MURIEL BOWSER
MAYOR

JAN 29 2020

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:

On behalf of the Fire and Emergency Medical Services Department (FEMS), enclosed for Council review, please find the "Emergency Medical Services Transport Contract Authority Third Annual Report (April 2018 – March 2019)."

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, 2018 and March 31, 2019. In our first annual reports in 2017 and 2018, 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 third 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. The third year of the AMR contract has supported the efforts of FEMS to improve the delivery of pre-hospital medical care to the visitors and residents of the District. As the Department continues to address the increasing demand for limited resources, this contract has been an efficient use of District resources to date.

Sincerely,

Muriel Bowser

Muriel Bowser
Mayor

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

Gregory M. Dean
Fire & EMS Chief

Emergency Medical Services Transport Contract Authority

Third Annual Report (April 2018 – March 2019)

December 2019

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, 2018 and March 31, 2019.

In our first and second annual reports in 2017 and 2018, 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 third 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 AMR contract has been one of the most significant factors in the Department's improved unit availability. The Department launched the AMR contract on March 28, 2016. Since June 2016, we have regularly had 11 or more FEMS transport units available over 90 percent of the time. During some weeks, this measure was achieved 100 percent of the time. The contract also enabled us to convert three BLS units to Advance Life Support (ALS) units in March 2017. The addition of these ALS units, combined with the Department's transition to Criteria Based Dispatch (CBD) in April 2018, improved our ALS unit availability. Since the launch of CBD, we are now more accurately dispatching calls, and ALS dispatches have decreased from 48% of calls to about 32% of calls. With a few exceptions, we have had five or more ALS transports available over 90 percent of the time since March 2017.

Frank D. Reeves Municipal Center
2000 14th Street, NW, Suite 500
Washington, DC 20009

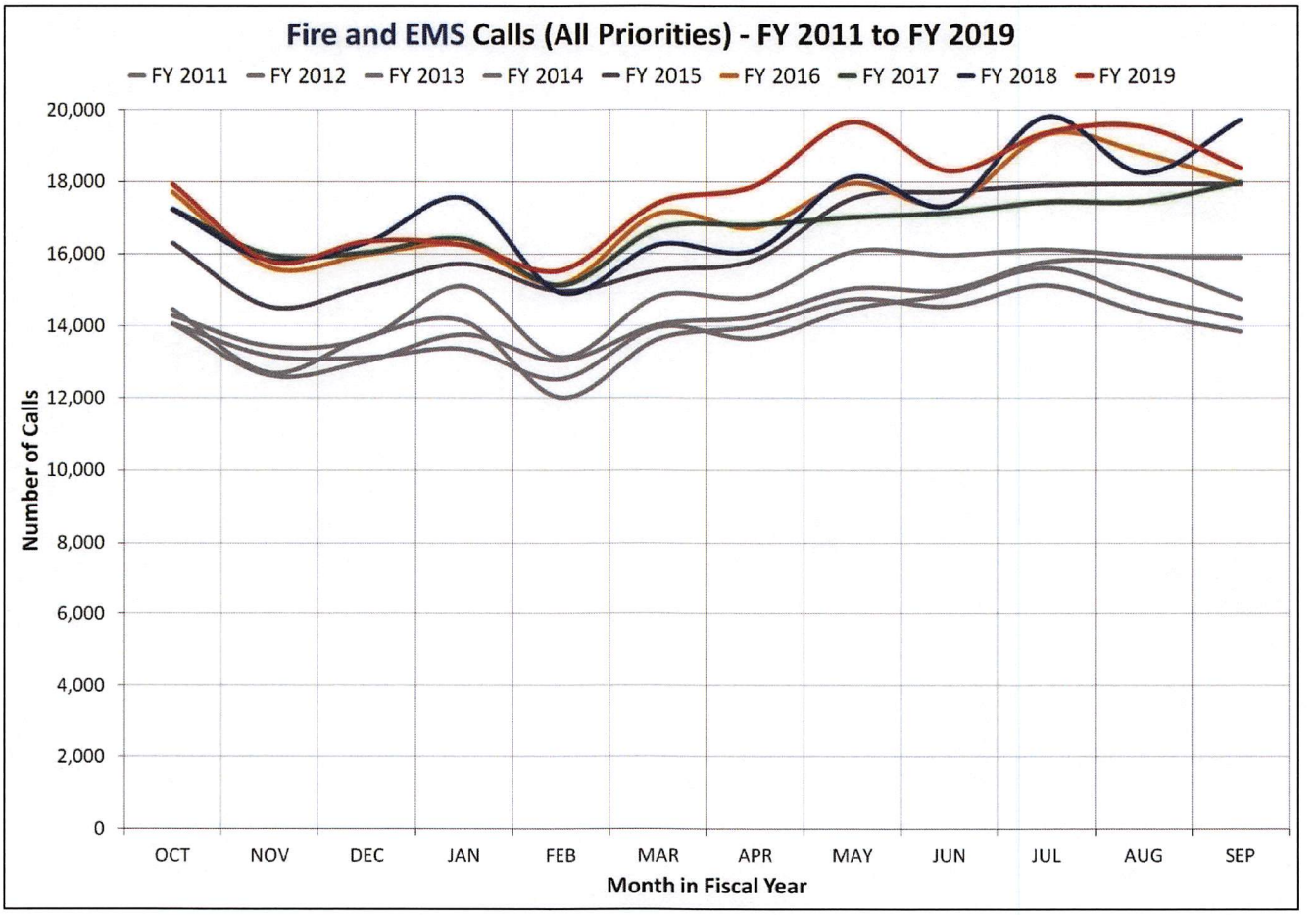
phone: (202) 673–3320
facsimile: (202) 462–0807
www.fems.dc.gov

While the AMR contract improved overall and BLS unit availability during its first two years, the CBD launch, combined with a growth in EMS call volume during the same year, has resulted in new pressures on our BLS unit availability. We believe the closure of Providence Hospital, which has increased our hospital "drop times," has also impacted our BLS unit availability.

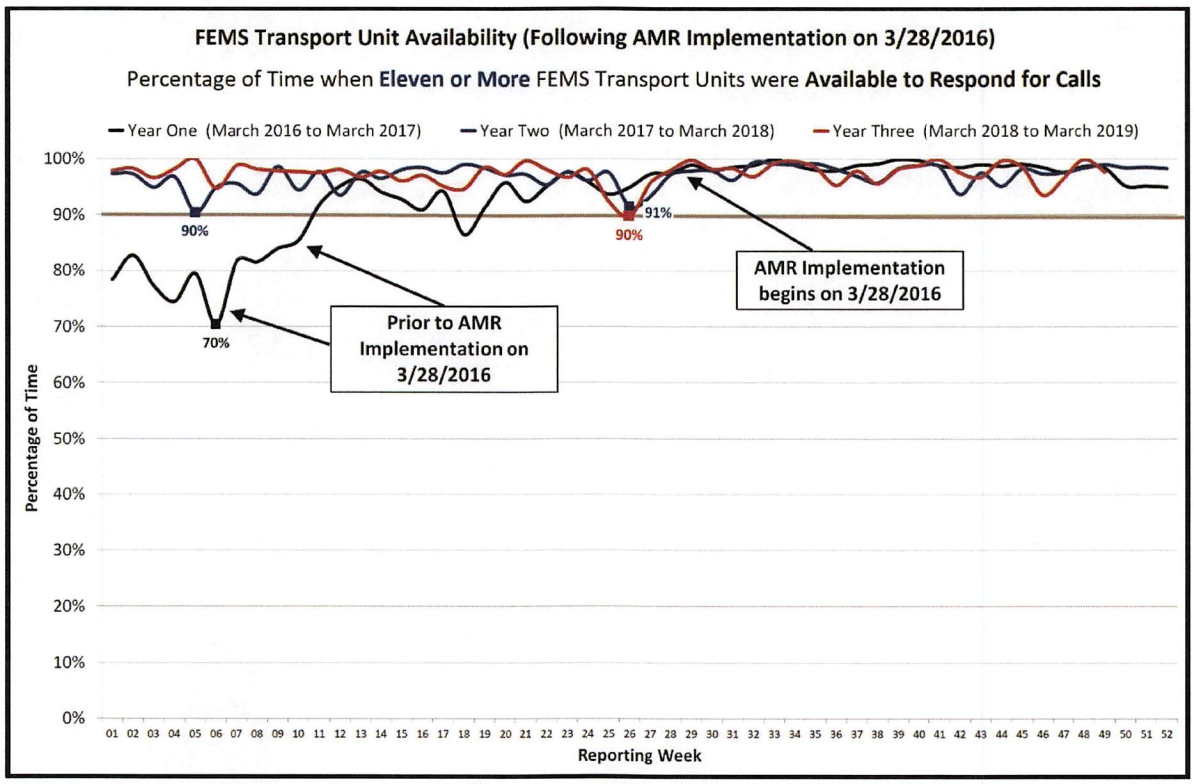
Since the last annual report, the Department has seen historically high EMS call volume, including reaching historic levels in October 2018 and February through April 2019. Factors which may be impacting call volume include:

Weather	Synthetic Drug Calls	Growing Population
•We experienced a warmer year than last year, which was unusually cool. Weather tends to be the most reliable predictor of our call volume.	•We have experienced consistently high rates of synthetic drug calls. In previous years we experienced "seasonal spikes" in the warmer months, but this year we have endured unusually high levels of calls during the winter and early spring months.	•The recent growth in population in the DMV area has been a factor in our call volume increases.

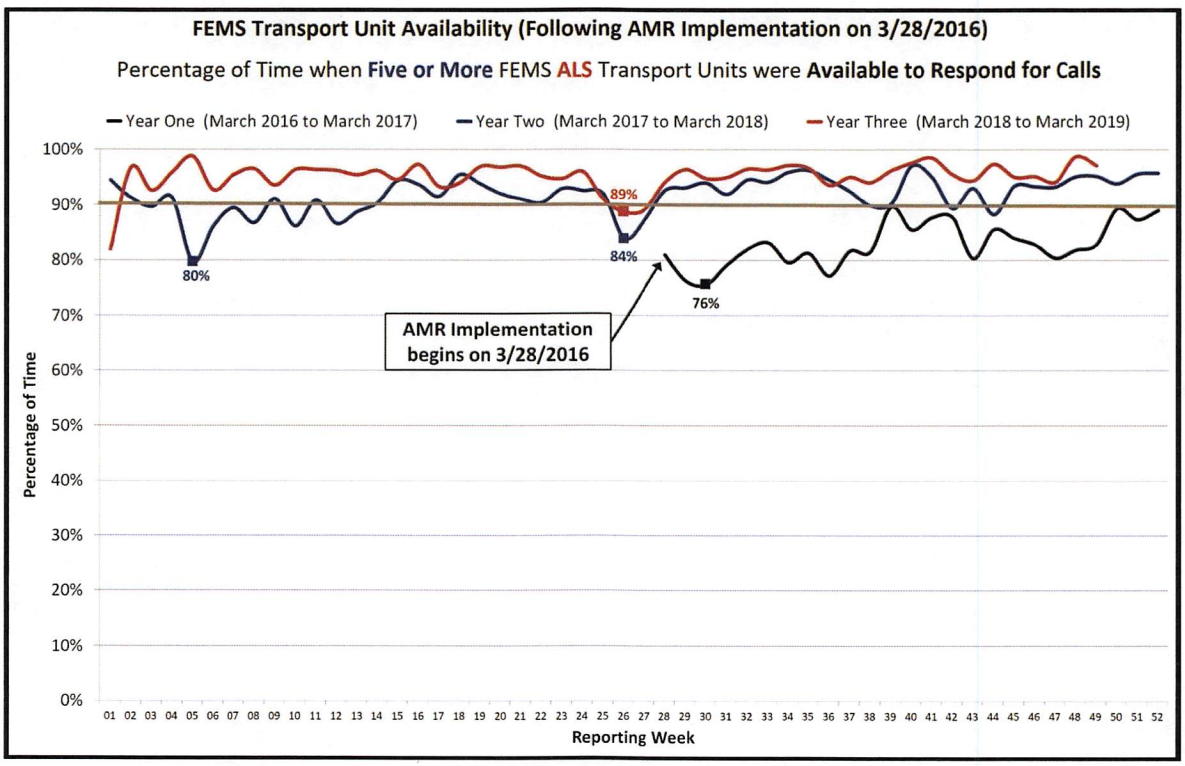
The following chart shows this increase in call volume:



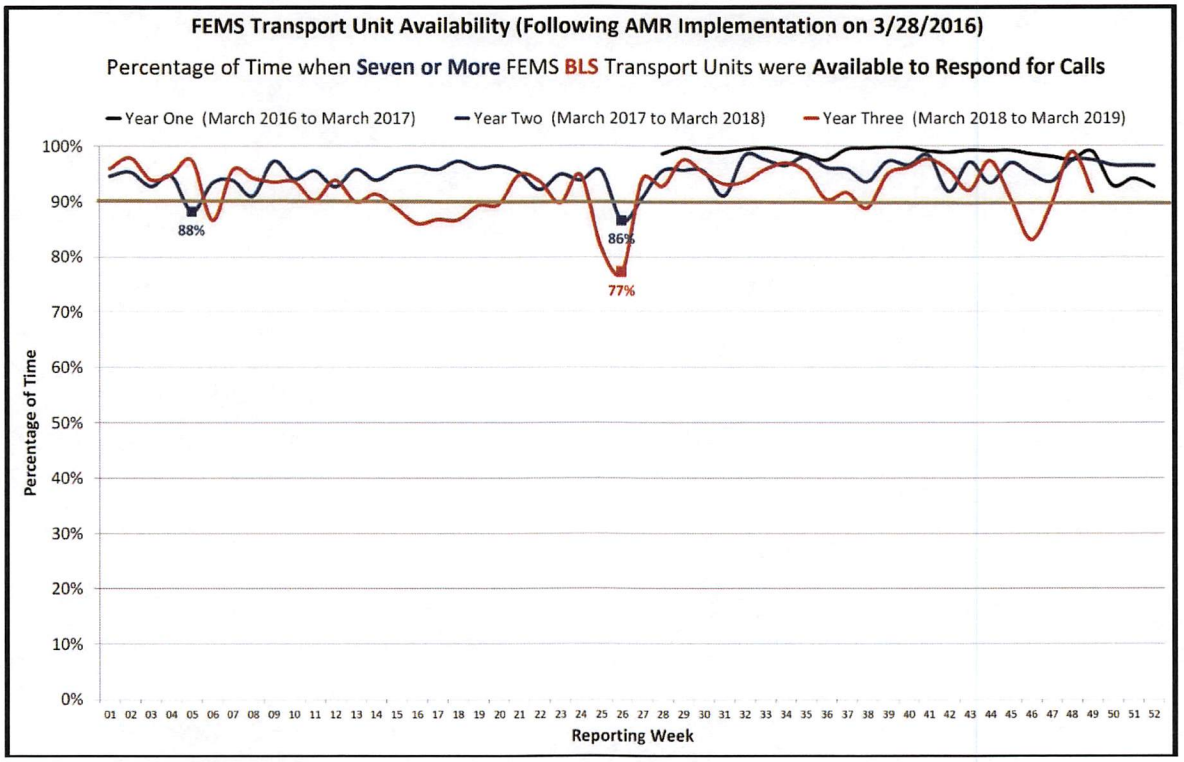
For details on our unit availability trends, please refer to the following charts. The first chart shows the improvement in our overall transport unit availability since the launch of the AMR contract (it also shows unit availability before the launch).



The second chart shows improved ALS unit availability in years 2 and 3 of the contract.



The third chart shows improved BLS unit availability since 2016, while also demonstrating the new strain on BLS unit availability in 2018-2019:



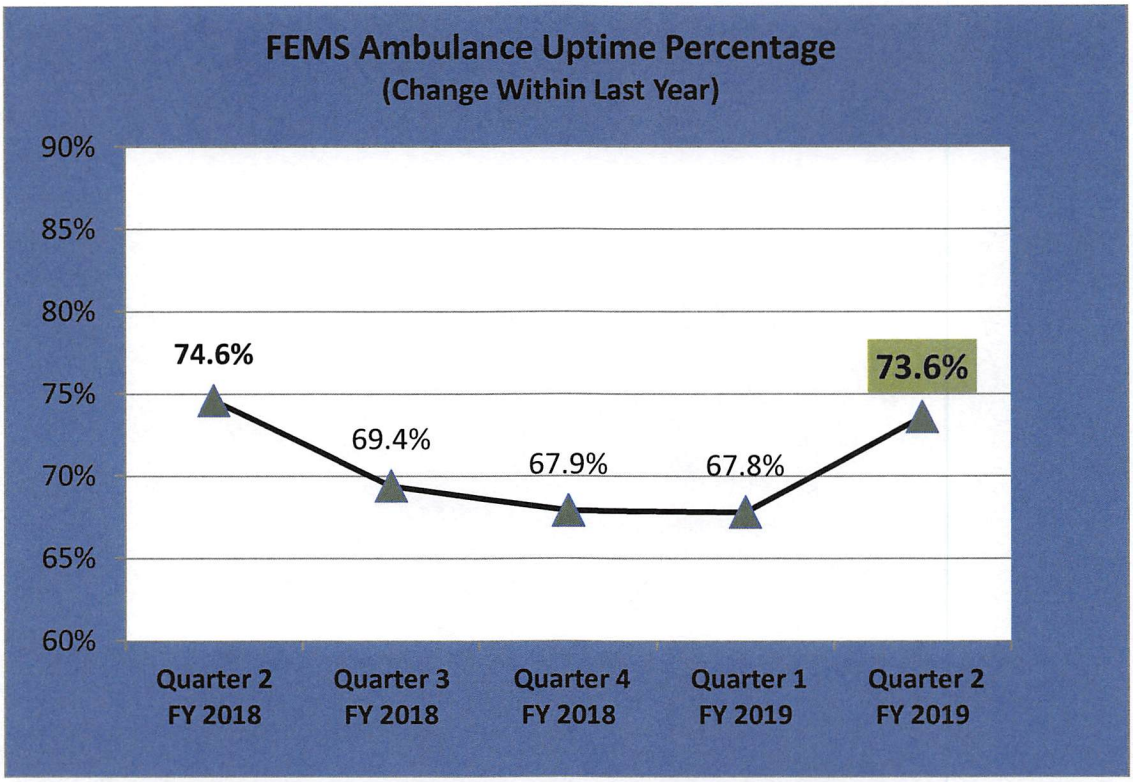
Since the closure of Providence Hospital, we have seen dips in unit availability to levels that we have not seen since before the AMR launch, which we are monitoring. Limitations in hospital capacity and efficient patient flow through hospitals have been an increased factor since the closure of Providence and caused the Department's drop times to increase by four minutes. Fortunately, our FY 2020 budget adds four ambulances to our daily deployment, which has helped alleviate this issue and which were in service on an overtime basis during the summer of 2019. As of the submission of this report, Ambulance A-03, A-08, A-19B and A-30B are in-service in neighborhoods in the center and eastern ends of the city, where we have the highest call volume.

The addition of four new full-time ambulances may help with this measure but call volume and the challenges created by the closure of Providence will continue to be barriers.

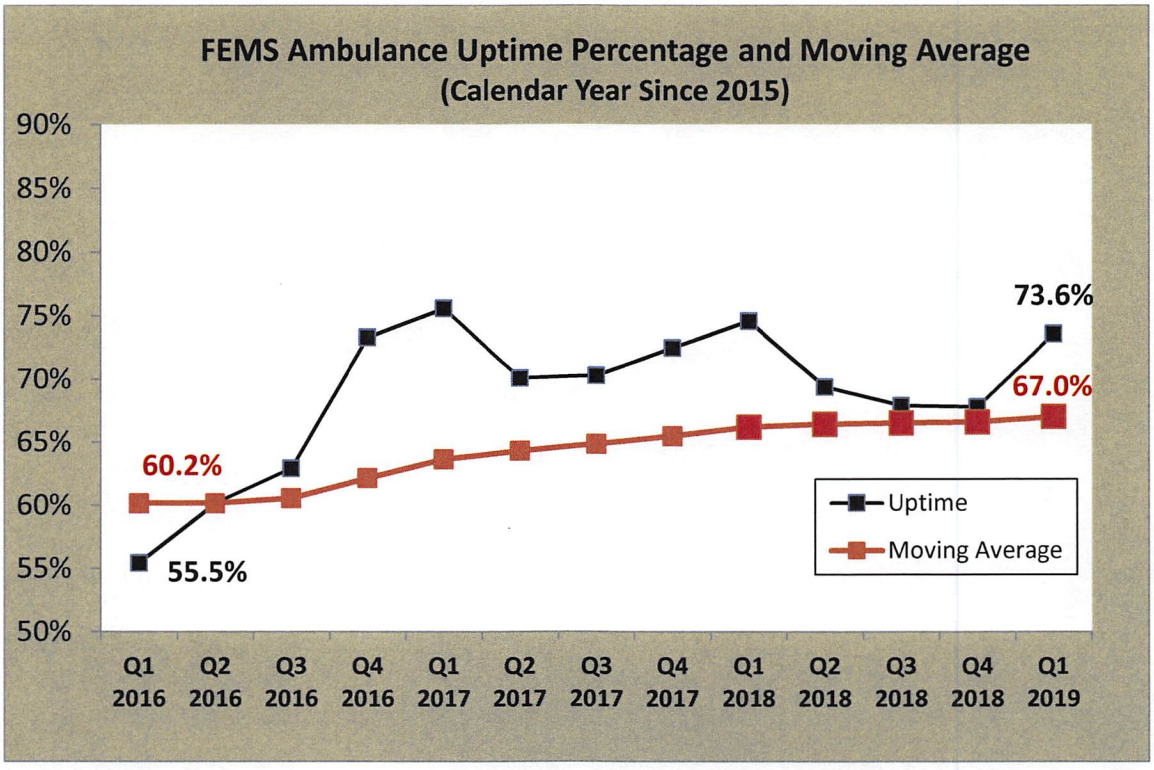
(2) The impact on the Department's fleet, including the ability to conduct preventative maintenance and the number of operational and reserve units available.

The launch of the AMR contract, as well as the addition of new ambulances to the Department's fleet, has had a positive impact on the Department's ability to conduct preventive maintenance, particularly for ambulances. This has contributed to an increase in the number of operational and reserve units available. We are now able to maintain a 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 again approached the target of 75 percent in Quarter 2 of FY 2019, like last year:



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



We now have a full complement of "frontline" and "reserve" units, including twenty reserve units that 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 2018, we achieved some progress with improving their availability.

The Department has made significant progress in its fleet modernization program. As we receive new frontline apparatus, uptime should continue to improve. This has already begun to occur for engines. In calendar year 2018, we took delivery or placed into service: 18 engines, a tower truck, two hazmat vehicles, nine ambulances, and 24 support vehicles. We expect to continue to regularly take delivery of new vehicles in the coming year.

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

The AMR contract continues to provide opportunities for training hours for all members. The Department prioritizes both the quality of instruction and maximizing the quantity of training hours in all disciplines for members. During the third year of the AMR contract, the Department continued to deliver a variety of types of EMS training including regular in-service EMS modular training for BLS and ALS providers, as well as a quarterly Paramedic Grand Rounds (PGRs) for its ALS providers. The PGRs are delivered by faculty from around the region, provide a yearly "hands-on" session and are at times interactive. In the summer of 2018 we partnered with George Washington University to provide skills training on endotracheal intubation, cricothyrotomies, and intraosseous infusion (IO) placement. In addition, a Mass Casualty Incident (MCI) plan to improve response preparedness in the daily operational plan was approved by the DC Department of Health and training has been delivered to department members. The new mass casualty triage program (Sort, Assess, Lifesaving Interventions, Treatment/Transport, or SALT) is now operational. Our firefighting companies also received training in a multitude of subjects, including multi-company firefighting evolutions and on our new fireground standard operating guidelines (SOGs).

The Department has developed a comprehensive annual training calendar with detailed monthly schedules. See below for a list of classes that have been held within the last year:

April 2018
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 2018

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
Swiftwater Rescue Course
Metro Tunnel Drill - Phase I
Marine Firefighting Course
Pediatric Advanced Life Support (PALS) - CNMC
Metro Tunnel Drill - Phase I
EMS Module 8 (Mental Health Safety)
Metro Tunnel Drill - Phase I
Advance Medical Life Support Refresher
June 2018
EMS Module 8 (Mental Health & Safety)
Supervisor II Course
Engine Company Operations
Infectious Disease Outbreaks
Metro Tunnel Drill - Phase I
Pre-Hospital Trauma Life Support Refresher
Advance Cardiac Life Support
Vehicle and Machinery Rescue Course
Metro Tunnel Drill - Phase I
Instructor I Course
Metro Tunnel Drill - Phase I
Advanced Cardiac Life Support
Advanced Medical Life Support
Trench Rescue Course
Metro Tunnel Drill - Phase I
Advanced Cardiac Life Support
July 2018
EMS Module 8 (Mental Health & Safety)
Engine Company Operations
Metro Tunnel Drill - Phase I
Advanced Cardiac Life Support
Seagrave Manufacturer Pumper Training
Paramedic Grand Rounds (ALS Skills Training)
Pediatric Advanced Life Support
Metro Tunnel Drill - Phase I
Pre-Hospital Trauma Life Support Refresher
Swiftwater Rescue Course
Advanced Cardiac Life Support
Pediatric Advanced Life Support
Seagrave Manufacturer Pumper Training
Paramedic Grand Rounds (Advanced Airway Skill Training)
EMS Module 9 (OB & Pediatric Emergency)

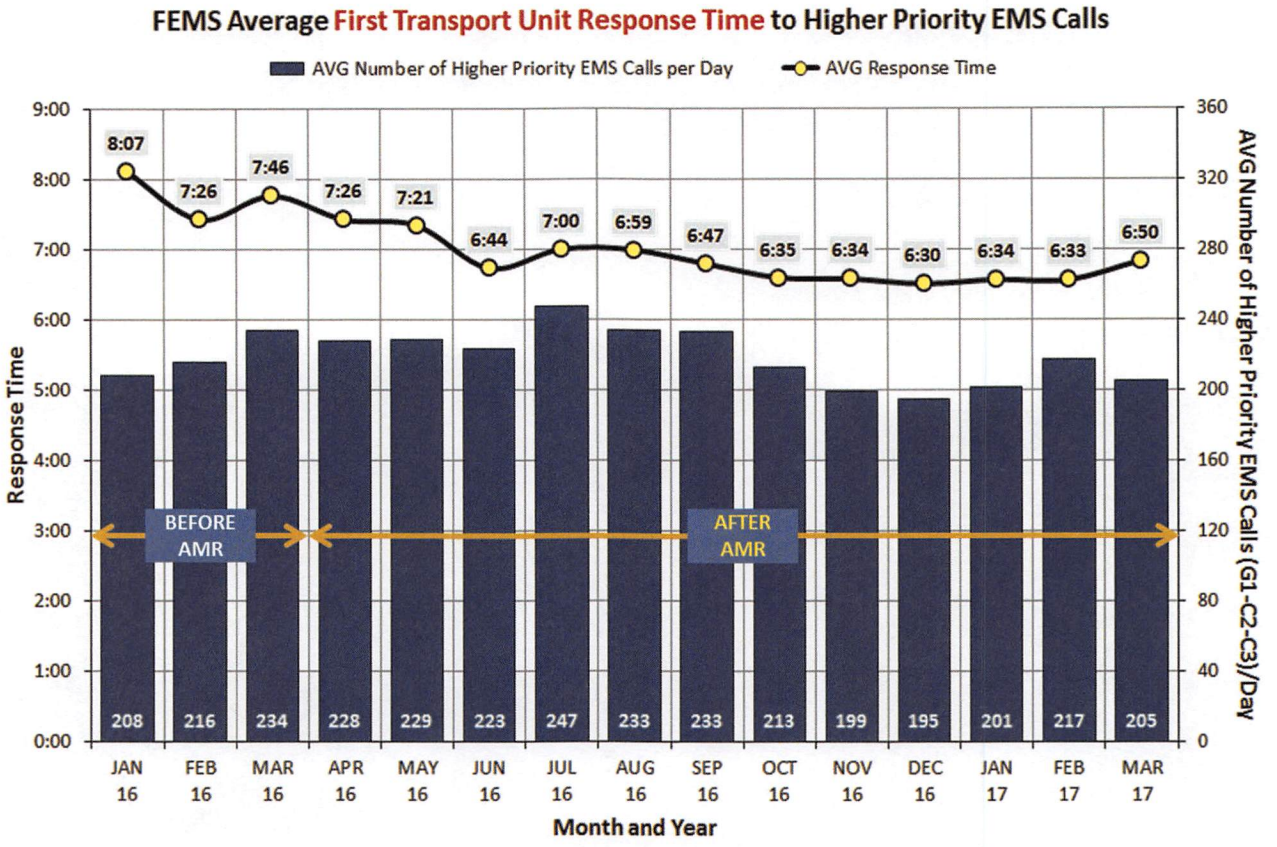
NFA - Leadership Thru Difficult Conversation
NIMS ICS 300 and 400
Advanced Medical Life Support
Advanced Cardiac Life Support
August 2018
Engine Company Operations
EMS Module 9 (OB & Pediatric Emergency)
Pediatric Advanced Life Support
Advanced Cardiac Life Support
Supervisor II Course
Fire Pattern Recognition (Fire Prevention)
Vehicle and Machinery Rescue Course
Pediatric Advanced Life Support
Rope Rescue Course
Infectious Disease Outbreaks
Seagrave Manufacturer Pumper Training
Advances Cardiac Life Support
September 2018
EMS Module 4 & 5 Make-Up (AMS, Wellness, HP-CPR)
Advanced Medical Life Support
Supervisor I Course
Confined Space Rescue Course
Advanced Medical Life Support
Emergency Boat Operations and Rescue Course
Pediatric Advanced Life Support
Paramedic Grand Rounds (Burn Injury/CO Poisoning)
Pre-Hospital Trauma Life Support Refresher
Multi-Company Firefighting Evolutions
Instructor I Course
Emergency Boat Operations and Rescue Course
Stress First Aid Peer Counseling Training
Advance Cardiac Life Support
October 2018
Multi-Company Firefighting Evolutions
Infectious Disease Outbreaks
MSHA Tunnel Rescue Recertification
Advanced Medical Life Support
Advanced Medical Life Support
Pediatric Advanced Life Support
Advanced Cardiac Life Support
Advanced Medical Life Support
Pierce Manufacturer Training
Pediatric Advanced Life Support
MSHA Tunnel Rescue Course
Advanced Medical Life Support
Pediatric Advanced Life Support
Pre-Hospital Trauma Life Support Refresher
Advanced Cardiac Life Support

Supervisor I Course
November 2018
Multi-Company Firefighting Evolutions
Advanced Medical Life Support
Advanced Cardiac Life Support
Advanced Medical Life Support
EMS Module 10 (Train the Trainer)
Pediatric Advanced life Support
EMS Module 10 (MCI & Field Triage)
Instructor I Course
SCBA Sustainment
Pre-Hospital Trauma Life Support Refresher
Advanced Cardiac Life Support
Pediatric Advanced Life Support
Advanced Medical Life Support
Advanced Cardiac Life Support
December 2018
Pediatric Advanced Life Support
Supervisor II Course
HazMat Technician
EMS Module 10 (MCI & Field Triage)
SCBA Sustainment
Advanced Medical Life Support
Advanced Cardiac Life Support
Mission Command Workshop
Advanced Medical life Support
Seagrave Manufacturer Pumper Training
Mission Command Workshop
Pediatric Advanced Life Support
Pre-Hospital Trauma Life Support Refresher
Advanced Cardiac Life Support
January 2019
EMS Module Make-Ups
Advanced Medical Life Support (Refresher)
Advanced Cardiac Life Support
Paramedic Ground Rounds (Case Review)
Advanced Cardiac Life Support
Pediatric Advanced Life Support
Pediatric Advanced Life Support
Pierce Manufacturer Pumper Training
Infectious Disease Outbreaks
Advanced Cardiac Life Support
Advanced Medical Life Support (Refresher)
Pediatric Advanced Life Support
February 2019
EMS Module Make-Ups
Health and Safety Officer
Supervisor II

Nurse Triage Line - Field Provider Referral (Train the Trainer)
Pediatric Advanced Life Support
Advanced Cardiac Life Support
Instructor II
Nurse Triage Line - Field Provider Referral (Battalions 2 & 4)
Step Up and Lead Seminar
ICS 300/400
Step Up and Lead Seminar
Advanced Medical Life Support (Refresher)
Pediatric Advanced Life Support
Incident Safety Officer
Stress First Aid - Peer Counseling
Advanced Cardiac Life Support
March 2019
EMS Module Make-Ups
Nurse Triage Line - Field Provider Referral (Battalions 2 & 4)
Supervisor III
Pierce Manufacturer Pumper Training
Advanced Cardiac Life Support (Refresher)
Supervisor III
Pediatric Advanced Life Support
Supervisor I
Supervisor III
HazMat: MX908 Meter Class
Tactical Emergency Casualty Care
Advanced Cardiac Life Support (Refresher)
Pediatric Advanced Life Support
Supervisor III
Seagrave Manufacturer Tower Training
Emergency Boat Operator
Instructor I
Leadership Series: Empowering Women to Lead Seminar
Advanced Cardiac Life Support (Refresher)

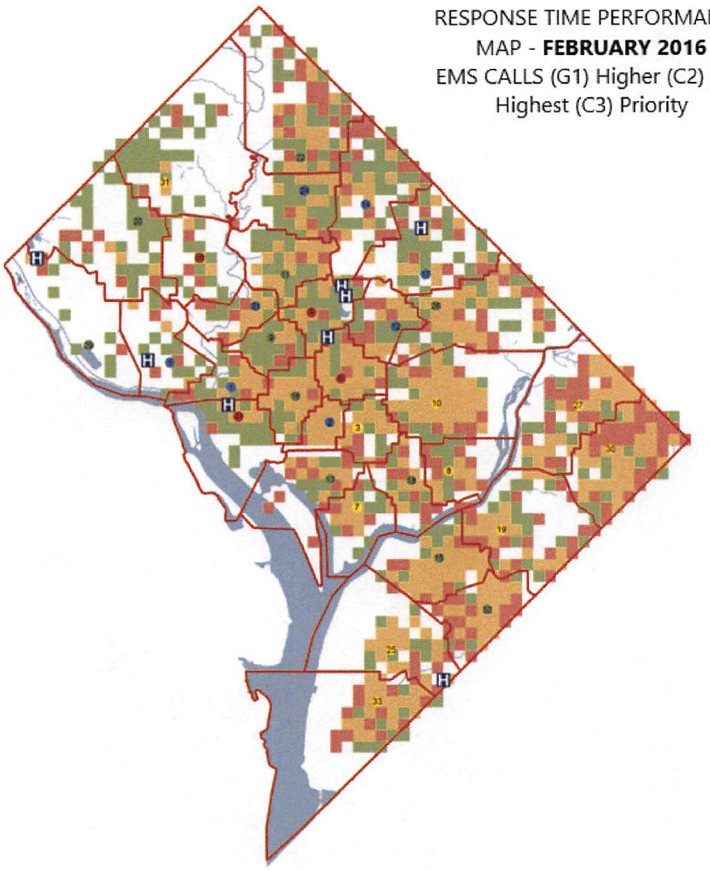
(4) (A) The impact on the Department's response times.

Since launching just over three years ago, the AMR contract has both improved the response time of the Department's ambulances, and significantly improved our ability to have an ambulance reserve which permitted the conversion of three BLS units to additional ALS units. 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 improved significantly over the first two years. See chart, below:

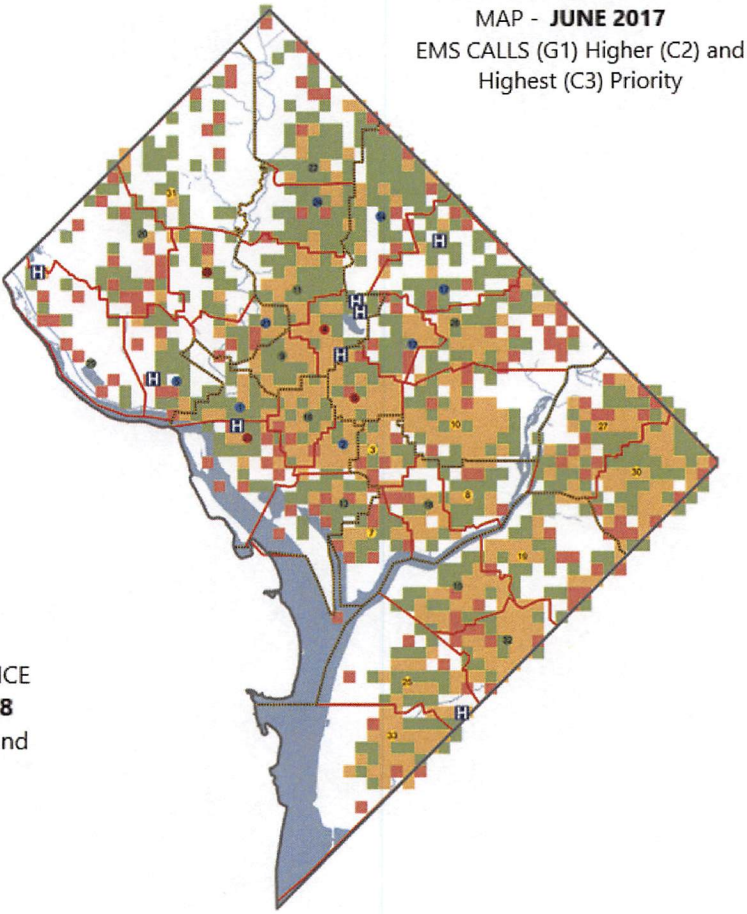


Call volume in calendar year 2018 and through the reporting period in 2019 exceeded prior year levels and stretched the Department's resources. Response times and hospital drop times consequently increased in Fall 2018; and in January and February, pressures on FEMS unit availability related to a combination of increased call volume and the Providence Hospital closure further exacerbated this challenge as described above.

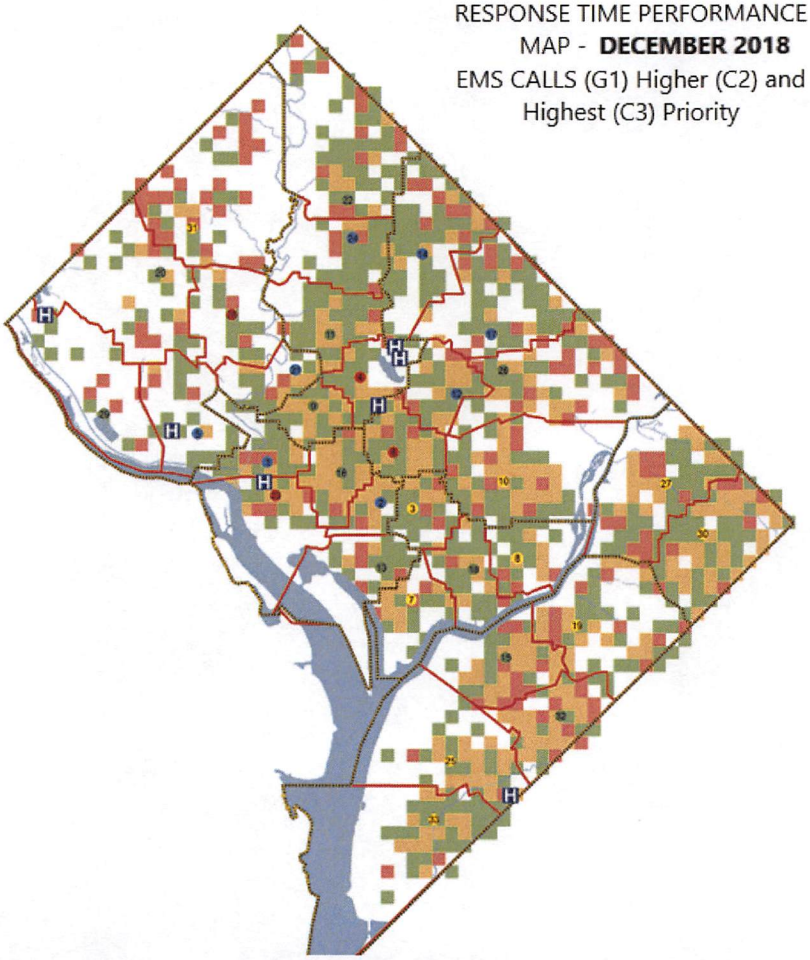
RESPONSE TIME PERFORMANCE
MAP - **FEBRUARY 2016**
EMS CALLS (G1) Higher (C2) and
Highest (C3) Priority



RESPONSE TIME PERFORMANCE
MAP - **JUNE 2017**
EMS CALLS (G1) Higher (C2) and
Highest (C3) Priority



RESPONSE TIME PERFORMANCE
MAP - **DECEMBER 2018**
EMS CALLS (G1) Higher (C2) and
Highest (C3) Priority



EMS Response Times
Measure 4 : First FEMS Transport Unit
Percentage of Responses in 9 minutes or Less

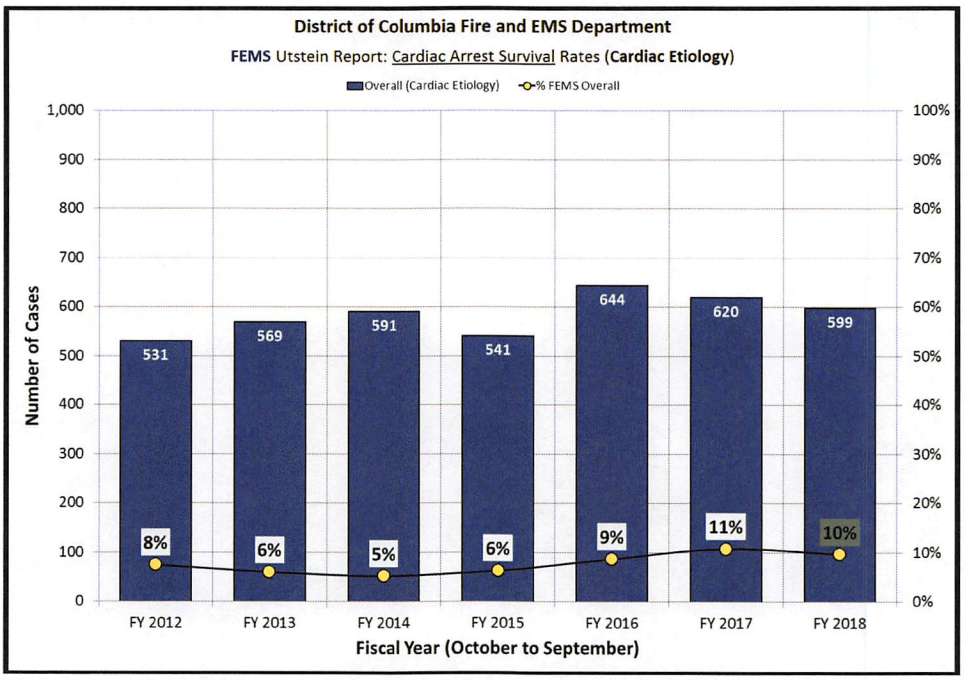
- 0 to 50%
- 50% to 90%
- 90% to 100%

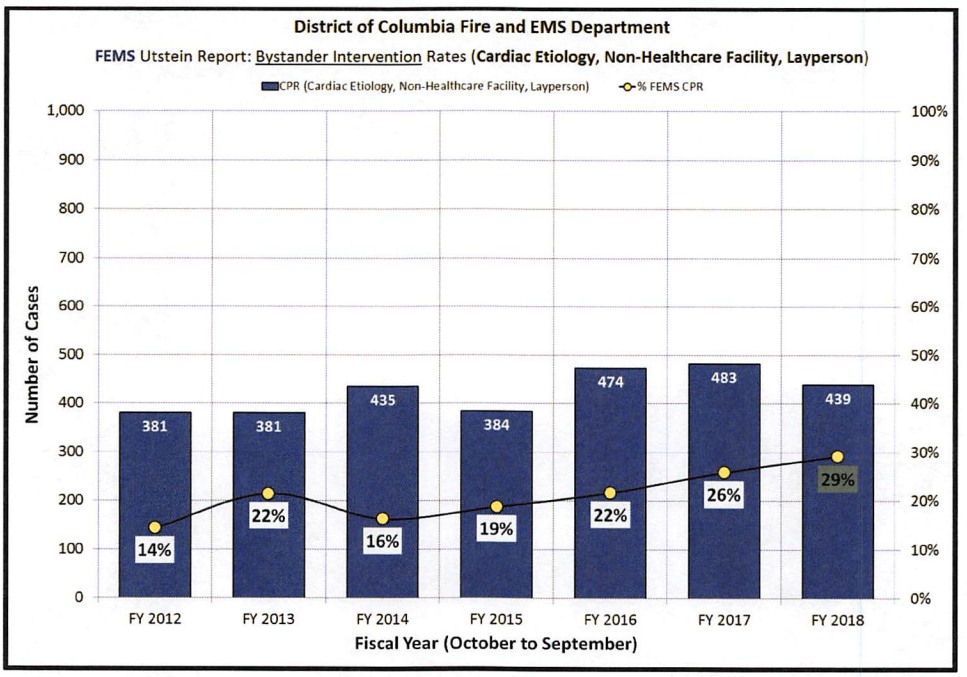
Company Type and Units

- ALS Engine Compancy (PEC)
- BLS Engine Company
- BLS Engine and Medic Unit
- PEC and Medic Unit
- Battalion District
- First Response Area

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

The Department continues to see progress in patient care outcomes. In FY18, we continued our positive trend in overall cardiac arrest survival rates, with double the rates of patients with cardiac etiology surviving cardiac arrest when compared with FY14 (see charts, below). We have trained over 50,000 residents in hands-only CPR since 2015 and we launched the Pulse Point app in 2018. We continue to see more cases where bystanders start CPR before we arrive. We believe this is contributing to more patients surviving:





The Department's Utstein cardiac survival rate (patients surviving non-traumatic cardiac arrests witnessed by bystander and found in a shockable rhythm) increased from 28.9 percent during 2017 to 43.1 percent in 2018. At the same time, the national survival rate for the same measure remained unchanged. In addition, 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 42.1 percent during 2017 to 48.6 percent in 2018. These categories are used to measure EMS performance because they are cases where EMS has the best chance at influencing patient outcome.

Measure	FY 2017	FY 2018
Overall (Cardiac Etiology)	10.80%	9.70%
Bystander Witnessed (Cardiac Etiology)	18.10%	15.80%
Unwitnessed (Cardiac Etiology)	4.80%	4.10%
Utstein (Cardiac Etiology, Bystander Witnessed, VF/VT)	28.90%	43.10%
Utstein Bystander (Cardiac Etiology, Bystander Witnessed, with CPR, VF/VT)	42.10%	48.60%
CPR (Cardiac Etiology, Non-Healthcare Facility, Layperson)	25.90%	29.20%
Public AED Use (Cardiac Etiology, Public Location, Layperson)	8.80%	9.80%

To put these graphs and charts in perspective, the District had an average of 35 lives saved from 2012-2015, and an average of 60 for 2016-2018. In sum, there were 75 additional cardiac arrest survivors from 2016-2018 than there would have been if we had kept the same cardiac arrest survival rates as 2012-2015.

(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 over $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.

FEMS has undertaken several investments that have improved the performance of the Fire and EMS Department across the board: increased frequency, quality, and number of EMS training hours; improved ambulance response times; the creation of an ambulance reserve fleet; more effective maintenance of vehicles; and improved patient outcomes. Even with all the progress we have made the

District's EMS call volume remains one of the highest per capita call volumes in the nation. The FY 2020 budget includes funding to support the staffing of four additional ambulance transport units to our daily operational deployment, totaling 43 units per shift. With this enhancement, we seek to absorb the increasing call volume from the District's growing population and help address increased hospital drop time and unit availability challenges associated with the closure of Providence Hospital. The Department has located these units in areas where they are most likely to impact persistent high call volume and longer response times and tested locations during FY19 using overtime.

At this time, the Department does not recommend providing the same service that AMR provides in-house. 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, plus marginal on-going staffing and maintenance cost. 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.

(7) Conclusion

The third 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. However, we cannot continue to improve EMS delivery without continuing to address demand.

The Department's innovative "Right Care, Right Now" (RCRN) Nurse Triage Line program continues to connect callers to 911 with non-emergency medical needs to non-emergency transportation, self-care, and walk-in appointments at community clinics. As we have reported previously, the nurse asks the caller questions and assesses his or her symptoms so that the nurse can refer the caller to the most appropriate non-emergency medical care available, either self-care or care at a community clinic or urgent care clinic in the caller's neighborhood. Over 2,000 patients have been diverted to date. While FEMS is still analyzing data from the first year of operations, patients who have gone through this process generally have a more positive health care and transportation experience than they would have taking an expensive ambulance ride to an emergency department. Efforts to increase utilization of the triage nurse for as many calls as appropriate, and to also reduce 911 volume are ongoing.

The research the Department reviewed before program launch suggested it may take a few years for patient behavior to change. As long as the program remains safe, efficient, and responsive to patients' health care needs, many patients eventually should stop using 911 and hospitals for their primary care needs.

To further address our non-emergency call volume, the Mayor established the Mayor's Commission on Healthcare Systems Transformation to make recommendations on strategies and investments necessary to transform health care delivery in the District of Columbia. The Commission's work has focused on developing recommendations to alleviate existing barriers and current stresses in the District's health care system, improving access to primary, acute, and specialty care services (including behavioral health care), and addressing health system capacity issues for inpatient, outpatient, pre-hospital and emergency room services. In addition, the commission has focused on promoting an equitable geographic distribution of acute care and specialty services in communities east of the Anacostia River. We are honored to have a position on the Commission, in recognition of the impact that this issue has on our agency and the pivotal role the Department plays in the delivery of health care in 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 the Department's progress.

Semiannual Performance Report

Provided To:

Council of the District of Columbia

and

DC Fire & Emergency Medical Services

October 1, 2018 - March 31, 2019

Transports Performed

- 22,845 patient transports were performed by American Medical Response (AMR) from October 1st of 2018 through March 30th of 2019.

- AMR responded to a total of 29,070 requests for service during this period, averaging 159 requests daily.

- Average Response Time by Month:

  October: 9 minutes, 21 seconds
  November: 9 minutes, 5 seconds
  December: 8 minutes, 55 seconds
  January: 9 minutes, 20 seconds
  February: 9 minutes, 38 seconds
  March: 9 minutes, 4 seconds

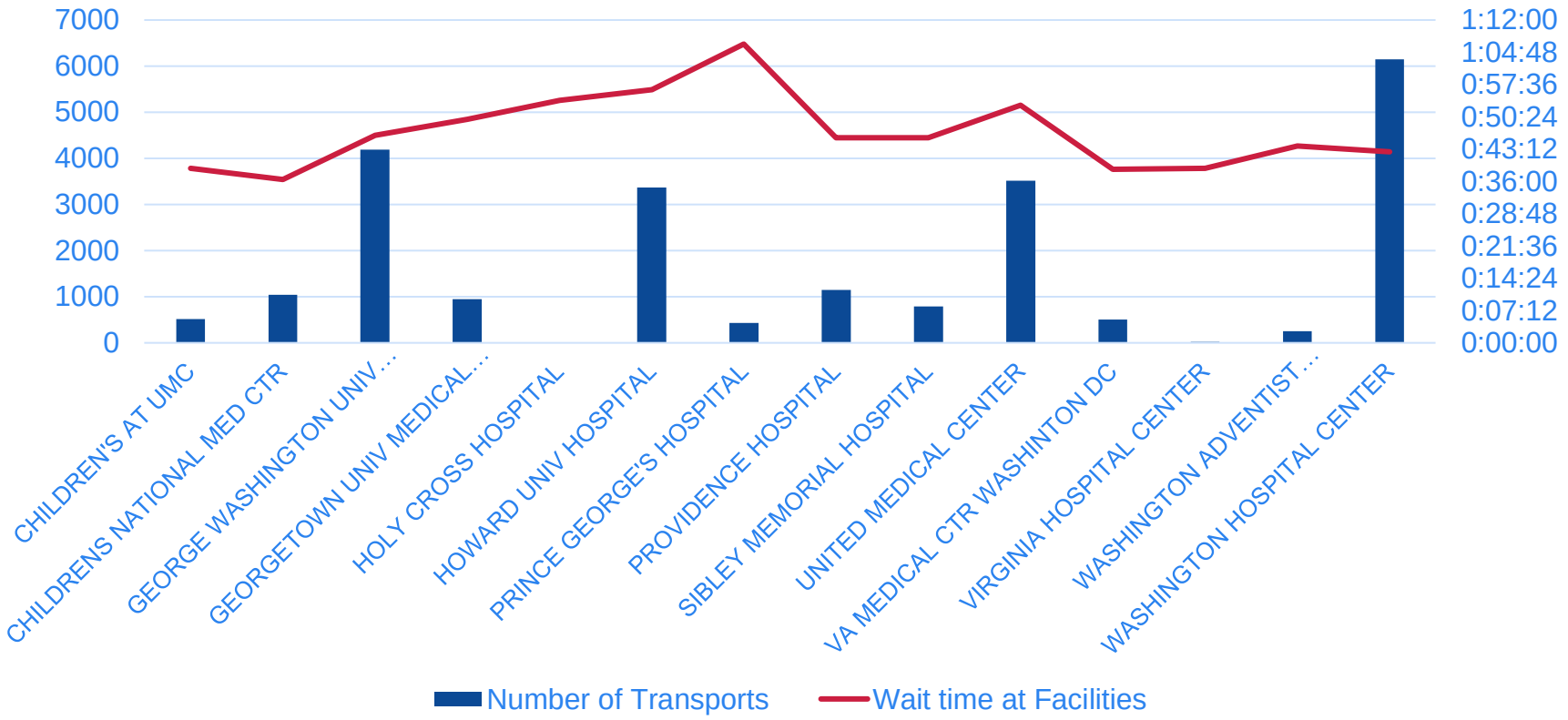
- AMR met each patient at the location of the incident and transported to the closest available hospital, or as directed by DC FEMS.

Transports Performed

Hospital Name	Transports	Drop Off Time
CHILDREN'S AT UMC	513	0:38:56
CHILDRENS NATIONAL MED CTR	1046	0:36:25
GEORGE WASHINGTON UNIV HOSP	4191	0:46:18
GEORGETOWN UNIV MEDICAL CTR	949	0:49:49
HOLY CROSS HOSPITAL	11	0:54:02
HOWARD UNIV HOSPITAL	3364	0:56:25
PRINCE GEORGE'S HOSPITAL	433	1:06:34
PROVIDENCE HOSPITAL	1152	0:45:41
SIBLEY MEMORIAL HOSPITAL	785	0:45:40
UNITED MEDICAL CENTER	3519	0:53:00
VA MEDICAL CTR WASHINTON DC	504	0:38:42
VIRGINIA HOSPITAL Center	20	0:38:52
WASHINGTON ADVENTIST HOSPITAL	251	0:43:53
WASHINGTON HOSPITAL CENTER	6147	0:42:36

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

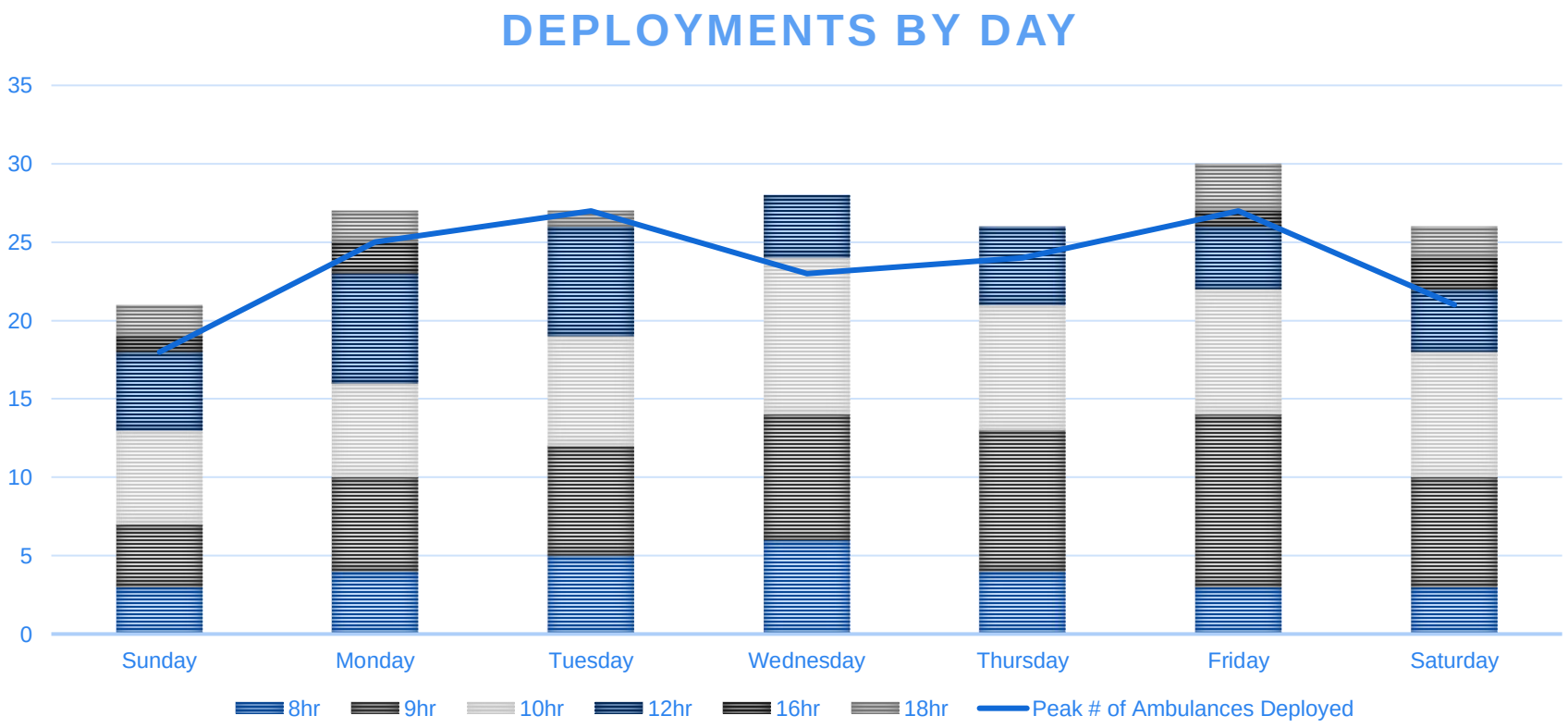
Transports Performed



Ambulance and Shift Information

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Current # of Shifts	21	27	27	28	26	30	26
# and Length of Shifts	3 – 8hr 4 - 9hr 6 - 10hr 5 - 12hr 1 – 16hr 2 – 18hr	4 – 8hr 6 - 9hr 6 - 10hr 7 - 12hr 2 – 16hr 2 – 18hr	5 – 8hr 7 - 9hr 7 - 10hr 7 - 12hr 1 – 18hr	6 – 8hr 8 - 9hr 10 - 10hr 4 - 12hr	4 – 8hr 9 - 9hr 8 - 10hr 5 - 12hr	3 – 8hr 11 - 9hr 8 - 10hr 4 -12hr 1- 16hr 3 -18hr	3 – 8hr 7 - 9hr 8 - 10hr 4 - 12hr 2 – 16hr 3- 18hr
Peak # of Ambulances Deployed	18	25	27	23	24	27	21

Ambulance and Shift Information



Average at Scene to At Patient Time*

* Approximate Times from Patient Care Reports

October	November	December	January	February	March
1:55	1:48	1:51	1:54	1:59	2:03

Personnel Data

- **202** Total Persons Employed in the Division
- **22%** are District Residents
- **48%** are Women
- **58%** Minority Represented

MURIEL BOWSER
MAYOR

July 14, 2020

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:

On behalf of the Fire and Emergency Medical Services Department (FEMS), enclosed for Council review, please find the "Emergency Medical Services Transport Contract Authority Semi-Annual Report (April 2019 – September 2019)."

Under D.C. Code §5-401, FEMS may contract with third parties to provide supplemental pre-hospital medical care and transportation to persons requiring Basic Life Support (BLS). This change in Department policy was necessary because the Department's resources could not meet the call volume demand, which put the lives of critical patients at risk. Since launching an emergency contract with American Medical Response (AMR) in March 2016, the Department has achieved many of the outcomes it put forth as goals of the contract, including vastly improved unit availability, reduced FEMS response times, improved condition of the fleet, and more training hours for providers. FEMS and the Office of Unified Communications (OUC) are required under the statute to provide semi-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 semi-annual report to FEMS and the Council regarding the contractor's operations (that report is attached).

The responses contained in this report are based on the best available data for the third and fourth quarters (the second half) of Fiscal Year 2019.

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.

Sincerely,

Muriel Bowser

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Fire and Emergency Medical Services Department
Office of Unified Communications

Emergency Medical Services Transport Contract Authority
Semi-Annual Report (April 2019 - September 2019)

February 2020

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). This change in Department policy was necessary because the Department's resources could not meet the call volume demand, which put the lives of critical patients at risk. Since launching an emergency contract with American Medical Response (AMR) in March 2016, the Department has achieved many of the outcomes it put forth as goals of the contract, including vastly improved unit availability, reduced FEMS response times, improved condition of the fleet, and more training hours for providers.

FEMS and the Office of Unified Communications (OUC) are required under the statute to provide semi-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 semi-annual report to FEMS and the Council regarding the contractor's operations (that report is attached).

The responses contained in this report are based on the best available data for the third and fourth quarters (the second half) of Fiscal Year 2019.

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.

1. **Fire and Emergency Medical Services Department**

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

In the third and fourth quarter of 2019, through our partnership with Granicus, the Department aggressively continued with digital public outreach efforts connected to *Right Care, Right Now* (RCRN) Nurse Triage Line. This work included weekly text messaging to high volume and low acuity 911 callers as well as individuals who have called 911 and been eligible for RCRN. In addition, emails and texts were sent weekly to those who have provided their contact information to the overlay on the FEMS/Right Care, Right Now website.

In addition to the above messaging campaign, our website (https://fems.dc.gov/page/frequently-asked-questions-right-care-right-now) has a variety of resources regarding the RCRN initiative, including:

- Frequently Asked Questions (also in six additional languages);
- 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.

Both television and print media outlets continued to run stories about Phase II, allowing for FEMS providers to contact the nurse for triage directly from the field, including the following from FOX 5 DC and American University Radio (WAMU 88.5). See links below and Appendix A for details:

1. WAMU article dated July 15, 2019
   https://wamu.org/story/19/07/15/d-c-wants-fewer-people-to-take-ambulances/

2. FOX 5 Washington DC article dated July 16, 2019
   https://www.fox5dc.com/news/dc-fire-and-ems-continues-to-push-diversion-program-meant-to-reduce-non-life-threatening-calls

All patients who participate in NTL are contacted by the nurse within 24 hours. Of those who have responded, the vast majority served by the NTL in the first year of operation have had a positive experience. Some of them shared their plan to use the primary care provider they were connected to in the future. The research the Department reviewed before program launch suggested it may take a few years for patient behavior to change.

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

The Department hired a total of 36 Firefighter EMTs and 21 Firefighter Paramedics between April 1 and September 30, 2019. For the residency of those hired, see table, below. Note that the states of residency for the hires listed reflect their residency at the time of application only.

Place of Residency	Firefighter/EMT	Firefighter Paramedic
District of Columbia	7	7
Maryland	20	3
Delaware	-	1
Pennsylvania	2	2
Virginia	7	8
Total: 57	**36**	**21**

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 16 new ambulances during the third and fourth quarters of FY 2019 to replace existing fleet units that were then placed into reserve. The Department places orders and receives ambulances on a regular replacement schedule to ensure that the ambulance fleet meets operational needs.

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 2019, the Department delivered a total of 44,971 EMS training hours.

Course Name	Number of Participants	Hours per Class	Total Hours
Advanced Cardiovascular Life Support (ACLS) Provider	3	16	48
Advanced Cardiovascular Life Support (ACLS) Refresher	70	8	560
Advanced Medical Life Support (AMLS) Provider	3	16	48
Advanced Medical Life Support (AMLS) Refresher	28	8	224
Advance Life Support (ALS) Operations/Protocols	41	60	2,460
Basic Life Support (BLS) Operations/Protocols	77	60	4,620
ALS/BLS Distance Learning Modules (via Target Solutions)	22	*Varies*	35
ALS-specific Distance Learning (via Target Solutions)	46	*Varies*	67
Emergency Medical Technician Course	45	307	13,815
Field Provider Referral - Nurse Triage Line (FPR-NTL) Training	837	2	1,674
LGBTQ Cultural Competency	116	2	232
Module 10: This Needs S.A.L.T.	1,776	4	7,104
Module 11: Pumps, Pipes, Clogs, and Leaks	1,436	4	5,744
Module 12: Sick, Psych, or Substance	1,534	4	6,136
Paramedic Grand Rounds (April 2019)	204	4	816
Paramedic Grand Rounds (July 2019)	185	4	740
Pediatric Advanced Life Support (PALS) Provider*	3	16	48
Pediatric Advanced Life Support (PALS) Refresher*	67	8	536
Pre-Hospital Trauma Life Support (PHTLS) Provider	3	16	48
Pre-Hospital Trauma Life Support (PHTLS) Refresher	2	8	16
			44,971

**Contracted with Children's National Medical Hospital*

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. During FY19, average drop time for both FEMS and AMR significantly increased due to the Providence Hospital closure. Fewer hospitals available to take patients means there are more patients spread among fewer emergency departments, often resulting in longer lines to drop off patients at hospitals. These issues are exacerbated by increased call volumes. AMR dispatchers are actively managing units waiting at facilities, and have been instructed to adjust crews and staffing, including dispatching supervisors to facilities to assist in clearing units to return to service. Average "Drop Time" for all FEMS transport units combined (including Ambulances and Medic Units) is shown (by month) in the table below:

Month (FY 19)	APR	MAY	JUN	JUL	AUG	SEP
AVG Drop Time	46:30	45:43	45:02	45:57	44:58	46:51

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*

This data is reported using ambulance billing information. For the reporting period (9/1/2018 to 8/31/2019), ambulance billing data indicated 101,819 patient transports were completed by FEMS and AMR ambulances. Of these transport cases, 99,345 involved patients that could be uniquely identified by full name and birthdate. The remaining 2,474 (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 (September 2018 to August 2019), for patients transported two or more times, **13,579 (or 22%) of patients** accounted for **50,344 (or 51%)** of **all patient transports:**

# of Transports	# of Patients	% of Patients	# of Total Transports	% of Total Transports
1	49,001	78%	49,001	49%
2 or more	**13,579**	**22%**	**50,344**	**51%**
TOTAL	**62,580**	**100%**	**99,345**	**100%**

During the last **twelve-month** period (September 2018 to August 2019), for patients transported two or more times, **7,005 (or 18%) of patients** accounted for **22,267 (or 41%)** of **all patient transports** completed by **FEMS ambulances:**

# of Transports	# of Patients	% of Patients	# of Total Transports	% of Total Transports
1	31,432	82%	31,432	59%
2 or more	**7,005**	**18%**	**22,267**	**41%**
TOTAL	**38,437**	**100%**	**53,699**	**100%**

During the last **twelve-month** period (September 2018 to August 2019), for patients transported two or more times, **5,664 (or 18%) of patients** accounted for **19,297 (or 42%)** of **all patient transports** completed by **AMR ambulances:**

# of Transports	# of Patients	% of Patients	# of Total Transports	% of Total Transports
1	26,349	82%	26,349	58%
2 or more	**5,664**	**18%**	**19,297**	**42%**
TOTAL	**32,013**	**100%**	**45,646**	**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 2019	14,298	53	140
May 2019	15,691	50	137
Jun 2019	14,681	49	141
Jul 2019	15,064	51	143
Aug 2019	15,404	48	138
Sep 2019	14,960	47	136

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)[1]		
	DC FEMS	**Third Party**
Apr 2019	45:44	48:46
May 2019	44:35	51:23
Jun 2019	44:26	54:14
Jul 2019	45:17	53:05
Aug 2019	44:18	53:34
Sep 2019	45:44	55:17

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. In particular, the OUC has maintained its support of FEMS's *Right Care, Right Now* under which the District's Nurse Triage Line (NTL) was launched last year. This year, the OUC relaunched the District's police non-emergency number. Residents and visitors should now dial 3-1-1 to report incidents

[1] FEMS and OUC note the variance in calculation between FEMS drop times and OUC off-load times. The agencies have not yet determined the cause of this variance, which has been consistent since the measurements started to be calculated.

that do not pose an immediate threat to safety and/or incidents that occurred at least one hour in the past.

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, as this information is not captured in CAD. It is included in the attached AMR report.

Emergency Medical Services Transport Contract Authority

Semi-Annual Report (April 2019 - September 2019)

Appendix A

1) WAMU article dated July 15, 2019
2) Fox 5 Washington DC article dated July 16, 2019

Emergency Medical Services Transport Contract Authority
Semi-Annual Report (April 2019 - September 2019)

Appendix B

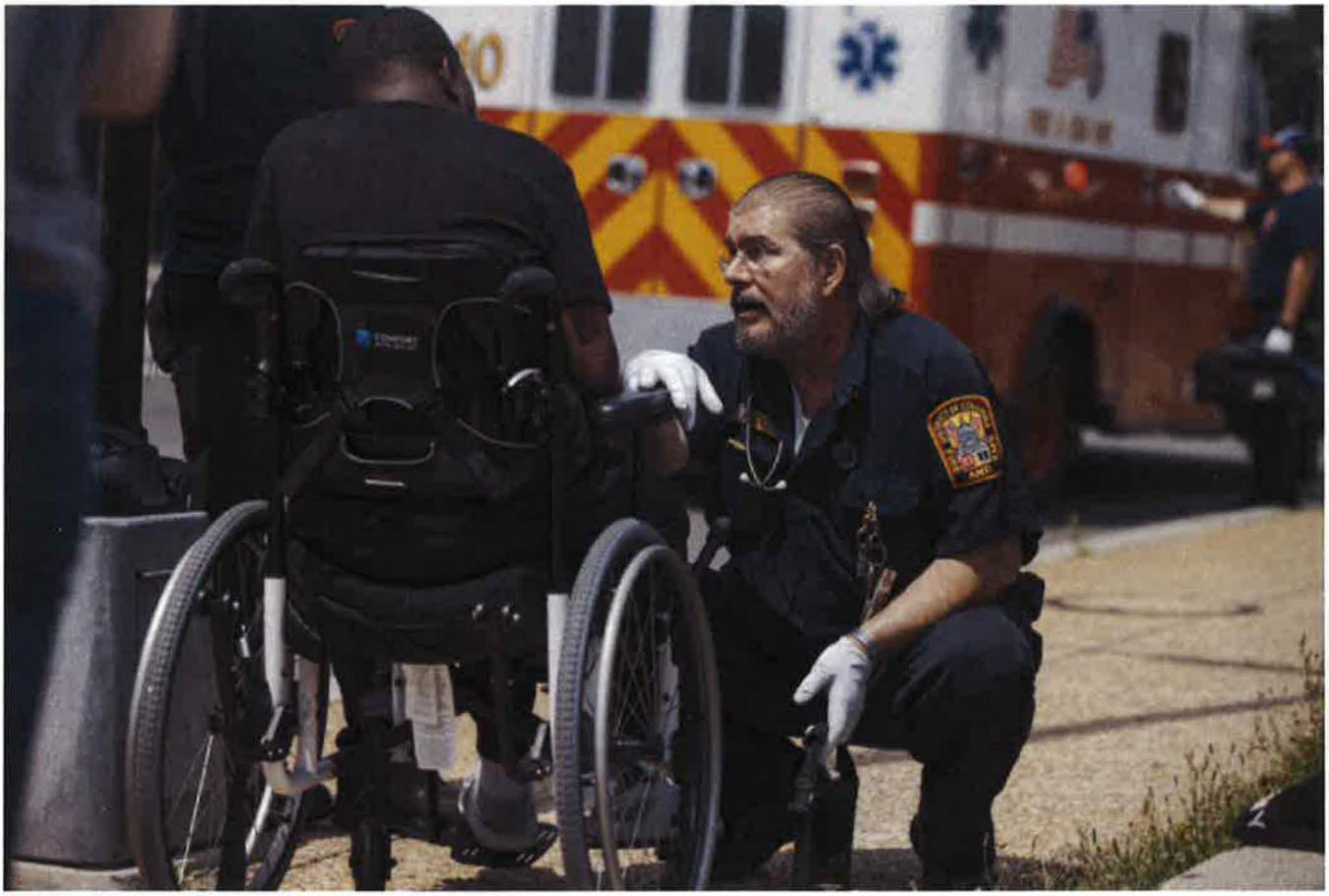
American Medical Response, Inc.
Quarterly Performance Report

WAMU | JUL 15, 2019

D.C. Wants Ambulances Used Only For Emergencies. But Who Decides What's An Emergency?

Elly Yu

LISTEN



D.C. Fire and EMS personnel talk to a man on H Street.

Tyrone Turner / WAMU

D.C. emergency officials have been trying to reduce the number of ambulance rides for patients who don't need them by diverting patients to clinics and rideshares instead. But over a year into the initiative, there's still a long way to go — and District residents are skeptical about the changes.

On an average day, D.C. Fire and EMS gets more than 400 medical calls. About 100 of them aren't life-threatening injuries or illnesses, according to the department. The District started the Right Care, Right Now program last year to address those less-severe cases. The program is based on the idea that patients can get care more quickly at clinics, and they can set up subsequent primary care appointments. This connects patients with long-term care and keeps ambulances and emergency rooms open for more severe cases.

Patients are sorted through a nurse triage line at the 911 call center. Since March, emergency responders can arrive on a scene and weigh in on whether a patient needs an ambulance.

But diversions are not yet common. Since April 2018, at least 1,617 people have been directed away from emergency care. That's only about four patients a day.

"At the same time that we've put this program into place, we faced a continued increase in our call volumes," says Dr. Robert Holman, medical director for D.C. Fire and EMS.

Holman says D.C. has one of the highest per capita call volumes in the country, and it's not letting up. He says call volumes have grown about 40% since around 2011, while the population has only grown by about 17%. Part of the increase in calls is due to the number of substance abuse cases in the District.

Holman says the department is working with a group of statistical scientists to see whether or not patients who use the nurse triage line end up getting comprehensive primary care in the long-run.

Saving Resources For True Emergencies

Paramedic Captain Andre Edwards drives to a call.

Tyrone Turner / WAMU

Captain Paramedic Andre Edwards, who's been with the department for 15 years, has responded to a lot of calls that didn't need an ambulance or an emergency room.

"I ran a guy who stapled his finger on accident with a regular office stapler, but he wanted to go to the hospital and get a tetanus shot, [or] calls where, you know, there might have been a kid who skinned their knee, and the parents didn't have anything to bandage it with, things like that," Edwards says.

He says calls like this have subsided lately, but the department still hears from people who have ignored a condition to a point where they felt like they need 911.

"So with the nurse triage, it's been educating the public," Edwards says. "If the issue is that you haven't been to the doctor in three weeks and you've been sick this whole time, you can go ahead and get you scheduled to go to the doctor and see what's really going on."

He says emergency rooms in the District have been overwhelmed, especially with the recent closing of Providence Hospital in Northeast D.C.

On a recent Thursday morning, Edwards was busy responding to patients — many who needed ambulance transport.

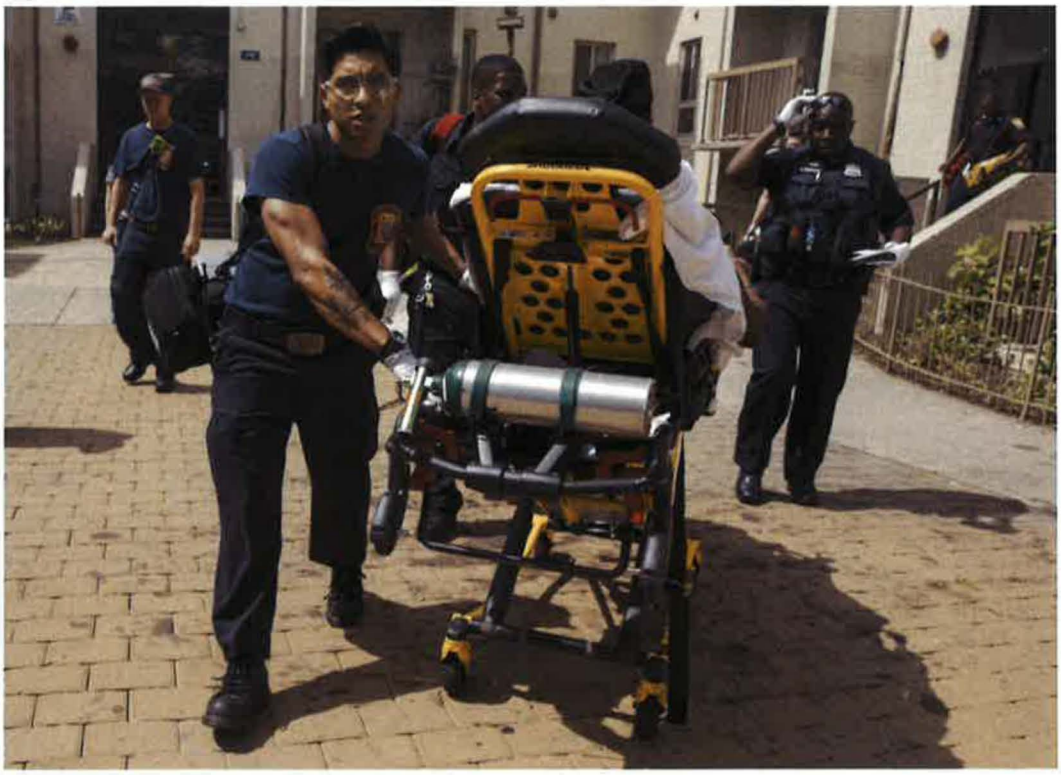
At a large apartment building in Northeast D.C., Edwards helped treat a man who EMTs rolled out on a gurney. The patient was conscious, but his torso was wrapped in bandages. The EMTs put him in an ambulance and sent him to the hospital.

"11 o'clock on a Thursday morning, somebody's getting stabbed in the middle of the day," Edwards says.

Edwards says ambulances responded pretty quickly to this call because the day hasn't been very busy. But it's early.

"Wait until maybe later on in the afternoon when people start really getting out and about and the city gets busy — especially on, say, a Friday, Saturday or Sunday — then it could be a medic unit coming from clear across the city," he says.

The diversion program is meant to make sure ambulances can always respond quickly to emergencies like a stabbing, no matter when they happen. But patients, nurses, and EMTs can have different ideas about what constitutes an emergency, and they can have different expectations for 911.



D.C. emergency personnel transport a person who had been stabbed.

Tyrone Turner / WAMU

"I Lost A Lot Of Faith In The 911"

The 911 system has been in place for 51 years, and Holman says the culture doesn't change easily.

"We have generations that are used to using the 911 system for, of course, serious and life threatening diseases, but also, in many cases, a sizable number, using the 911 system for non-life-threatening illnesses. And it's that group, which is actually pretty substantial, that we're really trying to break that cycle of calling 911 frequently and getting them into primary care," Holman says.

But some patients, like Edward McMahan, 60, are worried that the diversion program might mean they won't get the care they need.

McMahan called 911 last year when he his left leg hurt so much that he couldn't bend it.

"The pain last two days prior before I even called 911 because I was going to try to get to the ER on my own. So when I woke up that particular day in question, I couldn't move it, and I needed an ambulance to come and take me out," he said.

But an ambulance didn't come.

He said he spoke to a nurse who arranged for a rideshare ride to pick him up, paid through his Medicaid.

Edward McMahan, 60, called 911 last year after pain in his left leg became so painful that he couldn't move it. A nurse arranged a Lyft ride instead.
Elly Yu / WAMU

McMahan lives on the second floor, and said it was very hard to get down the steps. His wife and his daughter helped him down.

"It should have been an ambulance," he says. "I was mostly frightened so for 911 not to come out, [I was] a little shocked."

McMahan went to a Community of Hope clinic that's one of several clinics participating in the District's diversion program. He was diagnosed with gout, and he's been going to the clinic ever since for his primary care and regularly sees his doctor.

He says he understands that ambulances should be reserved for emergencies, but says at the time, he didn't know what was happening to his leg. McMahan has diabetes, and is currently undergoing treatment for multiple myeloma. He says with his age and other health conditions, he wants to be able to depend on 911.

"At the time, I didn't know — so for that to happen to me, I lost a lot faith in the 911," he says.

D.C. officials don't want people to lose faith, but want more people to find clinics for non-life-threatening cases.

"We still need community buy-in," says Holman. "Some individuals believe that going by lights and sirens through traffic to an emergency department gets them quicker care, and better care. And yet, we know that our patients who go to the clinic through the nurse triage line get care faster, and of course, the clinics are set up to give them a primary care, which is more comprehensive."

FILED UNDER: DC, Health, Health Care, Instagram, Local

Elly Yu

DC Fire and EMS continues to push diversion program meant to reduce non-life threatening calls

By Ayesha Khan, FOX 5 DC | **Published** July 16, 2019 | News | FOX 5 DC

WASHINGTON (FOX 5 DC) -- If you call 911 in the District, chances are you may not always get an ambulance.

"In the past, we would always have to transport no matter what," said Captain Richard Hall with Engine 2, in Chinatown. "It wasn't even a question of what the emergency was."

The fire department is one of many stations within the city that is working with the Right Care, Right Now nurse triage diversion program, meant to reduce calls that first responders don't always deem life-threatening.

"We are overtaxed and the emergency departments in the city are also overtaxed," said Dr. Robert Holman, medical director for D.C Fire and EMS.

He said that instead, patients are being diverted to clinics and rideshares as part of the diversion program that launched a little more than a year ago.

Holman said the city realizes that many people of the older generation may have some hesitations against the program but the hope is that the program will continue to change that habit and expose patients to the nurse line.

"We have been taught at a young age that if it's an emergency call 911," said Holman. "It's very difficult to change long-standing habits and so we are really trying to affect cultural change."

For Hall, the program means that his firefighters and ambulance medics can respond to more severe cases.

"I think it's important for the citizens to have confidence in the fire department that we are going to be there," said Hall. "And we are going to be available for when their grandmother goes into cardiac arrest."

Holman said that since the program was introduced, it has helped with directing at least 1,700 calls away from emergency care.

FOX 5 also inquired with the fire departments within Fairfax and Prince George's counties.

Mike Yourishin with Prince George's County's Fire Department said that the department does not have a similar program or policy to divert patients who call for transport. When an ambulance is called in in the county, the patient will be transported to a medical facility unless the patient refuses transport and signs a document stating their decision.

Semiannual Performance Report

Provided To:

Council of the District of Columbia

and

DC Fire & Emergency Medical Services

April 1, 2019 – September 30, 2019

Transports Performed

- 22,949 patient transports were performed by American Medical Response (AMR) from April 1st of 2019 through September 30th of 2019.

- AMR responded to a total of 28,843 requests for service during this period, averaging 158 requests daily.

- Average Response Time by Month:

April: 9 minutes, 16 seconds	July: 9 minutes, 35 seconds
May: 9 minutes, 18 seconds	August: 9 minutes, 15 seconds
June: 9 minutes, 21 seconds	September: 9 minutes, 35 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

Hospital Name	Transports	Drop Off Time
CHILDREN'S AT UMC	395	0:43:30
CHILDRENS NATIONAL MED CTR	993	0:40:33
GEORGE WASHINGTON UNIV HOSP	4584	0:52:17
GEORGETOWN UNIV MEDICAL CTR	1042	0:56:20
HOLY CROSS HOSPITAL	35	1:04:54
HOWARD UNIV HOSPITAL	3916	0:57:01
PRINCE GEORGE'S HOSPITAL	391	1:09:31
PROVIDENCE HOSPITAL	86	0:36:33
SIBLEY MEMORIAL HOSPITAL	663	0:56:06
UNITED MEDICAL CENTER	3220	0:57:25
VA MEDICAL CTR WASHINGTON DC	489	0:43:41
VIRGINIA HOSPITAL Center	15	0:45:11
WASHINGTON ADVENTIST HOSPITAL	211	0:45:46
WASHINGTON HOSPITAL CENTER	6883	0:48:50

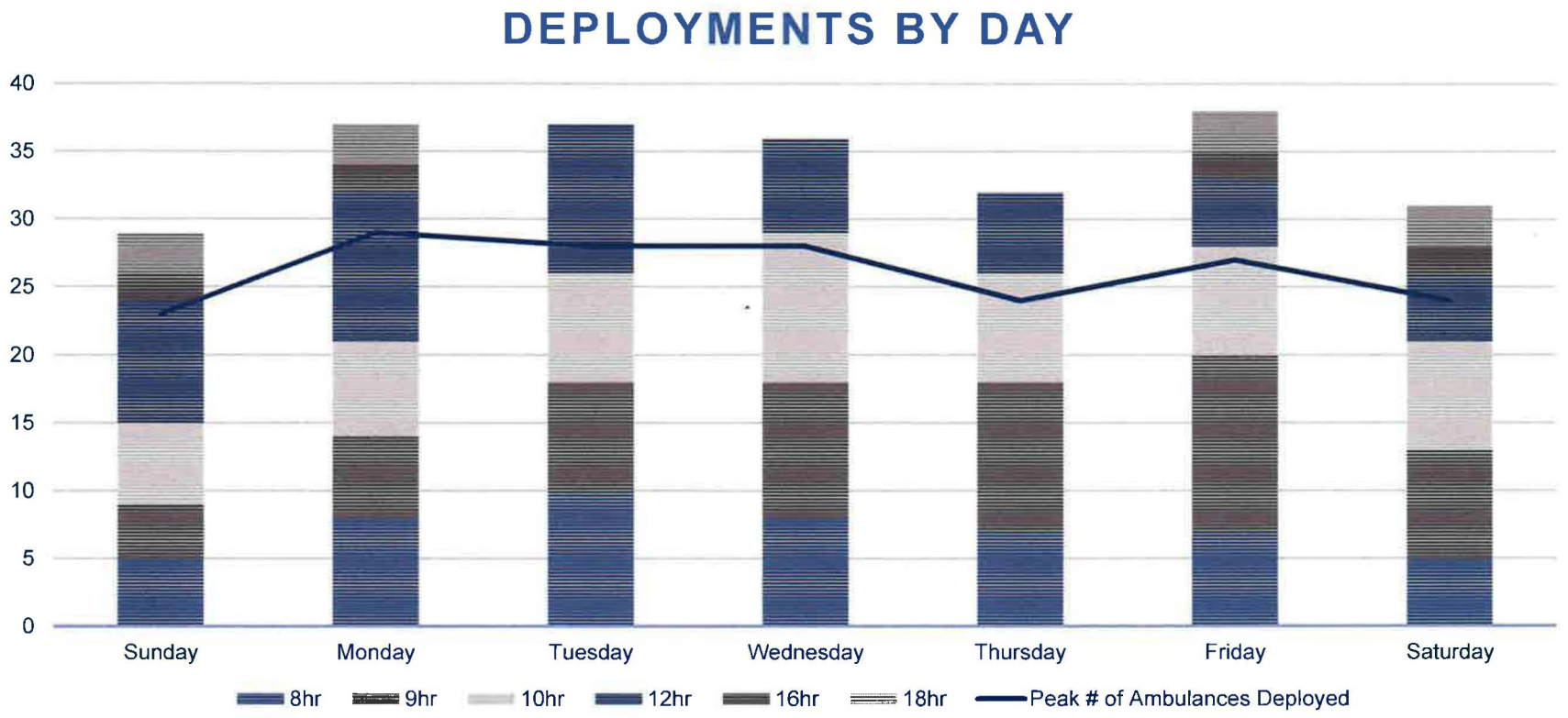
Note: Drop off time is average time in minutes. Hospitals with less than 10 transports not represented.

Transports Performed

Ambulance and Shift Information

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Current # of Shifts	29	37	37	36	32	38	31
# and Length of Shifts	5 – 8hr 4 - 9hr 6 - 10hr 9 - 12hr 2 – 16hr 3 – 18hr	8 – 8hr 6 - 9hr 7 - 10hr 11 - 12hr 2 – 16hr 3 – 18hr	10 – 8hr 8 - 9hr 8 - 10hr 11 - 12hr	8 – 8hr 10 - 9hr 11 - 10hr 7 - 12hr	7 – 8hr 11 - 9hr 8 - 10hr 6 - 12hr	7 – 8hr 13 - 9hr 8 - 10hr 5 -12hr 2 -16hr 3 -18hr	5 – 8hr 8 - 9hr 8 - 10hr 5 - 12hr 2 – 16hr 3- 18hr
Peak # of Ambulances Deployed	23	29	28	28	24	27	24

Ambulance and Shift Information



Average at Scene to At Patient Time*

* Approximate Times from Patient Care Reports

April	May	June	July	August	September
00:02:02	00:01:52	00:01:57	00:01:56	00:01:59	00:02:01

Personnel Data

* **186** Total Persons Employed in the Division
* **21.5%** are District Residents
* **50%** are Women
* **62%** Minority Represented