GOVERNMENT OF THE DISTRICT OF COLUMBIA
Fire and Emergency Medical Services Department

Public Hearing

on

A Review of the Fire and Emergency Medical Services Department's Contract with American Medical Response

The Final Report of the Integrated Healthcare Collaborative

B22-183, the "Affordable Emergency Transportation and Pre-Hospital Medical Services Amendment Act Of 2017"

Testimony of
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and
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Committee on the Judiciary and Public Safety
Charles Allen, Chairperson
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John A. Wilson Building
Room 120
1350 Pennsylvania Avenue, NW
Washington, DC 20004

Good morning Chairperson Allen, members and staff of the Committee on the Judiciary and Public Safety. I am Gregory M. Dean, Chief of the D.C. Fire and Emergency Medical Services Department ("the Department") and with me is the Department's Interim Medical, Dr. Robert P. Holman, who will testify on the Final Report of the Integrated Healthcare Collaborative (IHC). We are also joined by Commissioner Stephen Taylor, of the Department of Insurance, Securities, and Banking (DISB). We appreciate the opportunity to discuss the IHC, the Department's contract with American Medical Response (AMR) and to testify in support of Bill 22-183, the "Affordable Emergency Transportation and Pre-Hospital Medical Services Amendment Act of 2017."

AMR Contract Is Improving FEMS Capacity and Outcomes

I am proud to report that the first year of our partnership with AMR has been a success and has helped put the Department on the path of reform in how we provide Emergency Medical Services (EMS) to District residents and visitors.

When Mayor Muriel Bowser asked the Council for authority to enter into this contract in the fall of 2015, as an organization, we were in a different place and faced a number of fundamental and complicated challenges. At that time, we did not have sufficient resources to respond to our EMS call volume, which put our most critical patients at risk. Our goal in contracting with a third party provider was to create capacity within our Department. We said we would use this increased capacity to focus on EMS reform in order to improve unit availability, response times, vehicle maintenance and repair, training of our providers, and patient care.

One year after the AMR launch, we have met our goal, as shown in our first annual report on the contract, which I have attached to my testimony. I am pleased to report that the Department has made great progress and we are a better and stronger organization. While we still have a long road to travel together to create and maintain a world class EMS system, I am incredibly proud of the distance we have come. We have done this in partnership not only with AMR and our colleagues at the Office of Unified Communications, but also with our employees, two labor unions, the Council, and the community.

Our report demonstrates that we are restoring the Department's operational capacity with expanded availability of FEMS transport units during heavy call volume periods. First, since the launch of the AMR contract, we have had 11 or more units available over 90 percent of the time. Second, we have improved our medic unit availability since converting three FEMS Basic Life Support (BLS) units to medic units in early March. This result allows us to improve our service delivery to our most critical patients. Third, the data shows we have decreased the average response time of the first arriving FEMS transport unit to higher priority calls. Fourth, we have hired 108 new Firefighter/EMTs and Firefighter/Paramedics. Finally, we have built a reserve fleet of ambulances and met preventive maintenance and repair goals for our ambulances. For example, during the second quarter of FY 2017, our ambulances have been available for service over 75 percent of the time.

In addition to significantly building capacity, the AMR contract has allowed the Department to improve our EMS providers' skills, patient care, and fleet service personnel training. I want to

emphasize that as a result of this contract, we have been able to deliver a 40 percent increase in EMS-related training hours to our providers to strengthen their knowledge base and skillset (this represents a total of 30,635 additional hours). We also have observed promising preliminary data in patient outcomes and the quality of patient care, although it is too early to prove a definitive link between the contract and these measures.

Mayor Bowser's Fiscal Year 2018 budget fully funds the continuation of the AMR contract. We strongly recommend that the District maintain this important partnership as we continue to take steps to improve our delivery of EMS.

Bill 22-183, the "Affordable Emergency Transportation and Pre-Hospital Medical Services Amendment Act of 2017"

Moving next to Bill 22-183, the "Affordable Emergency Transportation and Pre-Hospital Medical Services Amendment Act of 2017," I want to clearly express my support for this legislation, which was jointly drafted with our colleagues at DISB to address balance billing issues and improve our emergency medical services.

The bill would require private insurance providers to pay the full amount of the District's charged rate for ambulance transport. Specifically, the bill would require a health insurer, hospital, medical service corporation, or health maintenance organization to reimburse the District for the cost of emergency ambulance and pre-hospital medical services at the rates established by the District. Currently, these entities reimburse the District at their own reimbursement rates – not the rate established by the District –which often do not cover the full amount billed for services. The remaining unreimbursed portion of the bill is either paid for by the patient or another insurance or payment provider, or it simply goes unpaid.

The bill will not increase the amount patients will pay out of pocket, and in some circumstances, that amount should actually decrease. The bill is projected by the Office of the Chief Financial Officer to result in $983,000 in new revenue in Fiscal Year 2018; that positive fiscal impact is built into the FY 2018 budget currently pending before Council.

I urge the Council to support Bill 22-183 so as to ensure our taxpayers and patients can afford emergency transportation costs.

I will now ask Dr. Holman to discuss the final topic of this morning's hearing: the IHC Report.

Implementing the Integrated Healthcare Collaborative Report is Essential to EMS Reform in the District

Good morning Chairperson Allen. I am Dr. Robert P. Holman, Interim Medical Director of the Department. Mayor Bowser's Fiscal Year 2018 proposed budget includes $1 million to support implementation of the recommendations of the Integrated Healthcare Collaborative (IHC). We appreciate the support of Chairperson Allen, this Committee, and the Council for this initiative and look forward to the Council's final vote approving its funding next week.

As Mayor Bowser relayed in her recent State of the District Address, when our emergency services are used for non-emergency calls, it decreases the resources available for our most critical patients. The District's calls to 911 are out of proportion with its population. While the District is the 27th largest city in the United States, the Department's call volume is the eighth highest – putting us in the company of much larger cities like New York, Chicago, and Los Angeles for call volume. Put another way, we have the highest per capita EMS call volume in the nation. This high call volume has long been a strategic challenge for our Department, and one that we look forward to addressing in a responsible way with all of our stakeholders.

In April 2016, I convened the IHC with the goal of reducing non-emergency calls to 911 by improving patients' access to the most appropriate medical services. The IHC was created with the goal of developing recommendations for District agencies to more efficiently target the delivery of emergency medical services and to connect patients to comprehensive health care. The overall goals are to improve the population's health and safety, connect low acuity callers to a more appropriate comprehensive source of care, reduce or eliminate the use of 911 resources for non-emergent medical issues and ensure rapid response, treatment and transport for high acuity, life-threatening medical calls. The IHC includes members representing each of the three then-participating Managed Care Organizations (Amerihealth Caritas, Medstar Family Choice, and Trusted), the D.C. Primary Care Association, D.C. Hospital Association, Department of Health Care Finance, Department of Health, Executive Office of the Mayor, Office of Unified Communications, Office on Aging, and FEMS.

In its final report, the IHC made the following recommendations:

- Implement a Nurse Triage Line accessed through the 911 system;
- Leverage existing non-emergency medical transportation services and consider expansion of those services to transport low acuity callers to the appropriate health care services;
- Utilize existing grant funding opportunities for onboarding to a Health Information Exchange (HIE) organization, a web-based care planning, and/or a specialized registry;
- Continue to leverage the FEMS Street Calls program to connect high volume utilizers with comprehensive preventive and primary care services;
- Revise the existing FEMS Patient Bill of Rights;
- Clarify the Department of Health definition of urgent care in the Certificate of Need process;
- Ensure that managed care organizations accommodate requests for members to access same-day care from providers who are not their primary care provider of record for acute illness and injury; and
- Develop a customized outreach strategy to educate residents about IHC recommendations and changes, to change behavior about using primary care, and decisions about where to go for healthcare and how to access it.

Mayor Bowser's FY 2018 budget included $1 million to fund the IHC Report's recommendations for nurse triage, Health Information Exchange (HIE), and customized outreach

process.[1] Additionally, the Department of Health Care Finance (DHCF) will fund the transportation recommendation for Medicaid patients within the agency's existing resources. Finally, FEMS will work closely with the Department of Health to ensure implementation of the IHC Report's recommendations on Certificate of Need and same-day care.

Under the nurse triage model, 911 call takers at the Office of Unified Communications will screen calls and redirect lower acuity calls to triage nurses for further assessment. Our proposal is based on the experience of similar programs in Fort Worth, Texas; Louisville, Kentucky; and Mesa, Arizona. With the guidance of algorithmically-driven protocols, a nurse will further assess and direct the caller toward non-emergency department destinations, to include self-care advice, or non-EMS transport to primary care or urgent care clinics. FEMS will work with DHCF to develop specific HIE tools such as a dynamic patient profile that will provide the nurse with up to date information on patients, including specific information regarding their insurance, clinical history, utilization patterns, and providers. In some cases, the triage nurse may recommend a standard EMS transport to a hospital emergency department. In other cases, our Department providers may still respond to the caller to assess the patient in person, and then redirect the patient to the triage nurse if it is determined that an ambulance transport is not necessary.

The triage nurse also will arrange transportation for Medicaid beneficiaries. DHCF is taking the lead on the transportation part of this initiative. Transportation will be provided by modernizing and increasing use of the existing Medicaid Non-Emergency Medical Transportation (NEMT) benefit. DHCF is working to streamline the NEMT benefit this summer with the intent to streamline access to transportation and develop new care initiatives that will support the nurse triage line.

In recent weeks, we have met with those clinics where we expect to send patients and have confirmed their capacity for receiving an increased patient load. We appreciate the support and partnership of multiple federally-qualified health clinics and the D.C. Primary Care Association, another strategic partner in this effort.

The implementation of the nurse triage line is an important part of the health care reform needed to benefit health care delivery. We believe we will be successful in directing our low acuity callers to the right care setting to meet their medical needs. But to measure whether this innovative program is meeting its goals, we are working with The Lab @ DC in the Office of City Administrator, a group of statistical scientists who are helping us design a randomization process for this intervention to prove its effectiveness.

We should note that in order to operationalize the nurse triage program, the Department's internal Patient Bill of Rights policy will have to be revised to guarantee that patients "receive a medical evaluation and a determination of appropriate medical care" and "if transported, to be transported in a clean and properly maintained vehicle to an appropriate medical facility." This would be a change to the current policy which guarantees patients transport no matter how non-critical their condition.

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[1] Consistent with the recommendation of the IHC Report, the Department will continue to fund the Street Calls program in its FY 2018 budget.

Appropriate public education about the initiative and the proper use of emergency requests for service will be critical to its success. This effort already began in late 2016 when, during the months leading up to the release of the IHC Report, Chief Dean and I began conversations with the public on the proper use of 911 through interviews on local television and radio outlets. The Department's leadership will continue to conduct a customized outreach strategy that will include a strong, coordinated, and effective marketing campaign prior to and during the launch of the initiative.

To be clear, our priority with this initiative is to ensure that we are connecting patients with the right medical resource for their condition. Our goal is not simply to say "no," but to connect patients with medical care that will lead to better overall health outcomes. This initiative also carries with it the potential of significant cost benefit savings over the long-term, not only for the Department, but for the whole health care system. Most importantly, it is critical to our ongoing efforts to strengthen our delivery of EMS to those patients whose lives depend on our being able to respond to them quickly, competently, and compassionately.

Chairperson Allen, thank you for giving us the opportunity to speak about these very important issues today. Chief Dean, Commissioner Taylor, and I are available to answer any questions you may have.