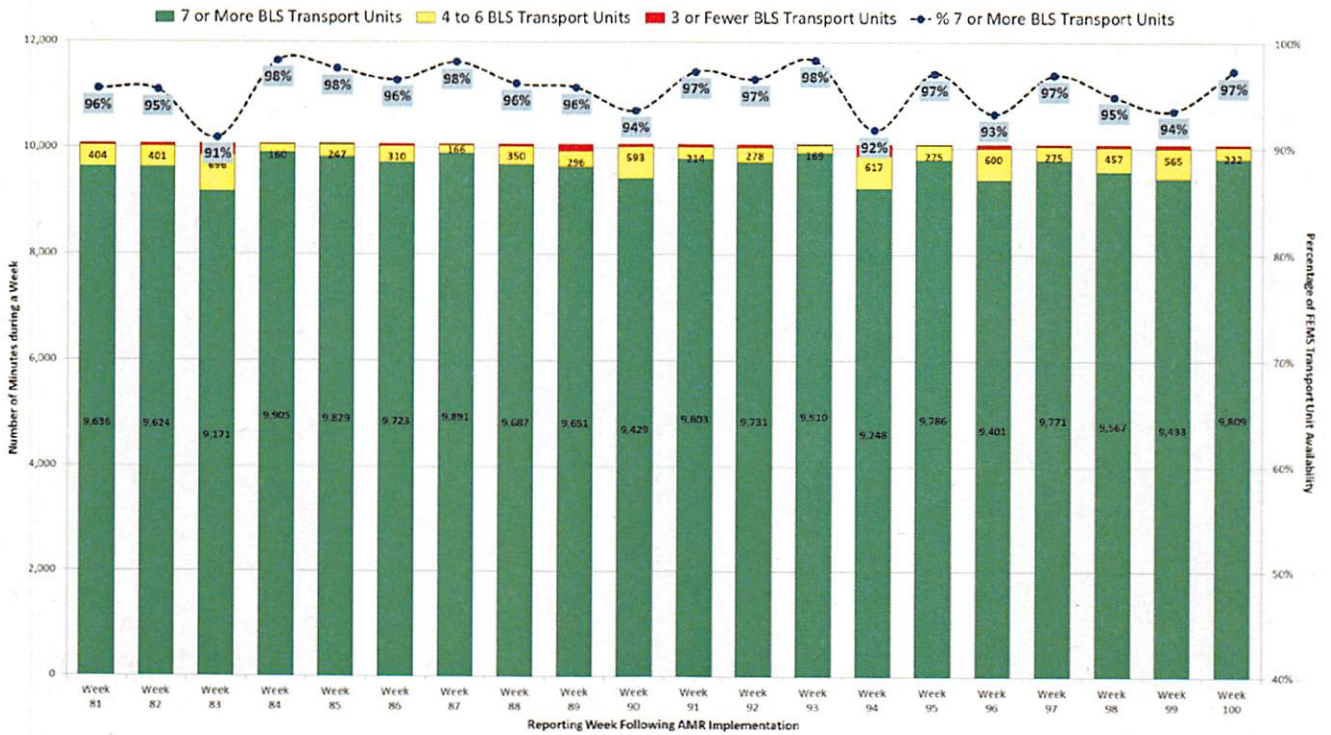
FEMS BLS Transport Unit Availability (by Minutes of the Day During the Week)

05/22/2017 (Week 61) to 10/09/2017 (Week 80) Following AMR Implementation



FEMS BLS Transport Unit Availability (by Minutes of the Day During the Week)

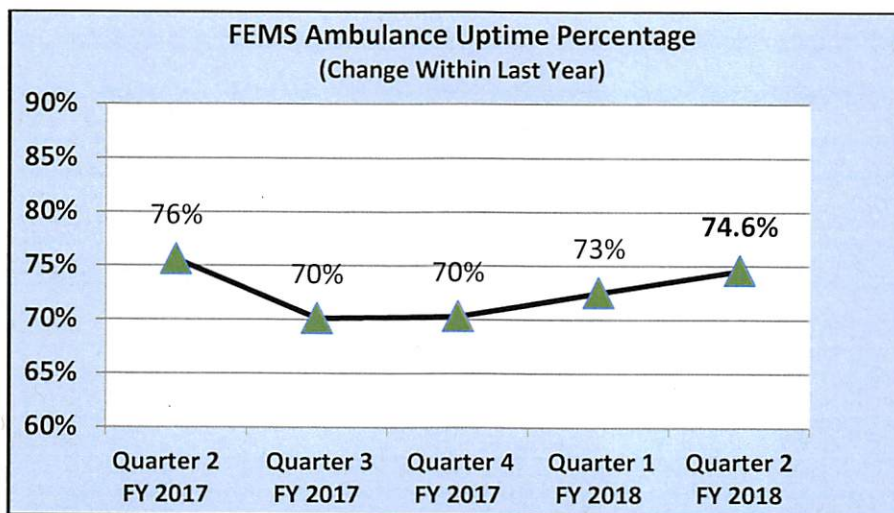
10/09/2017 (Week 81) to 02/26/2018 (Week 100) Following AMR Implementation



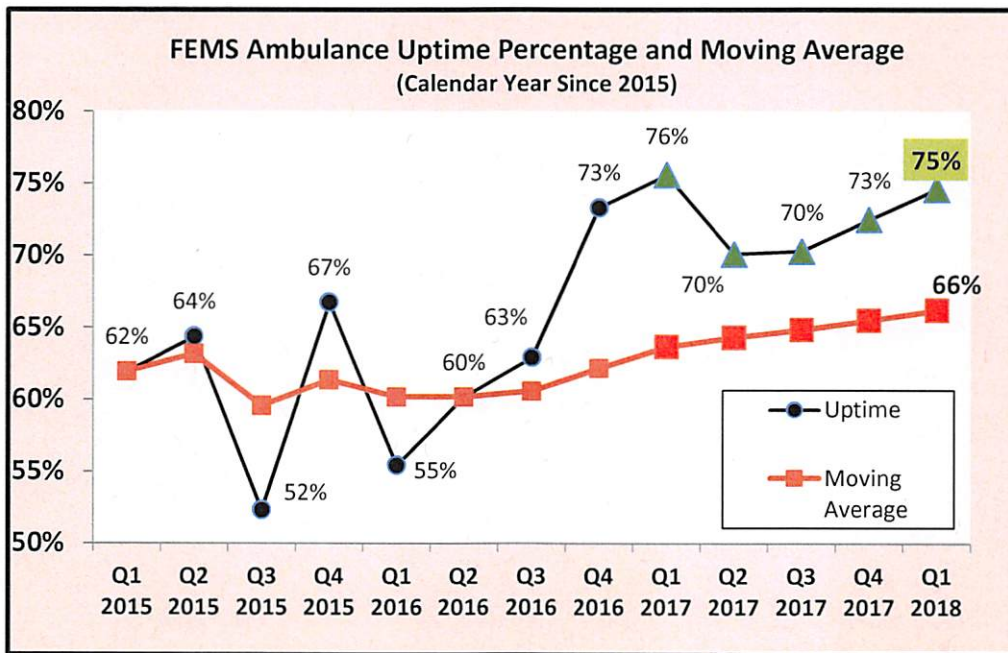
(2) The impact on the Department's fleet, including the ability to conduct preventative maintenance and the number of operational and reserve units available.

The launch of the AMR contract, as well as the addition of new ambulances to our Department's fleet, has had a positive impact on the Department's ability to conduct preventative maintenance. In addition, the AMR contract has led to an increase in the number of operational and reserve units available. We are now able to maintain a pragmatic repair and maintenance schedule for ambulances that also allows time for mechanics to participate in critical training and testing.

As the chart below shows, we have maintained an improved ambulance "up time" percentage during year two of the contract. We reached our target of 75 percent in Quarter 2 of FY 2018, similar to last year:



Our ambulance uptime percentage and moving average over the past 3 years to date clearly shows the Department is making steady progress. See chart, below:



The Department's total ambulance fleet stands at 96. Forty ambulances are designated as "frontline" units and 56 are designated as "reserve" units. Twenty of the 56 reserve units are used for the many special events that the District hosts throughout the year and for emergency mobilization operation plans. This high level of reserve units has allowed the Department to keep our fleet in good condition because we can take frontline units out of service to do regular preventive maintenance.

We have not yet met our uptime goal for fire engines and ladder trucks; however, in FY 2017, we achieved some progress with improving availability. As we receive new engines and ladder trucks, uptime should improve for these vehicles. At the time of writing, we have received one refurbished and 13 new fire engines in CY 2018 and will receive five more, as well as one new ladder truck, by the end of the calendar year.

(3) The impact on the Department's training schedule.

The Department continues to prioritize both the quality of instruction and maximizing the quantity of training hours in all disciplines for members. During the second year of the AMR contract, the Department continued to deliver the types of EMS training reported on in last year's report, including regular modular recertification training, Paramedic Grand Rounds, and partnerships with universities and other outside organizations, including the National Fire Academy. In July 2018, the Department delivered hands-on skills training to all of our ALS providers, in partnership with The George Washington University. This training included instruction on IO humeral head placement, cricothyrotomy, needle decompression, and endotracheal intubation.

This fiscal year, the Department also developed a comprehensive annual training calendar with detailed monthly schedules. See below for a list of classes that have been held and are going to be held moving forward in calendar year 2018:

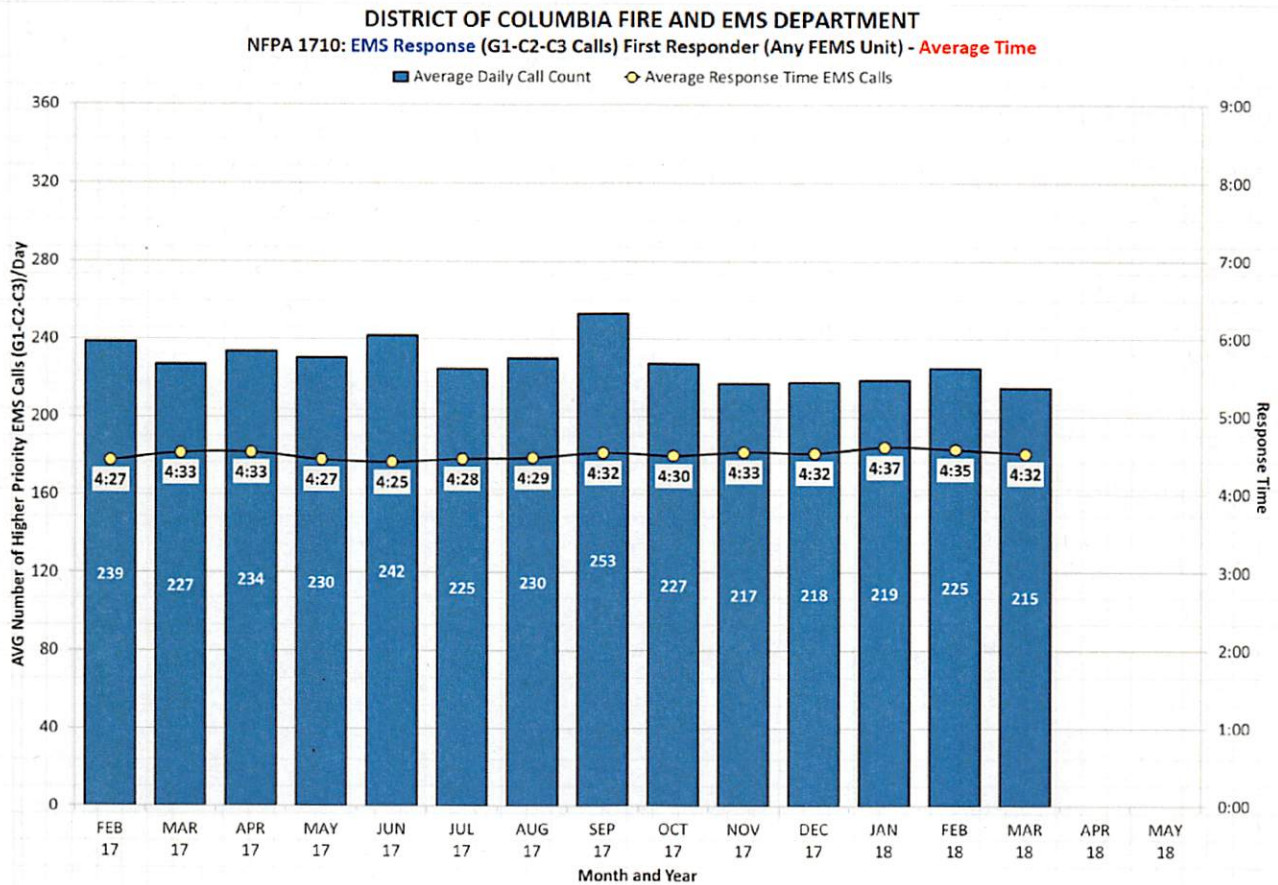
JANUARY
EMS Module Make-Ups
ICS/SOG Training
Fire Officer II Course (MFRI)
Fire Officer III Course (MFRI)
O2X Human Performance Workshop
FEBRUARY
Supervisor II Course
Supervisor II Course
1403 Live Burn Training
1403 Live Burn Training
Supervisor I Course
Pediatric Education for Prehospital Professionals
Pediatric Education for Prehospital Professionals
Pediatric Education for Prehospital Professionals
Paramedic Grand Rounds: Pediatrics
Advanced Cardiac Life Support (ACLS) - GW
MARCH
Paramedic Grand Rounds: Pediatrics
Pediatric Advanced Life Support (PALS) - CNMC
Supervisor II Course
NFA - Emergency Response to Terrorism
1403 Live Burn Training
Pediatric Education for Prehospital Professionals
Geriatric Education for EMS (GEMS)
1403 Live Burn Training
Instructor I Course
NIMS ICS 300 and 400
Advanced Cardiac Life Support (ACLS) - GW
Pediatric Advanced Life Support (PALS) - CNMC
Instructor II Course
1403 Live Burn Training
Emergency Boat Operations and Rescue Course
1403 Live Burn Training
Advanced Cardiac Life Support (ACLS) - GW
APRIL
NIMS ICS 300 and 400
Pediatric Advanced Life Support (PALS) - CNMC

Vehicle and Machinery Rescue Course
MSHA Tunnel Rescue Recertification Class
Engine Company Operations
Infectious Disease Outbreaks
Metro Tunnel Drill - Phase I
MSHA Tunnel Rescue Course
Metro Tunnel Drill - Phase I
Pediatric Advanced Life Support (PALS) - CNMC
Instructor II Course
Human Relations Sexual Harassment Prevention
Metro Tunnel Drill - Phase I
Supervisor I Course
MAY
Pediatric Advanced Life Support (PALS) - CNMC
O2X Human Performance Workshop
Human Relations Sexual Harassment Prevention
Engine Company Operations
Metro Tunnel Drill - Phase I
NFA - Leadership and Supervision
Metro Tunnel Drill - Phase I
Swift water Rescue Course
Metro Tunnel Drill - Phase I
Marine Firefighting Course
Pediatric Advanced Life Support (PALS) - CNMC
Metro Tunnel Drill - Phase I
EMS Module 8
Metro Tunnel Drill - Phase I
JUNE
Supervisor II Course
Engine Company Operations
Infectious Disease Outbreaks
Metro Tunnel Drill - Phase I
Vehicle and Machinery Rescue Course
Metro Tunnel Drill - Phase I
Instructor I Course
Metro Tunnel Drill - Phase I
Trench Rescue Course
Metro Tunnel Drill - Phase I
JULY
Engine Company Operations
Metro Tunnel Drill - Phase I

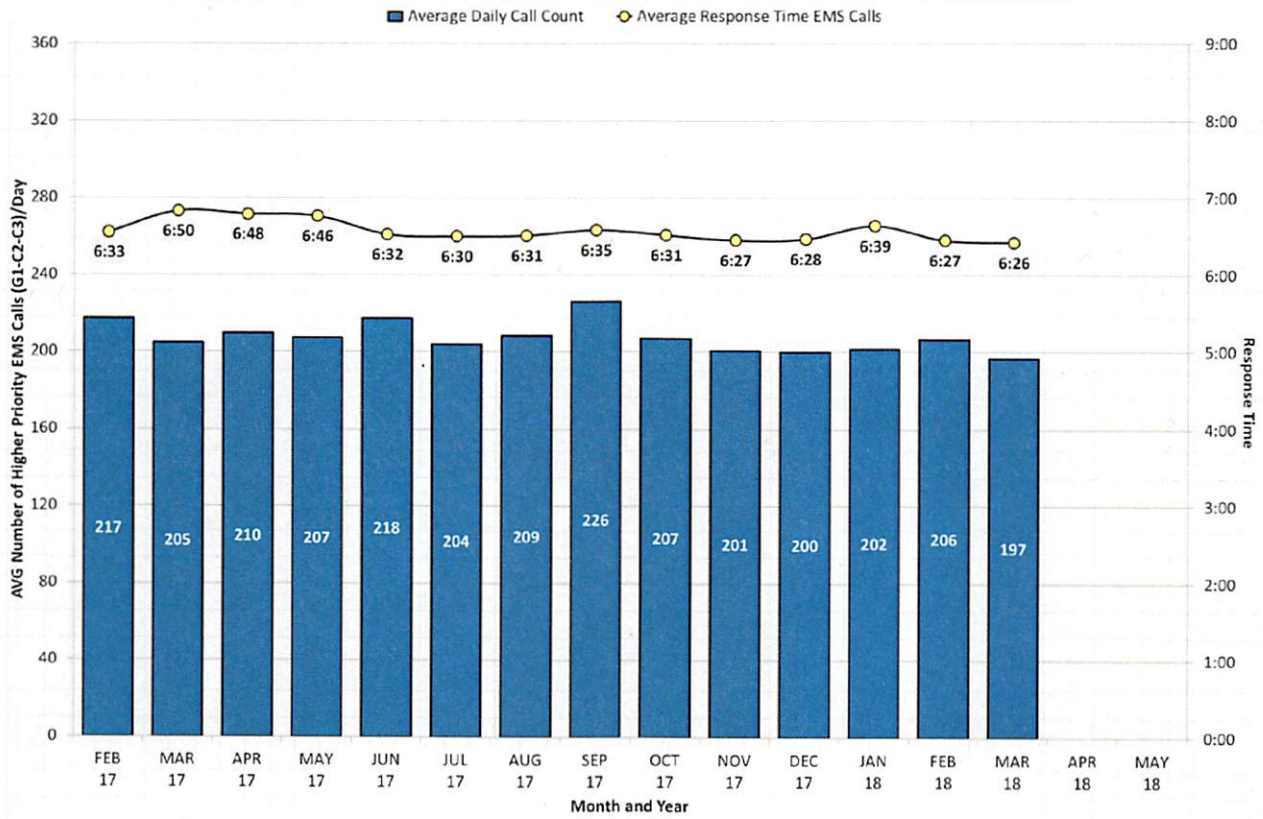
Metro Tunnel Drill - Phase I
Swift water Rescue Course
EMS Module 9
NFA- Leadership Thru Difficult Conversation
NIMS ICS 300 and 400
AUGUST
Arson Investigation (Continuing Education)
Engine Company Operations
Supervisor II Course
Vehicle and Machinery Rescue Course
Rope Rescue Course
Infectious Disease Outbreaks
SEPTEMBER
Supervisor I Course
Confined Space Rescue Course
Emergency Boat Operations and Rescue Course
Multi-Company Firefighting Evolutions
Instructor I Course
Emergency Boat Operations and Rescue Course
OCTOBER
Structural Collapse Rescue Course
Multi-Company Firefighter Evolutions
Infectious Disease Outbreaks
Hazardous Materials Technician Course
MSHA Tunnel Rescue Recertification
MSHA Tunnel Rescue Course
Incident Safety Officer Course
Supervisor I Course
NOVEMBER
Multi-Company Firefighter Evolutions
Aircraft Firefighting and Rescue Course
EMS Module 10
Instructor I Course
Health and Safety Officer Course
DECEMBER
Supervisor II Course
EMS Module 10

(4) (A) The impact on the Department's response times.

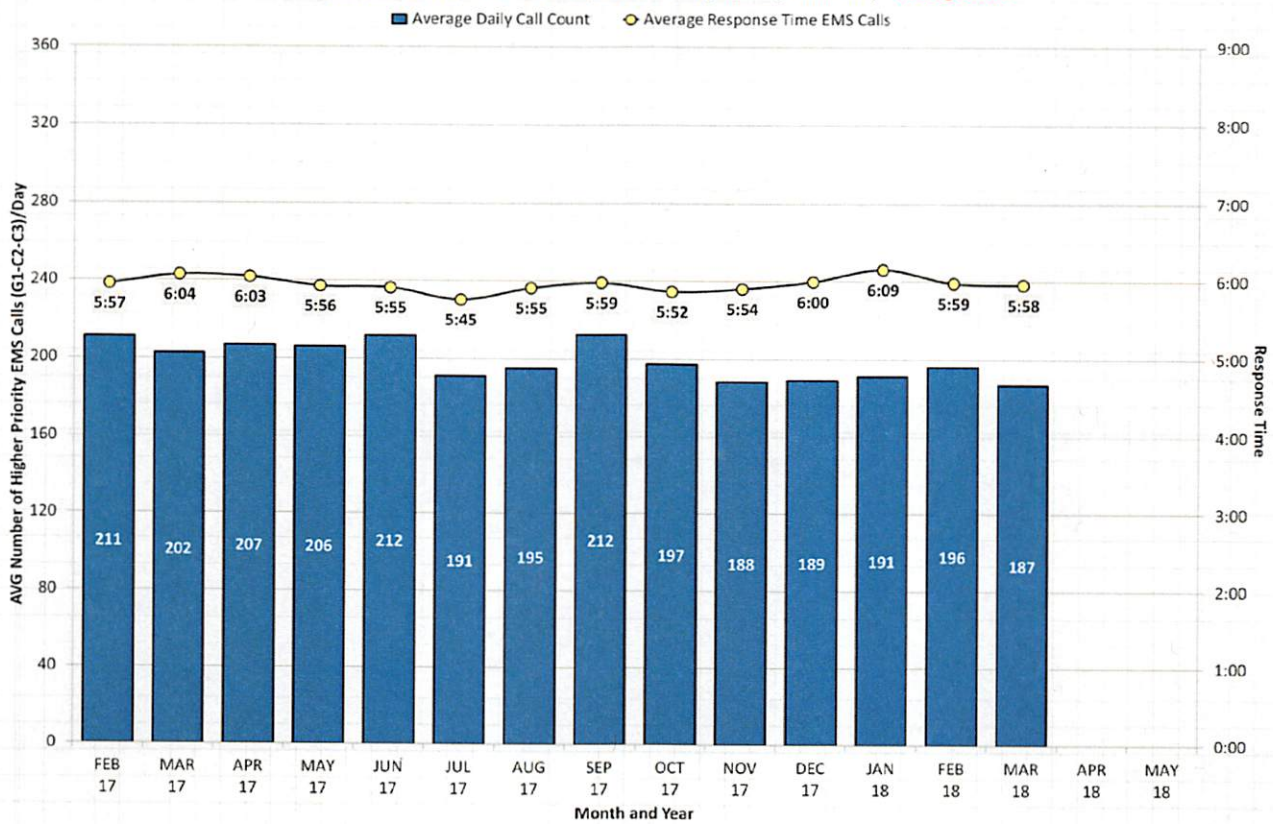
Since launching just over two years ago, the AMR contract has improved the response time of the Department's ambulances. Prior to implementation, average response of the first arriving FEMS transport unit to higher priority (ALS) EMS calls exceeded seven minutes. After implementation, average response times for FEMS transport units were reduced by almost one minute. See the following charts for updated EMS response time data for the period between February 1, 2017 through March 31, 2018. This data complies with National Fire Protection Association (NFPA) Standard 1710 for response time performance.



DISTRICT OF COLUMBIA FIRE AND EMS DEPARTMENT
FEMS: EMS Response (G1-C2-C3 Calls) First Transport Unit (Ambulance or Medic Unit) - Average Time

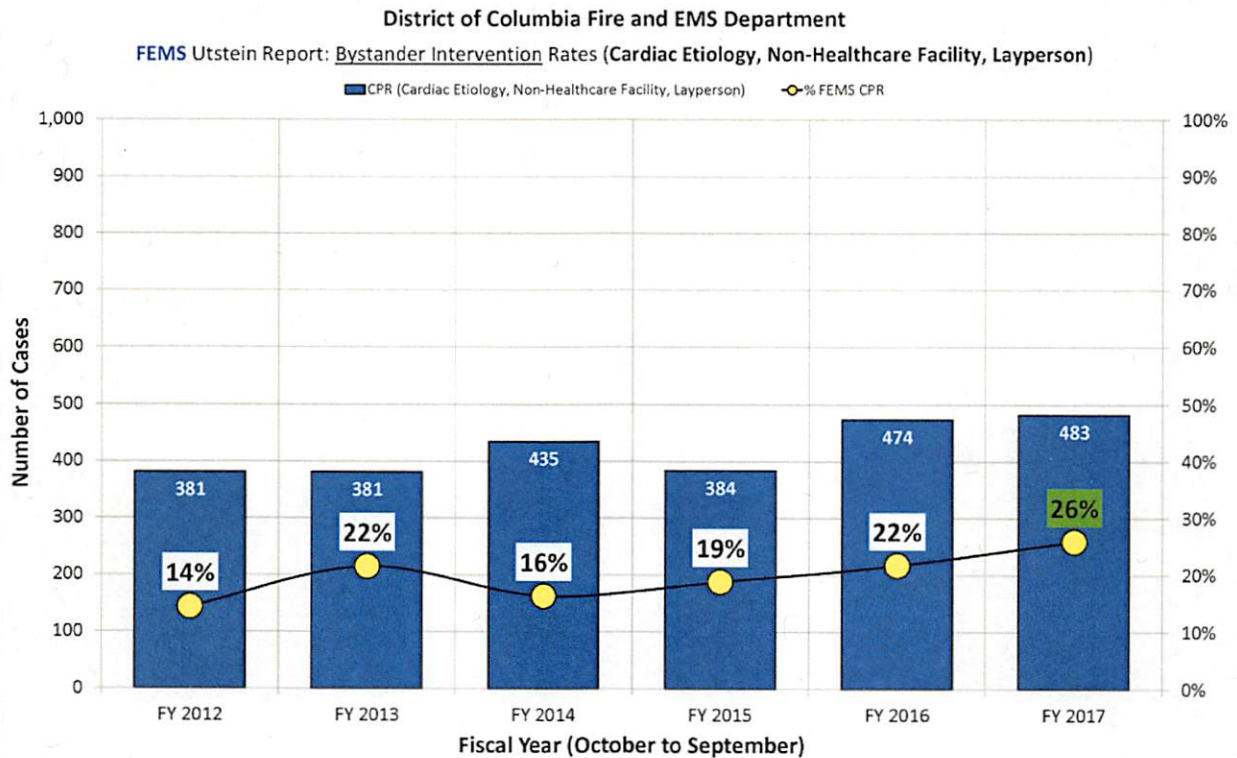


DISTRICT OF COLUMBIA FIRE AND EMS DEPARTMENT
FEMS: EMS Response (G1-C2-C3 Calls) First ALS Responder (Paramedic) - Average Time

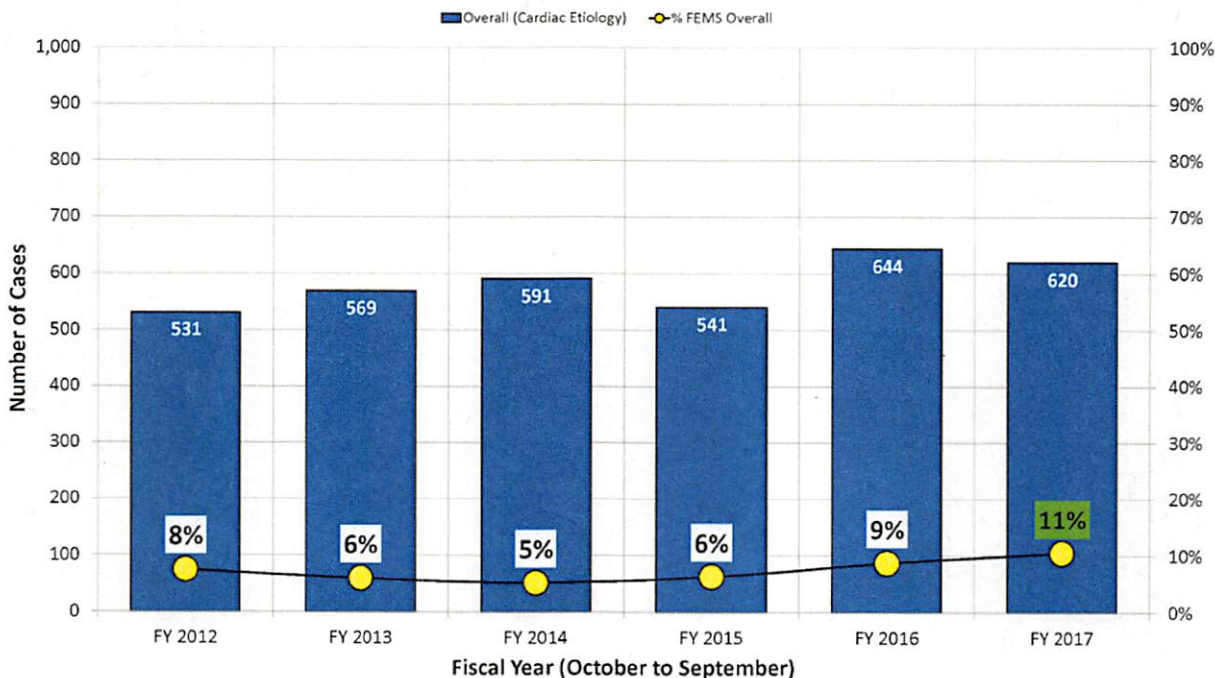


(4) (B) The impact on the Department's quality of patient care.

As detailed below, the Department continues to see progress in the area of patient care quality. Our cardiac arrest survival rates have increased for the fourth year in a row. The District is now at or above the national average in five out of seven Utstein categories, tracked by the national Cardiac Arrest Registry to Enhance Survival (CARES) database. The following two charts show that as our rate of cases where a bystander conducts CPR on a cardiac arrest patient has increased, so has our overall survival rate for cardiac arrest with cardiac etiology.



District of Columbia Fire and EMS Department
FEMS Utstein Report: Cardiac Arrest Survival Rates (Cardiac Etiology)



The Department's Utstein cardiac survival rate (patients surviving non-traumatic cardiac arrests witnessed by bystander and found in a shockable rhythm) decreased from 29.8 percent during 2016 to 28.9 percent in 2017. At the same time, the national survival rate for the same measure decreased from 33.4 percent to 29.9 percent.

The Department's Utstein Bystander cardiac arrest survival measure (patients surviving non-traumatic cardiac arrests witnessed by bystander, found in a shockable rhythm, and receiving bystander CPR and/or AED use) increased from 25.8 percent during 2016 to 42.1 percent in 2017, while the national survival rate for the same measure decreased from 37.6 percent to 33.4 percent.

Since October 1, 2015, we have trained over 45,000 individuals in CPR. We are putting AEDs in every school in the District of Columbia and we launched two initiatives – *Pulse Point* and the *Atrus* AED locator system – which will allow more civilian bystander first responders to know the location of cardiac arrest victims and AEDs. In addition, we have continued our focus on regular, high quality EMS training for our employees, including training in high performance CPR. We believe that these efforts, as well as the other operational improvements outlined in this report, are contributing to the positive trend in our cardiac arrest survival data.

See table below for details:

Measure	FY 2016	FY 2017
Overall (Cardiac Etiology)	8.70%	10.80%
Bystander Witnessed (Cardiac Etiology)	14.30%	18.10%
Unwitnessed (Cardiac Etiology)	3.90%	4.80%
Utstein (Cardiac Etiology, Bystander Witnessed, VF/VT)	29.80%	28.90%

Utstein Bystander (Cardiac Etiology, Bystander Witnessed, with CPR, VF/VT)	25.80%	42.10%
CPR (Cardiac Etiology, Non-Healthcare Facility, Layperson)	21.70%	25.90%
Public AED Use (Cardiac Etiology, Public Location, Layperson)	10.90%	8.80%

As we mentioned in our previous report, the Department also measures patient care through our Continuous Quality Improvement (CQI) Key Performance Indicator (KPI) measures. These KPIs review suspected STEMI (ST-segment elevation myocardial infarction, commonly known as a heart attack), stroke, and trauma cases to examine whether all of the required patient treatment elements were completed by FEMS personnel, the percentage of required patient treatment elements completed by FEMS personnel, and the overall completion rate for all required elements (combined).

The following tables summarize the latest CQI KPI results for FY 2016, FY 2017, and for the first and second quarter of FY 2018.

STEMI Patient Cases

STEMI (FY 2016) Measure	Q1 FY 2016	Q2 FY 2016	Q3 FY 2016	Q4 FY 2016	FYE 2016
Number of Identified STEMI Cases Reviewed	20	26	27	12	85
Aspirin Appropriately Administered	20	24	27	11	82
12 Lead EKG Completed	20	24	26	9	79
Patient Transport to STEMI Center	19	24	27	12	82
% Aspirin Appropriately Administered	100%	92%	100%	92%	96%
% 12 Lead EKG Completed	100%	92%	96%	75%	93%
% Patient Transport to STEMI Center	95%	92%	100%	100%	96%
Number of Required Elements	60	78	81	36	255
Number of Completed Required Elements	59	72	80	32	243
% Completed Required Elements	98%	92%	99%	89%	95%

STEMI (FY 2017) Measure	Q1 FY 2017	Q2 FY 2017	Q3 FY 2017	Q4 FY 2017	FYE 2017
Number of Identified STEMI Cases Reviewed	17	16	37	44	114
Aspirin Appropriately Administered	17	15	37	44	113
12 Lead EKG Completed	17	16	37	44	114
Patient Transport to STEMI Center	17	16	37	44	114
% Aspirin Appropriately Administered	100%	94%	100%	100%	99%
% 12 Lead EKG Completed	100%	100%	100%	100%	100%
% Patient Transport to STEMI Center	100%	100%	100%	100%	100%
Number of Required Elements	51	48	111	132	342
Number of Completed Required Elements	51	47	111	132	341
% Completed Required Elements	100%	98%	100%	100%	100%

STEMI (FY 2018) Measure	Q1 FY 2018	Q2 FY 2018	Q3 FY 2018	Q4 FY 2018	FYE 2018
Number of Identified STEMI Cases Reviewed	46	56			102
Aspirin Appropriately Administered	46	56			102
12 Lead EKG Completed	46	56			102
Patient Transport to STEMI Center	46	56			102
% Aspirin Appropriately Administered	100%	100%			100%
% 12 Lead EKG Completed	100%	100%			100%
% Patient Transport to STEMI Center	100%	100%			100%
Number of Required Elements	138	168			306
Number of Completed Required Elements	138	168			306
% Completed Required Elements	100%	100%			100%

Stroke Patient Cases

Stroke (FY 2016) Measure	Q1 FY 2016	Q2 FY 2016	Q3 FY 2016	Q4 FY 2016	FYE 2016
Number of Identified Stroke Cases Reviewed	189	208	196	205	798
Stroke Screening Exam Completed	189	206	195	199	789
BGL Obtained and Recorded	189	207	194	201	791
Patient Transport to Stroke Center	189	208	196	201	794
% Stroke Screening Completed	100%	99%	99%	97%	99%
% BGL Obtained and Recorded	100%	100%	99%	98%	99%
% Patient Transport to Stroke Center	100%	100%	100%	98%	99%
Number of Required Elements	567	624	588	615	2,394
Number of Completed Required Elements	567	621	585	601	2,374
% Completed Required Elements	100%	100%	99%	98%	99%

Stroke (FY 2017) Measure	Q1 FY 2017	Q2 FY 2017	Q3 FY 2017	Q4 FY 2017	FYE 2017
Number of Identified Stroke Cases Reviewed	175	186	130	167	658
Stroke Screening Exam Completed	174	185	115	167	641
BGL Obtained and Recorded	172	182	126	167	647
Patient Transport to Stroke Center	152	178	123	167	620
% Stroke Screening Completed	99%	99%	88%	100%	97%
% BGL Obtained and Recorded	98%	98%	97%	100%	98%
% Patient Transport to Stroke Center	87%	96%	95%	100%	94%
Number of Required Elements	525	558	390	501	1,974
Number of Completed Required Elements	498	545	364	501	1,908
% Completed Required Elements	95%	98%	93%	100%	97%

Stroke (FY 2018) Measure	Q1 FY 2018	Q2 FY 2018	Q3 FY 2018	Q4 FY 2018	FYE 2018
Number of Identified Stroke Cases Reviewed	161	153			314
Stroke Screening Exam Completed	161	153			314

BGL Obtained and Recorded	161	152			313
Patient Transport to Stroke Center	161	153			314
% Stroke Screening Completed	100%	100%			100%
% BGL Obtained and Recorded	100%	99%			100%
% Patient Transport to Stroke Center	100%	100%			100%
Number of Required Elements	483	459			942
Number of Completed Required Elements	483	458			941
% Completed Required Elements	100%	100%			100%

Trauma Patient Cases

Trauma (FY 2016) Measure	Q1 FY 2016	Q2 FY 2016	Q3 FY 2016	Q4 FY 2016	FYE 2016
Number of Identified Trauma Cases Reviewed	N/A	111	141	140	392
Primary Trauma Assessment Exam Completed	N/A	104	141	139	384
Patient Transport to Trauma Center	N/A	77	111	105	293
% Trauma Assessment Completed	N/A	94%	100%	99%	98%
% Patient Transport to Trauma Center	N/A	69%	79%	75%	75%
Number of Required Elements	N/A	222	282	280	784
Number of Completed Required Elements	N/A	181	252	244	677
% Completed Required Elements	N/A	82%	89%	87%	86%

Trauma (FY 2017) Measure	Q1 FY 2017	Q2 FY 2017	Q3 FY 2017	Q4 FY 2017	FYE 2017
Number of Identified Trauma Cases Reviewed	88	99	99	104	390
Trauma Assessment Exam Completed	87	93	98	104	382
Appropriate Incident Scene Time for Case	54	35	48	60	197
Patient Transport to Trauma Center	88	93	99	104	384
% Trauma Assessment Completed	99%	94%	99%	100%	98%
% Appropriate Incident Scene Time	61%	35%	48%	58%	51%
% Patient Transport to Trauma Center	100%	94%	100%	100%	98%
Number of Required Elements	264	297	297	312	1,170
Number of Completed Required Elements	229	221	245	268	963
% Completed Required Elements	87%	74%	82%	86%	82%

Trauma (FY 2018) Measure	Q1 FY 2018	Q2 FY 2018	Q3 FY 2018	Q4 FY 2018	FYE 2018
Number of Identified Trauma Cases Reviewed	103	94			197
Trauma Assessment Exam Completed	103	94			197
Appropriate Incident Scene Time for Case	52	52			104
Patient Transport to Trauma Center	103	94			197
% Trauma Assessment Completed	100%	100%			100%
% Appropriate Incident Scene Time	50%	55%			53%
% Patient Transport to Trauma Center	100%	100%			100%
Number of Required Elements	309	282			591

Number of Completed Required Elements	258	240			498
% Completed Required Elements	83%	85%			84%

Through our participation in the Chesapeake Regional Information System for Patients (CRISP), the Department has started to collect data from District hospitals on cases beyond those reviewed in the above categories, which will provide a more comprehensive view of patient outcomes. This will, in turn, inform our evaluation of patient care and our training.

(5) An assessment of the number of units, the number of personnel, the amount of training, and associated costs required to provide pre-hospital medical care and transportation without the use of third parties.

The Department estimates the cost of providing pre-hospital medical care and transportation without the use of a third party to be approximately \$30 million. This would ultimately include the cost of adding 25 additional ambulances to the Department’s fleet and 282 additional employees. Building this capacity would take approximately three to five years. This takes only the initial investment of personnel and equipment into consideration, and does not include the additional estimated expenditures of vehicle maintenance, equipment maintenance, and fuel. In addition, the Department would incur additional costs while engaging in the process of building apparatus capacity, and limitations in capacity for training and hiring.

(6) Recommendations for implementing any additional units, personnel, and training.

At this time, the Department does not recommend providing in-house the same service that AMR provides. First, providing the service through AMR is much more cost efficient, with the expenditure of \$12 million on the AMR contract versus the potential expenditure of approximately \$30 million for doing so in-house.

Second, a significant percentage of calls handled by AMR are for non-emergency medical problems that would be better addressed through non-emergency health care services. The Department launched the *Right Care, Right Now* Nurse Triage Line on April 19, 2018 to begin to address this challenge. We need to monitor the full implementation of this initiative before we re-assess this question and determine the proper level of funding for responding to our call volume.

Finally, before the Department can consider increasing our daily staffing, we recommend fully funding what is required to staff our apparatus on a daily basis. The Department is on track to implement the Mayor’s FY 2018 budget enhancement of hiring 48 new operational positions above attrition. This is the first step in putting the Department on the path to fully budget every operational position to the Department’s staffing factor and will help ensure that there are a sufficient number of employees to cover every seat on every unit on every shift, and put the Department on the path to reduced overtime spending. This should be done before contemplating a significant increase in daily staffing.

(7) Conclusion

The second year of the AMR contract has supported the Department’s efforts to improve the delivery of pre-hospital medical care to the visitors and residents of the District. We look forward to working with AMR, the OUC, our employees, our two labor unions, Mayor Bowser, the Council, and the community to continue to build on this progress.



OFFICE OF THE
SECRETARY
2019 FEB -4 PM 3:41

MURIEL BOWSER
MAYOR

FEB 4 2019

The Honorable Phil Mendelson
Chairman, Council of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Avenue, NW, Suite 504
Washington, DC 20004

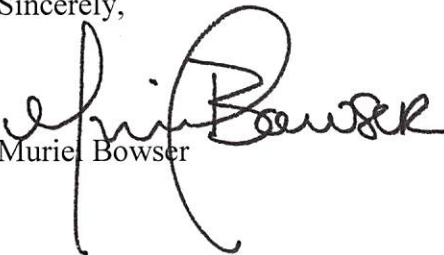
Dear Chairman Mendelson:

Enclosed for Council review, please find the "Emergency Medical Services Transport Contract Authority Bi-Annual Report (April – September 2018)" for the second and third quarters of Fiscal Year 2018.

Under D.C. Code § 5-401, the Fire and Emergency Medical Services Department (FEMS) may contract with third parties to provide supplemental pre-hospital medical care and transportation to persons requiring Basic Life Support. FEMS and the Office of Unified Communications are required under the statute to provide a bi-annual report to the Council regarding third party contractor operations. Further, each third-party contractor that enters into a contract pursuant to this authority is required to provide a report to the Department and to the Council regarding the contractor's operations.

If you have any questions, please contact Amy C. Mauro, Esq., Fire and Emergency Medical Services, at 202-673-3320 or Kelly Brown, Office of Unified Communications, at 202-730-0524.

Sincerely,


Muriel Bowser

GOVERNMENT OF THE DISTRICT OF COLUMBIA

The Honorable Muriel Bowser, Mayor



Emergency Medical Services Transport Contract Authority **Bi-Annual Report (April – September 2018)**

December 2018

As part of the “Fiscal Year 2017 Budget Support Act of 2016,” Mayor Bowser proposed and the Council approved the “Emergency Medical Services Transport Contract Authority Amendment Act of 2016.”

Under D.C. Code §5-401, the Fire and Emergency Medical Services Department (FEMS) or (“the Department”) may contract with third parties to provide supplemental pre-hospital medical care and transportation to persons requiring Basic Life Support (BLS). FEMS and the Office of Unified Communications (OUC) are required under the statute to provide bi-annual reports to the Council regarding third party contractor operations. Further, each third-party contractor that enters into a contract pursuant to this authority is required to provide a bi-annual report to FEMS and the Council regarding the contractor's operations (see attached).

The responses contained in this report are based on the best available data for the third and fourth quarters of Fiscal Year 2018.

If you have any questions, please contact Amy C. Mauro, Esq., Fire and Emergency Medical Services Department, at 202-673-3320 or Kelly Brown, Office of Unified Communications, at 202-730-0524.

A. Fire and Emergency Medical Services Department

- 1. Activity by the Department to educate the public on the proper use of emergency requests for service.*

The Right Care Right Now (RCRN) initiative was launched on April 19, 2018. Prior to and during the launch, various strategies were utilized to educate the public, and multiple media efforts were launched, including television, radio, newspaper, and social media interviews with Fire Chief Gregory M. Dean and Medical Director Dr. Robert Holman. Earned media included stories by WJLA News channel 7 (ABC), WTTG Fox 5 DC, WRC-TV News channel 4 (NBC), WDCW channel 50 TV Station, National Public Radio (NPR), American University Radio (WAMU), WTOP-FM Radio Station, PoPville, Current Newspapers, The



**RIGHT CARE
RIGHT NOW**

Kojo Nnamdi Show, and The Washington Post. Medical Director Dr. Robert Holman appeared in a September 23, 2018 Washington Post article (see Appendix A) to discuss the progress of the NTL system. The NTL nurses have gained experience over the months since the launch of the system and the efficiency of the triage has increased. Dr. Holman also mentioned that the Department is very pleased with the level of customer satisfaction demonstrated at the NTL and efforts are being made to increase the volume so more people can take advantage of the system. EMS patient satisfaction indicators are showing an overall percentage improvement of 2% over the last year, and a 6% increase in four years.

In addition, the Department continues its digital messaging campaign to high volume and low acuity 911 callers. The Department’s website has a variety of resources regarding the RCRN initiative, including:

- Frequently Asked Questions (including language access);
- Text 468311- Phone Alerts on RCRN;
- Informational flyer (includes information on "when and when not to Call 911" and list of participating clinics);
- Map of participating clinics;
- Public Service Announcement (PSA) from Chief Dean; and
- Press release information.

2. The number of employees hired after the contract award and their residency.

The Department hired a total of 43 Firefighter EMT’s and 13 Firefighter Paramedics between April 1 and September 30, 2018. For the residency of those hired, see table, below (*note the states of residency for the hires listed reflect their residency at the time of application only*):

Firefighter EMT	Firefighter Paramedic	Total Number	Place of Residency
34	1	35	District of Columbia
6	5	11	Maryland
1	2	3	Virginia
1	2	3	Pennsylvania
1	1	2	Delaware
0	1	1	South Carolina
0	1	1	Florida
43	13	56	

In addition to the above hires, Cadet Class 20 consisting of 17 cadets graduated in July 2018 and Cadet Class 21 began training in October 2018. Of the 17 cadets that graduated in Class 20, eight are women (47%) and nine are men (53%). 100% of the cadets are residents of DC.

3. Evaluation of pre-hospital medical care and transportation fees considering the reasonableness of the fees, the public interest, and the persons required to pay the fee.

The Department’s ambulance fees and charges are described by 29 DCMR 567.1 Such fees and charges have not changed, or otherwise been modified, since January 1, 2009.

4. *The number of ambulances added to the Department's frontline and reserve fleet after the date of the contract award, including whether added ambulances replace or supplement the current fleet.*

The Department received six new ambulances during the third and fourth quarters of FY 2018 to replace existing fleet units that were then placed into reserve. The Department places orders and receives ambulances on a regular replacement plan to ensure that the ambulance fleet is operational.

5. *The number of emergency medical services personnel training hours provided, including all pediatric training conducted pursuant to a memorandum of understanding between the Department and the pediatric training entity.*

During the third and fourth quarters of Fiscal Year 2018, the Department delivered a total of 41,020 EMS training hours (detailed in the table below).

Course Name	Number of Participants	Hours per Class	Total Hours
Advanced Cardiovascular Life Support (ACLS) Refresher	67	8	536
Advanced Medical Life Support	70	Variable	904
ALS Operations	25	125	3,125
Bob Page Advanced 12 Lead	24	8	192
BLS Operations	37	60	2,220
Emergency Medical Technician Course	44	307	13,508
LGBTQ Cultural Competency	31	2	62
Module 4: Altered Mental Status	54	4	216
Module 5: Wellness and Cardiac Arrest	60	4	240
Module 8: Changing Culture of Fire and EMS	1,317	4	5,268
Module 9: OB and Pediatric Emergencies	1,291	4	5,164
Paramedic Grand Rounds: Anatomy Lab	267	4	1,068
Paramedic Grand Rounds: Burn Care and CO	221	4	884
Pediatric Advanced Life Support (PALS)*	72	8	576
Pre Hospital Trauma Life Support (PHTLS)	37	16	592
ALS Specific Distance Learning	95	4	380
ALS/BLS Distance Learning Modules	1,217	Variable	6,085
<i>*Contracted with Children's National Medical Hospital</i>			41,020

6. *The average time that the Department's ambulances remained out of service while waiting to transfer the care of a patient to a healthcare company.*

"Drop Time," or the duration of time a Department ambulance spends at a hospital, is measured from the time an ambulance arrives at a hospital until the time it returns to service and is available for responding to other calls. Average "Drop Time" for all FEMS transport units combined (including Ambulances and Medic Units) is shown during FY 2018 (by month) in the table below:

Month (FY 18)	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
AVG Drop Time	42:02	41:45	42:08	41:43	41:29	41:03	41:12	41:11	41:41	41:55	41:49	43:37

7. *The number of patients who used the Department's transport services twice or more within the reporting period, including the number of times the patient used transport services during the previous 12 months.*

This data is reported using the best ambulance billing information available at the time of this report (for the reporting period of 9/1/2017 to 8/31/2018). During this period ambulance billing data indicated 104,611 patient transports were completed by FEMS and AMR ambulances. Of these transport cases, 102,223 involved patients that could be uniquely identified by full name and birthdate. The remaining 2,388 (or less than 3% of cases) could not be uniquely identified and were excluded from analysis. Because many high volume user (HVV) patients are often transported by both FEMS and AMR, the number of individual patients and transports reported separately in the FEMS and AMR tables (below) do not add up to the combined patients and transports reported in the uppermost table.

During the last twelve month period (September, 2017 to August, 2018), for patients transported two or more times, 14,241 (or 22%) of patients accounted for 51,171 (or 50%) of **all patient transports**:

# of Transports	# of Patients	% of Patients	# of Total Transports	% of Total Transports
1	51,052	78%	51,052	50%
2 or more	14,241	22%	51,171	50%
TOTAL	65,293	100%	102,223	100%

During the last twelve month period (September, 2017 to August, 2018), for patients transported two or more times, 6,578 (or 17%) of patients accounted for 20,072 (or 39%) of all patient transports completed by **FEMS ambulances**:

# of Transports	# of Patients	% of Patients	# of Total Transports	% of Total Transports
1	31,104	83%	31,104	61%
2 or more	6,578	17%	20,072	39%
TOTAL	37,682	100%	51,176	100%

During the last twelve month period (September, 2017 to August, 2018), for patients transported two or more times, 6,381 (or 18%) of patients accounted for 21,543 (or 42%) of all patient transports completed by **AMR ambulances**:

# of Transports	# of Patients	% of Patients	# of Total Transports	% of Total Transports
1	29,504	82%	29,504	58%
2 or more	6,381	18%	21,543	42%
TOTAL	35,885	100%	51,047	100%

B. Office of Unified Communications

1. *The number of calls dispatched and the average dispatch time.*

OUC Calls for Service and Dispatch Times			
	# of Calls Dispatched	Average Dispatch Times (seconds)	Average Call Processing + Dispatch Times (seconds)
Apr 2018	12,656	41	146
May 2018	13,731	47	142
Jun 2018	13,299	47	138
Jul 2018	15,082	48	137
Aug 2018	13,811	40	131
Sep 2018	15,092	51	137

2. *The average time within which the Department and the third-party contractor's ambulances reported arriving at a healthcare facility with a patient and returning to service.*

Average Hospital Offload Times (mm:ss)		
	DC FEMS	Third Party
Apr 2018	40:34	41:54
May 2018	40:32	43:23
Jun 2018	40:55	42:52
Jul 2018	41:05	43:10
Aug 2018	41:03	45:20
Sep 2018	42:47	45:37

3. *The protocol to reroute non-emergency calls.*

The OUC and FEMS continue to work together closely to engage the public on appropriate use of the 911 system. The OUC has also maintained its support of Dr. Robert Holman and the Integrated Healthcare Collaborative's efforts to connect 911 callers that have less serious and non-life-threatening injuries and conditions with primary care providers. One such initiative is FEMS's "Right Care, Right Now" under which the District's Nurse Triage Line (NTL) was launched on April 19, 2018.

In addition, OUC's Community Action Team used the significant media coverage of the NTL launch as a springboard in the continuation of its public education campaign activities that focus on the appropriate use of 911 services. The OUC is also working to initialize enhanced features of the SMART 911 program and meets regularly with target populations and focus groups to create a greater awareness of the benefits of registration in the program.

- 4. The average time between the on-scene arrival of the third-party contractor's ambulance and the time the third-party contractor is at the patient's side.*

The OUC is unable to provide data regarding the time difference between the arrival of the third party transport unit on the scene and its employee's arrival to the patient's side. This information is not captured in CAD but is captured by AMR and is included in AMR's quarterly report, which is attached.

Emergency Medical Services Transport Contract Authority
Bi-Annual Report (April – September 2018)

Appendix A

The Washington Post

“Nurses in D.C.’s 911 center are helping cut some unnecessary ambulance runs, but not most”

By Clarence Williams
September 23, 2018

Nurses in D.C.'s 911 center are helping cut some unnecessary ambulance runs, but not most

By Clarence Williams
September 23

D.C. Fire and EMS officials found positive signs in the first 90 days of a \$1 million nursing phone line at the 911 call center, but have yet to see big dividends in one of the program's intended goals: reducing ambulance trips for patients who don't need them.

D.C. Fire Chief Gregory Dean sent a letter to the department this month highlighting early data from the "Right Care, Right Now" program that staffs a triage line at the 911 center with registered nurses. The nurses are there to diagnose callers who appear to have nonlife-threatening maladies or injuries and may not need medics or a fire crew and a trip to the emergency room.

The fledgling program has been providing quick, private transportation for noncritical patients to clinics using a ride-share service, Dean's letter said, and 911 callers who were processed through the nurse gave uniformly positive reviews about their experience in follow-up surveys.

However, fire officials acknowledge that the program has not made a significant dent in the hundreds of calls they field daily that tie up EMTs, paramedics and ambulances with issues such as insect bites and toothaches.

"There is a habit or pattern that we need to change. A lot of time people are not familiar with getting to a clinic. They are just used to calling 911. That's not really what we wanted them to learn, but that's what they've learned," said Robert Holman, the D.C. Fire and EMS medical director. "We're trying to establish a new pattern."

The changes are also intended to offer better health-care options than an emergency room visit provides.

The triage program started in April, with nurses available on the 911 call line from 7 a.m. to 11 p.m. daily at a cost of \$1 million for salaries and a technology build-out.

In the first 90 days, Dean's letter showed, nearly half of all calls routed from a 911 dispatcher to the nurses still resulted in a D.C. fire unit being sent out because nurses sent the call back after hearing a caller describe their medical need.

As nurses grow more comfortable making decisions, the program could help redirect callers to less urgent but still appropriate medical options, Holman said.

"We are happy with the modest impact, but we would like to see this grow a bit more. I don't think our [department] members are feeling the effects of this just yet," in relieving first responders from tending to low-priority calls, he said.

Before the launch, officials had estimated that as many as 70 percent of their of the 911 medical runs involved patients with conditions that are not life-threatening emergencies.

The city's revitalization and expansion have not waned, which keeps emergency call volumes up and demands high on city emergency services even as the so-far-modest nurse triage program tries to relieve some of that pressure, said Dabney Hudson, president of the firefighter's labor union. "We've gained more calls through growth than they've gotten rid of with this," Hudson said. "We have a capacity issue."

Between the April 19 launch and late August, registered nurses fielded 1,103 calls to work through issues with 911 callers, who in their initial conversations described a seemingly not-urgent medical need.

Nurses can bounce back patients to a dispatcher if they decide an EMS or ambulance crew should respond. For the callers who need non-emergency medical care, the nurses will book an appointment with a primary-care doctor or clinic in the caller's neighborhood who can see them within two hours. The nurses will also send a Lyft driver to take Medicaid-covered patients to and from a doctor or clinic.

Of the 1,103 calls routed to nurses for questioning known as triaging, officials said that 130 patients were sent to clinics, 289 calls were canceled, and 131 calls received "self care," which includes nurses advising a caller to take prescribed medications to stabilize blood pressure or blood sugar levels or to buy over-the-counter ointments for other problems.

In the opening weeks, nurses "were over-triaging back to 911 and they were doing so with an abundance of caution," Holman said.

"I give feedback on every one of these calls," he added.

His feedback to nurses included instructions not to send ambulances for strains and pulled muscles in the lower back or migraines and headaches that did not indicate any other serious disorder like a spike in blood pressure.

Holman said that as nurses have gained experience and feedback, the calls resulting in emergency crews being dispatched has dropped from a weekly average of 33 in June to 15 by late August.

Hudson said he applauds the attempt to deal with call volume that cripples the department's efficiency and burdens the workforce. However, he said union officials warned the department that the nurse program might prove ineffective following interviews and research the union did about failed efforts in Philadelphia and Richmond.

"It's the same issue every other large city has run into that tried to implement this. The return on investment wasn't there," Hudson said. "They just sent a firetruck or an ambulance. Obviously that still doesn't solve our problem."

Transportation has been a significant success early on, Holman said, as officials report that on average it took 37 minutes from the time a patient spoke with a nurse to arrive at a clinic for a walk-in appointment. A non-emergency ambulance trip to the hospital, which would include a patient evaluation and processing, can take 40 to 60 minutes officials said, depending on the time of day and traffic.

Officials said nurses tried to call each patient to follow up on their treatment and to "review their customer service experience." During the first 90 days, officials said they received zero complaints and all 55 patients nurses contacted "provided positive feedback," the letter said.

Only one complaint arrived after the initial 90-day period, Holman said, and after reviewing that call he believes a nurse rightly refused a transport in August for a man with a sore throat.

"It's early but we're very pleased with our customer satisfaction," Holman said. "We think we've built a good system. We just want to increase the volume so more people can take advantage."

Destiny Banks was one of the early users.

A Lyft driver took her to the Unity clinic on Minnesota Avenue after she became lightheaded during a therapy session in the spring. Her therapist dialed 911 because Banks was pregnant, had a previous instance of passing out and suddenly could not finish sentences during the session.

She expected to hear sirens and see lights from an ambulance, but within about 15 minutes a Lyft driver arrived to take her to a clinic, which was initially disorienting for Banks.

"I was confused more than nervous. I was okay with it, it was just different," she recalled.

A clinic employee talked to her on site, and she was seen within about 20 minutes by medical personnel, much more quickly than in any previous emergency room situation, she said.

She was diagnosed as being dehydrated and sent home with instructions to drink more water.

Her daughter Avay'e was born Aug. 24, without issue.

The nurse triage and clinic referral "might be weird to other people, too. But I'm glad they put it into play. Not every time it's a dire emergency that you need an ambulance," Banks said. And getting to care "was really fast."



Clarence Williams

Clarence Williams is the night reporter for The Washington Post on the "night cops" beat, where he has spent nearly two decades chasing breaking news and writing in-depth, issues-based features about police, fire and rescue, and other public safety issues in and around Washington. [Follow](#)

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Emergency Medical Services Transport Contract Authority
Bi-Annual Report (April – September 2018)

Appendix B

American Medical Response, Inc.
Quarterly Performance Report



Biannual Performance Report

Provided To:

Council of the District of Columbia
and

DC Fire & Emergency Medical Services

April 1-September 30, 2018

Transports Performed

- * **24,947** patient transports were performed by American Medical Response (AMR) from April 1st through September 30th of 2018.
- * AMR responded to a total of **29,556** requests for service during this period, averaging **162** requests daily.
- * Average Response Time by Month:

April: 9 minutes, 12 seconds	July: 9 minutes, 3 seconds
May: 9 minutes, 24 seconds	August: 8 minutes, 56 seconds
June: 9 minutes, 18 seconds	September: 9 minutes, 26 seconds
- * AMR met each patient at the location of the incident and transported to the closest available hospital, or as directed by DC FEMS.

Transports Performed

<u>Hospital Name</u>	<u>Transports</u>	<u>Drop Off Time</u>
Children's National Medical Center	1,089	33:06
United Medical Center	4,185	47:46
Howard University Hospital	3,397	51:10
Children's @ United Medical Center	531	36:13
George Washington Hospital	4,129	44:17
Georgetown Hospital	388	38:08
VA Medical Center	477	38:34
Sibley Hospital	781	37:14
Prince Georges Medical Center	10	49:04
Providence Hospital	3,659	45:52
Washington Adventist Hospital	12	44:22
Washington Hospital Center	6,294	40:05

Note: Drop off time is average time in minutes. Hospitals with less than 10 transports not represented.

Ambulance and Shift Information

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Current # of Shifts	30	38	35	35	35	40	33
# and Length of Shifts	6 – 8hr 9 - 9hr 4 - 10hr 8 - 12hr 3 – 18hr	10 – 8hr 10 - 9hr 3 - 10hr 12 - 12hr 3 – 18hr	10 – 8hr 9 - 9hr 4 - 10hr 12- 12hr	9 – 8hr 14 - 9hr 3 - 10hr 12 - 12hr 1- 14hr	8 – 8hr 14 - 9hr 3 - 10hr 9 - 12hr 1 – 14hr	8 – 8hr 16 - 9hr 3 - 10hr 9 -12hr 1- 14hr 3 -18hr	7 – 8hr 12 - 9hr 4 - 10hr 7 - 12hr 3- 18hr
Peak # of Ambulances Deployed	17	26	27	25	24	27	19

Average at Scene to At Patient Time*

* Approximate Times from Patient Care Reports

October	November	December
2:25	2:38	2:19

Personnel Data

- * **199** Total Persons Employed in the Division
- * **24%** are District Residents
- * **48%** are Women
- * **51%** Minority Represented