



**Review of District of Columbia's Compliance with
the Recommendations of the Task Force on
Emergency Medical Services (*The Rosenbaum Task
Force*)**

June 18, 2015

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A Report by the Office of the District of Columbia Auditor
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The Honorable Phil Mendelson, Chairman
Council of the District of Columbia
1350 Pennsylvania Avenue, NW, Suite 504D
Washington, D.C. 20004

Letter Report: Review of District of Columbia’s Compliance with the Recommendations of the Task Force on Emergency Medical Services (The Rosenbaum Task Force)

Dear Chairman Mendelson:

The Office of the District of Columbia Auditor conducted a review of the District’s compliance with the [Task Force on Emergency Medical Services Report and Recommendations](#) issued on September 27, 2007 (Task Force Report).

Objectives, Scope and Methodology

The objective of this examination was to determine whether the District of Columbia, including its Department of Fire and Emergency Medical Services (DCFEMS), Department of Health (DOH), and Office of the City Administrator (OCA), implemented the recommendations contained in the Task Force on Emergency Medical Services Report, also known as the Rosenbaum Task Force.

The scope of this audit was from September 2007 through May 2015. The Auditor’s determination of compliance with the Task Force Report recommendations is based on the Agency’s implementation status as of May 2015.

In conducting this examination, we examined relevant laws, regulations, memoranda of understanding, policies and procedures; documents, databases, and other relevant systems, including but not limited to disciplinary, personnel, and medical systems. We also conducted interviews with staff and performed walk-throughs of relevant operations.

Background

On January 6, 2006, David Rosenbaum was assaulted in the District of Columbia and sustained a severe head injury. District of Columbia Fire and Emergency Medical Services (DCFEMS) responded and transported Mr. Rosenbaum to Howard University Hospital where he later succumbed to his injuries. The Task Force on Emergency Medical Services (Task Force) was appointed by Mayor Fenty “to learn lessons from what transpired on that day and to work to ensure that, in the future, any individual who calls EMS is provided with fast, compassionate, and professional care at every stage of the process.”¹

¹ “Task Force on Emergency Medical Services Report and Recommendations” issued on September 27, 2007, p. 3.

The Task Force outlined six policy directives that, taken together, could overcome what they identified as “longstanding obstacles to the reform of the District’s EMS system.”²

The six directives follow:

1. The Department of Fire and Emergency Medical Service shall transition to a fully integrated, all hazards agency;
2. Reform Department Structure to elevate and strengthen the EMS mission;
3. Improve the level of compassionate, professional, clinically competent patient care through enhanced training and education, performance evaluation, quality assurance, and employee qualifications and discipline;
4. Enhance responsiveness and crew readiness by revising deployment and staffing procedures;
5. Reduce misuse of EMS and delays in patient transfers; and
6. Strengthen Department of Health (DOH) oversight of emergency medical services.

After the Task Force Report was issued, Mayor Fenty accepted the six directives, which included a total of 36 individual recommendations, and directed DCFEMS, DOH, and related agencies to implement them.

It has been almost eight years since the Task Force report was issued. Since that time, the District has seen a significant increase in its population along with a decrease in the number of DCFEMS staff to serve them. Recent tragedies, involving emergency medical responders, have served as a reminder of the continuing need for many of the reforms advocated by the Task Force.

In 2010, Vincent Gray succeeded Adrian Fenty as Mayor and in 2014 Muriel Bowser was elected Mayor. Mayor Bowser announced the appointment of a new FEMS chief and tasked him with assessing the present state of the District’s Fire and Emergency Medical Services agency. This compliance review was undertaken to determine whether progress has been made by DCFEMS, DOH, and related agencies in implementing the recommendations contained in the Task Force Report.

² Ibid.

Results of the Auditor’s Examination

We conducted a review of each of the 36 recommendations outlined by the Task Force on EMS. We sent information requests to DCFEMS, OCA and DOH regarding the implementation status of the recommendations applicable to each agency. Based on the response provided, we then sought to verify the information regarding whether the recommendations had been implemented.

We found that the District’s overall implementation of the recommendations in the Task Force on EMS report is incomplete. Significant progress has been made on those recommendations directed specifically at the Office of the City Administrator and the Department of Health. Of the 36 recommendations, 11 have been implemented, 6 have been partially implemented, 4 were largely implemented but then later rescinded, and 15 have not been implemented. Figure 1 presents detailed information regarding the implementation status of each recommendation. Following the chart of recommendations are three findings explained in greater detail.

Figure 1

Implementation Status of Each Recommendation set Forth by the Task Force on Emergency Medical Services

Recommendation 1: The Department of Fire and Emergency Medical Services shall transition to a fully integrated, all hazards agency.		
	Requirement	Status
a.	<p>All entry-level candidates for operational positions shall be required to have the same minimum qualifications.</p> <p>All operational employees shall be cross-trained at basic levels of EMS, fire prevention, fire suppression, hazardous materials and technical rescue.</p>	<p>Status – Not Implemented</p> <p>The Auditor found that the Agency has established minimum requirements for dual-providers. In 2013, however, DCFEMS secured the approval of a variance from the District Department of Human Resources and hired 23 single-role providers in violation of the minimum requirement policy. (A more detailed explanation of this determination may be found on page 21 of this report).</p> <p>Operational employees receive training based on areas of specialization; such as, basic levels of EMS fire prevention, hazardous materials, or technical rescue. They do not receive cross-training at basic levels of EMS fire prevention, hazardous materials, and technical rescue.</p>
b.	<p>The Department shall offer current single-role providers basic training for all hazards on a phase-in basis.</p> <p>The Department shall allow single role providers to meet adjusted fitness standards that fairly and reasonably accommodate their incumbent status, including their age and level of experience.</p>	<p>Status – Not Implemented</p> <p>DCFEMS acknowledged that they had not implemented this recommendation. In response to our inquiry regarding their compliance status, the Agency offered the example of lateral transfer opportunities as evidence of partial implementation. We sought further explanation of how lateral transfer opportunities satisfied this recommendation requirement, but DCFEMS did not provide a further response.</p>

Recommendation 1: The Department of Fire and Emergency Medical Services shall transition to a fully integrated, all hazards agency.

	Requirement	Status
		<p>Although DCFEMS stated that they had implemented this recommendation, we found evidence that they did not comply. Single-role providers have not been required to meet adjusted fitness standards. Moreover, no employees of the Department were required to meet the fitness standards established by District law. (A more detailed explanation of this determination may be found on page 22 of this report).</p>
c.	<p>The Department shall continue to maintain a cadre of personnel who are specialized EMS providers at various levels of training who serve primarily in patient care. The overall size of the Department’s workforce creates an opportunity for specialization among employees, permitting the inclusion of those with a passion for patient care without compromising excellence in fire suppression, rescue, hazardous materials response, and other services.</p>	<p>Status –Implemented</p> <p>The Department requires its EMS providers to be certified in one of the following levels: Basic-Emergency Medical Technician (EMT), Intermediate-EMT, Advanced-EMT, or Paramedic-EMT.</p> <p>The Auditor selected a random sample of 105 employees to determine whether they had valid National Registry of Emergency Technicians (NREMT) and Department of Health (DOH) certifications as required by the District of Columbia. The Auditor validated both NREMT and DOH certifications for all but four of the sampled employees. Two of these individuals were cadets who were still in training and not required to have certification. The remaining two were no longer employees of DCFEMS. Therefore, our testing verified DCFEMS’s implementation of this recommendation.</p>
d.	<p>All employees shall have the same basic pay and benefits.</p> <p>The City Administrator shall develop a plan, no later than March 31, 2008, to transition to pay and benefits parity between current single-role medical providers and dual-role providers.</p>	<p>Status –Partially Implemented</p> <p>Single-role and dual-role firefighters have compensation and benefits packages that differ from single-role EMTs. The fire salary schedule allows for service longevity payments to firefighters while the single-role EMS schedule does not. Firefighters benefit from the Police and Firefighters Retirement and Relief Fund, while EMS workers may only participate in the Police and Firefighter’s Retirement and Relief Fund on a voluntary basis at their own expense.</p> <p>On May 30, 2008, Mayor Fenty transmitted legislation, the Paramedic and Emergency Medical Technician Transfer Amendment Act of 2008, to the Council, to implement the transition to “a fully-integrated, all hazards agency.” The Committee on Public Safety and the Judiciary held a hearing, including testimony by AFGE Local 3721, opposing the bill. The Committee renamed and rewrote the legislation to address the union’s concerns, and the administration subsequently opposed the committee version. FEMS Chief Dennis Rubin wrote that the legislation “would have the</p>

Recommendation 1: The Department of Fire and Emergency Medical Services shall transition to a fully integrated, all hazards agency.

	Requirement	Status
		practical effect of obstructing implementation of Recommendation 1” by “codifying the category of single-role EMS provider.” The Council enacted the Committee’s version and it became law. Mayor Fenty returned the bill unsigned, recommending further work “to develop a proposal that meets our shared goal of improving fire and emergency medical services.” The transition authority provided in the legislation has not been used.

Recommendation 2: Reform Department structure to elevate and strengthen the EMS mission.

	Requirement	Status
<p>a.</p>	<p>The Mayor shall appoint a Medical Director who shall hold the rank of Assistant Fire Chief. The Medical Director shall report to the Fire/EMS Chief but may be removed only by the Mayor. The Medical Director shall be a physician licensed to practice to medicine in the District of Columbia, board certified in a medical specialty that represents the broad patient base that EMS serves (emergency medicine, general surgery, family medicine, or internal medicine). Candidates must also have four years of substantial experience in EMS or other similar out-of-hospital care, including experience as EMS Medical Director, Assistant Medical Director or successful completion of a recognized EMS fellowship.</p> <p>The Medical Director shall: provide medical oversight for all aspects of emergency medical services provided by the Department including, but not limited to written policies, procedures and protocols for pre-hospital emergency medical care, medical training, and quality assurance of medical services; supervise the administration of emergency medical care; and work collaboratively with the Fire/EMS Chief, assistant and deputy chiefs, and other personnel in the Department. The provision of emergency medical care by the Department's certified emergency medical technicians shall be under the license of the Medical Director.</p>	<p>Status – Implemented</p> <p>Mayor Vincent Gray appointed Dr. Geoffrey Mountvarner Interim Medical Director of the Fire and Emergency Medical Services Department effective October 22, 2014. Dr. Mountvarner is a physician licensed to practice medicine in the District of Columbia and is Board Certified in Emergency Medicine. From 2007 to 2014 Dr. Mountvarner served as the Chief and Chairman of Howard University Hospital Emergency Medicine. Dr. Mountvarner also has served as the former Medical Director and Assistant Fire Chief of Fire and Emergency Medical Services from February 2010 to August 2011.</p> <p>The current Interim Medical Director, Dr. Geoffrey Mountvarner, finalized an update to the DCFEMS Emergency Medical Services Protocols in 2014. He oversees the quality improvement and quality assurance plans of operations staff as required by District regulations.³ While each emergency medical responder is required to be certified by DOH in order to practice emergency medical services in the District of Columbia, the Medical Director must certify/and or approve the application of each emergency medical responder seeking such certification as each provides medical services under the Medical Director's license.⁴</p>
<p>b.</p>	<p>There shall be an Assistant Chief for Emergency Medical Services (EMS), reporting directly to the Chief of the Department. The Assistant Chief for EMS shall have at least 15 years of experience in the practice of emergency medicine as a paramedic or higher level of practice and leadership experience in EMS.⁷ The Assistant Chief for EMS shall have the staff needed to implement and sustain the recommendations and meet the objectives of the Task Force, and will have responsibility for analysis and planning for all medical units, including strategic planning, budgeting,</p>	<p>Status – Implemented but Rescinded</p> <p>Chief Rafael Sa'adah served as the Assistant Fire Chief for Emergency Medical Services between 2007 and 2011. The position of Assistant Fire Chief for Emergency Medical Services was eliminated as part of an executive restructuring in 2011.</p>

³ 29 DCMR 556.1-556.3

⁴ 56 D.C. Reg. 1167 Sec.4 (h)

Recommendation 2: Reform Department structure to elevate and strengthen the EMS mission.

	Requirement	Status
	program evaluation, special operations, and prevention.	
c.	<p>The Chief shall also create additional positions of EMS Battalion Chiefs and EMS Captains for the purpose of:</p> <ol style="list-style-type: none"> 1. Ensuring strengthened, 24 hour a day, seven days a week, supervision of EMS delivery in the field; and 2. Creating an EMS career track for those personnel who are specialized EMS providers at various levels of training who serve primarily in patient care. 	<p>Status – Implemented but Rescinded</p> <p>DCFEMS acknowledged that in 2010, there was one Assistant Fire Chief-EMS, one Deputy Fire Chief-EMS, and seven Battalion Fire Chiefs-EMS.</p> <p>In 2011, all of these positions were frozen, eliminated, or reprogrammed as part of an executive restructuring leaving only one Battalion Fire Chief of EMS position.</p> <p>With the overall reduction of the number of EMS supervisors in DCFEMS, the supervision of EMS delivery in the field is greatly diminished.</p> <p>We requested information from DCFEMS to verify whether a career service track had been created for EMS employees. The Department provided information regarding the offering of one EMS Battalion Supervisor position in 2009 as evidence of compliance. After a review of this documentation, we asked DCFEMS how the offering of an EMS position in 2009 proved their implementation of this recommendation. We also requested information regarding whether a “career service” track was offered for non-managerial EMS employees. In response to both requests, DCFEMS provided no further explanation or documentation regarding how the position of EMS Battalion Supervisor, previously mentioned, supported their compliance or information regarding a Career service track for non-managerial EMS employees. Therefore, we were unable to verify their compliance with this recommendation.</p>

Recommendation 2: Reform Department structure to elevate and strengthen the EMS mission.

	Requirement	Status
d.	<p>Department leadership, at all levels, shall work to facilitate the integration of the full EMS mission and of single-role providers into multi-role operations. No later than November 20, 2007, the Chief will convene a group of departmental personnel, at least half of whom are current or former single-role personnel, to identify, review, address, and report to the City Administrator conditions that may convey a lower priority for the EMS mission or complicate integration of functions and employees. These issues include, but are not limited to:</p> <ul style="list-style-type: none"> • Station alarm bells for fire apparatus calls but not ambulance calls; • Ambulances positioned at rear doors rather than front doors, when available; • Station names and insignia that omit or de-emphasize EMS apparatus; • Use of “DCFD” insignia on some vehicles, uniforms, and other locations; • Omission or lower emphasis on the contributions of single-role EMS providers; • Obstacles, perceived and real, to incorporating single-role employees and their workload into multi-role operations. 	<p>Status – Not Implemented</p> <p>In 2007, DCFEMS created a working group to facilitate the integration of the full EMS mission and single-role providers into multi role operations under Deputy Chief Gregory Blalok. The working group began meeting in November 2007 and produced a report in 2008 regarding the conditions that convey a lower priority for the EMS mission. The report identified the following obstacles to achieving the goal: (1) Perceived or Real Lack of Respect for EMS personnel/Profession, (2) Staffing, Work Load and Consistency, (3) Acknowledging the “EMS Profession” by Using the Terms EMTs and Paramedics When Appropriate to Credit the Profession Whenever Possible, (4) Integrating Assigned Station Personnel to All Functions, Tasks and Privileges, (5) Distinct Identifiers for EMS Command Staff and Front Line Providers, (6) Training and Quality Assurance, (7) The Use of “DCFD” in Lieu of “DCFEMSD”, (8) Infrastructure Housing of EMS Units, and (9) Utilization of Station Alarm Bells to Turn out All Units on All Calls. We found no evidence that the recommendations contained in the 2008 report to address these obstacles were ever implemented.</p>

Recommendation 3: Improve the level of compassionate, professional, clinically competent patient care through enhanced training and education, performance evaluation, quality assurance, and employee qualifications and discipline.

	Requirement	Status
	Training and Education	
a.	The Medical Director shall implement, no later than December 31, 2008, a comprehensive training and educational program for emergency medical technicians and paramedics. The program shall include new employee orientation, periodic classroom and internet-based continuing training, case review and peer learning opportunities, simulation exercises, and field-based training. The Department shall pursue partnerships with medical education institutions to enhance training and clinical practice and increase the internal training capacity of the Department. The training program may include Department and external trainers under contract, as deemed appropriate by the Medical Director.	<p>Status –Implemented</p> <p>We verified new employee orientation for EMS workers as well as the agency’s implementation of an internet-based learning management system called “Target Solutions” for emergency medical responder training and certification. Case review and peer learning opportunities are provided by the Medical Director’s Continuous Quality Improvement program. Simulation exercises are currently provided through the use of adult and pediatric mannequins available at the DCFEMS Training Academy. We also verified that the Department has entered into educational partnerships with the Psychiatric Institute of Washington, the Children’s National Medical Center, the University of the District of Columbia and Providence Hospital in order to provide medical training opportunities.</p>
b.	The Medical Director shall establish, no later than November 20, 2007, procedures to certify the operational competency of medical providers at all levels of training within the Department. This may include, but is not limited to, (i) demonstration of compassionate and professional service to patients; (ii) successful execution of key clinical competencies in the field; and (iii) completion of a minimum number of hours or medical calls under provisional status.	<p>Status – Not Implemented</p> <p>The Interim Medical Director indicated that the Department has established a goal of re-evaluating providers on an annual basis. However, we determined that DOH certifies the operational competency of emergency medical responders on a biennial basis through its re-certification process. The Interim Medical Director (Agency) acknowledged that they are currently unable to certify on an annual basis because of staffing shortages.</p>
c.	The Medical Director shall establish, no later than November 20, 2007, a process to evaluate current employees for proficiency at their respective levels of clinical privileges. This evaluation and certification process shall be completed not later than December 31, 2008. Effective December 31, 2008, response to medical calls may be provided only by Department apparatus with at least one field-certified provider as described above.	<p>Status – Not Implemented</p> <p>The Department acknowledged that it did not comply with this recommendation since all employees were not evaluated as required.</p>
	Performance Evaluation	
d.	Effective immediately, the Medical Director shall oversee the clinical performance evaluation of all personnel with medical	<p>Status –Not Implemented</p> <p>The DCFEMS acknowledged that it did not implement this</p>

Recommendation 3: Improve the level of compassionate, professional, clinically competent patient care through enhanced training and education, performance evaluation, quality assurance, and employee qualifications and discipline.

	Requirement	Status
	<p>certification at least once a year. In addition to any other disciplinary basis (see sub-recommendation (k) below), based on the results of the annual performance evaluation, personnel may be approved for continued duty, assigned to supplemental training, placed on provisional EMS status, or temporarily or permanently relieved of their EMS proficiency status. The Department shall also provide enhanced field supervision as ongoing quality assurance for all personnel.</p>	<p>recommendation.</p>
<p>e.</p>	<p>The Medical Director shall establish, no later than December 31, 2007, a clearly documented chain of patient care with clear evaluation and treatment documented by each provider as follows:</p> <ul style="list-style-type: none"> • The first arriving provider should document the situation as well as patient evaluation and treatment; • A formal process for “giving report” and transferring care to the next provider should be conducted; this process should be repeated as patient care is transferred until full transfer to emergency department staff or other appropriate final patient destination staff; • Documentation requirements should include: (1) all evaluation and treatment, (2) All providers, (3) all care transfers, and (4) documentation of arrival at the receiving facility as well as who and when the transfer to receiving facility personnel occurred. • Online medical direction to FEMS personnel shall be provided only by licensed physicians who are adequately trained and are designated as qualified by the Medical Director. Online medical direction shall be subject to the QI process. 	<p>Status –Implemented</p> <p>We found that DCFEMS implemented this recommendation.</p> <p>The Department requires an ePCR (electronic patient care record) to be completed for every medical transport.</p> <p>We selected a random sample of 60 medical transports to determine whether each patient had an ePCR documenting: (1) evaluation and treatment, (2) all providers, (3) all care transfers, and (4) documentation of arrival at the receiving facility as well as who and when the transfer to the receiving facility personnel occurred. We found that all 60 ePCRs reviewed had the documented chain of patient care required. Therefore, our testing verified DCFEMS’s implementation of this recommendation.</p>

Recommendation 3: Improve the level of compassionate, professional, clinically competent patient care through enhanced training and education, performance evaluation, quality assurance, and employee qualifications and discipline.

	Requirement	Status
f.	The Chief, no later than December 31, 2007, shall design and implement an annual program to recognize and publicly reward employees for EMS performance that demonstrates exceptional compassion, professionalism, and clinical competence.	<p>Status –Implemented</p> <p>We reviewed the documentation provided by DCFEMS for EMS employee recognition in 1997, 2001, 2006, 2011, 2012, 2013, and 2014.</p>
g.	The Chief shall periodically conduct confidential, anonymous surveys of Department employees regarding their attitudes, concerns, and opinions relating to the Department’s provision of emergency medical services. The first survey shall be completed no later than December 31, 2007.	<p>Status –Implemented but Rescinded</p> <p>DCFEMS provided evidence that the agency performed one employee survey in 2007, but no information on any subsequent surveys.</p>
	Quality Assurance	
h.	<p>The Medical Director shall, no later than December 31, 2008, take the following steps to develop a performance evaluation and quality control/quality assurance:</p> <ul style="list-style-type: none"> • Establish a FEMS peer review program that promotes a culture of excellence; • Work with other jurisdictions and the federal government to regionalize system management; • Issue customer satisfaction surveys, internal and external, that focus on EMS service; • Improve response time evaluation that has a goal of measuring time to patient’s side; • Measure and analyze patient outcome; • Improve complaint tracking by FEMS. 	<p>Status – Partially Implemented</p> <p>DCFEMS has instituted the peer review program through the Continuous Quality Improvement Process.</p> <p>The DCFEMS acknowledged that it did not work with other jurisdictions and the federal system to regionalize system management. Therefore, no further documentation was provided by the Agency as proof of compliance nor necessary for verification of its non-compliant status.</p> <p>We verified that the Agency issues external customer satisfaction surveys that focus on EMS service. Along with the issuance of each bill, a survey is provided for the patient to return if they choose to do so. Patients who do not receive a bill, such as Medicaid recipients, receive the survey as a separate mailing. We found that DCFEMS tracks patient responses on returned surveys.</p> <p>We found that DCFEMS does not evaluate response time with the goal of measuring time to patient’s side but rather measures response time in terms of “Dispatch to Scene.”</p> <p>We verified that the DCFEMS does measure and analyze cardiac patient outcomes through its participation in the CARES program (Cardiac Arrest Registry to Enhance Patient Survival) Program. DCFEMS does not analyze patient outcomes for other medical conditions.</p>

Recommendation 3: Improve the level of compassionate, professional, clinically competent patient care through enhanced training and education, performance evaluation, quality assurance, and employee qualifications and discipline.

	Requirement	Status
		We determined that complaint tracking is provided through the Continuous Quality Improvement Program (CQI process). DCFEMS also indicated that complaints can be made through the Department’s website but we were unable to verify whether this process is actually tracked.
	Qualifications and Discipline	
i.	The Chief shall, no later than December 31, 2007, establish hiring preferences for candidates and, subject to collective bargaining agreements, promotional preferences for employees with degrees from recognized accredited higher education institutions and relevant certifications or skills.	Status – Not Implemented The DCFEMS acknowledged that it did not implement this recommendation.
j.	The Chief shall require, effective with the next contract: <ul style="list-style-type: none"> • All personnel to maintain or acquire EMS certifications in order to be retained as employees of the Department after December 31, 2010; • All candidates for promotion to the rank of Sergeant or higher to have served as a field-certified EMS provider, according to criteria established by the Medical Director that requires a minimum cumulative number of patient contacts, assessments and treatments. 	Status – Not Implemented The DCFEMS acknowledged that it did not implement this recommendation.
k.	The Chief shall, no later than December 31, 2008, establish an Internal Affairs Unit, table of penalties, online records and tracking for Quality Assurance/Quality Control, and disciplinary timelines for operational employees. Penalties for employee misconduct should be swift, fair and appropriate.	Status-Partially Implemented We found that DCFEMS established an Internal Affairs Unit, table of penalties, and disciplinary timelines for operational employees. We were not able to verify online records and/or tracking for quality assurance and quality control. DCFEMS reported that a customer can file a complaint on the Agency’s website but no further information was provided. As a result, the Auditor did not have sufficient documentation to support a determination that “online records and tracking for quality assurance and control” is performed by the DCFEMS.
l.	The District Attorney General, in consultation with the Chief of the Department, shall submit to the Chair of the DC Council Committee on	Status- Implemented In a letter dated November 16, 2007, the Attorney

Recommendation 3: Improve the level of compassionate, professional, clinically competent patient care through enhanced training and education, performance evaluation, quality assurance, and employee qualifications and discipline.

	Requirement	Status
	Public Safety and the Judiciary, no later than November 20, 2007, recommendations to strengthen the Department’s ability to terminate Department employees for medical malfeasance and misconduct.	General for the District of Columbia, Linda Singer and FEMS Chief Dennis Rubin submitted a letter to Councilmember Phil Mendelson, Chair of the Committee on Public Safety and the Judiciary, containing recommendations to strengthen the Fire/EMS Disciplinary Process. They recommended the following: (1) Convene Trial Boards only for demotion and termination cases, (2) Hire additional legal staff with specific expertise and experience in the area of personnel law, (3) Change functions of the Compliance Unit, and (4) Improve case tracking.
m.	The FEMS Chief, Dr. Barbera, and Mr. Halliday shall complete a plan to monitor implementation and performance measures relating to the recommendations of the Task Force that includes input, process and output metrics. Progress on implementation and performance shall be monitored through ongoing CapStat sessions to which all members of the Task Force shall be invited, including sessions in April and October of 2008 that will specifically address the implementation and performance monitoring plan.	Status- Implemented but Rescinded The DCFEMS acknowledged that the agency has not participated in CapStat sessions since 2010.

Recommendation 4: Enhance responsiveness and crew readiness by revising deployment and staffing procedures.

	Requirement	Status
a.	<p>The Mayor shall establish a goal of providing ALS response times according to the National Fire Protection Association Standard 1710, 100% of the time, as well as a goal of providing transport responses within 13 minutes, 100% of the time. No later than March 20, 2008, and every six months thereafter, the Mayor shall certify that the District of Columbia has met this goal, or announce what steps are being taken to achieve this goal.</p> <p>The Department shall conduct quality improvement review of those calls where the goal is not achieved.</p>	<p>Status – Partially Implemented</p> <p>We found that the certifications were not done consistently on a bi-annual basis, as required by this recommendation. We further found that the Mayor’s certifications, which we reviewed, were for various time periods. Some certifications were for a year and some were for periods as short as five months. There was no evidence provided that the Mayor certified that DCFEMS met response time goals after 2010.</p> <p>We verified that DCFEMS has an administrative issuance which directs Battalion Fire Chiefs to conduct end of the month reviews of chute time reports and identify any delays in response. Chute times that fall below benchmark standards established by the agency are forwarded to the Office of Risk Management for further action.</p>
b.	<p>The Mayor and Chief shall work together to come with a recommendation to the Council to implement shorter shifts for all employees and other recommendations to ensure the goal of having alert and awake employees who can provide competent patient care.</p>	<p>Status – Partially Implemented</p> <p>We verified that the Mayor submitted the Transportation Unit Redeployment Plan to the D.C. Council via Proposed Resolution 20-160, the “FEMS Ambulance Redeployment Resolution of 2013” in March 2013. The plan proposed reducing operational employees and changing shift schedules as well as restructuring the deployment of transport units to match peak load and call density. The Council Chair referred the Resolution to the Committee on Judiciary and Public Safety. The Committee changed the Resolution to a Disapproval Resolution and voted their disapproval. According to the Committee on the Judiciary and Public Safety report issued June 28, 2013, the Plan was not approved because the FEMS had not presented sufficient analysis for the committee to be certain that redeployment would not impact public safety.</p> <p>In July 2013, the full Council approved PR 20-0160, the “FEMS Ambulance Redeployment Disapproval Resolution of 2013.”</p>
c.	<p>The Chief shall establish, no later than March 31, 2008, and as available staff allows, a practice for assignment to transport duty in which employees are permanently assigned to ambulance service for periods of not less than 90 days, rather than intermittently with fire</p>	<p>Status – Not Implemented</p> <p>We asked DCFEMS for proof of their compliance with this recommendation. Because DCFEMS provided no documentation to substantiate the agency’s compliant status, we could not determine that this recommendation</p>

Recommendation 4: Enhance responsiveness and crew readiness by revising deployment and staffing procedures.

	Requirement	Status
	apparatus duty.	had been implemented.
d.	The Chief shall report, no later than March 31, 2008, on procedures for peak load staffing of transport units, that enable an adequate number of units to meet response time targets. The Chief shall also establish by the same date a procedure for dynamic deployment of units to provide coverage when any particular area of the District experiences a shortage of available units.	Status – Partially Implemented See response to 4(b) above.
e.	The Chief shall develop and implement a series of service delivery alternatives that provide efficient, rapid response with a variety of apparatus and personnel.	Status – Not Implemented We requested that the DCFEMS provide proof of their compliance with this recommendation. Because DCFEMS provided no documentation to substantiate compliance, we could not determine that this recommendation had been implemented.

Recommendation 5: Reduce misuse of EMS and delays in patient transfers.

	Requirement	Status
a.	The Chief, in partnership with other District agencies and providers, shall develop and begin to implement, no later than March 31, 2008, an outreach program for patients with chronic needs.	<p>Status – Implemented</p> <p>The Street Calls outreach program was created April 4, 2008 to address patients with chronic needs. Our review of the data provided by DCFEMS showed that as a result of the Street Calls program, there was a 24% decrease in transports for 2013 and a 13.9% decrease in transports in 2014 for patients with chronic needs.</p>
b.	The Chief, in cooperation with other District agencies, shall develop and implement, no later than March 31, 2008, a public education program regarding appropriate use of the 911 system.	<p>Status – Not Implemented</p> <p>DCFEMS provided a video for the "Make the Right Call" campaign which was created to educate the public regarding the proper and improper use of 911 but DCFEMS admitted that this video was never made public. We also found that the printed materials regarding the "Make the Right Call" campaign provided for our review were posted to the DCFEMS website, but not distributed to the public in order to educate the population on the appropriate use of 911.</p>
c.	The Chief and the Director of the Office of Unified Communications shall, no later than December 31, 2008, collaborate to improve the 911/311 dispatch process so that call takers and dispatchers have improved training and enhanced ability to distinguish between emergency and non-emergency medical calls.	<p>Status – Implemented</p> <p>We verified that the employees of the Office of Unified Communications and DCFEMS received continuing dispatch education training and certification.</p> <p>We verified Emergency Medical Dispatch Certification and Emergency Medical Dispatch- Quality Improvement (EMD and EMD-Q) certifications for appropriate staff.</p>
d.	The Medical Director, with the support of the City Administrator shall, no later than November 20, 2007, establish and clarify roles and responsibilities for the Department and the Metropolitan Police Department for treatment of uninjured intoxicated patients and for transport of patients to the District's detoxification facility.	<p>Status – Not Implemented</p> <p>We found that DCFEMS had not implemented this recommendation. DCFEMS admitted in their response to the Auditor that there are no sobering centers that will accept intoxicated patients transported by the department. Therefore, these patients are instead transported to area hospitals.</p>
e.	Effective immediately, the Medical Director should exercise his full authority to order hospital emergency rooms within the District not to close to Department transports, and to require hospitals and medical providers to accept the transfer of care of a patient or patients within a specified period of time.	<p>Status – Implemented</p> <p>We reviewed the Hospital Closure and Diversion policy implemented by DCFEMS in 2008 and found that the policy requires hospitals to obtain approval from the Medical Director in order to close a hospital to patient transports. The policy requires hospitals to assess and transfer patients brought by DCFEMS personnel transport units to the hospital's emergency department within</p>

Recommendation 5: Reduce misuse of EMS and delays in patient transfers.

	Requirement	Status
		<p>twenty-five minutes so that the transport unit can be released.</p> <p>In 2012, that standard was adjusted. The new standard requires hospitals to assess and transfer patients brought by DCFEMS personnel transport units to the hospital's emergency department within 10 minutes of arrival and a triage assessment be provided by hospital staff within 3 minutes of arrival to the hospital.</p>
f.	<p>The City Administrator shall, no later than November 20, 2007, convene a working group including hospital CEOs, DOH, and the Medical Director to meet quarterly to address and develop standards for drop times, diversion, and closure, and to improve procedures for tracking patient outcomes. The Medical Director should consider the results and recommendations of this group in exercising his discretion under the previous paragraph.</p>	<p>Status – Not Implemented</p> <p>We determined that this recommendation has not been implemented. Though the Medical Director of DCFEMS provided evidence of regular meetings held by the hospital working group, “ED Leaders”, we found that these meetings involve quality control functions. The ED Leaders establish metrics for the appropriate level of clinical practice to be performed by responders which they describe as “Eagles Measures”. Though there was evidence provided that the working group discussed drop times in two meetings no evidence was provided of working group discussions involving diversion, and closure policies required by this recommendation.</p>
g.	<p>The Medical Director shall, no later than September 30, 2008, develop a procedure to authorize patients to be transported to a pre-approved clinic or other non-emergency medical facility, appropriate to the patient's need.</p>	<p>Status – Not Implemented</p> <p>DCFEMS admitted that they have not implemented this recommendation. Based on information provided to the Auditor, we found that are only two pre-approved clinics for non-emergency medical transports in the District. They are the Psychiatric Institute of Washington (PIW) which is available for certain pediatric psychiatric patients and the Police and Fire Clinic which provides service for certain ill or injured police and fire department employees.</p>
h.	<p>The Medical Director and the Director of the Department of Health shall develop and implement, no later than September 30, 2008, a system of alternative transportation options (such as scheduled van service, taxi vouchers, or MetroAccess vouchers), as well as protocols to refuse transport for non-urgent patients, when appropriate, subject to the authorization of a medical supervisor.</p>	<p>Status – Not Implemented</p> <p>The Auditor found that DCFEMS has a policy for patient care which conflicts with this recommendation. The Auditor reviewed the Patient Bill of Rights which prohibits DCFEMS personnel from refusing to transport any patient including non-urgent patients. (A more detailed explanation of this determination may be found on page 23 of this report).</p>

Recommendation 6: Strengthen Department of Health (DOH) oversight of emergency medical services.

	Requirement	Status
a.	<p>The Director of the Department of Health, in collaboration with EMS stakeholders, shall, no later than December 31, 2007, draft legislation or regulations or other administrative actions to improve oversight of all EMS providers and ambulance companies in the District of Columbia. The Mayor shall present the resulting draft to the D.C. Council for consideration. The legislation shall include, but not be limited to:</p> <ul style="list-style-type: none"> • License and/or certification requirements for EMS provider agencies, vehicles, personnel, and training facilities; • Requirements for health care institutions, such as assisted care facilities, to provide or procure independent inter-facility transport services for non-emergent needs, and authority for DOH to impose fines and/or penalties for failure to comply; • Specified levels of education, training, and satisfactory test performance in order to be lawfully assigned to work in an EMS provider capacity. 	<p>Status –Implemented</p> <p>The Council Chairman, at the request of the Mayor, introduced the “Emergency Medical Services Act of 2008”⁵ on January 22, 2008. The final Act includes license and/or certification requirements for EMS provider agencies, vehicles, personnel, and training facilities. We also verified DOH’s policies on the license and/or certification requirements for EMS provider agencies, vehicles, personnel, and training facilities.</p> <p>We verified that the Act addresses the need for health care facilities to provide or procure inter-facility transport services independent of 911. We also found that the Act contains language authorizing the Mayor to establish fees for DOH to recover the cost of regulating emergency medical services agencies.</p> <p>We reviewed the Act and found that it enables the Mayor to establish the levels of education and testing required in the District to practice as an EMS provider. DOH transitioned to the NREMT EMS certification process and adopted the NREMT practical skill examination procedures for Emergency Medical Technicians and Emergency Medical Responders.</p>

⁵ D.C. Law 17-357, effective March 25, 2009.

Recommendation 6: Strengthen Department of Health (DOH) oversight of emergency medical services.

	Requirement	Status
a.	<ul style="list-style-type: none"> • Requirements for ongoing professional education and training and periodic recertification testing, both written and practical, administered by independent entities, as a condition for the renewal of certification; • Fair and effective enforcement, including sanctions for unacceptable performance and deliberate malfeasance, and standards and processes for revocation of EMS provider certification and EMS provider entity licensure and certification in appropriate cases; • Requirements for all EMS provider entities, including the Department, to provide routine reporting on quality of care issues to the Department of Health; • Authority to re-engineer the protocol revision process to improve timeliness with which EMS protocols are updated; and • Authority for DOH to issue fines and penalties to hospitals that fail to accept Department transports and assume care of patients within a specified period time pursuant to the procedures established through recommendation 5(f). 	<p>We reviewed an administrative issuance from DOH “Transition to NREMT Certification Requirement” and found that DOH transitioned to the certification process based on the National Registry of Emergency Technicians (NREMT) curriculum and course completion. DOH adopted the National Education Standards for Emergency Medical Services and certification through NREMT as a prerequisite to DOH certification in the District for all EMS responders.</p> <p>We reviewed the Act and verified that it contains language related to the procedures for sanctions against EMS providers which include the suspension of EMS provider certifications, and procedures for license and or/certification revocation.</p> <p>We reviewed §29 DCMR 556-558 and verified that these regulations require routine reporting of quality of care issues to the department through an annual report. We also reviewed an administrative issuance which requires the reporting of incidents or violations involving quality of care to the department within 72 hours.</p> <p>We reviewed §29 DCMR 504 and verified that this regulation establishes the Medical director as the party responsible for the establishment and enforcement of EMS protocols on pre-hospital medical care and treatment. Granting the medical director this authority, is deemed as the process to improve the timeliness of updating EMS protocols, as the protocols would not have to go through the more time consuming process of being established and enforced by the agency heads.</p> <p>We reviewed D.C. Code §44-509 (2015) provided by DOH as evidence of their implementation of this recommendation. We found no provision that authorizes DOH to issue fines and penalties to hospitals that fail to accept Department Transports.</p>
b.	<p>DOH shall immediately adopt the National Highway Traffic Safety Administration standards for EMS certification at all levels of training and as the minimum standard for the District of Columbia. Whenever possible, accreditation by nationally recognized bodies shall be adopted to establish testing and certification requirements.</p>	<p>Status –Implemented</p> <p>We found that DOH has implemented this recommendation. We further found that DOH adopted National Highway Traffic Safety Administration (NHTSA) standards, which includes the requirement of NREMT certification for all EMS responders.</p> <p>The Auditor selected a random sample of 105 employees to determine whether they had valid National Registry of</p>

Recommendation 6: Strengthen Department of Health (DOH) oversight of emergency medical services.

	Requirement	Status
		Emergency Technicians (NREMT) and Department of Health (DOH) certifications as required by the District of Columbia. We validated both NREMT and DOH certification for all of the sampled employees with the exception of four. Two of the employees were cadets who were still in training and not required to have certification. The remaining two were no longer employees of DCFEMS. Therefore, our testing verified DCFEMS's implementation of this recommendation.

Additional Information on Policy Implementation

1. DCFEMS utilized the grant of a variation to bypass the requirements of recommendation one and mislead the public regarding its implementation status.

We found that in 2013, DCFEMS hired 23 single-role providers, directly contradicting Recommendation 1 of the Task Force report. DCFEMS also modified its website in a manner that gave the appearance that the action was consistent with the “expressed language” contained in this recommendation rather than a departure from prior policy.

Recommendation 1 of the Task Force Report specifically provides that:

All entry-level candidates for operational positions shall be required to have the same minimum qualifications. All operational employees shall be cross-trained at basic levels of EMS, fire prevention, fire suppression, hazardous materials and technical rescue.

Though the recommendations contained in the Task Force Report are policy recommendations only, there are distinct areas in District law and/or regulations where their intent has been embodied. For example, the District’s Personnel Manual (DPM) defines an entry-level career service candidate for DCFEMS as a Firefighter/Emergency Technician (EMT) and/or a Firefighter/Paramedic⁶, or in other words, a dual-role provider.

In order for an agency under the authority of the Mayor to depart from the specific requirements of the DPM, a Variation must be granted by the D.C. Department of Human Resources (DCHR). In 2013, DCFEMS took steps to request a Variation Grant from DCHR and bypass the DPM and Task Force recommendation on dual-role providers as entry-level candidates. On April 8, 2013, Chief Kenneth Ellerbe issued a memorandum to the DCHR requesting a Variation grant under Section 400.1 of Chapter 4 of the DPM to “hire single-role providers without the need to cross-train these individuals in fire suppression.” Chief Ellerbe supported this request by describing the hardship of DCFEMS’ immediate need to fill 150 vacancies created by the departure of paramedics and emergency medical technicians in a city where “emergency medical services represent more than 80%of the emergency calls for service received...”⁷

On April 30, 2013, DCHR issued DPM Instruction No. 4-23 &8-72 granting DCFEMS the ability to hire single-role providers. We reviewed the Variation granted by DCHR and found that it did not clearly articulate “the steps that will be taken to limit the application of the variation only to the duration of the conditions that gave rise to it,” as required for a variation grant. Instead, DCHR defined the duration of the Variation granted without a definite end date, by which one could assume that the grant to hire single-role providers was for an indefinite period of time.

On the DCFEMS’ website, which tracks its implementation of the Task Force recommendations, the text of Recommendation 1 was modified to mask the Department’s return to its pre-Task Force practice of

⁶Firefighter/Emergency Medical Technician (EMT)-an employee of the Fire and Emergency Medical Services Department (FEMSD) who is cross-trained as a Firefighter and an EMT. §870.1 of Chapter 8 of the District of Columbia Personnel Manual; Firefighter/ Paramedic-an employee of the FEMSD who is cross-trained as a Firefighter and a Paramedic(§870.2 of Chapter 8 of the DPM)

⁷ 2013 Memorandum from Chief Jones to Shawn Stokes, Director of District Department of Human Resources requesting a Variance Grant.

hiring single-role providers, which could mislead the public regarding its compliance with the recommendation.⁸

During our review, we found evidence that in 2013, DCFEMS hired only single-role providers. DCFEMS stated that these single-role providers were required to be cross-trained as a condition of subsequent employment. When we sought to verify this information, we found that only 6 of the 23 single-role providers hired under the Variation transitioned to dual-role providers. The 17 remaining were still single-role providers, though 4 of those are no longer employed by the Department. At the time of our review, DCFEMS indicated that these remaining employees began their training on April 19, 2015 at the D.C. Fire Academy to become dual-role providers.

The Task Force recommendations are subject to the policy directives of the Mayor and Chief of DCFEMS. At the same time, they are a matter of a high level of public concern. Any policy change regarding the Agency's implementation of these recommendations should be communicated clearly to the public in the interest of transparency and in order to allow all stakeholders the opportunity to participate in the discussion.

2. DCFEMS does not perform fitness testing as recommended by the Task Force and required by District law.

We found that DCFEMS neither implemented Recommendation 1 (b) of the Task Force on EMS report nor performed biennial fitness testing as required by the "Omnibus Public Safety Agency Reform Amendment Act of 2004" (Act)⁹. Recommendation 1 (b) of the Task Force on EMS report states that, "The Department shall allow single-role providers to meet adjusted fitness standards that fairly and reasonably accommodate their incumbent status." When we inquired about the implementation status of this recommendation, DCFEMS provided a detailed response which suggested a lack of clarity regarding the Department's Fitness Standard. In order to determine the fitness standard applicable to the population subject to this recommendation and the Agency's level of compliance, we looked to District law for guidance. The Act provides:

All sworn members of the Fire and Emergency Medical Services Department shall be required to pass, at least biennially, a physical examination and a physical agility test. The physical examination shall be performed by a physician at the Police and Fire Clinic using current medical standards adopted after consultation with medical professionals within 180 days of September 30, 2004. **The physical agility testing shall be based on full-duty physical performance standards adopted within 180 days of September 30, 2004 (emphasis added).**¹⁰

⁸ In its response to the Auditor's request regarding the implementation status of recommendation one, DCFEMS responded as follows:

Please note that the Agency modified the text of Recommendation 1 on its website in the following manner (**modifications in italics**):

- "All entry-level candidates for operational positions shall be required to have the same minimum qualifications, ***except as adjusted by variance through the D.C. Department of Human Resource***."
- "All operational employees shall be cross-trained at basic levels of EMS, fire prevention, fire suppression, hazardous materials and technical rescue. ***The agency proposes to continue cross training all operational employees who desire dual role cross training (emphasis added).***"

⁹ D.C. Code §5-451(a) (2015)

¹⁰ Ibid.

District law describes the DCFEMS Fitness Standard as being comprised of two components: a physical examination and agility testing. In order to assess the Agency's level of compliance, we sent a testing sample of 95 employees to the Department and requested that verification be provided of the fitness testing performed in accordance with the District law cited above. In response to our request, DCFEMS provided verification that all 95 employees had received a "physical exam, lab-work, personal interview, and drug screen," but did not provide verification of any physical agility testing for anyone in our testing sample.

Furthermore, when we asked the Department for their full-duty physical performance standards drafted in response to the Act so we could measure how employee physical agility was tested, we were provided with excerpts from a fitness manual and a copy of an Administrative Issuance from 2007 that lacked any description of the agency's "full-duty physical performance standards." DCFEMS provided additional documentation which suggested that some physical agility testing had been performed in the past but only on a voluntary basis for a limited number of agency personnel. Specifically, DCFEMS provided documentation of Fitness Testing performed in 2012. The agency assessed 669 personnel using the following testing factors: (1) Sit and Reach, (2) Modified Curl Ups, (3) Push Ups, (4) Three Minute Step Test, (5) Body Mass Index, (6) Carbon Monoxide Screening, and (7) Blood Pressure Screening. Of the total population tested, DCFEMS reported that 46 percent of the total sample classified as obese. There was no evidence provided that any follow-up was performed.

Based on our review, we determined that the DCFEMS did not comply with the Task Force's recommendation or with the requirements of the Act. Furthermore, because DCFEMS could only provide evidence of agility testing on a voluntary basis for a limited number of Department personnel, we found that they did not comply with the fitness testing mandated by the Act.

During the course of this examination, DCFEMS indicated that they plan to begin a Work Evaluation Program in the fall of 2015, and indicated that this program would include physical agility testing designed around the performance of firefighting and emergency medical service duties. In the interest of public safety and the well-being of its employees, the Auditor strongly encourages the DCFEMS to implement this recommendation and fully comply with District law.

3. The Patient Bill of Rights prohibits DCFEMS from refusing to transport anyone by ambulance who requests service

DCFEMS did not implement Recommendation 5 (h) of the Task Force on EMS report regarding the provision of alternative transportation to non-emergency medical calls and the creation of protocols for non-emergency calls. The Department itself bars such actions in its "Patient Bill of Rights". Recommendation 5 (H) specifically requires:

The Medical Director and the Director of the Department of Health shall develop and implement, no later than September 30, 2008, a system of alternative transportation options (such as scheduled van service, taxi vouchers, or MetroAccess vouchers), as well as protocols to refuse transport for non-urgent patients, when appropriate, subject to the authorization of a medical supervisor.

The Department issued the "Patient Bill of Rights" as a bulletin to all staff in April 2011, stating that emergency medical responders in the District of Columbia have no "Right of Refusal". The document states that it is "the patient's right to never be refused transport or to be discouraged by any method

from receiving medical treatment or transportation,” by DCFEMS personnel. In short the “Patient Bill of Right” establishes that DCFEMS must provide transport for any 911 caller requesting transport, emergency or not. The Department would need to change this policy in order to implement Recommendation 5 (h) which requires that the agency offer alternative methods of transportation and create protocols for non-emergency calls. Should DCFEMS continue to decline to change this policy, the Department should fully implement recommendation 5 (b) and educate the public on the appropriate use of the 911 system to assist in the reduction of medical transports.

Conclusion

With a new administration and new leadership of the Department of Fire and Emergency Medical Services, the District of Columbia has a new opportunity to address the commitments made in 2007 to “improve the management, training, operations, and culture of the EMS function to provide the highest quality of professional and compassionate pre-hospital medical care” – language taken from the mission statement of the Task Force on Emergency Medical Services. The Office of the District of Columbia Auditor hopes that this compliance review will be of value and practical use to the administration, and to the D.C. Council in its ongoing oversight of the delivery of emergency medical services.

Sincerely yours,



Kathleen Patterson
District of Columbia Auditor

Agency Response

The Office of the District of Columbia Auditor requested a written response from the District of Columbia Department of Fire and Emergency Medical Services (DCFEMS), the Department of Health (DOH) and the Office of the City Administrator (OCA) outlining the agency's progress, as of May 2015, in implementing the recommendations outlined in the Task Force on Emergency Medical Services report issued on September 27, 2007.

The written responses received from each agency were combined and summarized in Appendix I, attached to this report. In some instances, the responses are not consistent with the Auditor's findings which are documented in the body of the report.

Appendix I

Appendix I

EMS Task Force Recommendations

Recommendation 1: The Department of Fire and Emergency Medical Services shall transition to a fully integrated, all hazards agency.

Status		Action Item	Progress
In Progress	a.	(Part 1) All entry-level candidates for operational positions shall be required to have the same minimum qualifications.	<p>From 2007 to 2013, all entry-level candidates for operational positions were required to achieve the following minimum certification requirements: National Registry Emergency Medical Technician (NREMT); CPR; Firefighter I & II (NFPA); Hazardous Materials Awareness & Operations; Emergency Vehicle Operator; and Technical Rescue Orientation.</p> <p>On April 18, 2013, the Agency sought a variance from the Department of Human Resources to hire single-role paramedics to meet a shortage of EMS personnel certified at the advanced life support (ALS) level. On April 30, 2013, the variance was granted. Thereafter, on August 26, 2013, the Agency began hiring single-role EMS personnel certified as paramedics. These personnel were not initially required to complete the following training: Firefighter I & II (NFPA 1001); Hazardous Materials Awareness & Operations (NFPA 472); Emergency Vehicle Operator; and Technical Rescue Orientation. Since that time, several of these hires have received fire suppression training to become dual role providers. See attached Special Order No. 39, Series 2013 (05/09/2013); Special Order No. 55, Series 2014 (06/10/2013); Bulletin No. 88; Special Order No. 74R, Series 2014 (08/27/2014); Paramedics Hired Under Variance (Spreadsheet); and Special Order No. 06, Series 2015 (02/02/2015).</p>
In Progress	a.	(Part 2) All operational employees shall be cross-trained at basic levels of EMS, fire prevention, fire suppression, hazardous materials and technical rescue.	<p>Approximately 25 pre-1987-hire firefighters remain who have not completed the EMT certification process. Approximately 130 single-role EMS workers remain who are not yet certified as firefighters. Approx. 44 former Single-Role Career Service or Management Supervisory Service personnel have been transitioned to All-Hazards status through the promotional process and have been receiving ongoing All-Hazards training since 2009.</p>

Appendix I

EMS Task Force Recommendations

Recommendation 1: The Department of Fire and Emergency Medical Services shall transition to a fully integrated, all hazards agency.

Status	Action Item	Progress
In Progress	b. The Department shall offer current single-role providers basic training for all hazards on a phase-in basis. The Department shall allow single role providers to meet adjusted fitness standards that fairly and reasonably accommodate their incumbent status, including their age and level of experience.	The Department continues to offer lateral-transfer opportunities for single-role EMS workers. A more detailed description of the Department's fitness standards can be found in Appendix B. <i>See also</i> Rubin Testimony for Mendelson 06-22-2010; and OT Testimony for Mendelson 09-23-2010 (attached). ¹
Implemented	c. The Department shall continue to maintain a cadre of personnel who are specialized EMS providers at various levels of training who serve primarily in patient care. The overall size of the Department's workforce creates an opportunity for specialization among employees, permitting the inclusion of those with a passion for patient care without compromising excellence in fire suppression, rescue, hazardous materials response, and other services.	The Department is committed to developing and maintaining a high-level of specialized EMS provider and supervisory capacity at all levels of the organization. There is a plan to develop an internal paramedic training program and an EMT-I-99 to Paramedic bridge course. There are supervisory positions that require paramedic certification.
Implemented	d. All employees shall have the same basic pay and benefits. The City Administrator shall develop a plan, no later than March 31, 2008, to transition to pay and benefits parity between current single-role medical providers and dual-role providers.	The Department developed a plan. On April 9, 2008, Mayor Adrian M. Fenty announced the One Force - one Standard unification plan. Under this plan, all civilian, single-role EMS providers would become sworn uniformed members, allowing them to have the same pay and benefit opportunities offered to firefighters. Under this plan there would be no loss of base pay, no loss of rank, and there would be a unified promotional process. Former single-role

1

Department Overtime Hearing on 6/22/2010:

http://dccarchive.oct.dc.gov/services/on_demand_video/channel13/June2010/06_22_10_JUDICI.aspx

Time sequence 23:25 to end (Testimony and discussion regarding delay of NREMT training).

Department Overtime Hearing on 9/23/2010:

http://dccarchive.oct.dc.gov/services/on_demand_video/channel13/September2010/09_23_10_JUDICI_2.aspx

Time sequence: 37:20 (Testimony regarding delay of NREMT training).

Time sequence: 45:08 (Discussion concerning NREMT training).

Appendix I

EMS Task Force Recommendations

Recommendation 1: The Department of Fire and Emergency Medical Services shall transition to a fully integrated, all hazards agency.

Status	Action Item	Progress
		<p>employees would have two career options: (1) they may elect to become all-hazards personnel (fully trained firefighters) or (2) they may receive an orientation to all-hazards operations and then function as specialized EMS providers. Details of the Unification Plan are available to Department employees and to the public on the agency website, under the link: Unification Initiative. On May 30, 2008, Chairman Vincent C. Gray, at the request of Mayor Adrian M. Fenty, introduced Bill 17-0768: "Paramedic and EMT Transfer Act of 2008 This bill was designed to support the unification of the operational personnel of the D.C. Fire & Emergency Medical Services Department into a fully-functional all-hazards workforce. Subsequently, on November 25, 2008, the Committee on Public Safety and the Judiciary transmitted the bill, now renamed the "Paramedic and Emergency Medical Technician Transition Amendment Act of 2008" to the Committee of the Whole. Regrettably, the Committee Print of Bill 17-0768 contained significant changes to the version introduced on behalf of the Mayor. These changes were contrary to the letter and intent of the original legislation. These changes have the practical effect of obstructing implementation of Recommendation 1 of the Task Force: "The Department of Fire and Emergency Medical Services shall transition to a fully integrated, all hazards agency." Fire & EMS Chief Dennis L. Rubin transmitted a letter to the Council on 12/15/08 highlighting these concerns. In addition, the Office of the Chief Financial Officer (OCFO) withdrew their fiscal impact statement due to the changes made to the legislation. Finally, the D.C. Retirement Board transmitted a letter to the Council on 12/15/08 raising legal and fiscal concerns about the amended legislation. The amended legislation was approved by the Committee of the Whole on 12/16/08 and transmitted to the Mayor for</p>

Appendix I

EMS Task Force Recommendations

Recommendation 1: The Department of Fire and Emergency Medical Services shall transition to a fully integrated, all hazards agency.

Status	Action Item	Progress
		signature. Mayor Fenty returned the bill unsigned. Mayor Fenty's letter to Chairman Gray dated 1/30/09 notes: "the Attorney General has raised legal questions regarding the amended bill's effect on employee participation in the District of Columbia Police Officers' and Firefighter's Retirement Plan, and the Chief Financial Officer has withdrawn its fiscal impact statement as a result of modifications to the original bill... the amended bill makes it difficult for F&EMS to implement the task force's recommendations. For these reasons I will not be able to sign Bill 17-768. However, I would be happy to work with the Council to develop a proposal that meets our shared goal of improving fire and emergency medical services."

Appendix I

EMS Task Force Recommendations

Recommendation 2: Reform Department structure to elevate and strengthen the EMS mission.

Status		Action Item	Progress
Implemented	a.	<p>The Mayor shall appoint a Medical Director who shall hold the rank of Assistant Fire Chief. The Medical Director shall report to the Fire/EMS Chief but may be removed only by the Mayor. The Medical Director shall be a physician licensed to practice to medicine in the District of Columbia, board certified in a medical specialty that represents the broad patient base that EMS serves (emergency medicine, general surgery, family medicine, or internal medicine). Candidates must also have four years of substantial experience in EMS or other similar out-of-hospital care, including experience as EMS Medical Director, Assistant Medical Director or successful completion of a recognized fellowship.</p>	<p>Dr. Michael D. Williams was the first Medical Director to be sworn in as an Assistant Fire Chief. He was succeeded by Dr. James J. Augustine, who began serving as Acting Assistant Fire Chief/Medical Director on August 19, 2008. Dr. Augustine's appointment as Assistant Fire Chief/Medical Director was confirmed by the Council of the District of Columbia on December 16, 2008. Dr. Geoffrey G. MountVarner became Interim Medical Director of the DC Fire & EMS Department on February 1, 2010. On March 18, 2011, Mayor Vincent C. Gray announced the nomination of Dr. David A. Miramontes to be the Medical Director of the District of Columbia Fire & EMS Department. Dr. Miramontes began work August 1, 2011. He was confirmed by Council on November 1, 2011, and remained in the position until tendering his resignation effective October 29, 2014. Dr. Geoffrey MountVarner returned as Interim Medical Director effective October 22, 2014 (Mayor's Order 2014-239.)</p>
Not Implemented	b.	<p>There shall be an Assistant Chief for Emergency Medical Services (EMS), reporting directly to the Chief of the Department. The Assistant Chief for EMS shall have at least 15 years of experience in the practice of emergency medicine as a paramedic or higher level of practice and leadership experience in EMS. The Assistant Chief for EMS shall have the staff needed to implement and sustain the recommendations and meet the objectives of the Task Force, and will have responsibility for analysis and planning for all medical units, including strategic planning, budgeting, program evaluation, special operations, and prevention.</p>	<p>Rafael Sa'adah served as the District of Columbia's first Assistant Fire Chief for EMS from 12/2007 through 04/2011. This position was eliminated on April 10, 2011 as part of an executive restructuring.</p>

Appendix I

EMS Task Force Recommendations

Recommendation 2: Reform Department structure to elevate and strengthen the EMS mission.

Status	Action Item	Progress
<p>Not Implemented</p>	<p>c. The Chief shall also create additional positions of EMS Battalion Chiefs and EMS Captains for the purpose of (1) ensuring strengthened, 24 hour a day, seven days a week, supervision of EMS delivery in the field and (2) creating an EMS career track for those personnel who are specialized EMS providers at various levels of training who serve primarily in patient care.</p>	<p>In December 2010, the number of EMS chief officer positions stood at eight (one AFC-EMS, one DFC-EMS, and seven BFC-EMS). During an executive restructuring process begun in 2011, all of these EMS chief officer positions were frozen, eliminated or reprogrammed, and eventually reduced to one Battalion Chief position. Accordingly, this is currently not being done.</p>
<p>Implemented</p>	<p>d. Department leadership, at all levels, shall work to facilitate the integration of the full EMS mission and of single-role providers into multi-role operations. No later than November 20, 2007, the Chief will convene a group of departmental personnel, at least half of whom are current or former single-role personnel, to identify, review, address, and report to the City Administrator conditions that may convey a lower priority for the EMS mission or complicate integration of functions and employees. These issues include, but are not limited to: Station alarm bells for fire apparatus calls but not ambulance calls; Ambulances positioned at rear doors rather than front doors, when available; Station names and insignia that omit or deemphasize EMS apparatus; Use of "DCFD" insignia on some vehicles, uniforms, and other locations; Omission or lower emphasis on the contributions of single-role EMS providers; Obstacles, perceived and real, to incorporating single-role employees and their workload into multi-role operations.</p>	<p>This group began meeting on 10/9/07. The working group's efforts at addressing these issues were ongoing.</p> <p>The process of removing the "DCFD" insignia began in 2011 and is ongoing with changes in uniforms, vehicle decals and signage. Firefighter Turnout gear is being replaced with DCFEMS insignia with current wear cycles and all new gear is compliant.</p>

Appendix I

EMS Task Force Recommendations

Recommendation 3: Improve the level of compassionate, professional, clinically competent patient care through enhanced training and education, performance evaluation, quality assurance, and employee qualifications and discipline.

Status		Action Item	Progress
Implemented	a.	<p>The Medical Director shall implement, no later than December 31, 2008, a comprehensive training and educational program for emergency medical technicians and paramedics. The program shall include new employee orientation, periodic classroom and internet-based continuing training, case review and peer learning opportunities, simulation exercises and field-based training. The Department shall pursue partnerships with medical education institutions to enhance training and clinical practice and increase the internal training capacity of the Department. The training program may include Department and external trainers under contract, as deemed appropriate by the Medical Director</p>	<p>The Department has completed several revisions of its Advanced Life Support (ALS) and Basic Life Support (BLS) refresher and continuing education curricula, most recently in 2012.</p> <p>The Department has invested in four realistic Patient Simulators: an Adult SIMMAN 3G, a Sim Baby, a SimJr. (child) and a SimMom (obstetrical).</p> <p>Current internal and external EMS trainings for BLS providers include: hands on training with the SIMMAN, ePCR mock-up training, training in assisting paramedics with LifePaks.; and a 2-week intensive EMS enhancement operations class for new employees.</p> <p>In 2009, all ALS providers successfully completed comprehensive education, training and testing on recognition and treatment of acute coronary syndromes (ACS) and ST segment elevation myocardial infarction (STEMI).</p> <p>Current internal and external EMS trainings include: Pediatric Advanced Life Support (PALS), Advanced Cardiac Life Support (ACLS), Advanced Medical Life Support (AMLS), and International Trauma Life Support (ITLS), ALS refresher courses.</p>

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Recommendation 3: Improve the level of compassionate, professional, clinically competent patient care through enhanced training and education, performance evaluation, quality assurance, and employee qualifications and discipline.

Status		Action Item	Progress
In Progress	b.	The Medical Director shall establish, no later than November 20, 2007 , procedures to certify the operational competency of medical providers at all levels of training within the Department. This may include, but is not limited to, (i) demonstration of compassionate and professional service to patients; (ii) successful execution of key clinical competencies in the field; and (iii) completion of a minimum number of hours or medical calls under provisional status.	Operational competency verification occurs through multiple assessment procedures, including National Registry of Emergency Technicians (NREMT) and Department of Health certification requirements, biannual recertification, initial training, remedial training and education as part of the CQI process, and focused mentorship and operational training for new entry-level employees before they can begin practice as independent medical providers.
In Progress	c.	The Medical Director shall establish, no later than November 20, 2007 , a process to evaluate current employees for proficiency at their respective levels of clinical privileges. This evaluation and certification process shall be completed not later than December 31, 2008 . Effective December 31, 2008 , response to medical calls may be provided only by Department apparatus with at least one field-certified provider as described above.	Although not fully compliant with this recommendation, the Department is substantially compliant. On November 16, 2007, the Department established a new field evaluation process for all EMS providers. The first complete cycle of field evaluations for the Operations Division was completed on March 10, 2009.

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Recommendation 3: Improve the level of compassionate, professional, clinically competent patient care through enhanced training and education, performance evaluation, quality assurance, and employee qualifications and discipline.

Status		Action Item	Progress
Not Implemented	d.	<p>(Part 1) Effective immediately, the Medical Director shall oversee the clinical performance evaluation of all personnel with medical certification at least once a year.</p> <p>In addition to any other disciplinary basis (see sub-recommendation (k) below), based on the results of the annual performance evaluation, personnel may be approved for continued duty, assigned to supplemental training, placed on provisional EMS status, or temporarily or permanently relieved of their EMS proficiency status.</p>	Annual clinical performance evaluations are not being done.
Not Implemented	d.	<p>(Part 2) The Department shall also provide enhanced field supervision as ongoing quality assurance for all personnel.</p>	Not being done.

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Status		Action Item	Progress
Implemented	e.	<p>(Part 1) The Medical Director shall establish, no later than December 31, 2007, a clearly documented chain of patient care with clear evaluation and treatment documented by each provider as follows: The first arriving provider (Fire-based or EMS) should document the situation as well as patient evaluation and treatment; A formal process for "giving report" and transferring care to the next provider should be conducted; this process should be repeated as patient care is transferred until full transfer to emergency department staff or other appropriate final patient destination staff; Documentation requirements should include: (1) all evaluation and treatment, (2) all providers, (3) all care transfers, and (4) documentation of arrival at the receiving facility as well as who and when the transfer to receiving facility personnel occurred;</p>	<p>Clearly documented chain of patient care was first accomplished in September 2006 with full implementation of the FEMS Form <u>902EMS</u> (First Responder Report)</p> <p>The majority of assessments and patient care currently is documented on the Department's Electronic Patient Care Report (ePCR). All units dispatched to a call are required to document their participation on the scene. First Responders may forward their ePCR to the transporting unit. The ePCR is currently compliant with established NEMSIS guidelines.</p>
In Progress	e.	<p>(Part 2) Online medical direction to FEMS personnel shall be provided only by licensed physicians who are adequately trained and are designated as qualified by the Medical Director. Online medical direction shall be subject to the QI process.</p>	<p>The Department, in collaboration with the directors of the local emergency departments, has re-engineered the online medical control process such that each receiving facility is now responsible for providing medical control to patients en-route to its facility. Protocol revisions allow for most emergency care to be delivered with standing orders. Online physician training is not provided by the Department.</p>
Implemented	f.	<p>The Chief, no later than December 31, 2007, shall design and implement an annual program to recognize and publicly reward employees for EMS performance that demonstrates exceptional compassion, professionalism, and clinical competence.</p>	<p>On May 23, 2007, DC Fire & EMS combined the annual EMS awards ceremony with the annual valor awards ceremony to demonstrate the value that it places on outstanding EMS performance. Beginning with the 2008 ceremony to present, the Department recognizes the need to acknowledge outstanding EMS providers.</p>

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Status		Action Item	Progress
			See attachments.
In Progress	g.	The Chief shall periodically conduct confidential, anonymous surveys of Department employees (both single-role and dual-role) regarding their attitudes, concerns, and opinions relating to the Department's provision of emergency medical services. The first survey shall be completed no later than December 31, 2007 .	The first confidential employee survey was distributed by the Office of the City Administrator on <u>December 7, 2007</u> : to all operational FEMS employees. The overall participation rate was just under 44%, with 781 out of 1,787 invitees responding. There have been no employee surveys on EMS since the 2007 survey.
Implemented	h.	(Part 1) The Medical Director shall, no later than December 31, 2008 , take the following steps to develop a performance evaluation and quality control/quality assurance: establish a FEMS peer review program that promotes a culture of excellence;	Peer review enabling legislation became effective on 4/15/08. As part of our CQI process the Department currently uses a peer review process that is not punitive and promotes a culture of excellence. We recently began using experienced retired DC/FEMS former CQI members as part of our review process.
Not Implemented	h.	(Part 2) The Medical Director shall, no later than December 31, 2008 , work with other jurisdictions and the federal government to regionalize system management.	This recommendation has not been fulfilled.

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Status		Action Item	Progress
Implemented	h.	(Part 3) The Medical Director shall, no later than December 31, 2008 , issue customer satisfaction surveys, internal and external, that focus on EMS service.	An EMS-focused customer survey is now mailed to all identifiable patients transported and/or treated by Department employees. The Department also provides the ability for the public to report customer satisfaction <u>online</u> through its agency website. For FY 2012, overall patient satisfaction rate was 91%. The Department has not conducted internal surveys.
In Progress	h.	(Part 4) The Medical Director shall, no later than December 31, 2008 , improve response time evaluation that has a goal of measuring time to patient's side.	The Department is utilizing multiple data streams and has very detailed metrics for response time, committed time, and patient drop time. Time to patient's side is still difficult to capture accurately.
In Progress	h.	(Part 5) The Medical Director shall, no later than December 31, 2008 , measure and analyze patient outcome.	<p>The Department is now participating in the CARES (Cardiac Arrest Registry to Enhance Survival) Program, a collaborative effort of the Centers for Disease Control and Prevention (CDC), the American Heart Association (AHA) and the Emory University Department of Emergency Medicine, Section of Prehospital and Disaster Medicine. The CARES program is a model national registry that will enable us to accurately measure our progress in the treatment of Out of Hospital Cardiac Arrest, as well provide comparative analysis of our performance as benchmarked to other national and international EMS systems.</p> <p>We also Participate in District STEMI, Stroke and Trauma Patient Care Quality Assurance registries.</p> <p>The Department is updating its evidence-based outcome performance measures for EMS (the "EAGLES" measures) so that they can be published on the web.</p>

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Status		Action Item	Progress
In Progress	h.	(Part 6) The Medical Director shall, no later than December 31, 2008 , improve complaint tracking by FEMS.	Investigation protocol and case-flow management system for CQI have been developed. Most complaints involve customer service and are investigated and tracked by the Operations Division and/or Internal Affairs, not the Office of the Medical Director.
Not Implemented	i.	(Part 1) The Chief shall, no later than December 31, 2007, establish hiring preferences for candidates with degrees from recognized accredited higher education institutions and relevant certifications or skills.	The agency is not compliant with this requirement.
Not Implemented	i.	(Part 2) The Chief shall, no later than December 31, 2007 , subject to collective bargaining agreements, establish promotional preferences for employees with degrees from recognized accredited higher education institutions and relevant certifications or skills.	The agency is not compliant with this requirement. Implementation of promotional preferences is subject to the collective bargaining process.
In Progress	j.	(Part 1) The Chief shall require, effective with the next contract: All personnel to maintain or acquire EMS certifications in order to be retained as employees of the Department after December 31, 2010 .	The agency is not fully compliant with this requirement. Approximately 25 pre-1987-hire firefighters remain who have not completed the EMT certification process. Employee attrition is anticipated.
Not Implemented	j.	(Part 2) The Chief shall require, effective with the next contract: All candidates for promotion to the rank of Sergeant or higher to have served as a field-certified EMS provider, according to criteria established by the Medical Director that requires a minimum cumulative number of patient contacts assessments and treatments.	The agency is not compliant with this requirement. Implementation of promotional preferences is subject to the collective bargaining process.
Implemented	k.	(Part 1) The Chief shall, no later than December 31, 2008 , establish an Internal Affairs Unit.	Internal Affairs Unit has been established.

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Recommendation 3: Improve the level of compassionate, professional, clinically competent patient care through enhanced training and education, performance evaluation, quality assurance, and employee qualifications and discipline.

Status		Action Item	Progress
In Progress	k.	(Part 2) The Chief shall, no later than December 31, 2008 , establish a table of penalties and disciplinary timelines for operational employees. Penalties for employee misconduct should be swift, fair and appropriate.	The Department relies on the Table of Penalties set forth in Chapter 16 of the District Personnel Manual. See Order Book Article VII, § 8(B)(7) (attached).
Implemented	k.	(Part 3) The Chief shall, no later than December 31, 2008 , establish online records and tracking for Quality Assurance/Quality Control.	The Case Manager feature of SafetyPad electronic patient care reporting system is the on-line records and tracking system for quality assurance / quality control,
Implemented	l.	The District Attorney General, in consultation with the Chief of the Department, shall submit to the Chair of the DC Council Committee on Public Safety and the Judiciary, no later than November 20, 2007 , recommendations to strengthen the Department's ability to terminate Department employees for medical malfeasance and misconduct.	The recommendations were sent on 11/19/2007. See Letter submitted on 11/19/07.
In Progress	m.	The FEMS Chief, Dr. Barbera and Mr. Halliday shall complete a plan to monitor implementation and performance measures relating to the recommendations of the Task Force that includes input, process and output metrics. Progress on implementation and performance shall be monitored through ongoing CapStat sessions to which all members of the Task Force shall be invited, including sessions in April and October of 2008 that will specifically address the implementation and performance monitoring plan.	The Implementation and Performance Measures Plan was completed February 20, 2008. The last CapStat session to monitor compliance was in 2010. The Department's CQI scorecard measures substantially overlap with the clinical measures in the performance monitoring plan.

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Recommendation 4: Enhance responsiveness and crew readiness by revising deployment and staffing procedures.

Status	Action Item	Progress
Implemented	<p>a. The Mayor shall establish a goal of providing ALS response times according to the National Fire Protection Association Standard 1710, 100% of the time, as well as a goal of providing transport responses within 13 minutes, 100% of the time. The Department shall conduct quality improvement review of those calls where the goal is not achieved. No later than March 20, 2008, and every six months thereafter, the Mayor shall certify that the District of Columbia has met this goal, or announce what steps are being taken to achieve this goal.</p>	<p>The Task Force recommendation concerning a “...goal of providing ALS response times according to the National Fire Protection Association Standard (NFPA) 1710, 100% of the time...” and the “...goal of providing transport responses within 13 minutes, 100% of the time,” are not the same measure. Furthermore, NFPA Standard 1710 does not include any mention of goals for “transport responses.” Instead, NFPA 1710 only defines “turnout time” (also called FEMS “chute time”) and “travel time” objectives for (1) “...the arrival of an advanced life support (ALS) unit at an emergency medical incident...” (NFPA 1710.4.1.2.1(5)) and, (2) “...the arrival of a unit with first responder with AED or higher level capability at an emergency medical incident...” (NFPA 1710.4.1.2.1(4)). Additionally, NFPA Standard 1710 does not define a “response time” standard. Instead, the language of NFPA 1710 only notes that fire departments “shall establish a performance objective of not less than 90 percent for the achievement of each turnout time and travel time objective...” (NFPA 1710.4.1.2.4). A “100% of the time” goal is not included in the language of the NFPA 1710 standard and, as such, the Department has consistently used a 90% standard. SO-2013-42, dated May 7, 2013, discussed procedures for quality review of delayed response cases. The order instructed that “each Battalion Fire Chief (BFC) shall conduct an end-of-the-month review of the prior month’s chute time management control reports with Company Officers and Battalion EMS Supervisors to ensure that each officer understands the data contained in such reports.” The order also required that “BFCs are responsible for improving performance by correcting inefficient work behaviors or practices by instituting company and/or unit level drills, etc. to meet the chute time performance benchmarks set forth in this order.” SO- 2013-69, dated July 11, 2013</p>

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Recommendation 4: Enhance responsiveness and crew readiness by revising deployment and staffing procedures.

Status	Action Item	Progress
		<p>instructed that special reports "...in reference to emergency responses which are deemed to be outside of the Department's established "Chute Time" benchmarks shall be immediately forwarded to the Risk Management Officer..."</p> <p>Such reports were then used by BFCs to evaluate performance, which included the counseling and discipline of employees for delayed response cases, if supported.</p>
<p>Implemented</p>	<p>b.</p> <p>The Mayor and Chief shall work together to come with a recommendation to the Council to implement shorter shifts for all employees and other recommendations to ensure the goal of having alert and awake employees who can provide competent patient care.</p>	<p>Mayor Vincent Gray and Chief Kenneth Ellerbe worked together to propose a shorter shift recommendation. The Department introduced a Redeployment Resolution in 2012 that would have restructured the deployment of transport units to match peak load times and call density. The plan also proposed reducing the number of operational employees and changing the shift schedule. On June 28, 2013, the Council Committee on Judiciary and Public Safety met to discuss the proposed resolution. After unfavorable discussion, the resolution was "disapproved" with four (4) Committee members voting to support "disapproval" and one Committee member abstaining.</p>
<p>Implemented</p>	<p>c.</p> <p>The Chief shall establish, no later than March 31, 2008, and as available staff allows, a practice for assignment to transport duty in which employees are permanently assigned to ambulance service for periods of not less than 90 days, rather than intermittently with fire apparatus duty.</p>	<p>The Department rotates personnel on the Emergency Transport Units. Each member spends a designated period of time that could range from 1 to 3 months on a transport unit, then the members are replaced by other personnel and returned to a Fire Suppression Unit until the time they are rotated back to the transport unit.</p> <p>It should also be pointed out that members of the Department are also tasked with daily details to the Advanced Life Support Units to provide staffing in the absence of Single Role Providers to ensure staffing on those units. In many cases when Firefighters are placed on the Advanced Life Supports Units it places those units in a downgraded status from ALS to BLS.</p>

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Recommendation 4: Enhance responsiveness and crew readiness by revising deployment and staffing procedures.

Status	Action Item	Progress
In Progress	<p>d. The Chief shall report, no later than March 31, 2008, on procedures for peak load staffing of transport units that enable an adequate number of units to meet response time targets. The Chief shall also establish by the same date a procedure for dynamic deployment of units to provide coverage when any particular area of the District experiences a shortage of available units.</p>	<p>The Department introduced a Redeployment Resolution in 2012 that would restructure the deployment of transport units to match peak load times and call density. On June 28, 2013, the Council Committee on Judiciary and Public Safety met to discuss the proposed resolution. After unfavorable discussion, the resolution was “disapproved” with four (4) Committee members voting to support “disapproval” and one Committee member abstaining.</p>
In Progress	<p>e. The Chief shall develop and implement a series of service delivery alternatives that provide efficient, rapid response with a variety of apparatus and personnel.</p>	<p>The Street Calls Program began on March 27, 2008: an innovative mobile outreach initiative designed to provide alternative services to high-volume individual 911 system users. The Street Calls Program uses FEMSD paramedics in a mobile response vehicle to perform pro-active prevention, intervention, and response to at-risk individuals (including the homeless, mentally ill, hoarders, and chronic public inebriates). These interventions also reduce the demand on other emergency units, increasing their availability for other responses.</p> <p>The Department remains a national leader in the use of alternative vehicles to manage EMS needs during special events and other planned and unplanned events of high crowd density. The Department has an EMS Bike Team with specialized training and advanced life support capabilities, and the Special Operations Division utilizes specially modified utility vehicles such as the Gator™ and the ASAP/Polaris ATV mini-ambulance to safely deliver EMS care and evacuate patients from areas of limited access.</p>

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Recommendation 5: Reduce misuse of EMS and delays in patient transfers.

Status	Action Item	Progress
Implemented	<p>a. The Chief, in partnership with other District agencies and providers, shall develop and begin to implement, no later than March 31, 2008, an outreach program for patients with chronic needs</p>	<p>On March 27, 2008, the Fire and Emergency Medical Services Department (FEMS) initiated the "Street Calls" Program, designed to perform mobile outreach and intervention for high-volume individual users of 911 services, including the homeless, hoarders, mentally ill, and chronic public inebriates. The Street Calls Program is staffed by FEMS paramedics that reach out to other DC government agencies, Hospitals and Healthcare providers to mitigate repeated use of 911.</p>
Implemented	<p>b. The Chief, in cooperation with other District agencies, shall develop and implement, no later than March 31, 2008, a public education program regarding appropriate use of the 911 system.</p>	<p>The Department updated the "Make The Right Call" campaign and partnered with the Office of Unified Communications to distribute material to District households on the proper use of 911 and 311. The program flyer is on the Department's web-site.</p>
Implemented	<p>c. The Chief and the Director of the Office of Unified Communications shall, no later than December 31, 2008, collaborate to improve the 911/311 dispatch process so that call takers and dispatchers have improved training and enhanced ability to distinguish between emergency and non-emergency medical calls.</p>	<p>The Office of Unified Communications (OUC) and the Fire & EMS Department are jointly implementing EMD-Q™ (Emergency Medical Dispatch Quality Assurance) and AQUA™ (Advanced Quality Assurance) for the Medical Priority Dispatch System (MPDS™). Certification for supervisory personnel at the OUC has been completed, and DC Fire & EMS and the OUC will continue to train additional personnel as needed to provide robust quality assurance of the medical call-taking and dispatch process. In April 2015, the Medical Director began convening quarterly medical quality meetings with OUC leadership. In May 2015, the Acting FEMS Chief and the Interim OUC Director began having weekly meetings to initiate a comprehensive review designed to improve the operational relationship between the two agencies.</p>

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Recommendation 5: Reduce misuse of EMS and delays in patient transfers.

Status		Action Item	Progress
In Progress	d.	<p>The Medical Director, with the support of the City Administrator shall, no later than November 20, 2007, establish and clarify roles and responsibilities for the Department and the Metropolitan Police Department for treatment of uninjured intoxicated patients and for transport of patients to the District's detoxification facility.</p>	<p>See Joint statement/ progress report issued on 11/19/07, which establishes and clarifies roles and responsibilities for the Department and the Metropolitan Police Department for treatment of uninjured intoxicated patient. See also MPD General Order No. 502.7 (04/01/2014), <i>Medical Treatment and Hospitalization of Prisoners</i>; MPD General Order No. 501.03 (02/25/2003), <i>Handling Intoxicated Persons</i>.</p> <p>There are no sobering centers in the District of Columbia. All such patients are transported to area hospitals. Accordingly, the Agency is not compliant with the requirement for transport of patients to the District's detoxification facility.</p>
Implemented	e.	<p>Effective immediately, the Medical Director should exercise his full authority to order hospital emergency rooms within the District not to close to Department transports, and to require hospitals and medical providers to accept the transfer of care of a patient or patients within a specified period of time.</p>	<p>A new Closure/Diversion policy was issued on June 12, 2008. This policy was developed with the active participation and endorsement of the hospital working group formed under Recommendation 5 (f).</p> <p>Current Collaboration with the ED Leaders Meetings, attempts to mitigate delays in patient transfer. Hospital Closure is now a rare occurrence for extreme circumstances only and must be approved by the DC FEMS Medical Director. Numerous initiatives have been implemented in 2012 to strive for a less than 10 minute time until transfer of an EMS Patient to Hospital owned equipment. Further metrics and initiative are needed in this area.</p>
Implemented	f.	<p>The City Administrator shall, no later than November 20, 2007, convene a working group including hospital CEOs, DOH, and the Medical Director to meet quarterly to address and develop standards for drop times, diversion, and closure, and to improve procedures for tracking patient outcomes. The Medical Director should consider the results and recommendations of this group in exercising his discretion under the previous paragraph.</p>	<p>This group has been meeting since November 14, 2007.</p> <p>Closure rarely occurs and requires DC FEMS Medical Director approval prior to a Hospital closing to EMS units.</p>

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Recommendation 5: Reduce misuse of EMS and delays in patient transfers.

Status		Action Item	Progress
In Progress	g.	<p>The Medical Director shall, no later than September 30, 2008, develop a procedure to authorize patients to be transported to a pre-approved clinic or other non-emergency medical facility, appropriate to the patient's need.</p>	<p>At present DC FEMS transport units may transport Police and Fire employees to the Police and Fire Clinic instead of a Hospital ER. DC FEMS transport units also transport Pediatric Psychiatric patients directly to Psychiatric Institute of Washington as a pilot program in late 2012 to divert such patients not needing medical care from area Emergency rooms.</p> <p>For all other (<i>non-employee</i>) patients, the Agency is not compliant with this recommendation.</p>
Not Implemented	h.	<p>The Medical Director and the Director of the Department of Health shall develop and implement, no later than September 30, 2008, a system of alternative transportation options (such as scheduled van service, taxi vouchers, or MetroAccess vouchers), as well as protocols to refuse transport for non-urgent patients, when appropriate, subject to the authorization of a medical supervisor.</p>	<p>The Department does not offer alternative transportation options.</p> <p>The Department's Patient Bill of Rights, implemented in March 2011, specifically does not allow the <i>Department</i> to refuse transport by ambulance to those requesting service. However, we implemented a Patient Bill of Rights that addresses <i>patient</i> refusals.</p>

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Recommendation 6: Strengthen Department of Health (DOH) oversight of emergency medical services.

Status	Action Item	Progress
Implemented	<p>a. The Director of the Department of Health, in collaboration with EMS stakeholders, shall, no later than December 31, 2007, draft legislation or regulations or other administrative actions to improve oversight of all EMS providers and ambulance companies in the District of Columbia. The Mayor shall present the resulting draft to the DC Council for consideration. The legislation shall include, but not be limited to: License and/or certification requirements for EMS provider agencies, vehicles, personnel, and training facilities; Requirements for health care institutions, such as assisted care facilities, to provide or procure independent inter-facility transport services for non-emergent needs, and authority for DOH to impose fines and/or penalties for failure to comply; Specified levels of education, training, and satisfactory test performance in order to be lawfully assigned to work in an EMS provider capacity; Requirements for ongoing professional education and training and periodic recertification testing, both written and practical, administered by independent entities, as a condition for renewal of certification; Fair and effective enforcement, including sanctions for unacceptable performance and deliberate malfeasance, and standards and processes for revocation of EMS provider certification and EMS provider entity licensure and certification in appropriate cases; Requirements for all EMS provider entities, including the Department, to provide routine reporting on quality of care issues to the Department of Health; Authority to re-engineer the protocol revision process to improve the timeliness with which EMS</p>	<p>1. License and/or certification requirements for EMS provider agencies, vehicles, personnel, and training facilities: See D.C. Official Code §§ 7-2341.03 (agencies), 7-2341.04 (vehicles), 7-2341.05-06 (personnel), and 7-2341.07 (training facilities); see also 29 DCMR §§ 502-541; see further Policy 2014-0024 (31 Mar 2014) "Procedure for Certification as an EMS Agency", Policy 2010-0010 (15 Nov 2010) "Ambulance Interior Climate Standards", Policy 2014-0023 (10 Jan 2014) "Minimum EMS Vehicle Equipment Standards and Inspection Program", Policy 2010-0001 (28 Jan 2010) "Transition to NREMT Certification Requirement" (Originally issued as a memorandum on 13 April 2009), Policy 2010-0011 (01 Dec 2010) "EMS Education Institution Certification Standards", and Policy 2010-0012 (01 Dec 2010) "EMS Instructor Standards" Please note that the EMS Act of 2008 also provides requirements for instructors.</p> <p>2. Requirements for healthcare institutions, such as assisted care facilities, to provide or procure independent inter-facility transport services for non-emergent needs, and authority for DOH to impose fines and/or penalties for failure to comply: See D.C. Official Code § 7-2341.23(a)(11); see also 29 DCMR § 552.5.</p> <p>3. Specified levels of education, training, and satisfactory test performance in order to be lawfully assigned to work in an EMS provider capacity: See D.C. Official Code § 7-2341.05; see also 29 DCMR §§ 515-520; see further Policy 2010-0001 (28 Jan 2010) "Transition to NREMT Certification Requirement", Policy 2012-0020 (06 July 2012) "EMT Practical Skill Examination Procedures", and Policy 2012-0021 (06 July 2012) "EMR Practical Skill Examination Procedures".</p> <p>4. Requirements for ongoing professional</p>

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Recommendation 6: Strengthen Department of Health (DOH) oversight of emergency medical services.

Status	Action Item	Progress
	<p>protocols are updated; and Authority for DOH to issue fines and penalties to hospitals that fail to accept Department transports and assume care of patients within a specified period of time pursuant to the procedures established through recommendation 5 (f).</p>	<p>education and training and periodic recertification testing, both written and practical, administered by independent entities, as a condition for renewal of certification: See D.C. Official Code § 7-2341.05(j); see also 29 DCMR § 521; see further Policy 2010-0001 (28 Jan 2010) "Transition to NREMT Certification Requirement".</p> <p>5. Fair and effective enforcement, including sanctions for unacceptable performance and deliberate malfeasance, and standards and processes for revocation of EMS provider certification and EMS provider entity licensure and certification in appropriate cases: See D.C. Official Code §§ 7-2341.15-18; see also 29 DCMR §§ 563-564; see further Policy 2012-0019 (12 Apr 2012) "Requirements for the Suspension or Revocation of EMS Provider Certification".</p> <p>6. Requirements for all EMS provider entities, including the Agency, to provide routine reporting on quality of care issues to the Department of Health: See 29 DCMR §§ 556-558; see also Policy 2010-0003 (01 Feb 2010) "EMS Quality Assurance and Improvement Plan".</p> <p>7. Authority to re-engineer the protocol revision process to improve the timeliness with which EMS protocols are updated: See 29 DCMR §§ 504.1(g) and 504.4; see also Policy 2010-0009 (15 Nov 2010) "EMS Provider Scope of Practice".</p> <p>8. Authority for DOH to issue fines and penalties to hospitals that fail to accept Agency transports and assume care of patients within a specified period of time pursuant to the procedures established through recommendation 5(f): See D.C. Official Code §§ 44-509(b), 44-509(e)(1), and 44-509(f); see also 22-B DCMR § 2024.4 and 16 DCMR §§ 3606.1(m), 3200.1(a), and</p>

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Recommendation 6: Strengthen Department of Health (DOH) oversight of emergency medical services.

Status		Action Item	Progress
			3201.1(a); see further Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, as explained in DOH’s response dated May 15, 2015.
Implemented	b.	DOH shall immediately adopt the National Highway Traffic Safety Administration standards for EMS certification at all levels of training and as the minimum standard for the District of Columbia. Whenever possible, accreditation by nationally recognized bodies shall be adopted to establish testing and certification requirements.	See 29 DCMR § 515.5; see also, Policy 2010-0001 (28 Jan 2010) “Transition to NREMT Certification Requirement”, Policy 2010-0009 (15 Nov 2010) “EMS Provider Scope of Practice”, Policy 2010-0011 (01 Dec 2010) “EMS Education Institution Certification Standards”, Policy 2011-0015 (01 Aug 2011) “EMS Curriculum and Course Standards”, Policy 2011-0016 (01 Aug 2011) “EMS National Education Standards Transition Procedures”, Policy 2012-0020 (06 July 2012) “EMT Practical Skill Examination Procedures”, Policy 2012-0021 (06 July 2012) “EMR Practical Skill Examination Procedures”, and Policy 2014-0023 (10 Jan 2014) “Minimum EMS Vehicle Equipment Standards and Inspection Program”.