

Testimony of

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Prepared for the

Council of the District of Columbia
Committee on the Judiciary

Public Hearing on
The State of Emergency Medical Services in the District of Columbia

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1350 Pennsylvania Avenue, NW
Washington, DC 20004

Good afternoon Chairman McDuffie and members of the Committee on the Judiciary. Thank you for the invitation to share the results of our audit released in June reviewing compliance with the policy recommendations made in 2007 to improve emergency medical services in the District. I am Kathy Patterson, D.C. Auditor, and am joined by Tia L. Clark, who was lead auditor on this project.

As noted in the compliance review, nine years after Washington journalist David Rosenbaum died from wounds sustained in an assault, we found that the District government had implemented or partially implemented just 17 of the 36 recommendations made by the task force created in the wake of the journalist's death. We found that of the 36 specific recommendations to improve service delivery, 11 had been implemented, 6 had been partially implemented, 15 had not been implemented, and 4 were largely implemented but then later reversed or rescinded.

I will outline the six overarching recommendations in the task force report, and what our compliance review found in terms of meeting the individual recommendations within each area.

The Department of Fire and Emergency Medical Services shall transition to a fully integrated all-hazards agency.

As of June of this year, the Department of Fire and Emergency Medical Services (DCFEMS) had only implemented this transition in part. We found the department established minimum standards for dual-providers, but then in 2013 secured permission to hire 23 single-role providers. The department has not implemented the recommendation to provide all-hazards training to all current single-role providers. The department has implemented a recommendation to permit personnel to specialize in various levels of patient care and our sample of employees found an appropriate level of certification. The task force recommended that "all employees shall have the same basic pay and benefits" and that has not been accomplished. That said, the Fenty Administration did submit legislation in 2008 to begin implementing staff integration, but the Council took a different position and enacted legislation that does not meet the intent of the task force recommendation.

Reform Department structure to elevate and strengthen the EMS mission.

There has been on-again, off-again implementation of this policy directive. With actions taken to date by the Bowser Administration, the department has moved closer to meeting the task force recommendation. A medical director was appointed with the rank of assistant fire chief. In addition, an assistant fire chief for emergency medical services was named, but the position rescinded in 2011. In June, Chief Gregory Dean recreated the position of assistant chief for emergency medical services and named to that position former DCFEMS Chief Interim Chief Edward R. Mills III, though Mills did not have the emergency medical background called for by the task force (15 years as a paramedic). And he appointed a new Medical Director – Juliette

M. Saussy, MD. Additional leadership and supervisory positions within the medical service were created in the Fenty Administration, scaled back in the Gray Administration, and have been restored to a large degree in the current administration. The initiatives announced this week include strengthened training in emergency medical services, reflecting continued commitment to the EMS mission.

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

Of the 13 separate initiatives included in this recommendation, as of June 2015, only two had been implemented: a comprehensive training and education program for emergency medical technicians and paramedics, and a “clearly documented chain of patient care with clear evaluation and treatment documented by each provider.” An employee survey and regular performance monitoring were implemented but then stopped in the last administration. Other steps including annual assessments of medical staff and medical providers and development of performance evaluation and quality assurance programs were either not implemented or only partially implemented. As indicated earlier, some of the actions previewed by the mayor and chief earlier this week can be expected to contribute to the kinds of performance and quality assurance practices envisioned by the task force.

Enhance responsiveness and crew readiness by revising deployment and staffing procedures.

None of the five policies reflected in this task force recommendation had been fully implemented as of June. Over time, in fact, the department actually stepped back from reporting whether they had met the stated goals for the average response times for advanced life support calls. The task force recommended that a plan be developed to ensure shorter shifts for all employees. Mayor Gray submitted a plan to the Council in 2013, and the Council voted its disapproval of that plan, stating that there had not been sufficient analysis to ensure that public safety would not be affected by the proposed change in shifts. The fifth directive was “the Chief shall develop and implement a series of service delivery alternatives that provide efficient, rapid response with a variety of apparatus and personnel.” Perhaps more than any of the Rosenbaum Task Force recommendations, this one would appear to be met by the proposal announced this week to temporarily contract for private ambulance service.

Reduce misuse of EMS and delays in patient transfers.

The Department of Fire and Emergency Medical Services has implemented three of the eight policies included in this task force recommendation. We found the government has implemented an outreach program for patients with chronic disease, improved training for 911/311 dispatch operators to better enable them to distinguish emergency from non-emergency calls, and exercised the Medical Director’s full authority to direct emergency rooms remain open to Department transports and meet guidelines for the length of time required to transfer patient care. Steps that had not been taken as of the publication of our report: a new

public education program on appropriate use of the 911 system; clarification of the role of the Metropolitan Police Department in treating and transporting uninjured intoxicated patients; recommendations on drop times, diversion, closure and patient tracking to be developed by a broadly-representative working group; and development of alternative transportation options for non-urgent patients.

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

This included two comprehensive sets of policies, and both have been implemented. The Council approved legislation submitted by the mayor in 2008 covering licensing and certification for EMS provider agencies, vehicles, personnel, and training facilities – meeting all of the quality assurance policies included in the task force report. The Department of Health also adopted the National Highway Traffic Safety Administration standards for EMS certification. We tested a sample of employees and validated that they met both the national and DOH standards.

This concludes a summary of where the District stood earlier this year in meeting the recommendations of the Rosenbaum Task Force, a compliance record that appears to be improving with the initiatives announced this week. A majority – but not all – of the recommendations of the task force are within the purview of the executive branch of the District government. Our report highlighted areas where legislative action also is required, and I would like to flag this for the committee for your consideration. The dual-role all-hazards department that provides timely and competent care envisioned by the task force includes recommendations 1d, 4b and 5h. These are, specifically:

1d -- 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.

4b -- The Mayor and Chief shall work together to come up 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.

5h -- 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.

On the first two, both the mayor and Council took action, but were not able to come to agreement on how best to ensure pay and benefits parity and to address what was seen as a need for significant shift changes. These are difficult issues, with strongly held views on the part of the labor organizations representing employees of the Department. The third –

addressing the overuse of department staff and vehicles for what are non-urgent medical calls – is no less difficult in that it involves a historical pattern of District residents relying on the Department for securing routine medical care. It is my hope that with new departmental leadership, this committee and the Council will be able to work with Chief Dean and his team to address what have been intractable issues up until now. Moving forward now will require consensus and collaboration among the Executive, the Council, and both leadership and employees of the department.

Thank you for the opportunity to testify, and I am happy to respond to questions.