



MURIEL BOWSER
MAYOR

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:

I am pleased to submit to the Council of the District of Columbia the enclosed "Emergency Medical Services Transport Contract Authority Fifth Annual Report (April 2020 – March 2021)."

Pursuant to Section 1 of An Act To classify the officers and members of the fire department of the District of Columbia, and for other purposes, approved June 20, 1906 (34 Stat. 314; 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 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 FEMS unit availability; (2) The impact on FEMS fleet, including the ability to conduct preventative maintenance and the number of operational and reserve units available; (3) The impact on FEMS training schedule; (4) The impact on FEMS 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, 2020 and March 31, 2021.

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

If you have any questions regarding the report, please contact Amy C. Mauro, Esq., FEMS Chief of Staff, at 202-673-3320.

Sincerely,

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

Muriel Bowser

Enclosure

Government of the District of Columbia
FIRE AND EMERGENCY MEDICAL SERVICES DEPARTMENT



**Emergency Medical Services
Transport Contract Authority
Annual Report**

April 2020 – March 2021



WE ARE WASHINGTON
DC GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Emergency Medical Services Transport Contract Authority

Fifth Annual Report (April 2020 – March 2021)

October 2021

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, 2020, and March 31, 2021.

In our previous annual reports, we reported on the positive impact our contract with American Medical Response (AMR) has had in each of the above areas. We are pleased to report this progress continued in the fifth year of implementation. This 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 continues to be the most important factor in the Department’s improved unit availability since 2016. The Department launched the AMR contract on March 28, 2016 and since then 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 Advanced Life Support (ALS) units in March 2017, which, combined with the Department’s transition to Criteria Based Dispatch (CBD) in April 2018, improved ALS unit availability. With a few exceptions, we have had five or more ALS transports available over 90 percent of the time since March 2017. In 2019, the Department added four FEMS BLS ambulances, the first time it added to its 24/7 ambulance response fleet since 2008.

As the COVID-19 pandemic arrived in the District, EMS call volume began a steady decline, presumably due to a decrease in commuter population in the District, a decrease in activity generally during periods of quarantine, and a change in patient behavior towards seeking health care. Nonetheless, a sharp increase in cardiac arrests, as well as the need to don personal protective equipment (PPE) and to decontaminate vehicles because of COVID-19 created new capacity challenges. The continuation of the

AMR contract and the addition of four new FEMS BLS ambulances allowed the Department to successfully manage these challenges.

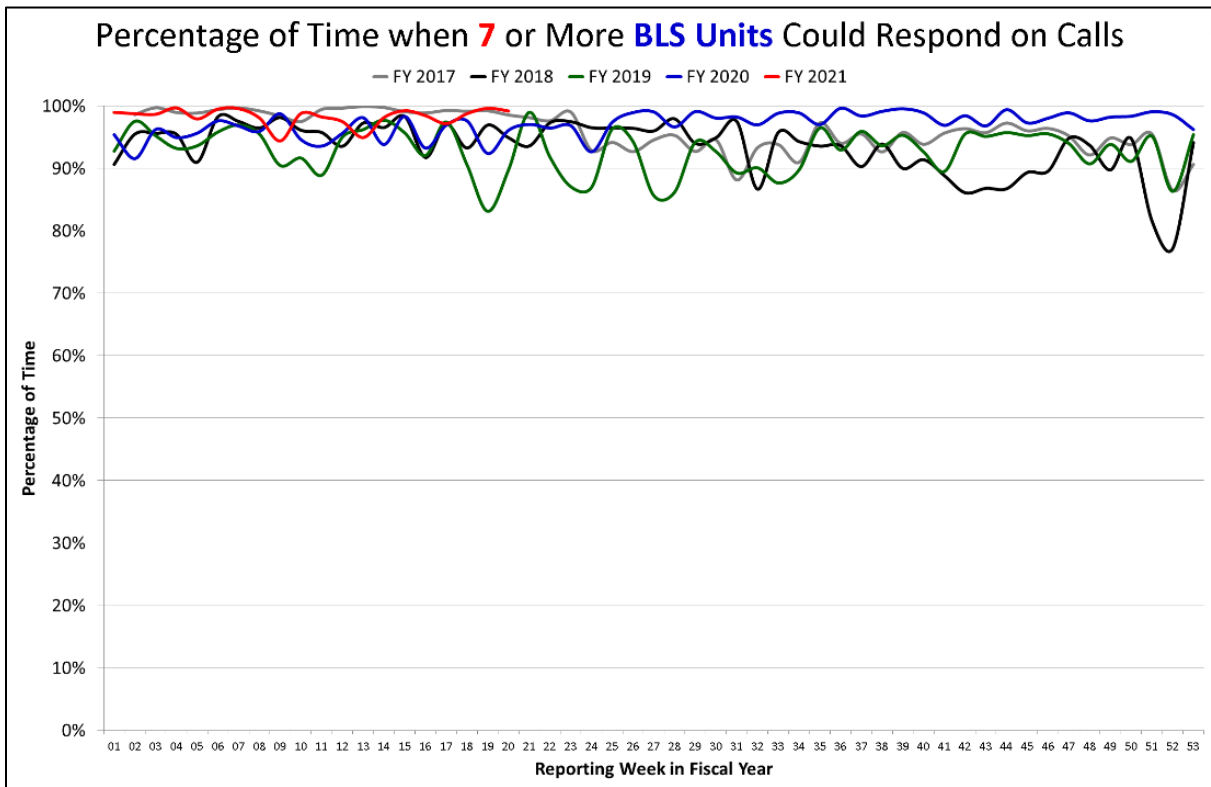
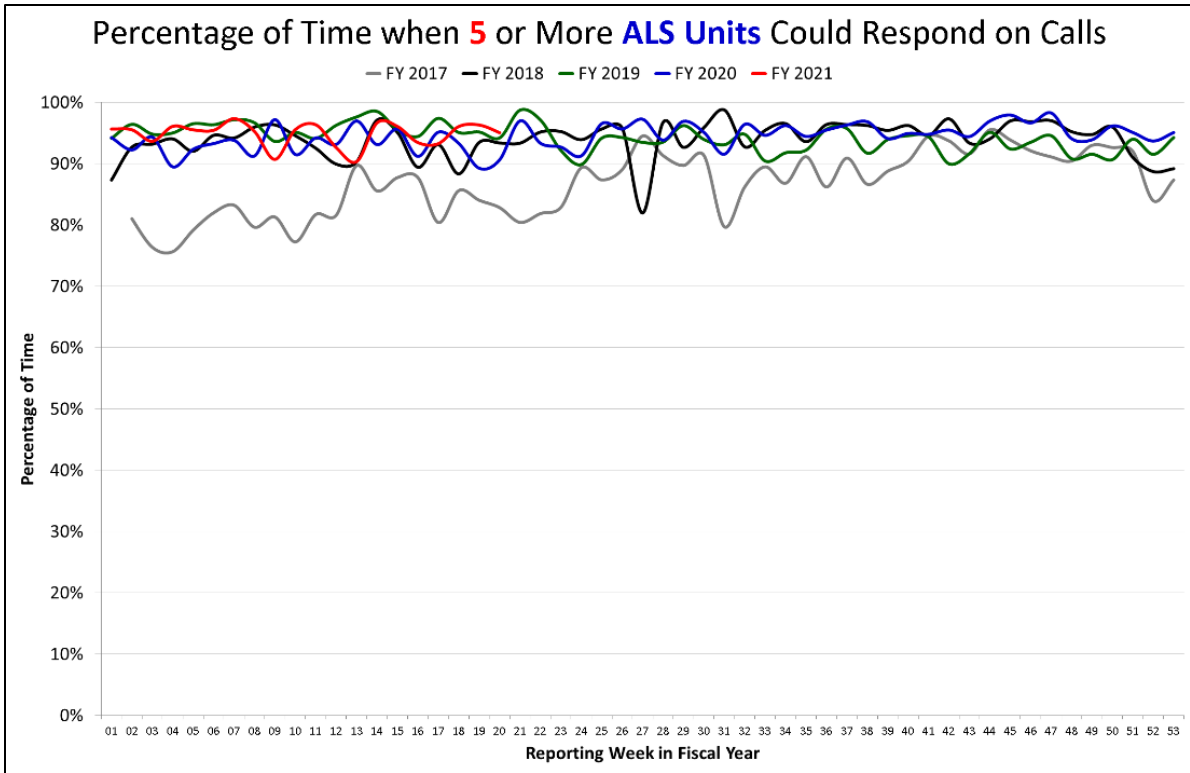
In addition, the *Right Care, Right now* Nurse Triage Line (NTL) was a critical tool in responding to the pandemic. The District is now a national leader in the use of the NTL to divert traffic from emergency departments, a model which jurisdictions around the country scrambled to stand up after the pandemic started. Use of the NTL has enabled both the Department and hospital emergency departments to maintain resources for critical patients throughout the COVID-19 crisis, unlike many other jurisdictions that were overwhelmed by the demands of the pandemic. Addressing these challenges with the NTL is possible and benefits the whole health care system.

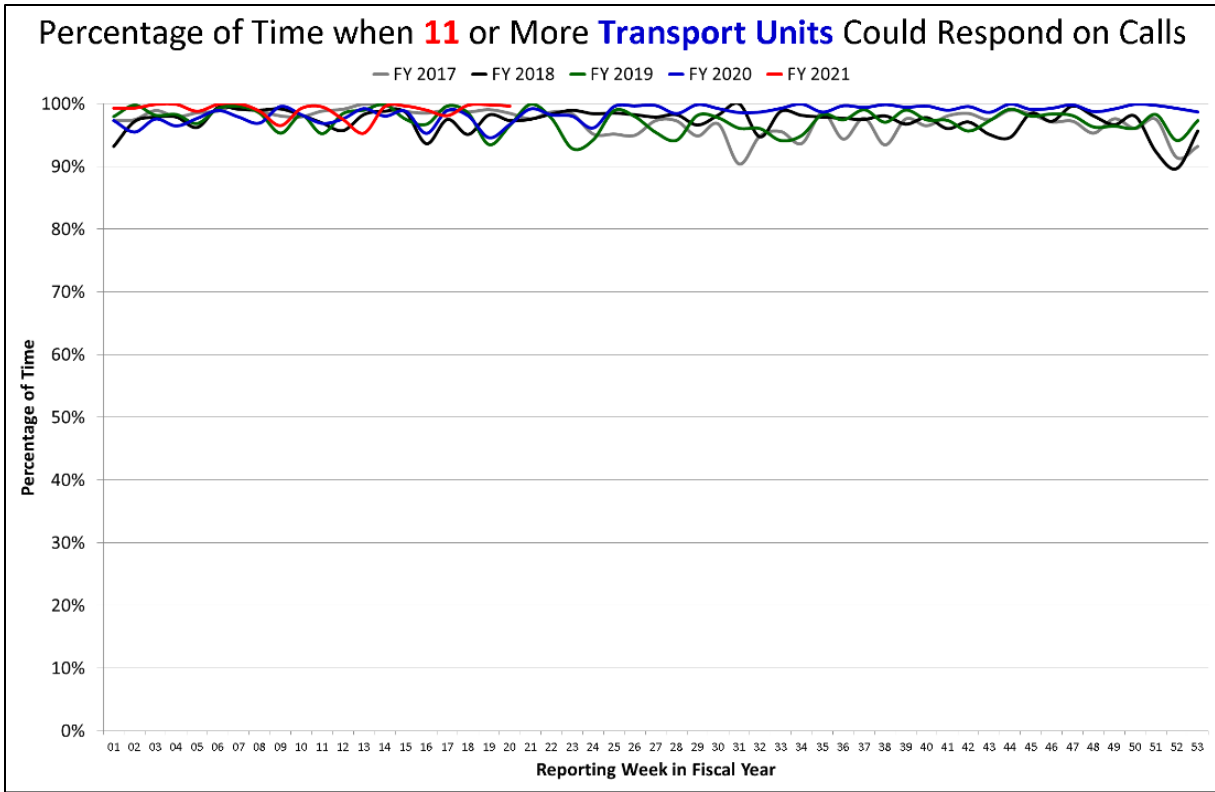
The table below shows FEMS transport unit availability by fiscal year (average percentage of time during each fiscal year) from 10/3/2016 to 3/1/2021:

TRANSPORT UNIT AVAILABILITY	FY-17 Average %	FY-18 Average %	FY-19 Average %	FY-20 Average %	FY-21 Average %
5 or More (ALS)	83%	92%	95%	93%	95%
7 or More (BLS)	98%	95%	92%	94%	98%
11 or More (ALL)	93%	97%	97%	97%	99%

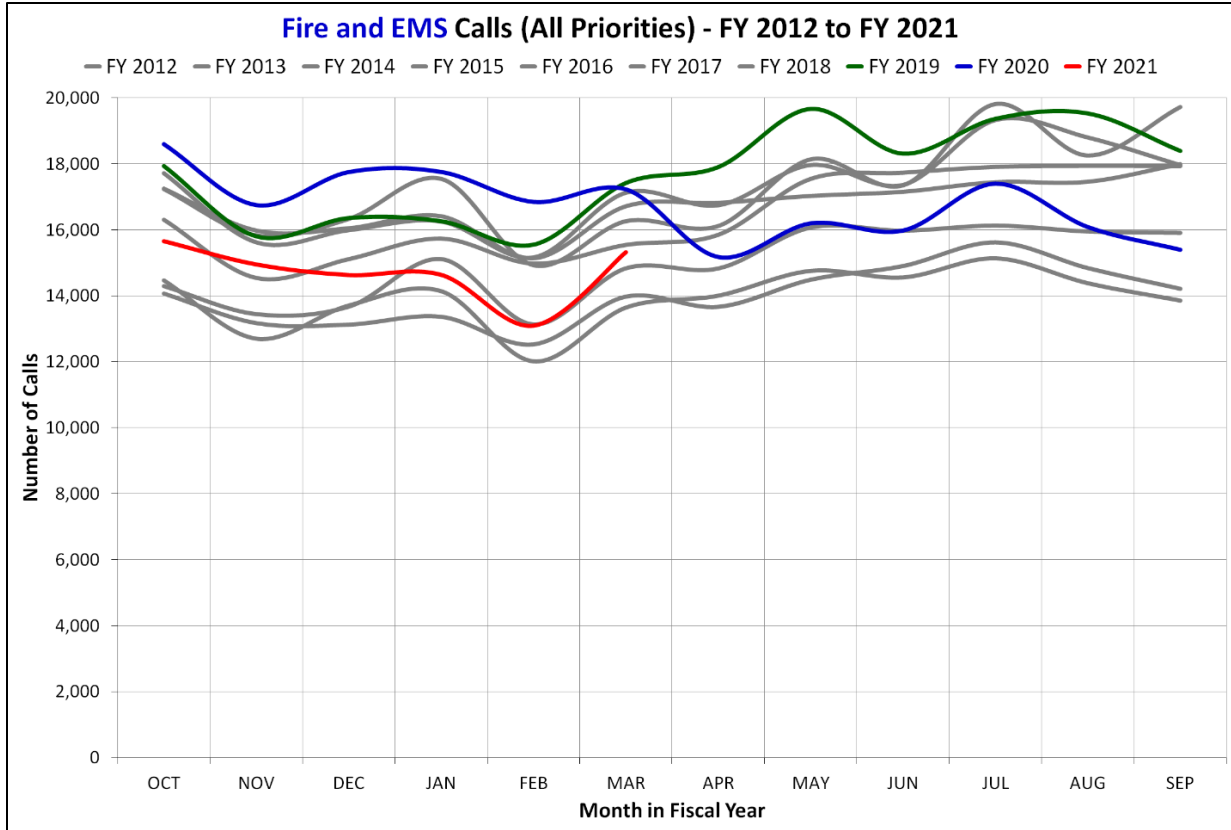
Transport Unit Availability by Week

The charts below show FEMS ALS, BLS and combined transport unit availability by week (percentage of time during each week of the fiscal year) from 10/3/2016 to 3/1/2021:





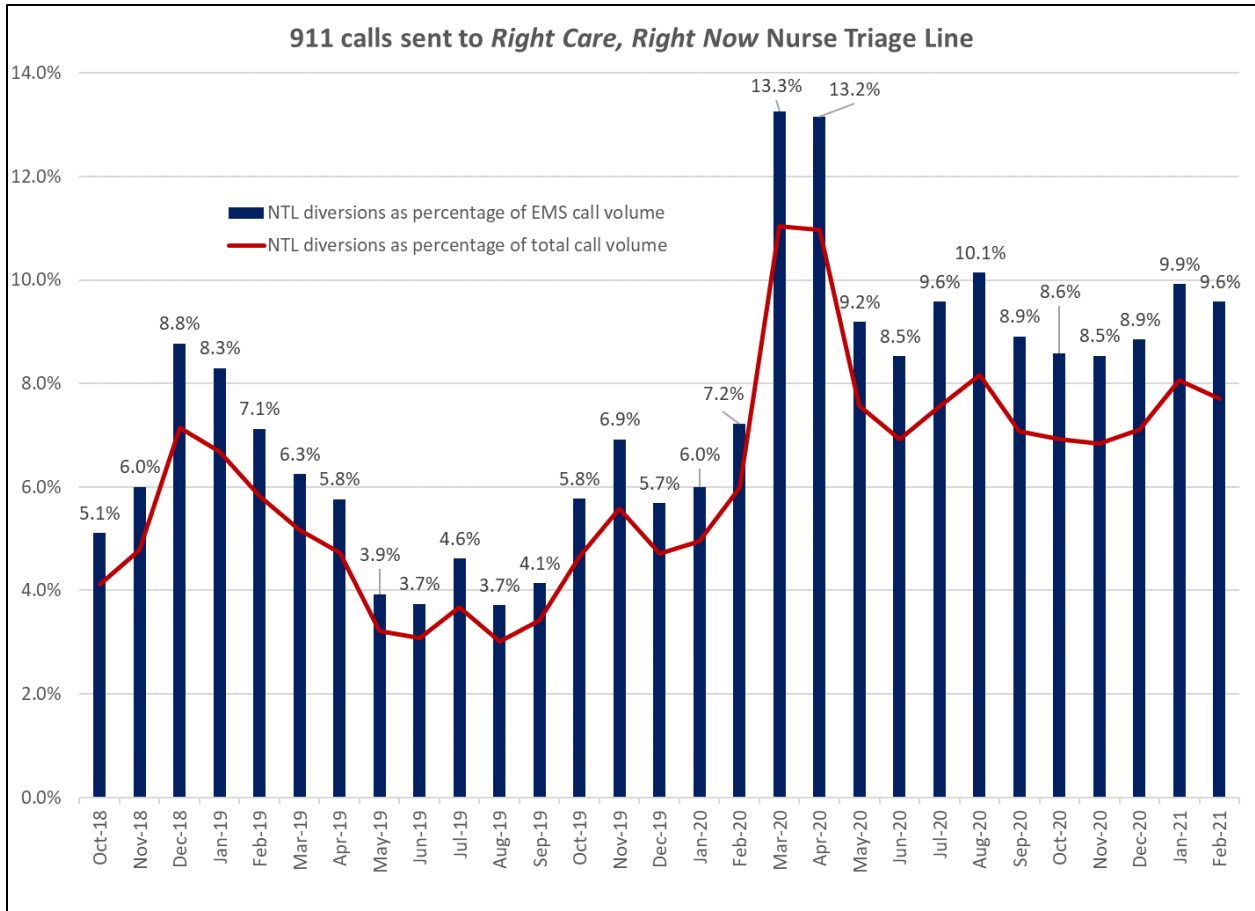
The following chart shows the high call volume we experienced late in FY 2020, followed by the significant drop during the advent of COVID-19. FY 2021 call volume is trending back to pre-COVID 19 levels.



Patient Diversions from ER Departments

Through March 2021, we regularly divert between eight and 10% of our daily EMS call volume to the NTL for triage, ultimately diverting about 18 patients daily from Emergency Departments. NTL has had a modest impact on overall call volume since its launch, but has continued to be successful in diverting patients from Emergency Departments and linking those patients to better quality primary care. Our Continuous Quality Improvement (CQI) Division continues to monitor clinical performance related to the use of the NTL for patients referred from Department EMTs and paramedics.

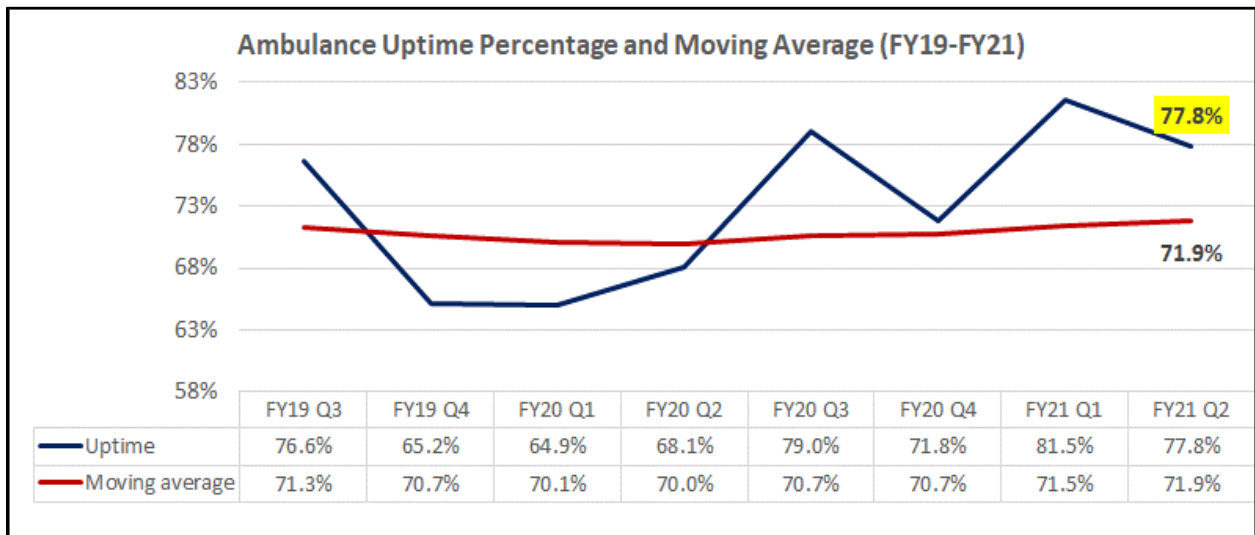
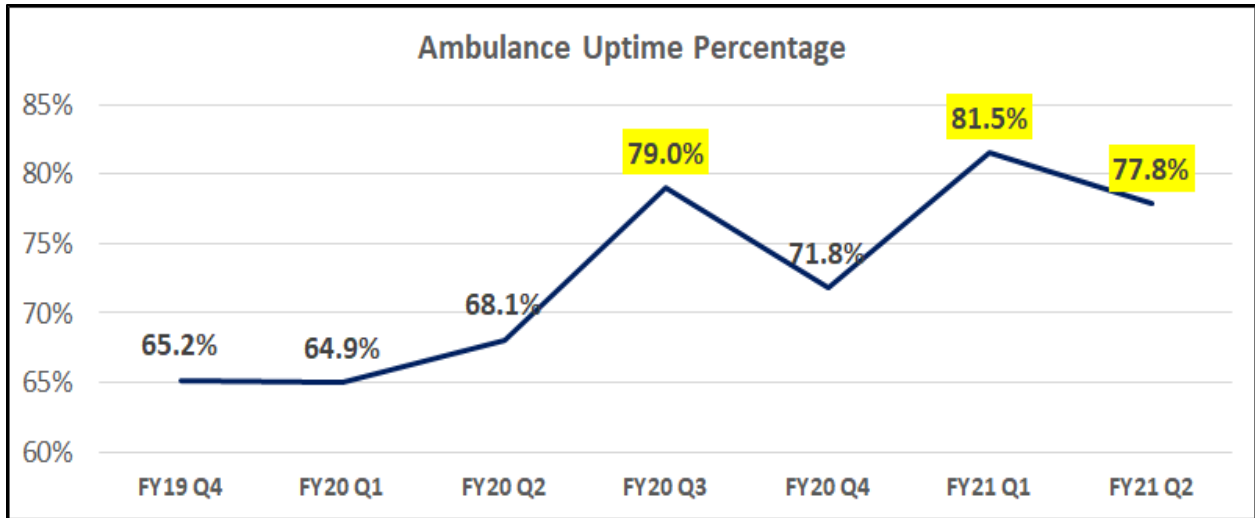
The chart below details our NTL diversions as a percentage of call volume from October 2018 through February of 2021.



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

Within the last year, the accomplishments of the Department’s Apparatus Division were remarkable as Fleet produced the highest uptime numbers across all asset classes (ambulances, engines, and ladder trucks) in recent history. Our AMR partnership has contributed to the factors that lead to this success, including the ability to provide consistent preventative maintenance efforts and adhere to the apparatus replacement plan. Throughout the COVID-19 pandemic, the division has remained fully operational, with some staffing challenges from COVID infections.

As the charts below show, we have maintained an improved ambulance “up time” percentage during year five of the AMR contract. Although we did not meet our goal during the first two quarters of FY 2020, we saw vast improvement during the second half of the year, and the Department’s ambulance uptime percentage and moving average over the past three years shows our progress.



The AMR contract and the District’s efforts to stay on schedule with ambulance purchases have enabled the Department to conduct significantly more preventive maintenance and have also increased the lifespan of its vehicles. Delivery of apparatus generally has been subject to global supply chain challenges in raw materials used for assembly, which continued through the reporting period and into the end of FY 2021. The Department took delivery of 10 new transport units from October 1, 2020, through March 31, 2021. These units will be placed in frontline service which will allow for replacing other units in our reserve fleet of transport units.

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

The AMR contract continues to support our efforts to conduct regular training for our members and to be able to rapidly deliver novel training as the need arises. Due to the more frequent in-service training provided since the AMR launch, new operational components can be more easily introduced and any updates from external credentialing bodies can be more effectively made.

EMS/Related Training

The table below outlines the EMS training courses provided by the Department from April 1, 2020, to March 31, 2021. The Department delivered a total of 107,436 hours of training:

EMS TRAINING HOURS				
	Course Name	Number of Participants	Hours per Class	Total Hours
1	Advanced Cardiovascular Life Support (ACLS) Provider	39	16	624
2	Advanced Cardiovascular Life Support (ACLS) Refresher	172	8	1,376
3	Advanced Medical Life Support (AMLS) Provider	50	16	800
4	Advanced Medical Life Support (AMLS) Refresher	49	8	392
5	AHA Full Code App Tutorial	332	1	332
6	Albuterol MDI Training	1,564	1	1,564
7	ALS Operations/Protocols	51	200	5,720
8	BLS Operations/Protocols	112	80	7,680
9	CAPCE-approved Target Solutions Courses	<i>All Members</i>	<i>Varies</i>	18,588
10	Controlled Medications Program: Roles and Responsibilities	52	2	104
11	COVID-19 Triage Protocols and Care Modifications	1,450	2	1,505
12	CPR/BLS for Healthcare Providers	179	4	716
13	Emergency Medical Technician Course	76	311	23,636
14	Expedient Application of the LUCAS Device	535	1	535
15	Field Training Officer/Mentorship Program	32	16	512
16	Frazer Ambulance Training	63	1	63
17	LGBTQ Cultural Competency Refresher	1,015	2	2,030
18	Module 11: Pumps, Pipes, Clogs, and Leaks	279	4	1,116
19	Module 12: Sick, Psych, or Substance?	251	4	1,004
20	Module 13: Homeless, NOT Helpless	295	4	1,180
21	Module 14: Brains, Trauma, and Triage	1,691	4	6,764
22	Module 15: All About Pediatrics	1,638	4	6,552
23	Module 16: Cardiac Issues and End-of-Life Care	1,447	4	5,788
24	NFPA Bloodborne Pathogens Safety	74	1	74
25	Nurse Triage Line Performance Report	1,489	1	1,489
26	Paramedic Grand Rounds Sessions (various)	1,235	4	4,940
27	Pediatric Advanced Life Support (PALS) Provider	56	16	896
28	Pediatric Advanced Life Support (PALS) Refresher	147	8	1,176
29	Pet O2 Mask Training	1,526	1	1,526
30	Pre-Hospital Trauma Life Support (PHTLS) Provider	37	16	592
31	Pre-Hospital Trauma Life Support (PHTLS) Refresher	181	8	1,448
32	Spinal Motion Restriction Updates	2,017	2	4,034
33	Transition to D10W Protocol for Hypoglycemia	58	1	58
34	Updated FEMS Stroke Protocol	879	1	879
35	VAN/FAST Stroke Assessment Scale	325	1	325
36	Viral Filter Training	1,418	1	1,418
				107,436

The Training Academy continues to fulfill its mission while meeting COVID-19 social distancing guidelines. Recruit and other classes were temporarily put on hold in 2020, but the Department adapted with more use of distance learning and smaller classes and has adjusted to the new normal of COVID-19. Additionally, the Department has added training capability at the PR Harris School in Southeast as well as the old Engine 22 in Brightwood. Two comprehensive training classrooms were developed at PR Harris to increase the ability to provide real life scenario training for our members, and classroom and drive-up simulation space was added at Old Engine 22.

The Department has also continued to work with AMR and the Eastern High School Health Science coordinator to offer pathways to employment to students who successfully complete the National Registry EMT process. AMR offers job-fair style programs for Eastern High School in hopes of increasing the number of students who apply to participate in the EMT program being offered. AMR is also supporting the startup of a non-profit to support cost assistance and training for youth in underserved communities within the District interested in becoming EMTs. AMR has agreed to provide employment opportunities to individuals who successfully complete the training program.

Fire-Based/Related Training

The table below outlines the fire-based/related training courses provided by the Department in the second half of FY 2020, and first half of FY 2021:

FIRE-BASED/RELATED TRAINING COURSES
Course Name
Back to Basics RIT: 2019
Confined Space - Rescue Technician
Emergency Vehicle Operator Training
EVOC Train-the-Trainer
Hazardous Materials Technician
Health and Safety Officer
ICS 300/400
Incident Safety Officer
Initial Emergency Vehicle Operator Training
Instructor I
Instructor II
Instructor II (Web-based virtual classroom)
Mine Safety and Health Administration (MSHA) Standards Review
MSHA Standards Refresher
MSHA Tunnel Rescue Certification
MSHA Tunnel Rescue Re-Certification
NFPA 1403: Live Fire Training Evolutions
Site Operations
Structural Collapse - Rescue Technician
Structural Collapse Rescue
Supervisor II
Trench Rescue
Vehicle Rescue
Wrecker Class (Special Ops)

Our Department's In-Service Fire Suppression Proficiency Skills assessments are continuing, and we will have over 70% of our officers, technicians, and firefighters assessed by the end of FY 2021. These assessments allow for the evaluation of our members abilities and to identify where training needs can be adjusted to improve skills and ensure safety and effectiveness. The assessments are also helping to uncover cultural deficiencies within the department as they relate to our overall operational abilities.

Below are some of our recent observations:

- Most of our challenges during these assessments are resulting from members not being correctly dressed within standard time frames for an emergency (90 seconds). However, there have been weekly failures as a result of a members missing one or two pieces of personal protective equipment upon reporting to the Training Academy (for example, members reporting without a hood, gloves or the correct face piece).
- Our members did well on the "Calling a MAYDAY" assessment, using a portable radio. The largest deficiency found was the inexperience of our Firefighters in using a portable radio. This should be an ongoing drill topic that is practiced at the company level.
- For the past several years, the Training Academy has provided forcible entry training (which utilizes traveling door props that are rotated around the city for companies to use). Failures during recent assessments have been routine because of the incorrect use of tools and/or attempts to use brute-force instead of using a mechanical advantage. Continued training in this area is needed.
- Ground ladder placement failures have been observed which have mostly been a result of improper placement of the tip vs. the window and overall use. Fine tuning these skills should be performed at the company level and will be incorporated in upcoming fire-based drills at the Training Academy.
- Our greatest challenges have been with our assessments of how to advance a pre-connected handline. Failure rates were observed as a result of the back-up firefighter not properly managing a majority of the attack line. This is an issue that was identified prior to the Proficiency Skills Assessments and is now a focal area for Recruit and Cadet firefighter training.

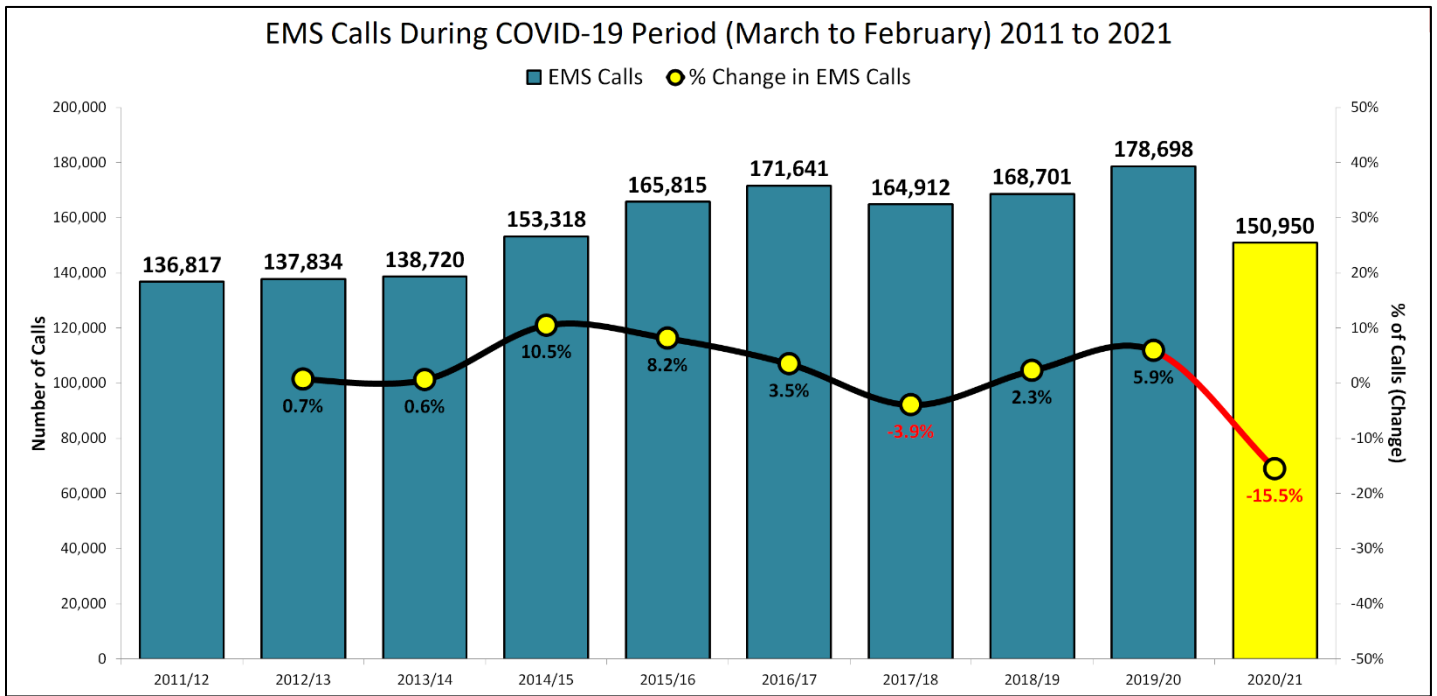
The Training Division will be using the compiled data from these assessments to revise training curriculum moving forward to strengthen safety levels and promote efficiency.

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

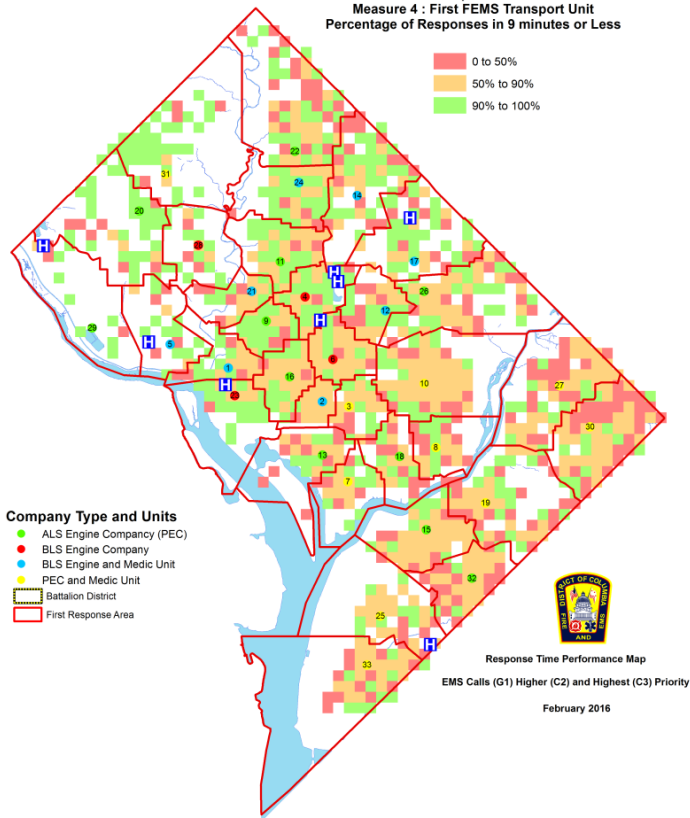
As we have shown in previous reports, after launching the AMR contract our ambulance response times significantly improved from 2016 to 2018. After that period, increased call volume trends continued through the reporting period in 2019-2020, thus increasing response times and hospital drop times. These factors, as well as the Providence Hospital closure, contributed to higher response times.

EMS call volume began a steady decline from the onset of COVID-19 in the District due to the periods of quarantine and a change in patient behavior towards seeking health care. The time required for personnel to don personal protective equipment (PPE) and to decontaminate vehicles created new

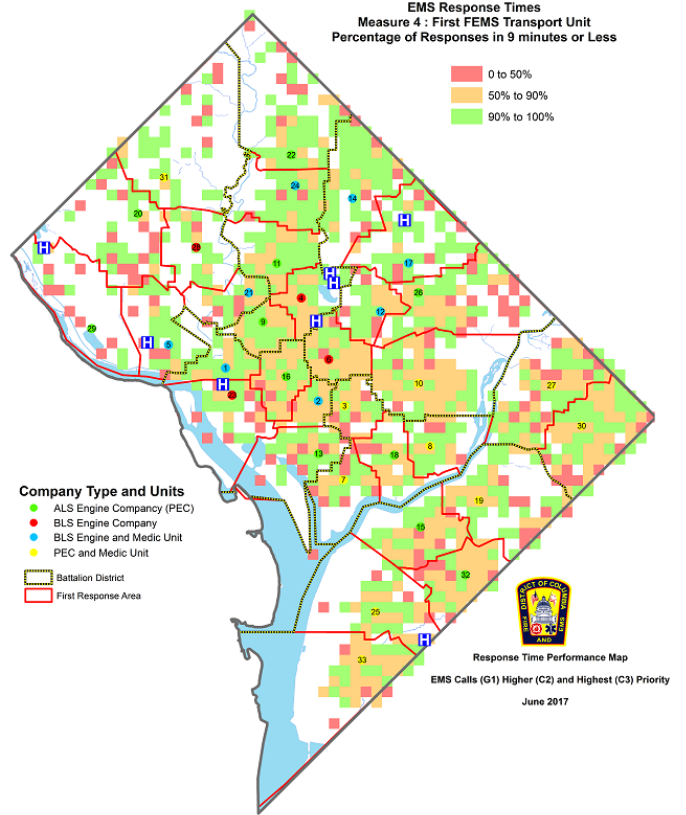
capacity challenges. The chart and the maps below show our call volume details from 2011 to 2021 and our response time improvements from the beginning of the AMR contract to current.



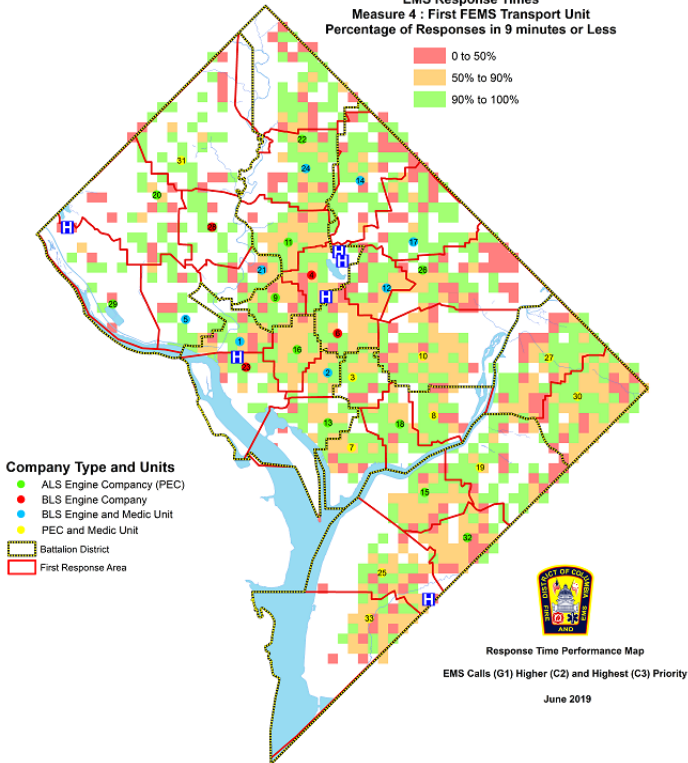
EMS Response Times
Measure 4 : First FEMS Transport Unit
Percentage of Responses in 9 minutes or Less



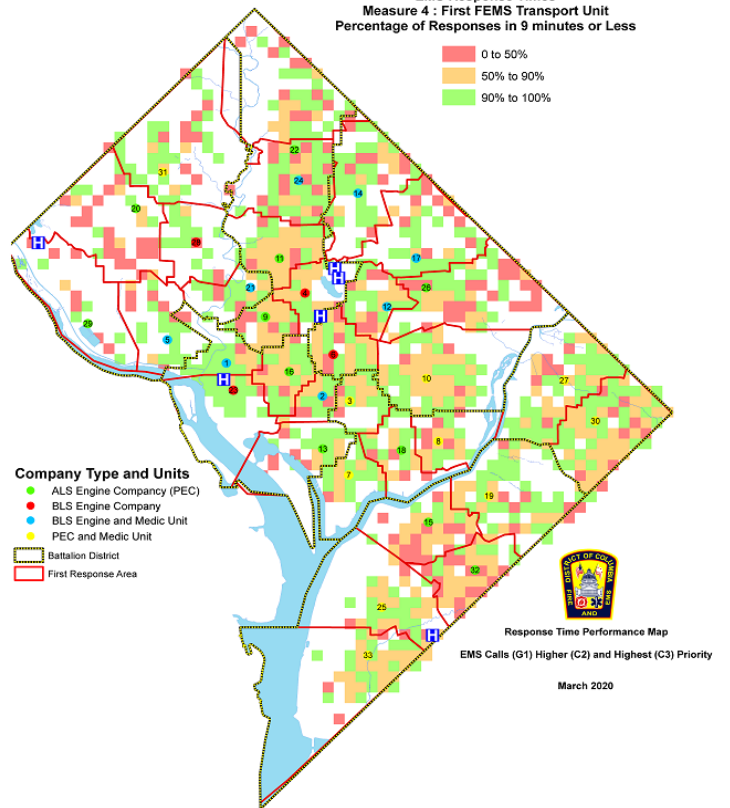
EMS Response Times
Measure 4 : First FEMS Transport Unit
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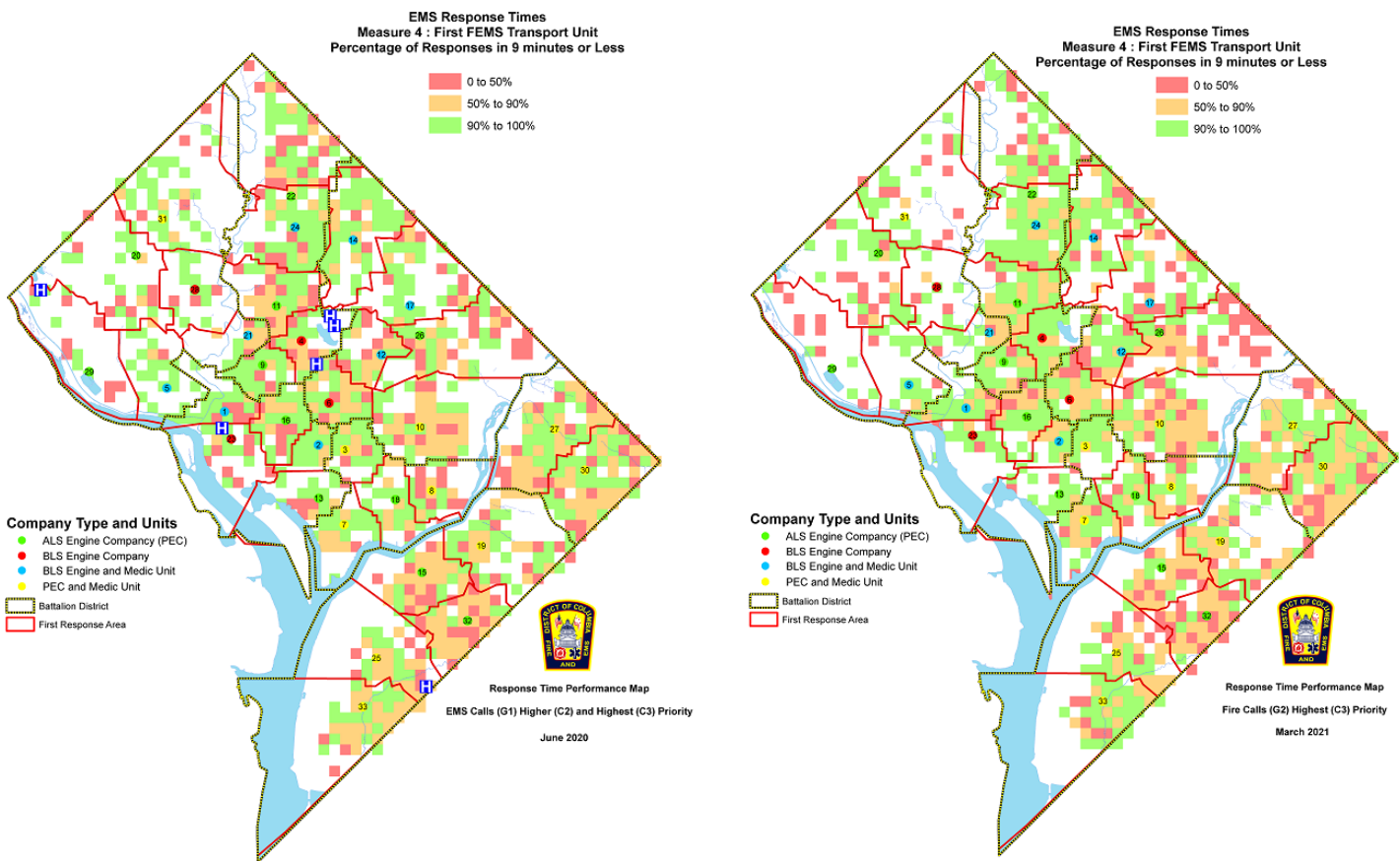


EMS Response Times
Measure 4 : First FEMS Transport Unit
Percentage of Responses in 9 minutes or Less



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





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

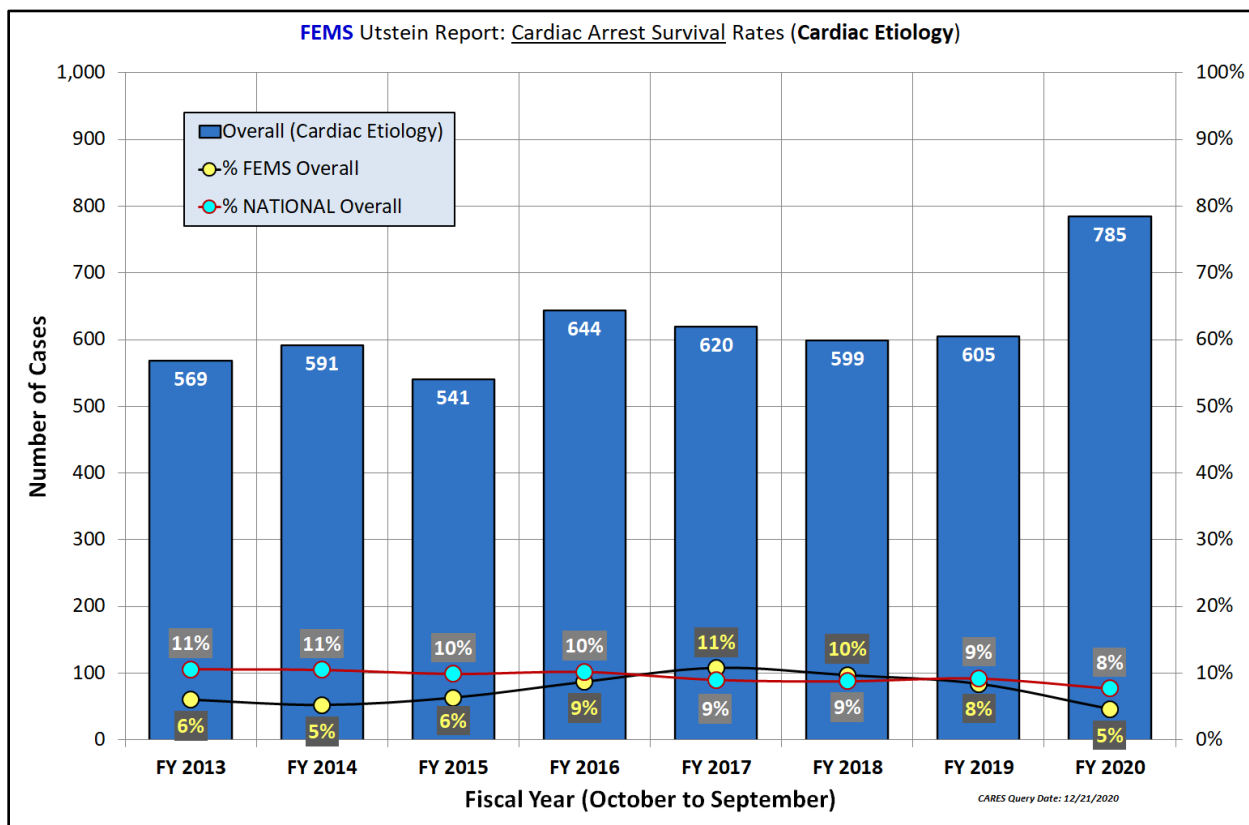
Third party transport, NTL, and measures intended to improve patient care overall (training, the best equipment, and strong Continuous Quality Improvement) are all critical components to the Department’s ongoing efforts to improve EMS care in the District. Efforts to increase utilization of the NTL for as many calls as appropriate, and to also reduce 911 volume are ongoing and will undoubtedly improve the delivery of pre-hospital medical care to the visitors to and residents of the District. At the same time, we are cognizant that patients’ fears about seeking health care during the pandemic can have negative patient outcomes. For this reason, we have used our NTL public education budget throughout the pandemic to also fund messages about the importance of seeking help for symptoms that may indicate a serious or life-threatening condition, and we will continue to do so throughout the pandemic.

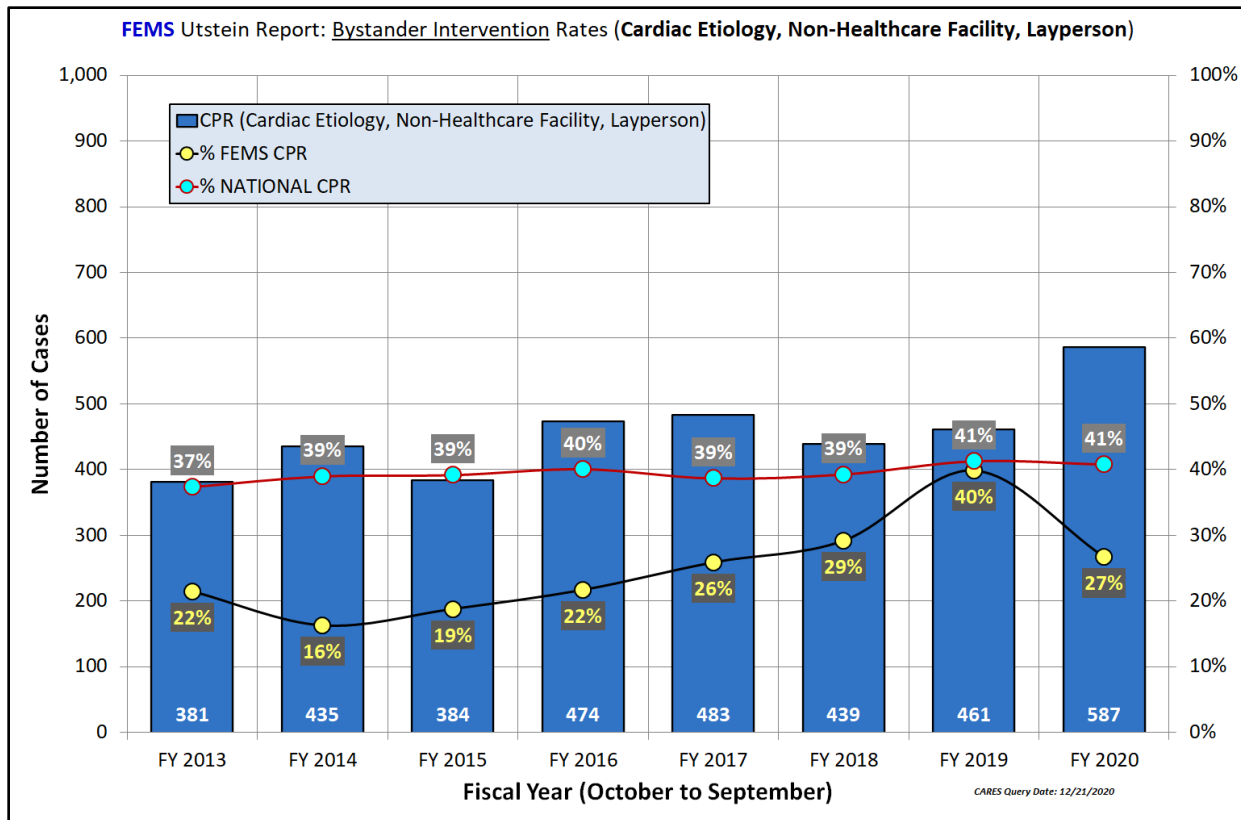
Cardiac Arrest Survival and CPR Performance

The Department continues its efforts to increase the District’s cardiac arrest survival rates. The following charts below compare the District’s sudden cardiac arrest survival outcomes to the national average and to prior years. The first three charts are those Utstein measures used by the national EMS community to measure EMS performance because they analyze cases where EMS intervention is most

likely to affect the patient’s outcome. The fourth chart measures the rate of bystander CPR in these cases. Through 2019, the District continued its positive trend in survival rates. In 2020, however, the pandemic had a devastating impact on cardiac arrest survival in the District. There was also a sharp decrease in bystander CPR presumably due to the increase in the number of unwitnessed arrests due to social distancing, as well as perhaps a resistance among bystanders to providing help because of the virus. The District’s experience in 2020 with these decreases was consistent with the national experience. See <https://mycares.net/>.

Fortunately, the District continues to perform favorably for those cases where EMS intervention is most likely to succeed, and that are the best measure for EMS performance in sudden cardiac arrest. As the District reopens, the Department is reinvigorating its Hands on Hearts program, which was suspended due to COVID-19 restrictions.





Stroke Performance

During FY 2020, the Continuous Quality Improvement Division began reviewing the assessment and care of stroke patients after the implementation of a screening tool known as the VAN assessment (Vision, Aphasia, Neglect), which is specific to occlusions of large arteries in the brain. This review examined how often stroke assessments are performed, as well the outcomes associated with a prehospital positive stroke assessment. The report found when a stroke assessment was conducted by Department EMTs and paramedics, 50% had a confirmed stroke. Additionally, large vessel occlusion screening was introduced in FY20.

During FY 2021, the Department is adopting the National EMS Quality Alliance Compass 2.0 Measure (Compass Measures) to monitor and evaluate clinical performance. The measures, which are part of an effort to establish a national standard for EMS performance, fall into six clinical and operational categories which are based on the most relevant and up to date prehospital evidence for hypoglycemia, pediatrics, stroke, seizure, trauma, and safety. In FY 2022, the Department will report on its performance goals for these measures using FY 2021 as a baseline for improvement.

- (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 includes the cost of adding 25 additional ambulances

to the Department's fleet and almost 300 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.

The Department does not recommend providing the same service that a third party BLS provider provides in-house. Providing the service through the current contract is much more cost efficient, with the expenditure of \$12 million versus the potential expenditure of well over \$30 million for doing so in-house, plus continuing staffing and maintenance costs. Also, 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.

Preserving the AMR partnership is particularly critical because of the Department's experience during the COVID-19 pandemic. Depending on the advancement of treatment and vaccines, it is highly likely that when the District fully reopens, we will quickly find ourselves again with high call volume challenges. Because of this, we advise that we continue to do the following:

- Maintain full funding of the AMR contract. This is critical and if it is jeopardized, we will return to the days of an unsafe EMS system where demand outpaces capacity;
- Continue to transport non-ambulatory patients to clinics using AMR;
- Support the continued growth/strengthening of the Nurse Triage Line;
- Invest in public education for the types of care which are best handled at neighborhood clinics rather than Emergency Departments; and
- Implement Health Care Transformation Commission recommendations that have the same intent and goals as the Nurse Triage Line, including:
 - Creating alternative pathways for mental health and substance abuse patients; and
 - Implementing changes at hospitals that improve patient throughput, for example, regulatory changes and more transparency in real time info on the number of hospital beds available.
 - DBH/FEMS Stabilization and Sobering Center is in development with the goal of starting operations in FY22.

(7) Conclusion

Thanks, in part, to the stability created by the Department's partnership with AMR, the Department has been able to make several important investments over the course of the last five years that have improved patient outcomes and saved lives across the District. The statutory authority for the AMR contract has been critical in freeing up FEMS resources to respond to patients with life threatening injuries and illnesses. In fact, the AMR contract has been the foundation of our reform of the EMS system.

We believe our EMS system has evolved into a system that makes more medical and financial sense than the old one, a system that preserves our most specialized resources for our most critical patients and that uses supplemental, more efficient resources for lower acuity patients. Our improvements have received national attention and we must continue this momentum.



MURIEL BOWSER
MAYOR

The Honorable Phil Mendelson
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Dear Chairman Mendelson:

I am pleased to submit to the Council of the District of Columbia the enclosed "Emergency Medical Services Transport Contract Authority Semi-Annual Report (October 2020 – March 2021)."

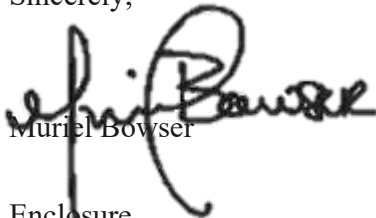
Pursuant to Section 1 of An Act To classify the officers and members of the fire department of the District of Columbia, and for other purposes, approved June 20, 1906 (34 Stat. 314; D.C. Code § 5-401), the Fire and Emergency Medical Services Department (FEMS) is authorized to contract with third parties to provide supplemental pre-hospital medical care and transportation to persons requiring basic life support (BLS).

FEMS, the Office of Unified Communications (OUC), and the third-party ambulance operator are required under the statute to provide semi-annual reports to the Council regarding third party contractor operations. The enclosed report provides the required information for the period from October 2020 through March 2021.

Prior to legislative authorization, FEMS's ambulance and staff resources did not adequately meet the District's emergency services call volume demand, and FEMS contracted for the transport of BLS patients by a third-party provider in 2016 to supplement those resources. Third-party transport has stabilized a system that was in crisis in 2016. It has allowed FEMS to improve ambulance unit availability, up-time for all vehicles, training for members, and patient outcomes, including improvement in cardiac arrest survival. This stability also allowed FEMS and OUC to launch the innovative *Right Care, Right Now* Nurse Triage Line (NTL) in 2018 and address previously unforeseen challenges like the COVID-19 pandemic.

If you have any questions regarding the enclosed report, please contact Amy C. Mauro, Esq., FEMS Chief of Staff, at 202-673-3320.

Sincerely,


Muriel Bowser

Enclosure



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 (October 2020 – March 2021)**

October 2021

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). Prior to this legislative authorization, the Department’s resources could not meet the call volume demand, which put the lives of critical patients at risk. The Department began transport of BLS patients by a third-party provider in 2016. This change to decades of Department practice has been the foundation of Mayor Bowser’s commitment to reform of the District’s Emergency Medical Services (EMS) system. Third-party transport has stabilized a system that was in crisis in 2016. It has allowed the Department to improve ambulance unit availability, up-time for all vehicles, training for members, and patient outcomes, including improvement in cardiac arrest survival. This stability also allowed the Department to launch the innovative *Right Care, Right Now* Nurse Triage Line (NTL) in 2018 and address previously unforeseen challenges like the COVID-19 pandemic.

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 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 first and second quarters (the first half) of Fiscal Year 2021.

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.*

In the first and second quarters of FY 2021, the Department continued outreach to educate the public on the availability of non-emergency health care through primary care physicians and neighborhood health clinics, as well as continuing public education on the Nurse Triage Line (NTL). Use of the NTL has enabled both the Department and hospital emergency departments to maintain resources for critical patients throughout the COVID-19 crisis, unlike many other jurisdictions that were overwhelmed by the demands of the pandemic. The Department has engaged public relations firm Granicus to develop and implement public outreach in coordination with the internal Public Information Office.

The Department continues to host a variety of resources regarding the proper use of 911 and the Right Care Right Now (RCRN) initiative on our website (<https://fems.dc.gov/page/frequently-asked-questions-right-care-right-now>), 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; and
- Press release information.

All patients who participate in the NTL are contacted for a follow-up by the nurse within 24 hours. Of those who responded, the vast majority served by the NTL in the first two years of operations have had a positive experience. Some of them shared their plan to use the primary care provider they were connected to in the future. Efforts to increase utilization of the triage nurse for as many calls as appropriate, and to also reduce 911 volume, are ongoing and improve the delivery of pre-hospital medical care to the visitors to and residents of the District.

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

The Department hired a total of 29 Firefighter EMTs and 18 Firefighter Paramedics between October 1, 2020, and March 31, 2021. For the residency of those hired, along with civilian hires, see table, below.

Place of Residency	Firefighter/EMT	Firefighter Paramedic	FF Cadet	Civilian
District of Columbia	15	2	22	2
Maryland	8	5	-	4
Virginia	2	6	-	1
Pennsylvania	1	2	-	-
New Jersey	3	-	-	-
Delaware	-	2	-	-
West Virginia	-	1	-	-
Total:	29	18	22	7

Please note that the states of residency for the hires listed reflect their residency at the time of application only.

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.

The Mayor proposed increasing fees to reflect the true cost of providing that service as part of the “Fiscal Year 2022 Budget Support Act of 2021” (Bill 24-285, introduced May 27, 2021). The new cap for fees will allow the Department to negotiate higher reimbursement rates from Medicaid, Medicare, and private insurers. The Department retains broad authority to ensure District residents will be minimally impacted by any increased EMS fees through existing waiver processes. Council approved the “Emergency Medical Services Fees Amendment Act of 2021” at Final Reading on August 10, 2021 (Sec. 3001).

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 took delivery of 10 new transport units from October 1, 2020, through March 31, 2021. These units were placed in frontline service which allowed for replacing other units in our reserve fleet of transport units.

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 first and second quarters of FY 2021, the Department delivered over 68,000 hours of EMS training to our membership. We have been integrating in-person training (maintaining appropriate COVID-19 safety precautions), while continuing our emphasis on effective online training developed during the beginning of the pandemic. These new content delivery methods have been well-received by our membership. The Department was able to significantly increase EMS training hours over Q3/Q4 of FY 2020 (as indicated by the previous semi-annual report, when we reported a total of 38,900 hours for the 6-month period).

Course Name	Number of Participants	Hours per Class	Total Hours
Advanced Cardiovascular Life Support (ACLS) Provider	25	16	400
Advanced Cardiovascular Life Support (ACLS) Refresher	111	8	888
Advanced Medical Life Support (AMLS) Provider	36	16	576
Advanced Medical Life Support (AMLS) Refresher	38	8	304
AHA Full Code App Tutorial	92	1	92
Albuterol MDI Training	197	1	197
ALS Operations/Protocols	23	200	4,600
BLS Operations/Protocols	80	80	6,400
CAPCE*-approved Target Solutions Courses	<i>All Members</i>	<i>Varies</i>	9,428
Controlled Medications Program: Roles and Responsibilities	29	2	58
COVID-19 Triage Protocols and Care Modifications	55	2	110

Course Name	Number of Participants	Hours per Class	Total Hours
CPR/BLS for Healthcare Providers	143	4	572
Emergency Medical Technician Course	42	311	13,062
Expedient Application of the LUCAS Device	115	1	115
Field Training Officer/Mentorship Program	32	16	512
Frazer Ambulance Training	63	1	63
LGBTQ Cultural Competency Refresher	856	2	1,712
Module 11: Pumps, Pipes, Clogs, and Leaks	244	4	976
Module 12: Sick, Psych, or Substance?	205	4	820
Module 13: Homeless, NOT Helpless	225	4	900
Module 14: Brains, Trauma, and Triage	834	4	3,336
Module 15: All About Pediatrics	1,638	4	6,552
Module 16: Cardiac Issues and End-of-Life Care	1,447	4	5,788
NFPA Bloodborne Pathogens Safety	74	1	74
Nurse Triage Line Performance Report	249	1	249
Paramedic Grand Rounds Sessions (various)	841	4	3,364
Pediatric Advanced Life Support (PALS) Provider**	42	16	672
Pediatric Advanced Life Support (PALS) Refresher**	104	8	832
Pet O2 Mask Training	1,526	1	1,526
Pre-Hospital Trauma Life Support (PHTLS) Provider	23	16	368
Pre-Hospital Trauma Life Support (PHTLS) Refresher	168	8	1,344
Spinal Motion Restriction Updates	841	2	1,682
Transition to D10W Protocol for Hypoglycemia	15	1	15
Updated FEMS Stroke Protocol	879	1	879
VAN/FAST Stroke Assessment Scale	70	1	70
* Commission on Accreditation for Prehospital Continuing Education			68,536
**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. Average "drop time" for all FEMS transport units combined (including ambulances and medic units) is shown during the first half of FY 2021 (by month) in the table below:

Month (FY 21)	OCT	NOV	DEC	JAN	FEB	MAR
AVG Drop Time	49:19	39.48 ¹	48.22	48.43	49.54	53.38

¹ FEMS identified a gap in reported "transport arrive" (TA) CAD time stamps during the reporting period. This error began on or about 10/26/20, the date of a scheduled systems upgrade. OUC was notified of the error and corrected the fault. Because FEMS transport counts and drop time measures are recorded using TA data time stamps, the transport count and drop time performance data reported for November is inaccurate (Ambulances and Medic Units without TA time stamps were not counted).

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 (3/1/2020 to 2/28/2021), 72,244 patient transports were completed by FEMS and AMR ambulances. Of these transport cases, 45,122 were patients that could be uniquely identified by full name and birthdate. The remaining 2,445 (or approximately 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 (March 2020 to February 2021), for patients transported two or more times, **10,319 (or 23%) of patients** accounted for **37,441 (or 52%) of all patient transports**:

# of Transports	# of Patients	% of Patients	# of Total Transports	% of Total Transports
1	34,803	77%	34,803	48%
2 or more	10,319	23%	37,441	52%
TOTAL	45,122	100%	72,244	100%

During the last **twelve-month** period (March 2020 to February 2021), for patients transported two or more times, **5,017 (or 18%) of patients** accounted for **15,573 (or 41%) of all patient transports** completed by **FEMS ambulances**:

# of Transports	# of Patients	% of Patients	# of Total Transports	% of Total Transports
1	22,697	82%	22,697	59%
2 or more	5,017	18%	15,573	41%
TOTAL	27,714	100%	38,270	100%

During the last **twelve-month** period (March 2020 to February 2021), for patients transported two or more times, **4,440 (or 19%) of patients** accounted for **14,939 (or 44%) of all patient transports** completed by **AMR ambulances**:

# of Transports	# of Patients	% of Patients	# of Total Transports	% of Total Transports
1	19,035	81%	19,035	56%
2 or more	4,440	19%	14,939	44%
TOTAL	23,475	100%	33,974	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 2020	12,206	52	139
Nov 2020	11,653	50	133
Dec 2020	11,318	47	136
Jan 2021	11,659	50	139
Feb 2021	10,286	47	139
Mar 2021	12,097	52	140

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 (hh:mm:ss)		
	DC FEMS	Third Party
Oct 2020	48:09	1:10:35
Nov 2020	39:35	1:12:15
Dec 2020	47:30	1:15:51
Jan 2021	48:02	1:16:01
Feb 2021	49:05	1:14:46
Mar 2021	52:38	1:19:02

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

The OUC and FEMS continue to work together closely to engage the public on the appropriate use of the 911 system. In particular, the OUC has maintained its support of NTL. OUC also collaborates with FEMS’ community engagement teams to impart unified and consistent messaging to stakeholders about the availability of the NTL.

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 (October 2020 - March 2021)

Appendix A

American Medical Response, Inc.
Quarterly Performance Report



Semiannual Performance Report

Provided To:

Council of the District of Columbia

and

DC Fire & Emergency Medical Services

October 1, 2020 – March 31, 2021

Transports Performed

- * 17,155 patient transports were performed by American Medical Response (AMR) from October 1st of 2020 through March 31st of 2021.
- * AMR responded to a total of 20,465 requests for service during this period, averaging 112 requests daily.
- * Average Response Time by Month:
 - October: 9 minutes, 55 seconds January: 10 minutes, 27 seconds
 - November: 10 minutes, 21 seconds February: 10 minutes, 14 seconds
 - December: 10 minutes, 24 seconds March: 10 minutes, 33 seconds
- * AMR met each patient at the location of the incident and transported to the closest available hospital, or as directed by DC FEMS.



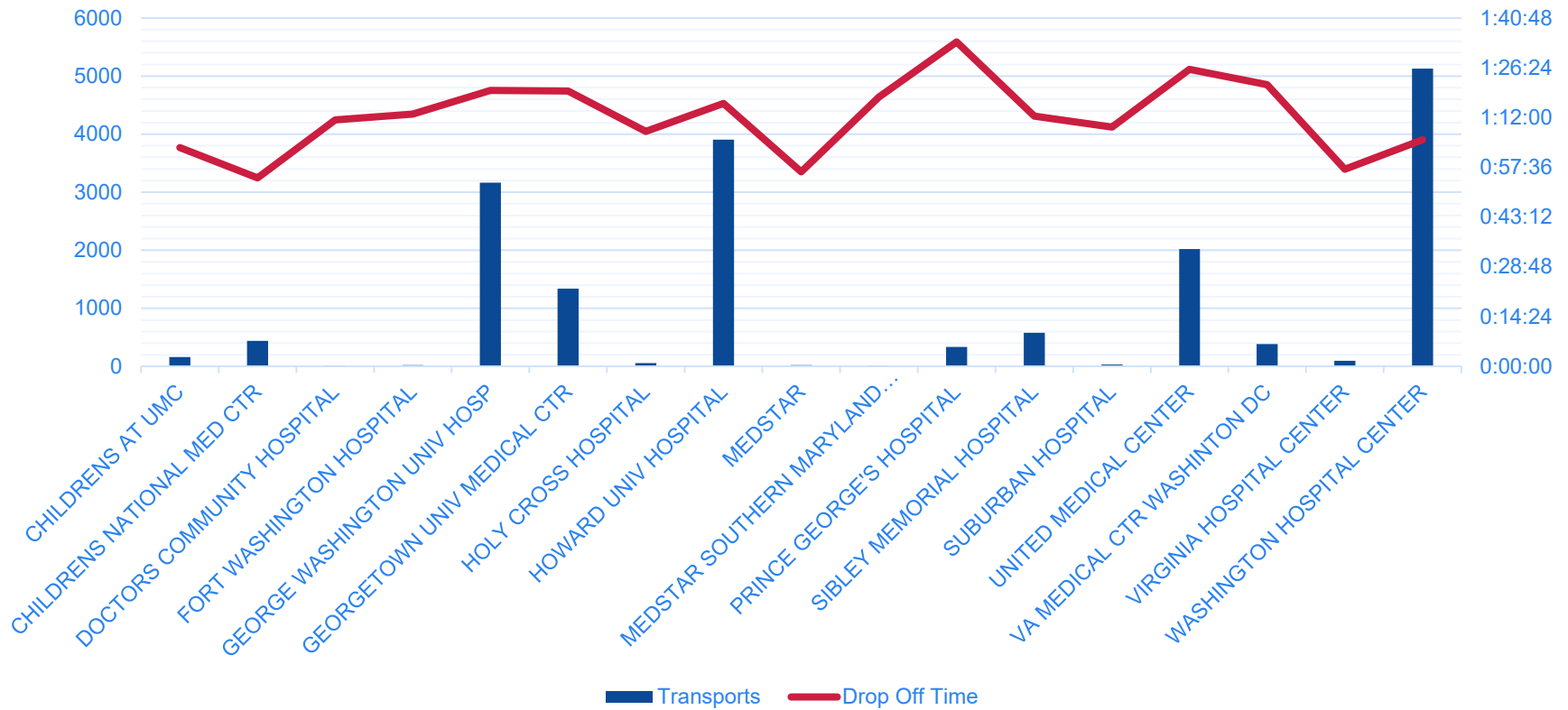
Transports Performed

<u>Hospital Name</u>	<u>Transports</u>	<u>Drop Off Time</u>
CHILDRENS AT UMC	161	01:03:18
CHILDRENS NATIONAL MED CTR	438	00:54:32
DOCTORS COMMUNITY HOSPITAL	17	01:11:19
FORT WASHINGTON HOSPITAL	22	01:13:01
GEORGE WASHINGTON UNIV HOSP	3163	01:19:52
GEORGETOWN UNIV MEDICAL CTR	1338	01:19:41
HOLY CROSS HOSPITAL	59	01:07:59
HOWARD UNIV HOSPITAL	3905	01:16:05
MEDSTAR	20	00:56:16
MEDSTAR SOUTHERN MARYLAND HOSPITAL	16	01:17:55
PRINCE GEORGE'S HOSPITAL	334	01:33:53
SIBLEY MEMORIAL HOSPITAL	577	01:12:23
SUBURBAN HOSPITAL	32	01:09:14
UNITED MEDICAL CENTER	2022	01:25:55
VA MEDICAL CTR WASHINTON DC	384	01:21:30
VIRGINIA HOSPITAL CENTER	97	00:57:03
WASHINGTON HOSPITAL CENTER	5127	01:05:35

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



Transports Performed



Ambulance and Shift Information

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Current # of Shifts	26	32	26	27	32	33	30
# and Length of Shifts	2 – 8hr 2 - 9hr 4 - 10hr 14 - 12hr 1 – 16hr 3 – 18hr	3 – 8hr 4 - 9hr 5 - 10hr 16 - 12hr 2 – 16hr 2 – 18hr	3 – 8hr 2 - 9hr 7 - 10hr 11 - 12hr 2 – 16hr 1 – 18hr	3 – 8hr 3 - 9hr 9 - 10hr 9 - 12hr 3 – 18hr	4 – 8hr 4 - 9hr 9 - 10hr 13 - 12hr 2 – 16hr	3 – 8hr 5 - 9hr 8 - 10hr 12 -12hr 1 - 16hr 4 -18hr	4 – 8hr 4 - 9hr 8 - 10hr 9 - 12hr 2 – 16hr 3- 18hr
Peak # of Ambulances Deployed	24	28	23	24	28	28	26

Average at Scene to At Patient Time*

* Approximate Times from Patient Care Reports

October	November	December	January	February	March
00:02:10	00:02:00	00:02:12	00:02:17	00:02:12	00:01:58

Personnel Data

- * 191 Total Persons Employed in the Division
- * 24.08% are District Residents
- * 52.88% are Women
- * 57.07% Minority Represented