Metropolitan Area EMS Authority (MAEMSA)

dba MedStar Mobile Healthcare

Board of Directors

December 7, 2022

METROPOLITAN AREA EMS AUTHORITY
DBA MEDSTAR MOBILE HEALTHCARE
NOTICE OF MEETING

Date and Time: December 7, 2022 at 10:00 a.m.

Location: MedStar Board Room, 2900 Alta Mere Drive, Fort Worth, TX 76116

The public may observe the meeting in person, at https://meetings.ringcentral.com/j/1462025089 **phone at** (469) 445-0100 (**meeting** ID: 146 202 5089).

AGENDA

I.	**CALL TO ORDER**		Dr. Janice Knebl
II.	**INTRODUCTION OF GUESTS**		Dr. Janice Knebl
III.	**CITIZEN PRESENTATIONS**	Members of the public may address the Board on any posted agenda item and any other matter related to Authority business. All speakers are required to register prior to a meeting using the link on the Authority's website, (see, http://www.medstar911.org/board-of-directors/ where more details can be found, including information on time limitations). The deadline for registering is 4:30 p.m. December 6, 2022. No person shall be permitted to speak on an agenda item or address the Board during Citizen Presentations unless they have timely registered and have been recognized by the Chair.	
VI.	**CONSENT AGENDA**	Items on the consent agenda are of a routine nature. To expedite the flow of business, these items may be acted upon as a group. Any board member may request an item be removed from the consent agenda and considered separately. The consent agenda consists of the following:	
	BC – 1538	Approval of Board Minutes for October 26, 2022	Dr. Janice Knebl Pg. 1
	BC – 1539	Approval of Board Minutes for November 17, 2022	Dr. Janice Knebl Pg. 5
	BC – 1540	Approval of Check Register for October	Dr. Janice Knebl Pg. 8

V. NEW BUSINESS

BC- 1541	Authorize expenditure of funds to remediate cyber-attack, not to exceed $2 million without further approval by Board.	Kenneth Simpson

VI. MONTHLY REPORTS

A.	Chief Executive Officer Report	Kenneth Simpson
B.	Office of the Medical Director Report	Dwayne Howerton Dr. Veer Vithalani
C.	Chief Transformation Officer	Matt Zavadsky
D.	Chief Financial Officer	Steve Post
E.	Human Resources	Leila Peeples
F.	FRAB	Fire Chief Jim Davis Fire Chief Doug Spears
G.	Operations	Chris Cunningham
H.	Compliance Officer/Legal	Chad Carr Kristofer Schleicher
I.	EPAB	Dr. Brad Commons

VII. OTHER DISCUSSIONS

A.	Requests for future agenda items	Dr. Janice Knebl

VIII. CLOSED SESSION

The Board of Directors may conduct a closed meeting in order to discuss matters permitted by any of the following sections of Chapter 551 of the Texas Government Code, including but not limited to any item on this agenda:

1. Section 551.071: To seek the advice of its attorney(s) concerning pending or contemplated litigation or a settlement offer, or on any matter in which the duty of the attorney to the Board and the Authority to maintain confidentiality under the Rules of Professional Conduct of the State Bar of Texas clearly conflicts with the Open Meetings Act, including without limitation, consultation regarding legal issues related to matters on this Agenda;

or

2. Section 551.089: To deliberate security assessments or deployments relating to information resources technology; network security information; or the deployment of, or specific occasions for implementation, of security personnel, critical infrastructure, or security devices.

The Board may return to the open meeting after the closed session and may take action on any agenda item deliberated in the closed session.

IX ADJOURNMENT

MAEMSA
BOARD COMMUNICATION

Date: 12.07.2022	**Reference #:** BC-1538	**Title:** Approval of Board of Directors Minutes

RECOMMENDATION:

It is recommended that the Board of Directors approve the board minutes for October 26, 2022.

DISCUSSION:

N/A

FINANCING:

N/A

Submitted by: **Kenneth Simpson** **Board Action:**
_____Approved
_____Denied
_____Continued until _____________

MINUTES

METROPOLITAN AREA EMS AUTHORITY
DBA MEDSTAR MOBILE HEALTHCARE
BOARD OF DIRECTORS REGULAR MEETING
OCTOBER 26, 2022

The Metropolitan Area EMS Authority Board of Directors conducted a meeting at the offices of the Authority, with some members participating by video conference call pursuant to Section 551.127(c) of the Texas Government Code. The public was invited to observe the meeting at that location, or by phone or videoconference.

I. CALL TO ORDER

Chair Dr. Janice Knebl called the meeting to order at 10:07 a.m.

Board members participating through video conferencing: Dr. Chris Bolton, Councilman Carlos Flores, Fire Chief Doug Spears, Fire Chief Jim Davis, Bryce Davis, Teneisha Kennard, Susan Alanis, and Dr. Veer Vithalani (Ex-officio). Board members physically present were Chair Dr. Janice Knebl, Dr. Brad Commons, and Ken Simpson (Ex-officio). Others present were General Counsel Kristofer Schleicher, Chris Cunningham, Leila Peeples, Dwayne Howerton, Steve Post, Matt Zavadsky, and Chad Carr.

Guests on phone or in person as attendees: Dr. Angela Cornelius, Dr. Brian Miller, Fire Chief Brian Jacobs, Fire Chief Jeff Ballew, Fire Chief Kirt Mays, Fire Chief Ryan Arthur, Andrew Malone, Ben Coogan, Bettina Martin, Bob Strickland, Bradley Crenshaw, Cerenity- Jenkins Jones, Heath Stone, Kristine Martinez, Lindy Curtis, Maerissa Thomas, Matt Willens, Michael Griffith, Misti Skinner, Pete Rizzo, Shaun Curtis, Tiffany Pleasant, Timothy Statum, Tyler Stein, Whitney Morgan, and William Gleason.

II. INTRODUCTION OF GUESTS

Dr. Brian Miller introduced Dr. Farris with UTSW, Dr. Merlin with JPS, and Dr. Ross with Baylor.

III. CONSENT AGENDA

BC-1533 Approval of Board Minutes for September 28, 2022
BC-1534 Approval of Check Register September

The motion to approve all items on the Consent Agenda was made by Dr. Brad Commons and seconded by Dr. Chris Bolton. The motion carried unanimously.

IV. NEW BUSINESS

BC-1535 Approval of Ambulance Surplus

The motion to approve was made by Dr. Brad Commons and seconded by Dr. Chris Bolton. The motion carried unanimously.

BC-1536 Purchase of Deployment Software

The motion to approve was made by Dr. Brad Commons and seconded by Carlos Flores. The motion carried unanimously.

BC-1537 Annual Review of Executive Performance and Compensation

Following a Closed Session, a motion to approve an annual salary adjustment of 2.3% for the Chief Executive Officer and the Chief Legal Officer / General Counsel was made by Doug Spears and seconded by Dr. Brad Commons. Consideration of an annual performance bonus was deferred until November 17th.

V. MONTHLY REPORTS

A. Chief Executive Officer- Ken Simpson referred to Tab A and informed the Board of the recent IT challenges, provided an update on System Performance Meeting- Dr. Vithalani, and Whitney Morgan met to review and discuss methodology and Q/A along with deferring some of the operational conversations to the next meeting. Ken thanked the Board for approving Executive Coaching and provided an overview of training. We are continuing to work with EMS|MC and have seen a steady cash flow in the last few months.

B. Office of the Medical Director - Dr. Veer Vithalani referred to Tab B and informed the Board, the Office of the Medical Director continues to work on-going projects and continuing education efforts with MedStar and core responder colleagues.

C. Chief Transformation Officer - Matt Zavadsky referred to Tab C and informed the Board, we have two amazing kiddos which were nominated for our Trick-or-Treat event this Saturday.

D. Chief Financial Officer- Ken Simpson informed the Board due to events last week, we were not able to include the financial reports within the packet but once we are granted access to Tyler Munis reports will be provided by Steve Post.

E. Chief Human Resources Officer- Leila Peeples referred to Tab E and informed the Board, Human Resources has continued their focus on recruiting, retention, and engagement. We will be hosting a Trunk or Treat on Monday.

F. FRAB - Chief Spears informed the Board, some of the member city chiefs have reached out with concerns to extended response times on critical patients during the recent cyber-attack, they will be forwarding any concerns to me. Ken informed the Board we will be working on an action plan for future incidents.

G. Operations - Shaun Curtis referred to Tab G.

H. Compliance and Legal- Chad Carr referred to Tab H.

I. EPAB - Dr. Brad Commons informed the Board, the next EPAB Board Meeting is scheduled for December 8th and will be under new leadership as Dr. Jeff Jarvis fully transitions into the role of Medical Director. Due to recent events, hospital safety is a topic of concern across the country, and we should take the necessary precautions to ensure our staff is able to provide patient care within a safe environment.

VI. REQUEST FOR FUTURE AGENDA ITEMS

None.

VII. CLOSED SESSION

Dr. Knebl called the meeting into a closed session at 10:47 a.m. under Section 551.071 of the Texas Government Code. The Board returned to open session at 12:14 p.m.

The Board took action on BC-1537 as noted above.

VIII. ADJOURNMENT

The board stood adjourned at 12:15 p.m.

Respectfully submitted,

____

Douglas Spears
Secretary

MAEMSA
BOARD COMMUNICATION

Date: 12.07.2022	**Reference #:** BC-1539	**Title:** Approval of Board of Directors Minutes

RECOMMENDATION:

It is recommended that the Board of Directors approve the board minutes for November 17, 2022.

DISCUSSION:

N/A

FINANCING:

N/A

Submitted by: Kenneth Simpson	**Board Action:**	_____Approved _____Denied _____Continued until ______________

METROPOLITAN AREA EMS AUTHORITY
DBA MEDSTAR MOBILE HEALTHCARE
MINUTES OF CALLED MEETING
NOVEMBER 17, 2022

The Metropolitan Area EMS Authority Board of Directors conducted a meeting at the offices of the Authority, with some members participating by video conference call pursuant to Section 551.127(c) of the Texas Government Code. The public was invited to observe the meeting at that location, or by phone or videoconference.

I. CALL TO ORDER

Dr. Janice Knebl called the meeting to order at 2:05 p.m.

Board members participating through video conferencing: Dr. Chris Bolton, Dr. Brad Commons, Councilman Carlos Flore, Fire Chief Doug Spears, Fire Chief Jim Davis, Susan Alanis, and Teneisha Kennard. Board members physically present were Chair Dr. Janice Knebl, Dr. Jeffrey L. Jarvis (Ex-officio), and Ken Simpson (Ex-officio). Others present were General Counsel Kristofer Schleicher, Chris Cunningham, Leila Peeples, Steve Post, Matt Zavadsky, and Chad Carr.

Guests on phone or in person as attendees: Andrew Malone, Bettina Martin, Cerenity Jenkins-Jones, Joleen Quigg, Lindy Curtis, Maerissa Thomas, and Pete Rizzo.

II. INTRODUCTION OF GUESTS

There were no guests. Dr. Knbel introduced the new Chief Medical Officer / System Medical Director, Dr. Jeffrey L. Jarvis.

III. CITIZEN PRESENTATIONS

There were no citizen presentations.

IV. CLOSED SESSION

The Board of Directors went into a closed session at 2:09 p.m.to deliberate item BC-1525 and BC- 1537 under Sections 551.071 & 551.074 of the Texas Government Code. The Board returned to open session at 2:55 p.m.

V. OLD BUSINESS

BC- 1525 Carlos Flores moved the Board to appoint Bill Masterton to System Performance Committee and seconded by Dr. Chris Bolton. The motion passed unanimously.

BC- 1537 Doug Spears moved the Board to approve an annual salary adjustment of 4.01% for the Chief Executive Officer and the Chief Legal Officer / General Counsel, seconded by Dr. Chris Bolton. The motion passed unanimously.

VI. ADJOURNMENT

The meeting was adjourned at 2:57 p.m.

MAEMSA
BOARD COMMUNICATION

Date: 12.07.2022	**Reference #:** BC-1540	**Title:** Approval of Check Register for October

RECOMMENDATION:

It is recommended that the Board of Directors approve the Check Register for October 2022.

DISCUSSION:

N/A

FINANCING:

N/A

Submitted by: **Kenneth Simpson** **Board Action:** _____Approved
_____Denied
_____Continued until _____________

Metropolitan Area EMS Authority dba MedStar Mobile Healthcare

AP Check Details Over 5000
For Checks Between 10/1/2022 and 10/31/2022

Check Number	CK Date	Vendor Name	Check Amount	Description
109931	10/6/2022	AMBU Inc	5,118.97	Various Medical Supplies
109937	10/6/2022	Bound Tree Medical LLC	12,897.76	Various Medical Supplies
109943	10/6/2022	Fort Worth Heat & Air	9,852.50	Seasonal HVAC Maint - Main Bld
109945	10/6/2022	Galls Parent Holding LLC	7,802.00	Blauer jacket orders
109953	10/6/2022	Medline Industries, Inc.	8,233.68	Various Medical Supplies
109955	10/6/2022	MetLife - Group Benefits	36,799.19	Dental/Basic Life/STD/LTD
109963	10/6/2022	Pearson Education	6,398.36	EMT books
109974	10/6/2022	Zoll Medical Corporation	115,954.40	New Truck Monitors
109977	10/13/2022	Airgas USA, LLC	5,542.78	Cylinder Rental - Main - Sep22
109978	10/13/2022	All-Pro Construction & Commerical	5,807.81	Onsite Misc Materials - Main -
109983	10/13/2022	Bound Tree Medical LLC	16,324.50	Various Medical Supplies
109987	10/13/2022	CyrusONe	7,865.68	Colocation/Bandwidth Charges
109992	10/13/2022	Founder Project RX Inc	6,229.03	Various Medical Supplies
109993	10/13/2022	Galls Parent Holding LLC	6,091.00	Blauer jacket orders
109994	10/13/2022	Gulfstream Outsourcing and Specialized	20,210.02	Aged/Historical Project
109996	10/13/2022	ImageTrend	24,545.00	Monthly Fee - Elite EMS Saas
110006	10/13/2022	M-Pak, Inc.	6,035.46	Uniforms
110009	10/13/2022	Medline Industries, Inc.	12,492.92	Various Medical Supplies
110021	10/13/2022	Paranet Solutions	44,837.21	IT Monthly Services - Oct22
110025	10/13/2022	ReNew Biomedical Services, LLC	9,956.25	service agreement, IV pumps Yr
110030	10/13/2022	Stryker	2,111,268.44	Stryker Equipment
110040	10/13/2022	VLI Tech Inc	5,500.00	Vanguard Application & Analyti
2568331	10/3/2022	Frost	39,363.52	Frost Loan #39001
2578806	10/5/2022	M Davis and Company Inc	5,240.00	Detection of Elder Abuse - Sep
2578967	10/5/2022	WEX Bank	182,049.40	Fuel
2629227	10/19/2022	UMR Benefits	50,593.32	Health Insurance - October Pre
2674401	10/31/2022	Integrative Emergency Service Physician	15,000.00	Contract Services - A Cornelius
2674407	10/31/2022	UT Southwestern Medical Center	12,833.33	Contract Services - B Miller
10032022	10/3/2022	Frost	61,053.88	Frost Loan #30001
10042022	10/4/2022	Frost	38,540.62	Frost Loan #4563-001
10182022	10/18/2022	JP Morgan Chase Bank, N.A.	34,535.29	MasterCard Bill
10252022	10/25/2022	Frost	52,993.77	Frost Loan #4563-002

Tab A – Chief Executive Officer

Metropolitan Area EMS Authority dba MedStar Mobile Healthcare

Chief Executive Officer's Report- November 1, 2022

<u>Reprioritization Subcommittee/EMS System Performance</u>- The reprioritization subcommittee met on October 25, 2022. They revisited the methodology for reprioritizing calls and the effect that would bring to the system. Given the timing as it relates to the ransomware attack, we did not get into any other information. We will have another subcommittee meeting on January 4, 2023.

<u>Billing/EMS|MC</u>- We continue to work with EMS|MC to address issues as they occur. They have added some additional leadership, and our cash collections have been positive. Some of the payors that denied claims due to timely filing issues from November-February are agreeing to re-evaluate those claims. They have not hit their collections goals yet, but we are continuing to monitor and work with them to achieve our goals.

Several months ago our finance team engaged a specialty collections organization that focuses on finding and collecting motor vehicle claims. So far they have worked through a little less than half of the old claims they were sent, and they have generated net collections of about $200,000, which was unanticipated revenue. We are exploring opportunities to include them in normal billing practices moving forward.

<u>Organizational Reports</u>- After the ransomware attack the organization fell back to previous days prior to when the cyber analysts believe the ransomware actors gained access to the system. This meant that the computer aided dispatch reverted back to the call numbers of those previous days. The database is set up to accept only unique call numbers for reporting purposes. This has created challenges with compliance reporting, and, since we were without CAD for several days the mutual aid report is not accurate for October either. Rather than providing reports with flaws we have elected not to include the compliance and mutual aid reports for this month. We are working to get this fixed and/or noted for data collection purposes as we move forward.

<u>After Action Process</u>- We are engaging the Oklahoma Quality Award Foundation for the provision of after-action activities. The format will be built around the Baldridge Excellence & Cybersecurity Framework. There will be an opening meeting we will invite stakeholders to attend, if interested, to kick off a weeklong learning and review period for the organization. The final report will include short, mid, and long-range objectives and action plans.

<u>Gasoline Ambulances</u>- We recently received notification that Ram was increasing the price of diesel chassis again. We conducted a quick analysis of gasoline chassis vs. diesel chassis and there is a cost savings of approximately $21,000 per chassis. Over the life of the vehicle a conservative estimate is that we will save over $8,800 annually for each gasoline chassis due to fuel, maintenance, and capital savings. If the gasoline chassis work as expected and the fleet is converted to gas this would mean a savings of over $700,000 per year. We are starting with six to eleven chassis as we already have diesel chassis awaiting ambulance modules. We anticipate the first gas ambulances to arrive next summer.

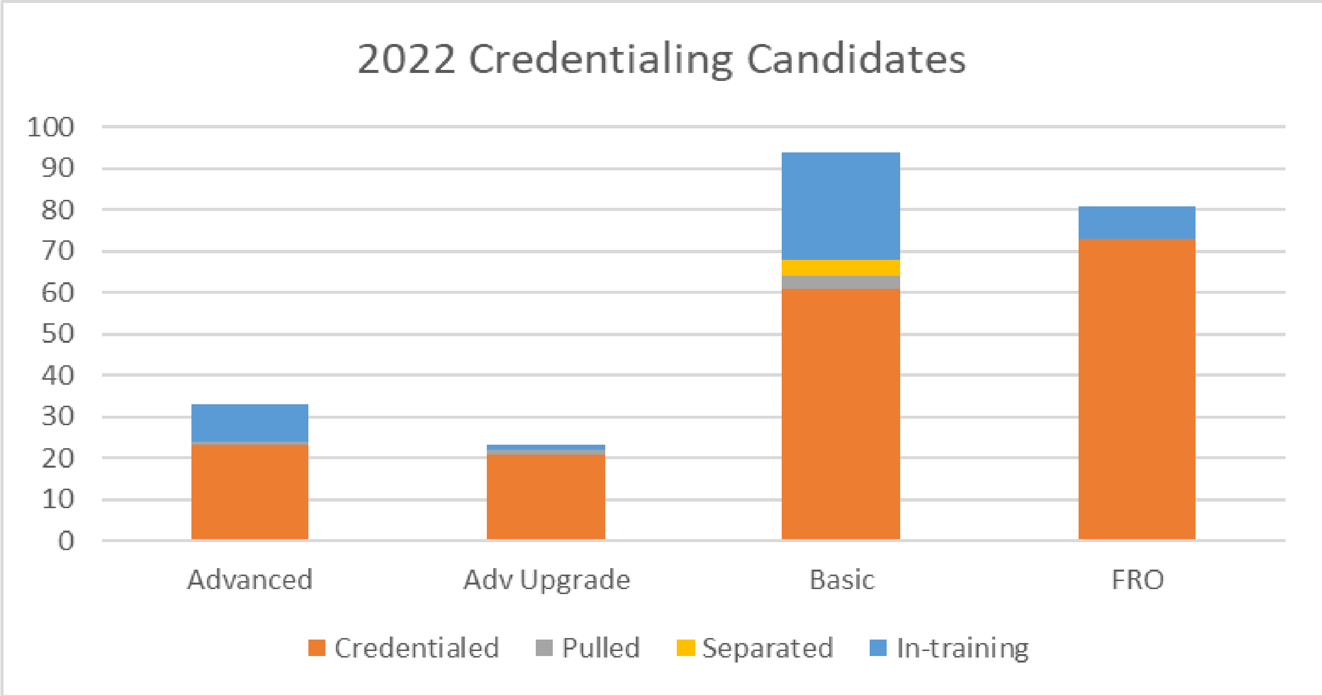
Tab B – Office of the Medical Director

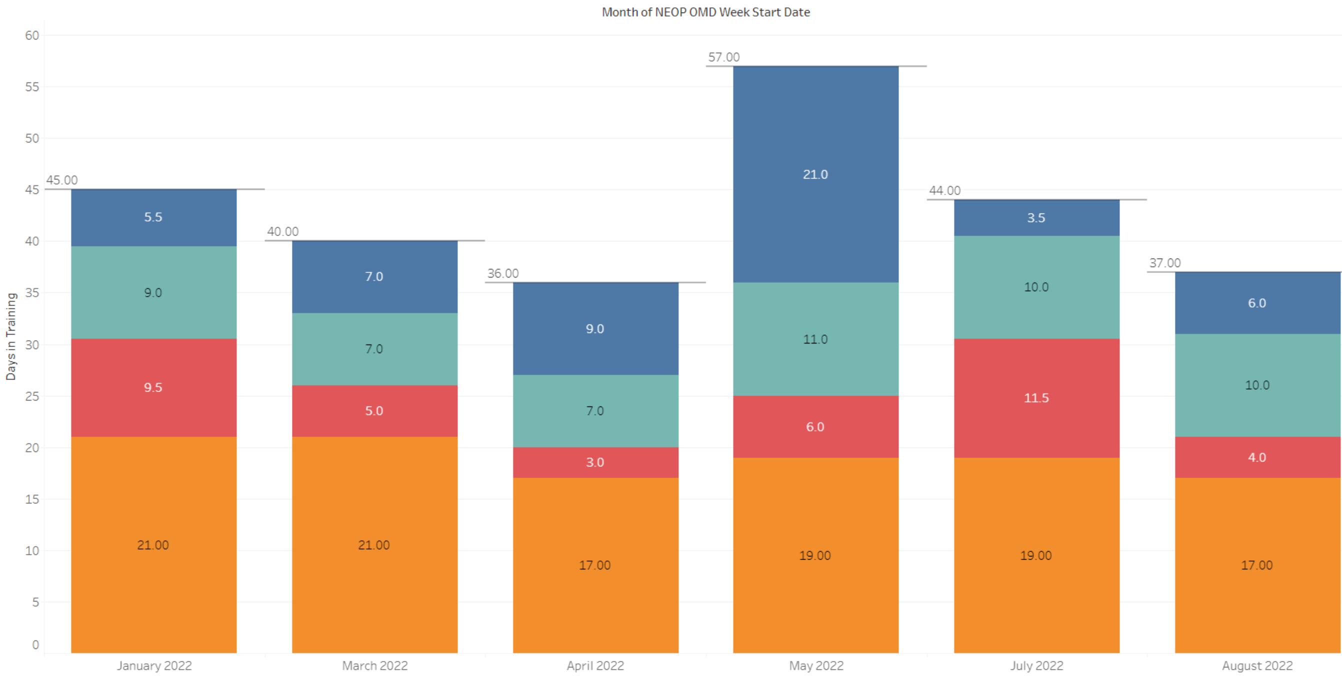
Education and Training

- OMD 22Q4 CE – December/January
    - Airway / Advanced Procedure Cadaver Lab
- System Education Committee
    - Annual System CE plan developed
        - October – Pediatrics
        - November – Cold Emergencies / CO
- MHP Course scheduled in early Spring

Course Attendance	BCLS	ACLS	Pedi	AMLS	PHTLS	Additional Course Challenges
MedStar	76	58	41	70	49	7
FRO	0	3	0	37	3	0
External	5	0	1	3	4	0

Credentialing





* Begins with the first day of clinical NEOP through credentialing.

- System Credentialing Committee

- Review of current credentialing requirements on hold for Medical Director transition

Quality Assurance

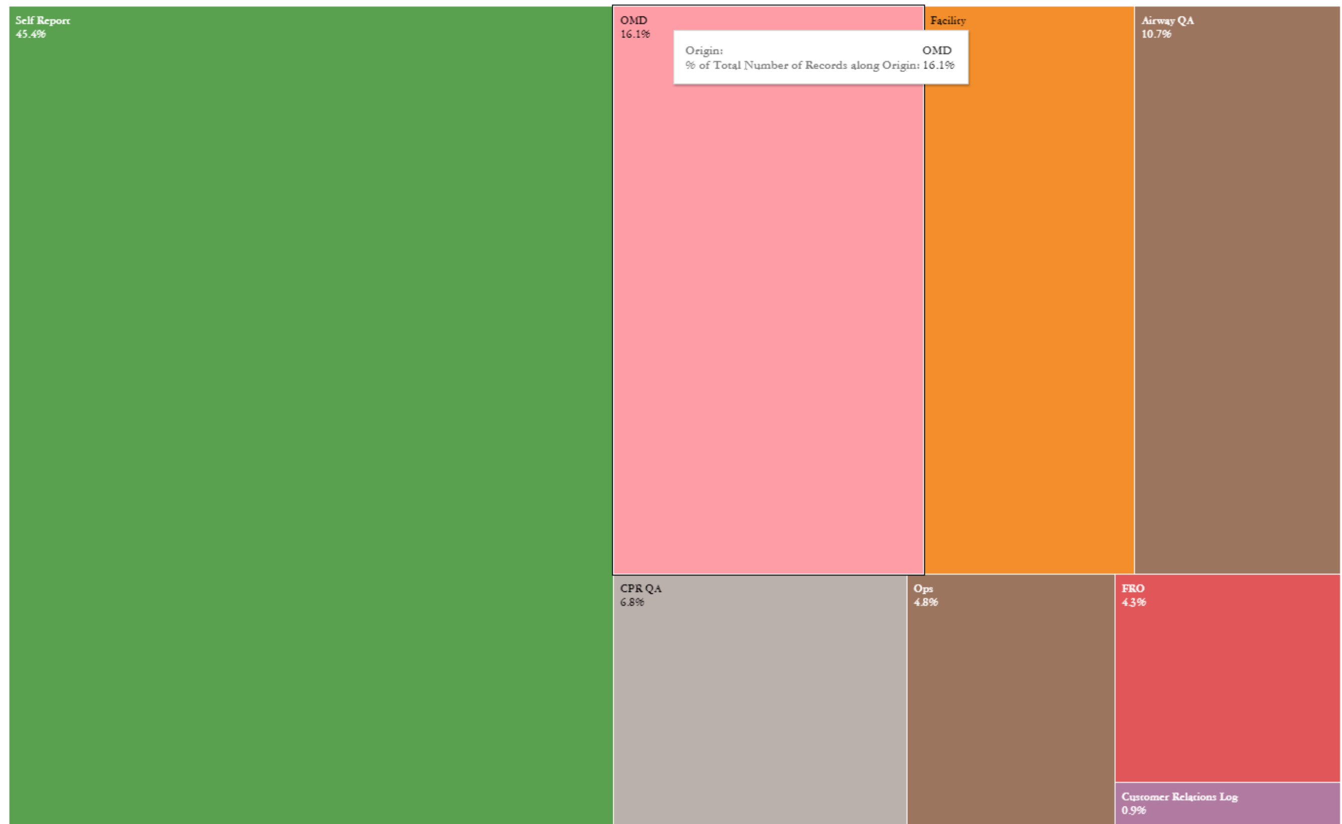
Case Acuity

	September 2022	October 2022
High	5 *(8.2%)*	
Moderate	12 *(19.7%)*	2 *(22.2%)*
Low	37 *(60.7%)*	5 *(55.6%)*
Non QA/QI	7 *(11.5%)*	2 *(22.2%)*
Grand Total	61 *(100.0%)*	9 *(100.0%)*

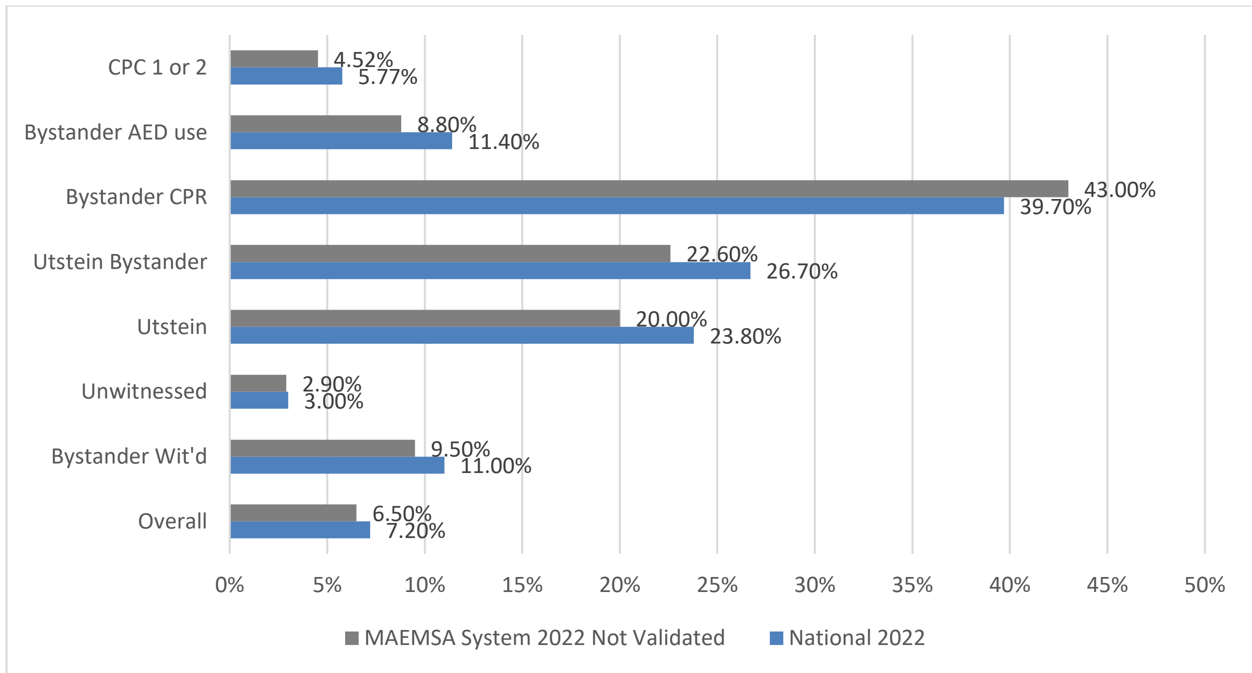
Case Disposition

	September 2022	October 2022
Clinically Appropriate	1 *(1.6%)*	
Needs Improvement	43 *(70.5%)*	5 *(55.6%)*
Clinically Inappropria..	1 *(1.6%)*	
No Fault	13 *(21.3%)*	3 *(33.3%)*
Pending	3 *(4.9%)*	1 *(11.1%)*
Grand Total	61 *(100.0%)*	9 *(100.0%)*

Cases by Origin



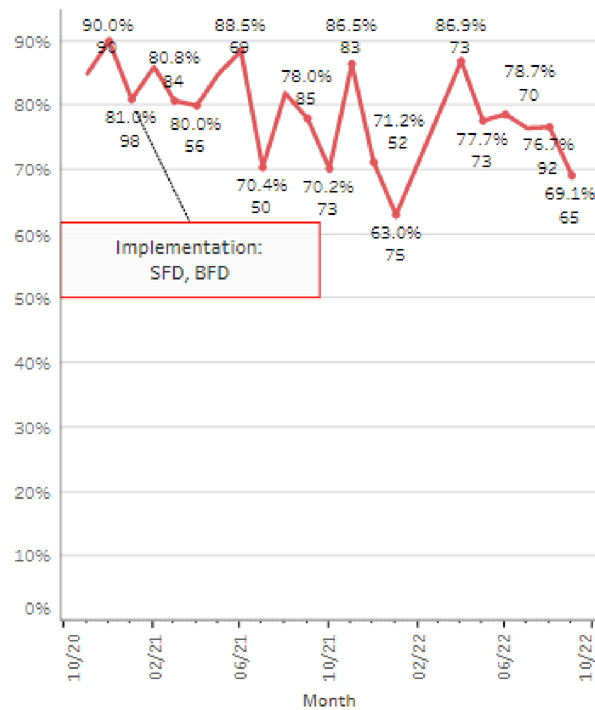
- CARES 2022
    - 1019 worked cardiac arrest
    - 48 pending hospital outcomes



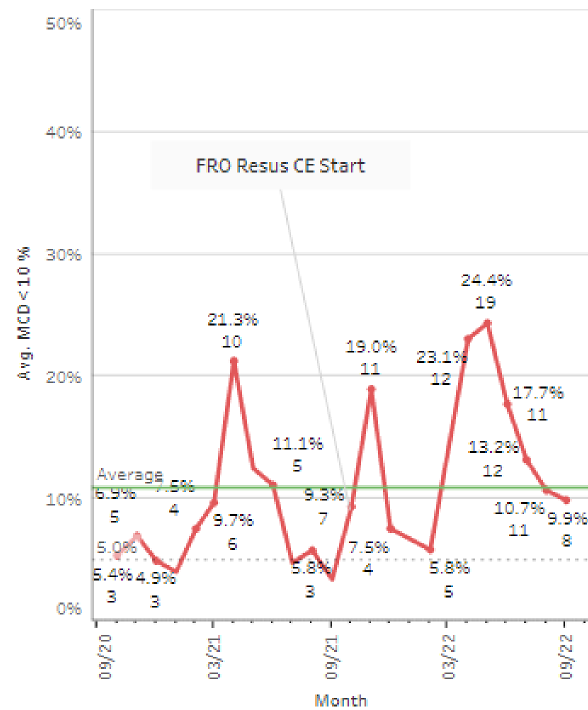
- Resuscitation Center - ECPR

ECPR Outcome Measures										
Measure	**Goal**	**Total**	**22-Feb**	**22-Mar**	**22-Apr**	**22-May**	**22-Jun**	**22-Jul**	**22-Aug**	**22-Sep**
Patients meeting prehospital criteria		**59**	**13**	**10**	**5**	**10**	**5**	**8**	**8**	**4**
Patients transported to an ECPR center		**25**	**1**	**2**	**3**	**4**	**3**	**6**	**6**	**4**
Patients meeting hospital criteria		**10**	**1**	**2**	**2**	**2**	**0**	**2**	**1**	
% of eligible patients discharged with CPC 1or2 that received ECPR	**35%**			0	0	0		0		
Overall hospital survival rate of those receiving ECPR	**Track**	**0%**	0	0	0	0	0	0	0	
Arrival at ECPR Center in less than 30-minutes of FMC	**85%**	**40%**	100.00%	0.00%	33.33%	75.00%	33.33%	50.00%	16.67%	0.00%
Avg time from FMC to ECPR Center		**0:39:04**	0:28:52	0:47:22	0:44:47	0:28:18	0:30:30	0:32:51	0:51:54	0:47:55
Appropriate protocol initiation	**85.00%**	**48.24%**	7.69%	20.00%	60.00%	40.00%	60.00%	75.00%	75.00%	100.00%
Prehospital notification given to receiving ECPR Center prior to transport	**100%**	**33.33%**	100.00%	100.00%	33.33%	0.00%	0.00%	0.00%	0.00%	0.00%
Prehospital notification given			1	2	1					
Patients cannulated		**4**	0	1	1	1	0	1	0	
Avg time from FMC to ECMO cannulation	**< 45 min**	**0:52:26**		0:56:55	0:59:35	0:34:03		0:59:10		
% of patients meeting ECPR Center exclusion criteria	**Track**	**82%**	92.31%	80.00%	60.00%	80.00%	100.00%	75.00%	87.50%	100.00%
Avg hospital length of stay	**Track**	**0**								

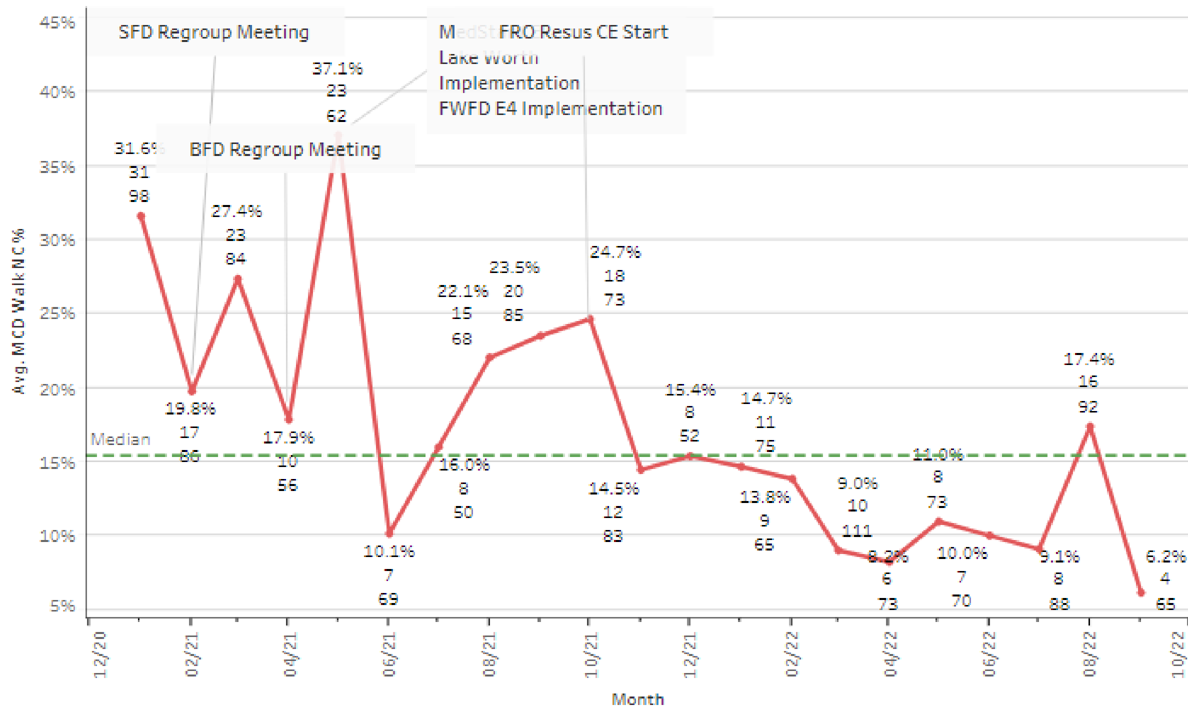
MCD Placement %



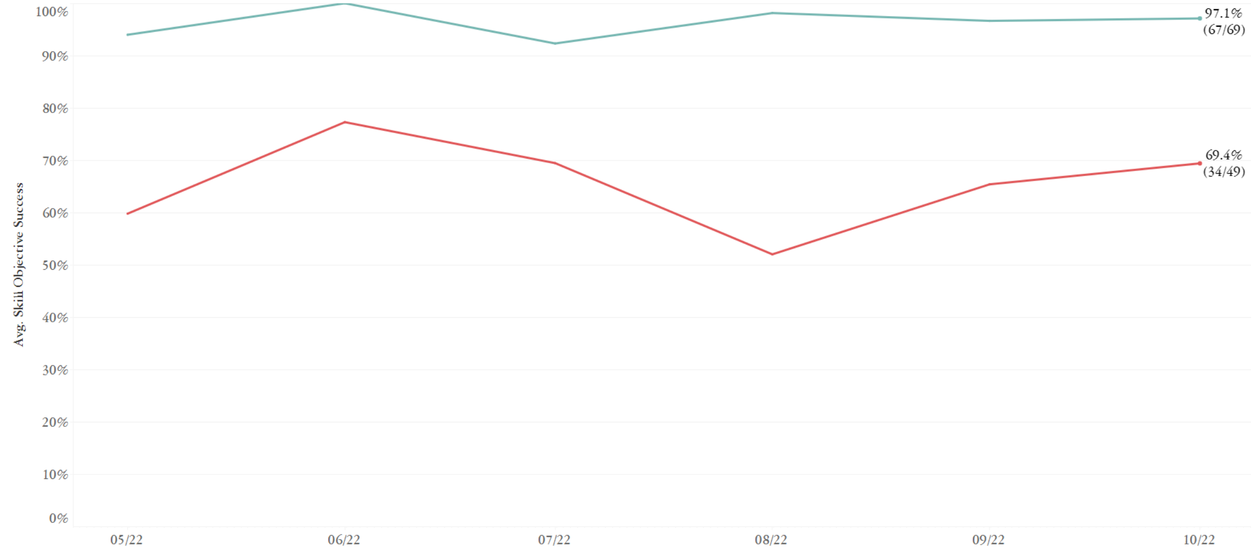
MCD Placement < 10 sec %

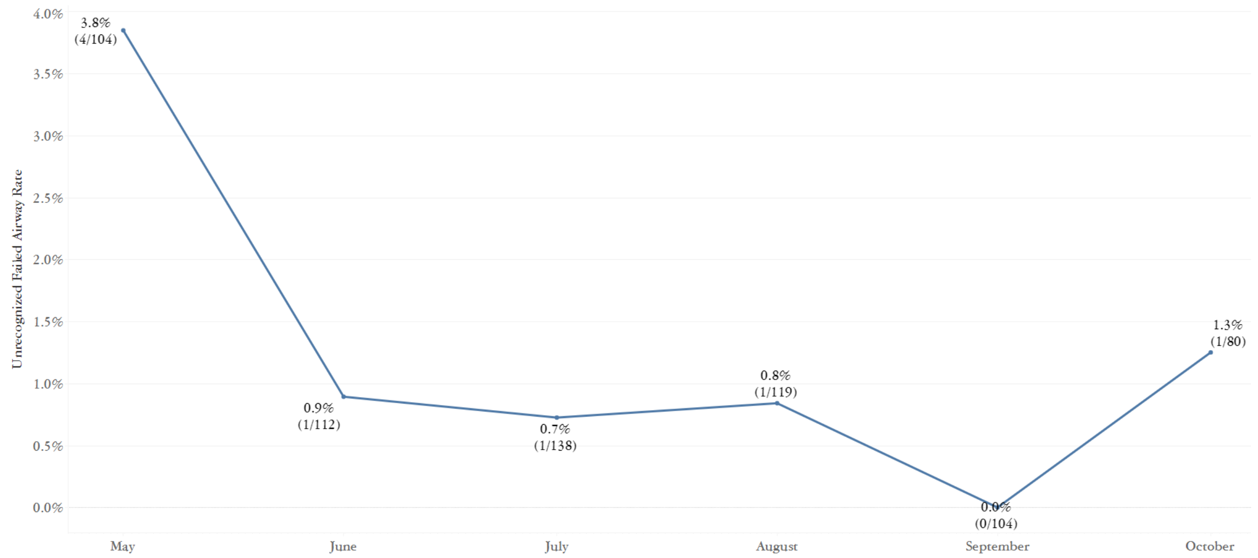


% of Uncorrected MCD Walk/Overall placement



- Airway Management





OMD Quality Improvement & Quality Assurance Definitions

Risk Categories:

High-Priority:
Cases in which there is a high index of suspicion for a critical lapse in clinical care, and for which there is significant concern for further lapses in the absence of appropriate remediation or retraining or potential or actual deleterious patient outcome directly related to inadequate assessment or inadequate/inappropriate application of protocol or skill

Moderate Priority:
Involve deviations from protocol or clinical care, or pose potential risks for adverse outcome, not deemed to be high priority in nature, as described above

Low Priority:
Involve potential deviations from protocol or clinical care but do not pose a substantial risk for adverse outcomes

QA Dispositions:

No Fault:
These cases include those where no deviation from protocol or clinical care was found, and where the care provided did not pose a substantial risk for an adverse outcome.

Clinically Appropriate:
These cases include those where deviations from protocol or clinical care were found, but which did not pose a substantial risk for an adverse outcome and may have resulted in improved clinical course or outcome.

Needs Improvement:
These cases include those where deviations from protocol or clinical care were found and may have posed potential risk for an adverse outcome.

Clinically Inappropriate:
These cases include those where a critical lapse in clinical care was identified, and where significant concern for further lapses exists in the absence of appropriate remediation or retraining. These cases may also include those where a potential or actual deleterious patient outcome may have resulted from inadequate assessment or inadequate/inappropriate application of protocol or skill.

System Diagnostics

Cardiac Arrest	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Current Avg.		Goal
% of recognizable Out-of-Hospital Cardiac Arrests (OHCA) cases correctly identified by Dispatch	84.9%	75.5%					86.0%		75%
Median time between 9-1-1 call and OHCA recognition	0:01:22	0:01:33					0.0%		< 0:01:30
% of recognized 2nd party OHCA cases that received tCPR	93.6%	94.3%					98.6%		75%
Median time between 9-1-1 Access to tCPR hands on chest time for OHCA cases	0:03:05	0:03:19					0.1%		<0:02:30
% of cases with time to tCPR < 180 sec from first key stroke	60.7%	69.1%					71.3%		
% of cases with CCF $\geq$ 90%	59.0%	70.0%	64.2%	62.3%	70.3%	65.0%	79.9%		90%
% of cases with compression rate 100-120 cpm 90% of the time	94.5%	93.4%	92.9%	97.5%	92.2%	96.4%	89.7%		90%
% of cases with compression depth that meet appropriate depth benchmark 90% of the time	52.7%	34.4%	49.4%	59.3%	43.7%	44.1%	33.7%		90%
% of cases with mechanical CPR device placement with < 10 sec pause in chest compression	7.0%	30.3%	24.4%	17.7%	13.2%	10.7%	19.9%		
% of cases with Pre-shock pause < 10 sec							89.2%		
% arrive at E/D with ROSC	18.5%	21.0%	13%	21.1%	9.3%	16.4%	16.7%		
% discharged alive	5.4%	9.9%	7.1%	7.8%	4.1%		7.1%		
% neuro intact at discharge (Good or Moderate Cognition)	3.8%	7.4%	5.9%	4.4%	4.1%		5.3%		
% of cases with bystander CPR	47.7%	40.7%	37.6%	45.4%	40.0%	61.3%	48.7%		
% of cases with bystander AED use	16.9%	17.3%	25.9%	17.8%	24.7%	24.5%	19.8%		

STEMI	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Current Avg.		Goal
% of suspected STEMI patients correctly identified by EMS	55.2%	66.7%	59.4%	59.4%	53.3%	37.5%	62.0%	75.0%	75%
% of suspected STEMI patients w/ASA admin (*in the absence of contraindications)*	94.4%	96.3%	97.1%	93.9%	92.1%	92.3%	94.5%	90.0%	90%
% of suspected STEMI patients w/NTG admin (*in the absence of contraindications)*	94.4%	88.9%	94.3%	93.9%	76.3%	80.8%	87.7%	90.0%	90%
% of suspected STEMI patients with 12L acquisition within 10 minutes of patient contact	77.8%	66.7%	85.7%	81.8%	92.1%	50.0%	72.1%	90.0%	90%
% of suspected STEMI patients with 12L transmitted within 5 minutes of transport initiation	72.2%	74.1%	74.3%	84.9%	68.4%	65.4%	62.4%	90.0%	90%
% of suspected STEMI patients with PCI facility notified of suspected STEMI within 10 minutes of EMS patient contact	8.3%	14.8%	31.4%	36.4%	34.2%	23.1%	18.5%	75.0%	75%
% of patients with Suspected STEMI Transported to PCI Center	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.6%	100.0%	90%
% of suspected STEMI patients with EMS activation to Cath Lab intervention time < 90 minutes	23.1%	25.0%	33.3%	37.5%	37.5%	0.0%	32.7%	50.0%	50%

Tab C – Chief Transformation Officer

Transformation Report
December 2022

Alternate Payment Models & Expanded Services
- Working with Humana to establish "ET3-Like" services for commercial members
- Working with JPS to establish ET3 and MIH services for Connection patients
- Working with Medically Home Group on agreement for Hospital @ Home program

CMS ET3 Project
- Invited by CMS to be on the CMS ET3 Quality Measures Workgroup
    - 1st Measure: ED Recidivism (ED visit within 72 hours of ET3 intervention)
    - Determined a potential data anomaly w/CMS on the way they track this metric?
    - Have written CMS requesting clarification (attached)

Reducing HOT Vehicle Operations Project
- Continuing to track with Re-Prioritization project
    - Goal = reduce HOT responses to ~30-40% of calls
        - Currently ~70% of calls
    - OMD/Data Analyst refined clinical outcome data based on EMD Determinant
        - Priority 1 – 4 calls would be "HOT" response, w/Medical First Response requested
        - ~33.7% of current EMS response volume

Texas Legislative Session
- Texas EMS Alliance finalized 2023 Texas legislative session agenda/priorities (attached).
- Scheduling meetings with all local legislatures to share the agenda.
    - Patient Protection from Surprise Insurance Payments
    - Medicaid Rate Increase to Parity with Medicare Allowable
    - Implementation of Revisions to Ambulance Supplemental Payment Program (ASPP)

High Performance EMS Projects
- AIMHI releasing quarterly data on clinical, operational, and financial performance and structure of High Performance/High Value EMS systems
    - Most recent report attached
- Developing "EMS: Structured for Quality" guide and inform policy makers on the hallmarks and measures of effective EMS system design, implementation and evaluation based on metrics that matter for patient outcomes
    - May release in partnership with ICMA

Holiday Community Service
- Desi working with several area non-profit agencies on toy and goodies drive.
    - May result in another Exec Team Christmas Story Bunny Suit event 😊

Upcoming Presentations:

Event (location)	Date	Attendees
ICMA National Webinar – EMS: On Life Support?	Nov 2023	~150
NAEMSP Annual Conference (Tampa, FL)	Jan 2023	~700
ICMA Regional Conference (Travers City, MI)	Feb 2023	~500
IAED Navigator (Denver, CO)	Apr 2023	~1,000
North Carolina EMS Leadership Conf. (Greensboro, NC)	Mar 2023	~150
FDIC/JEMSCon	Apr 2023	~7,000
National EMS Safety Summit/Financial Symposium (Denver, CO)	Apr 2023	~300

Media Summary

Local –

- Halloween Safety
    - CBS 11, FOX 4, KRLD, Star-Telegram
- Trick or Treat Event
    - CBS 11, NBC 5, FOX 4, ABC 8
- Thanksgiving Safety & Driving
    - NBC 5, CBS 11, FOX 4, ABC 8, KRLD, WBAP
- Cyber Attack
    - CBS 11

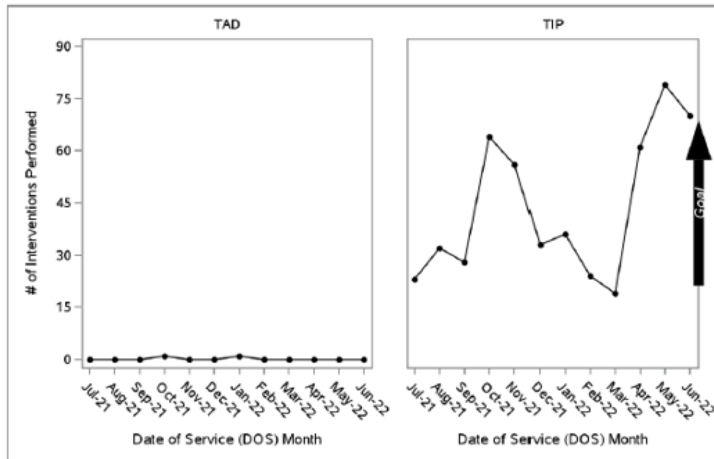
From: Matt Zavadsky
Sent: Monday, November 14, 2022 10:30 AM
To: CMS ET3 Model <ET3Model@cms.hhs.gov>
Subject: MedStar (ET3-0507) MDR Questions - October 2022

Since the initiation of the MDR reports, we, and other agencies, have been puzzled by the reported % of Medicare beneficiaries with an ED visit with 72 hours of the ET3 intervention.

We'd like to better understand how this % is derived, specifically, the 'denominator' for the calculation.

For example, the October MDR for us shows 70 Medicare ET3 interventions for June 2022, with 17 claims paid.

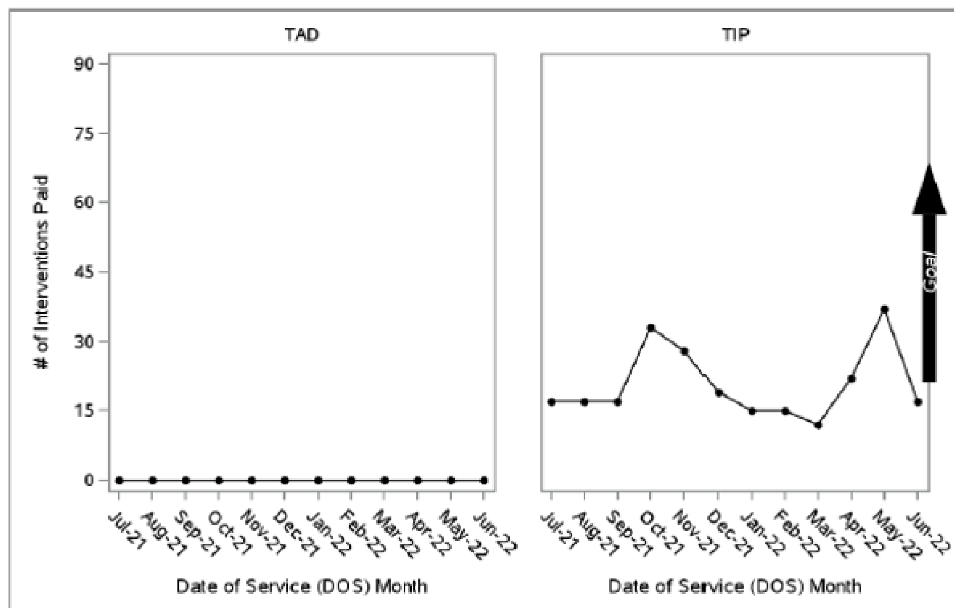
1. Number of TAD/TIP Interventions Performed



DOS Month	Number of TAD	Number of TIP
Jul-21	0	23
Aug-21	0	32
Sep-21	0	28
Oct-21	1	64
Nov-21	0	56
Dec-21	0	33
Jan-22	1	36
Feb-22	0	24
Mar-22	0	19
Apr-22	0	61
May-22	0	79
Jun-22	0	70
Total	2	525

Note: Metric #1 represents a preliminary summation of data about Medicare Fee-For-Service (FFS) patients and may include non-Medicare FFS patients depending upon each Participant's policies and practices regarding completion of ET3 custom elements and other PCR fields.

2. Number of TAD/TIP Interventions Paid (Medicare FFS)



DOS Month	Number of TAD	Number of TIP
Jul-21	0	17
Aug-21	0	17
Sep-21	0	17
Oct-21	0	33
Nov-21	0	28
Dec-21	0	19
Jan-22	0	15
Feb-22	0	15
Mar-22	0	12
Apr-22	0	22
May-22	0	37
Jun-22	0	17
Total	0	249

For the 12 months of July 2021 - June 2022, there have been 525 intervention claims submitted, with 249 (47%) paid.

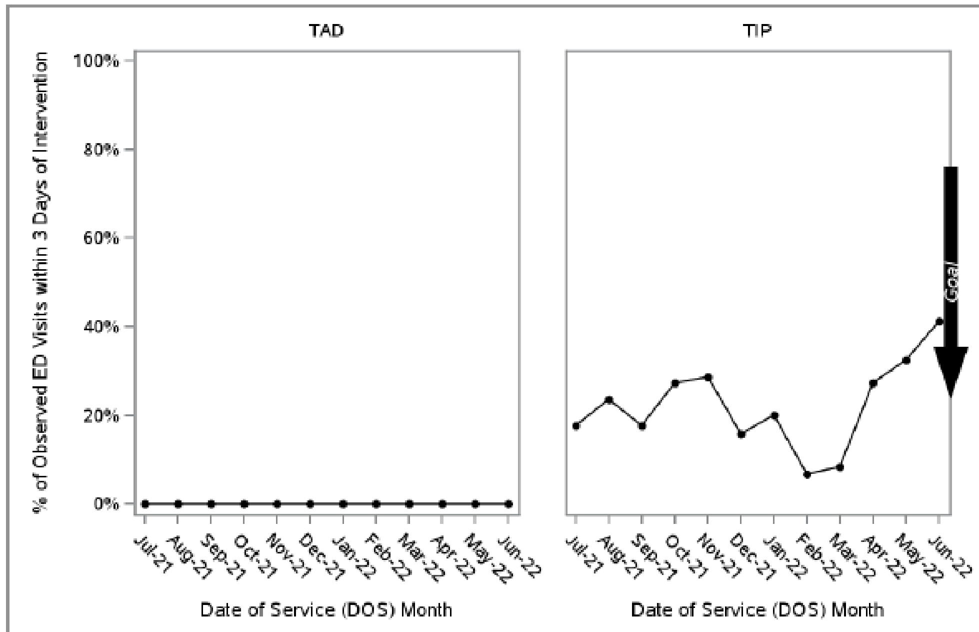
It seems, based on the #4 measure, "*Percent of Observed ED Visits within Three Days of TAD/TIP Intervention (Medicare FFS*)", that the number of **PAID CLAIMS** (17) is being used as the denominator for the number of TIP interventions measure.

Therefore, if 7 beneficiaries of the 17 PAID claims had an ED visit within 72 hours, it would yield the referenced 41% rate (7 / 17 = 0.4118).

However, if 7 of the beneficiaries *who had an intervention performed* (70) had an ED visit, the rate would be 10% (7/70 = 0.100).

Could we please confirm that the rate being calculated is based on claims *submitted*, or claims *paid*?

4. Percent of Observed ED Visits within Three Days of TAD/TIP Intervention (Medicare FFS)



DOS Month	Number of TAD	Percent ED Visits After TAD	Number of TIP	Percent ED Visits After TIP
Jul-21	0	0.0%	17	17.6%
Aug-21	0	0.0%	17	23.5%
Sep-21	0	0.0%	17	17.6%
Oct-21	0	0.0%	33	27.3%
Nov-21	0	0.0%	28	28.6%
Dec-21	0	0.0%	19	15.8%
Jan-22	0	0.0%	15	20.0%
Feb-22	0	0.0%	15	6.7%
Mar-22	0	0.0%	12	8.3%
Apr-22	0	0.0%	22	27.3%
May-22	0	0.0%	37	32.4%
Jun-22	0	0.0%	17	41.2%
Total	0	0.0%	249	24.1%

2022-2023 Legislative Priorities

Federal –

Assure extension of Medicare Extender Payments

- Due to expire 12/31/22
  - If not extended, will reduce our Medicare allowable by 2%
  - Were extended pending Ambulance Cost Data Collection data
    - Cost collection data delayed due to PHE
- Bill introduced
  - Strong support from numerous members of Congress
  - Advocacy partners include:
    - National Association of Emergency Medical Technicians
    - American Ambulance Association
    - International Association of Fire Chiefs
    - International Association of Fire Fighters

Add inflation additional adjustment to Medicare Extenders

- Proposal to increase Medicare Extender payments by 3%
  - Based on CPI and cost increases
- Some Congressional support, no bill introduced yet, hope by the end of the calendar year
  - Advocacy partners include:
    - National Association of Emergency Medical Technicians
    - American Ambulance Association
    - International Association of Fire Chiefs
    - International Association of Fire Fighters

Make certain CMS PHE Waivers Permanent

- Waivers allowing payment for ambulance Treatment In Place (TIP), Transport to Alternate Destinations (TAD), and EMS originated Telehealth have proven value for the patient, healthcare systems, agencies and payers.
  - These waivers should become standard reimbursable services.
  - In discussions with members of Congress, some support for this initiative
  - No language written yet
  - Advocacy partners include:
    - National Association of Emergency Medical Technicians
    - American Ambulance Association
    - International Association of Fire Chiefs
    - International Association of Fire Fighters

<u>State –</u>

Patient Protection from Surprise Insurance Payments

- Commercial insurers are randomly assigning payments for ambulance that are far below Fair Health established rates.
  - Contrary to current Insurance Regulations prohibiting such practice.
- This leaves patients in the middle of a payment dispute with the EMS provider.
- Support legislation that removes the patient from these disputes and requires arbitration between the payer and the provider.
- Advocacy partner –
  - Texas EMS Alliance

Medicaid Rate Increase to Parity with Medicare Allowable

- The state's Medicaid reimbursement for ambulance service has not changed since 2007.
- Costs have dramatically increased since then.
- Discussions with HHSC in 2011 about an increase led to them asking "EMS" to clean our house regarding fraud and abuse.
  - EMS agencies got a bill passed in 2012 that dramatically reduced F & A in Texas.
  - Has resulted in reducing licensed ambulance agencies in Texas by ~400, with Medicaid savings.
- Several other healthcare provider groups also seeking Medicaid rate adjustments.
- Support from many state legislators for EMS rate adjustment.
- Advocacy partner:
  - Texas EMS Alliance

Implementation of Revisions to Ambulance Supplemental Payment Program (ASPP)

- HHSC filed State Plan Amendment (SPA) with CMS in September 2019 changing ASPP from cost-based to Average Commercial Reimbursement (ACR) basis.
  - Much better supplemental payment to MedStar due our low-cost.
- CMS initially approved the SPA, then revoked approval when administration changed.
- CMS and HHSC have been exchanging questions and answers to get the SPA approved, but HHSC has not submitted responses to CMS's latest questions in over 18 months.
- We're encouraging HHSC to get the SPA approved but may need 'encouragement' from the legislature.
- Advocacy Partners
  - Texas EMS Alliance
  - Houston Fire
  - Dallas Fire
  - Texas City Fire
  - PCG

ACADEMY OF INTERNATIONAL MOBILE HEALTHCARE INTEGRATION

2022 High-Performance EMS Benchmarking Study

Part 1: System Demographics and Operational Performance

The AIMHI benchmarking studies perform a fundamental service to EMS by providing tools through which we can continue to learn about the successes and opportunities of today's emergency care system, ensure its progress and growth, and work to expand the reputation and efficiency of EMS nationally and internationally. The 2022 study is the latest addition to the body of knowledge required for effective service delivery and improvement.

Since the first study in 1998, AIMHI has developed valuable ***evidenced-based*** studies to share ***clinical, operational, and economic*** data across EMS systems serving diverse geographic and demographic communities. Our goal is to provide the EMS community, elected and appointed officials, and regulators with tools, data, and outcomes that demonstrate the value of high-performance, high-value mobile healthcare as the initial point of entry to, and the safety net of, the healthcare continuum.

Agency Name	Organizational Structure
Emergency Medical Services Authority (Oklahoma City, OK)	Public Utility Model: Self-Operated
Emergency Medical Services Authority (Tulsa, OK)	Public Utility Model: Self-Operated
Mecklenburg EMS Agency (Charlotte, NC)	Public Utility Model: Self-Operated
Medic Ambulance (Solano, CA)	Private
MEDIC EMS (Davenport, IA)	501c3
MedStar Mobile Healthcare (Fort Worth, TX)	Public Utility Model: Self-Operated
Metropolitan EMS (Little Rock, AR)	Public Utility Model: Self-Operated
Niagara Emergency Medical Services (Region of Niagara, CA)	Third Service Model
Northwell Health Center for EMS (Syosset, NY)	Health System Based EMS Agency
Novant Health New Hanover EMS (New Hanover County, NC)	Hospital-Based
Pinellas County EMS - Sunstar (Pinellas County, FL)	Public Utility Model: Contracted
Pro EMS (Cambridge, MA)	Contractor
Regional Emergency Medical Services (Reno, NV)	Public Utility Model: Self-Operated
Richmond Ambulance Authority (Richmond, VA)	Public Utility Model: Self-Operated

What Is High Performance/High Value EMS (HP/HVEMS)?

HP/HVEMS systems share key features of system design rarely associated with less cost-effective systems. Characteristics typically include:

- **Sole provider:** All emergency and non-emergency ambulance services are granted to a sole and often competitively selected provider for a specific population or service area.
- **Control center operations:** The ambulance provider has control of the dispatch center.
- **Accountability:** HP/HVEMS systems have performance requirements that can result in financial penalties or replacement of the provider when the requirements are not met. HP/HVEMS systems use and collect data regularly to meet these performance requirements, which has allowed for the ability to collect data for the HP/HVEMS Market Study.
- **Revenue maximization:** HP/HVEMS systems incorporate the business function into their operations, resulting in an understanding of the billing requirements, thus collecting all appropriate revenues from Medicare, Medicaid, self-pay and other third-party payors.
- **Flexible production strategy:** HP/HVEMS match scheduled resources with predicted changes in response demand based on time of day, day of week and time of year.
- **System Status Management (SSM):** HP/HVEMS systems use the dynamic deployment techniques to position resources in anticipation of when and where ambulances will be needed.

Key Metrics & Takeaways

- **36%** of the HP/HVEMS systems have **transitioned from an all-ALS ambulance deployment to a Tiered Deployment (ALS/BLS)** to better match resources with emergency needs and enhance ALS provider utilization and experience.

- **64%** of HP/HVEMS systems **do not use Medical First Response on all calls**, reserving MFR for calls with a higher medical acuity, based on EMD determinants derived through an accredited communications center.
  - Across these systems, **an average of 52% of EMS calls do not receive Medical First Responders**.

- **61%** of the emergency responses in the HP/HVEMS systems **receive a lights & siren (HOT) response**.
  - **9%** of the patients transported to hospitals receive a **HOT transport**.

- The **Median ambulance response time** in HP/HVEMS systems is **8 minutes, 41 seconds**.
  - The response time calculation begins at time call received in **42%** of HP/HVEMS systems

- AIMHI Member agencies serve a **combined population of 17.6 million** people and a geography of over **14,000 square miles.**

- Member agencies responded to **1.5 million emergency ambulance calls** in 2021, **transporting 996,080** patients for a **transport ratio of 67.8%.**

- **100% of AIMHI member agencies hold at least one accreditation. 93% are accredited by the *Commission on the Accreditation of Ambulance Services (CAAS)*** and **79% of member dispatch centers are accredited by the *International Academies of Emergency Dispatch***.

CURRENT AIMHI MEMBERS

Emergency Health Service
Halifax, NS

Emergency Medical Services Authority
Tulsa & Oklahoma City, OK

Mecklenburg EMS Agency
Charlotte, NC

Medic Ambulance
Vallejo, CA

MEDIC Emergency Medical Services
Davenport, IA

MedStar Mobile Healthcare
Fort Worth, TX

Metropolitan Emergency Medical Services
Little Rock, AR

New Hanover EMS
Wilmington, NC

Niagara Emergency Medical Services
Niagara-On-The-Lake, ON

Northwell Health Center for EMS
Syosset, NY

Pinellas County EMS Authority/Sunstar Paramedics
Largo, FL

Pro EMS
Cambridge, MA

Regional EMS Authority
Reno, NV

Richmond Ambulance Authority
Richmond, VA

Three Rivers Ambulance Authority
Fort Wayne, IN

Learn more about membership at www.aimhi.mobi!

About the Academy of International Mobile Healthcare Integration

The Academy of International Mobile Healthcare Integration (AIMHI) represents high performance emergency medical and mobile healthcare providers in the U.S. and abroad. Member organizations employ business practices from both the public and private sectors. By combining industry innovation with close government oversight, AIMHI affiliates are able to offer unsurpassed service excellence and cost efficiency. www.aimhi.mobi | hello@aimhi.mobi | @AIMHI_MIH | www.fb.me/aimhihealthcare

Table 1: EMS System Delivery Changes

Agency	What was the change?
Emergency Medical Services Authority (Oklahoma City, OK)	Transitioned from a contracted provider to a self-operated PUM. Changed from all ALS to tiered ambulance deployment.
Emergency Medical Services Authority (Tulsa, OK)	Transitioned from a contracted provider to a self-operated PUM. Changed from all ALS to tiered ambulance deployment.
Mecklenburg EMS Agency (Charlotte, NC)	Changed response time goal for low-acuity medical responses.
MedStar Mobile Healthcare (Fort Worth, TX)	Changed from all ALS to tiered ambulance deployment.
Niagara Emergency Medical Services (Region of Niagara, CA)	Recent update to MPDS v13.3 Omega included a determinant-by-determinant review that included linked hospital outcome data. This data was used in to update response priorities based on information such as aggregate 1- and 7-day mortality, number of ER interventions, length of stay, SCU admissions and length of stay.
Pinellas County EMS - Sunstar (Pinellas County, FL)	Changed from all ALS to tiered ambulance deployment.
Regional Emergency Medical Services (Reno, NV)	Changed from all ALS to tiered ambulance deployment. Additional further utilization of Nurse Health Line for low acuity call determinants.

Table 2: Medical First Response Utilization

Agency Name	Percentage of calls with Medical First Response (MFR)
Emergency Medical Services Authority (Oklahoma City, OK)	46%
Emergency Medical Services Authority (Tulsa, OK)	53%
Mecklenburg EMS Agency (Charlotte, NC)	77%
MEDIC EMS (Davenport, IA)	75%
MedStar Mobile Healthcare (Fort Worth, TX)	70%
Metropolitan EMS (Little Rock, AR)	40%
Novant Health New Hanover EMS (New Hanover County, NC)	31%
Regional Emergency Medical Services (Reno, NV)	40%
Richmond Ambulance Authority (Richmond, VA)	40%

Table 3: HOT Vehicle Operations

Agency Name	HOT Response %	HOT Transport %
Emergency Medical Services Authority (Oklahoma City, OK)	36.7%	8.4%
Emergency Medical Services Authority (Tulsa, OK)	31.5%	7.9%
Mecklenburg EMS Agency (Charlotte, NC)	21.0%	6.1%
Medic Ambulance (Solano, CA)	79.2%	4.2%
MEDIC EMS (Davenport, IA)	73.9%	13.7%
MedStar Mobile Healthcare (Fort Worth, TX)	72.4%	4.8%
Metropolitan EMS (Little Rock, AR)	98.1%	7.4%
Niagara Emergency Medical Services (Region of Niagara, CA)	25.0%	20.6%
Northwell Health Center for EMS (Syosset, NY)	80.0%	16.0%
Novant Health New Hanover EMS (New Hanover County, NC)	68.8%	9.4%
Pinellas County EMS - Sunstar (Pinellas County, FL)	71.1%	2.0%
Pro EMS (Cambridge, MA)	100.0%	0.0%
Regional Emergency Medical Services (Reno, NV)	74.6%	6.8%
Richmond Ambulance Authority (Richmond, VA)	75.2%	0.6%
Overall Average	**60.9%**	**8.9%**

Table 4: Accreditations by Agency

Agency Name	Agency Accreditations or Awards
Emergency Medical Services Authority (Oklahoma City, OK)	CAAS; IAED/ACE
Emergency Medical Services Authority (Tulsa, OK)	CAAS; IAED/ACE
Mecklenburg EMS Agency (Charlotte, NC)	CAAS; IAED/ACE
Medic Ambulance (Solano, CA)	CAAS; IAED/ACE; AMBY (AAA) / CAASE (CAA)
MEDIC EMS (Davenport, IA)	CAAS; IAED/ACE
MedStar Mobile Healthcare (Fort Worth, TX)	CAAS; IAED/ACE; AMBY (AAA)
Metropolitan EMS (Little Rock, AR)	CAAS; IAED/ACE
Niagara Emergency Medical Services (Region of Niagara, CA)	IAED
Northwell Health Center for EMS (Syosset, NY)	CAAS; IAED/ACE; CAMTS
Novant Health New Hanover EMS (New Hanover County, NC)	CAAS; Mission: Lifeline Gold Plus
Pinellas County EMS - Sunstar (Pinellas County, FL)	CAAS; IAED/ACE; CAMTS
Pro EMS (Cambridge, MA)	CAAS
Regional Emergency Medical Services (Reno, NV)	CAAS; IAED/ACE
Richmond Ambulance Authority (Richmond, VA)	CAAS; IAED/ACE

Table 5: Population, Service Area & Population Density

Agency Name	Jurisdiction Type	Service Area Population	Service Area (Sq. Miles)	Population Density
Emergency Medical Services Authority (Oklahoma City, OK)	Multiple	787,047	714	1,102
Emergency Medical Services Authority (Tulsa, OK)	Multiple	514,100	261	1,973
Mecklenburg EMS Agency (Charlotte, NC)	Single	1,115,482	546	2,043
Medic Ambulance (Solano, CA)	Single	451,716	821	550
MEDIC EMS (Davenport, IA)	Multiple	175,000	450	389
MedStar Mobile Healthcare (Fort Worth, TX)	Multiple	1,139,236	433	2,631
Metropolitan EMS (Little Rock, AR)	Multiple	400,000	1,800	222
Niagara Emergency Medical Services (Region of Niagara, CA)	Single	481,727	716	673
Northwell Health Center for EMS (Syosset, NY)	Multiple	10,253,230	1,455	7,049
Novant Health New Hanover EMS (New Hanover County, NC)	Single	229,018	192	1,193
Pinellas County EMS - Sunstar (Pinellas County, FL)	Single	980,810	280	3,503
Pro EMS (Cambridge, MA)	Multiple	350,000	200	1,750
Regional Emergency Medical Services (Reno, NV)	Multiple	486,492	6,302	77
Richmond Ambulance Authority (Richmond, VA)	Single	226,610	63	3,622
Total/Average		**17,590,468**	**14,232**	**1,236**

Table 6: System EMS Responses

Agency Name	Total Emergency Responses
Emergency Medical Services Authority (Oklahoma City, OK)	110,500
Emergency Medical Services Authority (Tulsa, OK)	108,835
Mecklenburg EMS Agency (Charlotte, NC)	139,327
Medic Ambulance (Solano, CA)	48,000
MEDIC EMS (Davenport, IA)	27,083
MedStar Mobile Healthcare (Fort Worth, TX)	138,993
Metropolitan EMS (Little Rock, AR)	91,000
Niagara Emergency Medical Services (Region of Niagara, CA)	64,428
Northwell Health Center for EMS (Syosset, NY)	164,740
Novant Health New Hanover EMS (New Hanover County, NC)	46,693
Pro EMS (Cambridge, MA)	15,000
Pinellas County EMS - Sunstar (Pinellas County, FL)	170,059
Regional Emergency Medical Services (Reno, NV)	71,659
Richmond Ambulance Authority (Richmond, VA)	48,292
Total	**1,244,609**

Table 7: Response Time Goal

Agency Name	High Acuity Call Compliance Standard	Low Acuity Call Compliance Standard
Emergency Medical Services Authority (Oklahoma City, OK)	90% < 10:59	90% < 24:59
Emergency Medical Services Authority (Tulsa, OK)	90% < 10:59	90% < 24:59
Mecklenburg EMS Agency (Charlotte, NC)	90% < 10:59	90% < 60:00
Medic Ambulance (Solano, CA)	90% < 9:00	90% < 25:00
MEDIC EMS (Davenport, IA)	90% < 07:59	90% < 14:59
MedStar Mobile Healthcare (Fort Worth, TX)	85% < 11 minutes, no more than 1.5% > 16:30	85% < 17 minutes, no more than 1.5% > 25:30
Metropolitan EMS (Little Rock, AR)	90% < 08:59	90% < 12:59
Northwell Health Center for EMS (Syosset, NY)	90% < 12:00	90% < 30:00
Novant Health New Hanover EMS (New Hanover County, NC)	N/A	90% < 19:59
Pinellas County EMS - Sunstar (Pinellas County, FL)	91% < 10:00	No Standard
Pro EMS (Cambridge, MA)	90% < 14:59	No Standard
Regional Emergency Medical Services (Reno, NV)	90% < 8:59	90% < 20:59
Richmond Ambulance Authority (Richmond, VA)	90% < 8:59	90% < 29:59

Table 8: Average Response Time

Agency Name	High Acuity Average Response Time	Low Acuity Average Response Time
Emergency Medical Services Authority (Oklahoma City, OK)	11:23	18:37
Emergency Medical Services Authority (Tulsa, OK)	08:20	14:07
Mecklenburg EMS Agency (Charlotte, NC)	08:10	11:44
Medic Ambulance (Solano, CA)	05:00	10:52
MEDIC EMS (Davenport, IA)	06:45	09:36
MedStar Mobile Healthcare (Fort Worth, TX)	09:13	12:16
Metropolitan EMS (Little Rock, AR)	07:30	12:59
Northwell Health Center for EMS (Syosset, NY)	09:47	17:41
Novant Health New Hanover EMS (New Hanover County, NC)	05:56	07:53
Pinellas County EMS - Sunstar (Pinellas County, FL)	06:30	10:30
Regional Emergency Medical Services (Reno, NV)	06:48	9:30
Richmond Ambulance Authority (Richmond, VA)	09:19	20:56
Median	**08:41**	**12:31**

2022 High-Performance EMS Benchmarking Study

Part 2: Clinical Outcomes & Total Quality Management

The AIMHI benchmarking studies perform a fundamental service to EMS by providing tools through which we can continue to learn about the successes and opportunities of today's emergency care system, ensure its progress and growth, and work to expand the reputation and efficiency of EMS nationally and internationally. The 2022 study is the latest addition to the body of knowledge required for effective service delivery and improvement.

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Medic Ambulance (Solano, CA)	Private
MEDIC EMS (Davenport, IA)	501c3
MedStar Mobile Healthcare (Fort Worth, TX)	Public Utility Model: Self-Operated
Metropolitan EMS (Little Rock, AR)	Public Utility Model: Self-Operated
Niagara Emergency Medical Services (Region of Niagara, CA)	Third Service Model
Northwell Health Center for EMS (Syosset, NY)	Health System Based EMS Agency
Novant Health New Hanover EMS (New Hanover County, NC)	Hospital-Based
Pinellas County EMS - Sunstar (Pinellas County, FL)	Public Utility Model: Contracted
Pro EMS (Cambridge, MA)	Contractor
Regional Emergency Medical Services (Reno, NV)	Public Utility Model: Self-Operated
Richmond Ambulance Authority (Richmond, VA)	Public Utility Model: Self-Operated

What Is High Performance/High Value EMS (HP/HVEMS)?

HP/HVEMS systems share key features of system design rarely associated with less cost-effective systems. Characteristics typically include:

- **Sole provider:** All emergency and non-emergency ambulance services are granted to a sole and often competitively selected provider for a specific population or service area.
- **Control center operations:** The ambulance provider has control of the dispatch center.
- **Accountability:** HP/HVEMS systems have performance requirements that can result in financial penalties or replacement of the provider when the requirements are not met. HP/HVEMS systems use and collect data regularly to meet these performance requirements, which has allowed for the ability to collect data for the HP/HVEMS Market Study.
- **Revenue maximization:** HP/HVEMS systems incorporate the business function into their operations, resulting in an understanding of the billing requirements, thus collecting all appropriate revenues from Medicare, Medicaid, self-pay and other third-party payors.
- **Flexible production strategy:** HP/HVEMS match scheduled resources with predicted changes in response demand based on time of day, day of week and time of year.
- **System Status Management (SSM):** HP/HVEMS systems use the dynamic deployment techniques to position resources in anticipation of when and where ambulances will be needed.

Clinical Quality and Total Quality Management Key Metrics & Takeaways

- **100%** of AIMHI member agencies **hold at least one accreditation**.
- **53%** of AIMHI member agencies **changed ambulance deployment from all ALS, to tiered responses**, including the use of Emergency Vehicle Operator (EVO) / EMT staffing for low-acuity transfers.
- 100% of AIMHI member agencies require CPR and EMD certification for dispatch personnel, and **84% are Accredited Centers of Excellence by the International Academies of Emergency Dispatch**.
- **100%** of AIMHI member agencies **publish Clinical Performance Dashboards**.
- **None of the HP/HV EMS systems require ALS Medical First Response** (MFR).

Table 1: EMS System Delivery Changes

Agency	Have you changed ambulance staffing configuration in the past 3 years?	What changed in your staffing configuration?
EMSA - Oklahoma	Yes	From all ALS to tiered ambulance deployment.
Mecklenburg EMS Agency - MEDIC (Charlotte, NC)	Yes	From all ALS to tiered ambulance deployment.
Metropolitan EMS (Little Rock, AR)	Yes	Added BLS emergencies and EVO/EMT units for low acuity transfers
MedStar Mobile Healthcare (Fort Worth, TX)	Yes	From all ALS to tiered ambulance deployment.
Northwell Health Center for EMS (Syosset, NY)	Yes	From all ALS to tiered ambulance deployment.
Regional Emergency Medical Services (Reno, NV)	Yes	Ability to utilize an EMT vs. EMT-I on ALS Ambulance with Paramedic
Richmond Ambulance Authority (Richmond, VA)	Yes	From all ALS to tiered ambulance deployment.

Table 2: Dispatch Center Accreditation

Agency	Accreditation?
EMSA - Oklahoma	IAED/ACE
Mecklenburg EMS Agency - MEDIC (Charlotte, NC)	IAED/ACE
Medic Ambulance (Solano, CA)	IAED/ACE
MEDIC EMS (Davenport, IA)	IAED/ACE
Metropolitan EMS (Little Rock, AR)	IAED/ACE
MedStar Mobile Healthcare (Fort Worth, TX)	IAED/ACE
Niagara Region EMS (Niagara, Canada)	IAED/ACE
Northwell Health Center for EMS (Syosset, NY)	IAED/ACE
Regional Emergency Medical Services (Reno, NV)	IAED/ACE
Richmond Ambulance Authority (Richmond, VA)	IAED/ACE

Table 3: Emergency Medical Dispatch (EMD) System, Personnel & Response Modes

Agency	Formal EMD Program	EMD System	CPR	EMD	EMR	EMT	How is your response mode (HOT/COLD) determined?
EMSA - Oklahoma	Yes	MPDS ProQA	X	X	X		EMD Determinant
Mecklenburg EMS Agency - MEDIC (Charlotte, NC)	Yes	MPDS ProQA	X	X			EMD Determinant
Medic Ambulance (Solano, CA)	Yes	MPDS ProQA	X	X			N/A
MEDIC EMS (Davenport, IA)	Yes	MPDS ProQA	X	X			EMD Determinant
Metropolitan EMS (Little Rock, AR)	Yes	MPDS ProQA	X	X			EMD Determinant
MedStar Mobile Healthcare (Fort Worth, TX)	Yes	MPDS ProQA	X	X			EMD Determinant
Niagara Region EMS (Niagara, Canada)	Yes	MPDS ProQA	X	X			EMD Determinant
Northwell Health Center for EMS (Syosset, NY)	Yes	MPDS ProQA	X	X		X	EMD Determinant
Novant Health New Hanover EMS (New Hanover County, NC)	Yes	MPDS ProQA	X	X			EMD Determinant
Pro EMS (Cambridge, MA)	Yes	MPDS ProQA	X	X			EMD Determinant
Regional Emergency Medical Services (Reno, NV)	Yes	MPDS ProQA	X	X		X	EMD Determinant
Richmond Ambulance Authority (Richmond, VA)	Yes	MPDS ProQA	X	X		X	EMD Determinant

Table 4: Cardiac Arrest Outcomes

Agency	Utstein survival to discharge w/CPC 1 or 2 percentage for last reported outcomes	Total number of total cases meeting Utstein criteria for the last reported outcomes?	Do you have a field termination of resuscitation protocol?	# of field terminations in calendar year 2021
EMSA - Oklahoma	25.3%	71	Yes	489
Mecklenburg EMS Agency - MEDIC (Charlotte, NC)	41.0%	130	Yes	395
Medic Ambulance (Solano, CA)	68.0%	25	Yes	201
MedStar Mobile Healthcare (Fort Worth, TX)	22.6%	84	Yes	654
Novant Health New Hanover EMS (New Hanover County, NC)	45.8%	24	Yes	86
Pro EMS (Cambridge, MA)	25.0%	4	Yes	8
Regional Emergency Medical Services (Reno, NV)	25.0%	511	Yes	801
Richmond Ambulance Authority (Richmond, VA)	25.9%	27	Yes	115

Table 5: Medical First Response (MFR) - Minimum Qualifications

Agency	What is the minimum level of certification of your Medical Fir[…]se personnel?					
	None	CPR / First Aid	EMR	EMT	Paramedic	
EMSA - Oklahoma		X				
Mecklenburg EMS Agency - MEDIC (Charlotte, NC)				X		
Medic Ambulance (Solano, CA)				X		
MEDIC EMS (Davenport, IA)			X			
Metropolitan EMS (Little Rock, AR)	X					
MedStar Mobile Healthcare (Fort Worth, TX)			X			
Niagara Region EMS (Niagara, Canada)			X			
Northwell Health Center for EMS (Syosset, NY)				X		
Novant Health New Hanover EMS (New Hanover County, NC)				X		
Pro EMS (Cambridge, MA)		X				In MA, First Responders are locally certified, but not certified as EMRs
Regional Emergency Medical Services (Reno, NV)				X		
Richmond Ambulance Authority (Richmond, VA)				X		

Table 6: Ambulance Staffing / Response Plan

Agency	Do you staff all ALS, or a combination of ALS and BLS ambulances?	Are non-ALS ambulances authorized for 911 responses	What is the minimum staffing for an ALS Ambulance?	What is the minimum staffing for a BLS Ambulance?
EMSA - Oklahoma	ALS and BLS	Yes	EMT - Paramedic	EMT - EMT
Mecklenburg EMS Agency - MEDIC (Charlotte, NC)	ALS and BLS	Yes	EMT - Paramedic	EMT - EMT
Medic Ambulance (Solano, CA)	ALS only	No	EMT - Paramedic	EMT - EMT
MEDIC EMS (Davenport, IA)	ALS and BLS	No	EMT - Paramedic	EMT - EMT
Metropolitan EMS (Little Rock, AR)	ALS and BLS	Yes	EMT - Paramedic	EMR - EMT
MedStar Mobile Healthcare (Fort Worth, TX)	ALS and BLS	Yes	EMT - Paramedic	EMT - EMT
Niagara Region EMS (Niagara, Canada)	Advanced or Primary Care Paramedics	N/A	2 Primary Care Paramedics	N/A
Northwell Health Center for EMS (Syosset, NY)	ALS and BLS	Yes	EMT - Paramedic	EMR - EMT
Novant Health New Hanover EMS (New Hanover County, NC)	ALS only	N/A	Paramedic/AEMT	NA
Pro EMS (Cambridge, MA)	ALS and BLS	Yes	EMT - Paramedic	EMT - EMT
Regional Emergency Medical Services (Reno, NV)	ALS/ILS/BLS	Yes	EMT or EMT-I with Paramedic	EMT - EMT
Richmond Ambulance Authority (Richmond, VA)	ALS and BLS	Yes	EMT - Paramedic	CPR / First Aid Driver - EMT

Table 7: Publication of Clinical Performance Dashboards

Agency	Clinical Dashboards Published?	Cardiac Arrest Management	Ventilation Management	STEMI	Stroke	Trauma	Other
EMSA - Oklahoma	Yes		X	X	X	X	X
Mecklenburg EMS Agency - MEDIC (Charlotte, NC)	Yes		X		X	X	X
Medic Ambulance (Solano, CA)	Yes		X	X	X	X	X
MEDIC EMS (Davenport, IA)	Yes		X				
Metropolitan EMS (Little Rock, AR)	Yes		X				
MedStar Mobile Healthcare (Fort Worth, TX)	Yes		X	X	X	X	X
Niagara Region EMS (Niagara, Canada)	Yes				X		
Northwell Health Center for EMS (Syosset, NY)	Yes		X		X	X	X
Novant Health New Hanover EMS (New Hanover County, NC)	Yes		X		X	X	X
Pro EMS (Cambridge, MA)	Yes		X		X	X	
Regional Emergency Medical Services (Reno, NV)	Yes		X		X	X	X
Richmond Ambulance Authority (Richmond, VA)	Yes		X		X	X	

AIMHI ACADEMY OF INTERNATIONAL MOBILE HEALTHCARE INTEGRATION

Table 8: Service Innovations in the past 3-years.

Agency	Innovations
EMSA - Oklahoma	• 2021 Moved patient care reporting systems to allow for health data exchange. Currently 65% live with partner hospitals and working on outcomes-based metrics. • July / August 2019 Airway Task Force initiative rolled out, was a field provider, OMD, and management task force to review and update airway management practice and tools. • Changed Laryngoscopes to Intubrite, control cric system for surgical airways, and moved from King LTD to iGels. • This incorporated retraining and shifting to emphasis on full team dynamics in intubations, the EMT is just as responsible for intubation success as the Paramedic. 2019 Rolled out Handtevy Pediatric Reference APP and training. 2021 Handtevy Pediatric Kits implemented.
Medic Ambulance (Solano, CA)	• Implemented Mechanical Chest Compression Devices (MCDs).
MEDIC EMS (Davenport, IA)	• Implemented program where rural operation paramedic personnel conduct quality audits for all rural first responders utilizing the statewide Image Trend system.
MedStar Mobile Healthcare (Fort Worth, TX)	• COVID Testing for the community. • COVID vaccines for the community. • mAb infusions. • Partnership with a commercial payer to reimburse for treat/no transport. • New MIH agreements with Medicaid MCO and Care Management Organization. • Launched "MedStar On Demand" subscription-based MIH program.
Richmond Ambulance Authority (Richmond, VA)	• Implemented in-house EMT classes as well as virtual/online continuing education.
Regional Emergency Medical Services (Reno, NV)	• Alternative care pathways consistent with ET3 initiatives including transport to alternative destinations and treatment in place telehealth referral. • Routing additional low acuity dispatch determinants to Nurse Health Line for review prior to dispatching an ambulance resource.

Agency	Innovations
Northwell Health Center for EMS (Syosset, NY)	• Telehealth services available 24x7 for EMS, OLMC, D2C, 9-1-1 Navigation, physician off-hours service.
Metropolitan EMS (Little Rock, AR)	• Partnered with an insurance carrier to trial community paramedicine with a specific population of their insured. • Partnered with a local hospital providing CP as a "safety net" for a patient population sent home earlier than normal on telemedicine.
Niagara Region EMS (Niagara, Canada)	• Added Emergency Communications Nurses embedded within our dispatch center. • Updated our MPDS response plans with the inclusion of linked clinical outcome data from our local hospital systems.
Pro EMS (Cambridge, MA)	• In April 2020 we initiated COVID testing; this grew into a program that has handled over 3 million COVID tests covering locations throughout New England. • We have also done extensive vaccinations in the City of Cambridge.

CURRENT AIMHI MEMBERS

Emergency Health Service
Halifax, NS

Emergency Medical Services Authority
Tulsa & Oklahoma City, OK

Mecklenburg EMS Agency
Charlotte, NC

Medic Ambulance
Vallejo, CA

MEDIC Emergency Medical Services
Davenport, IA

MedStar Mobile Healthcare
Fort Worth, TX

Metropolitan Emergency Medical Services
Little Rock, AR

New Hanover EMS
Wilmington, NC

Niagara Emergency Medical Services
Niagara-On-The-Lake, ON

Northwell Health Center for EMS
Syosset, NY

Pinellas County EMS Authority/Sunstar Paramedics
Largo, FL

Pro EMS
Cambridge, MA

Regional EMS Authority
Reno, NV

Richmond Ambulance Authority
Richmond, VA

Three Rivers Ambulance Authority
Fort Wayne, IN

Learn more about membership at www.aimhi.mobi!

About the Academy of International Mobile Healthcare Integration

The Academy of International Mobile Healthcare Integration (AIMHI) represents high performance emergency medical and mobile healthcare providers in the U.S. and abroad. Member organizations employ business practices from both the public and private sectors. By combining industry innovation with close government oversight, AIMHI affiliates are able to offer unsurpassed service excellence and cost efficiency. www.aimhi.mobi | hello@aimhi.mobi | @AIMHI_MIH | www.fb.me/aimhihealthcare

Readmission Avoidance / Obs Admit Avoidance

MedStar Mobile Healthcare | Mobile Integrated Healthcare

Texas Health
Harris Methodist Hospital
FORT WORTH

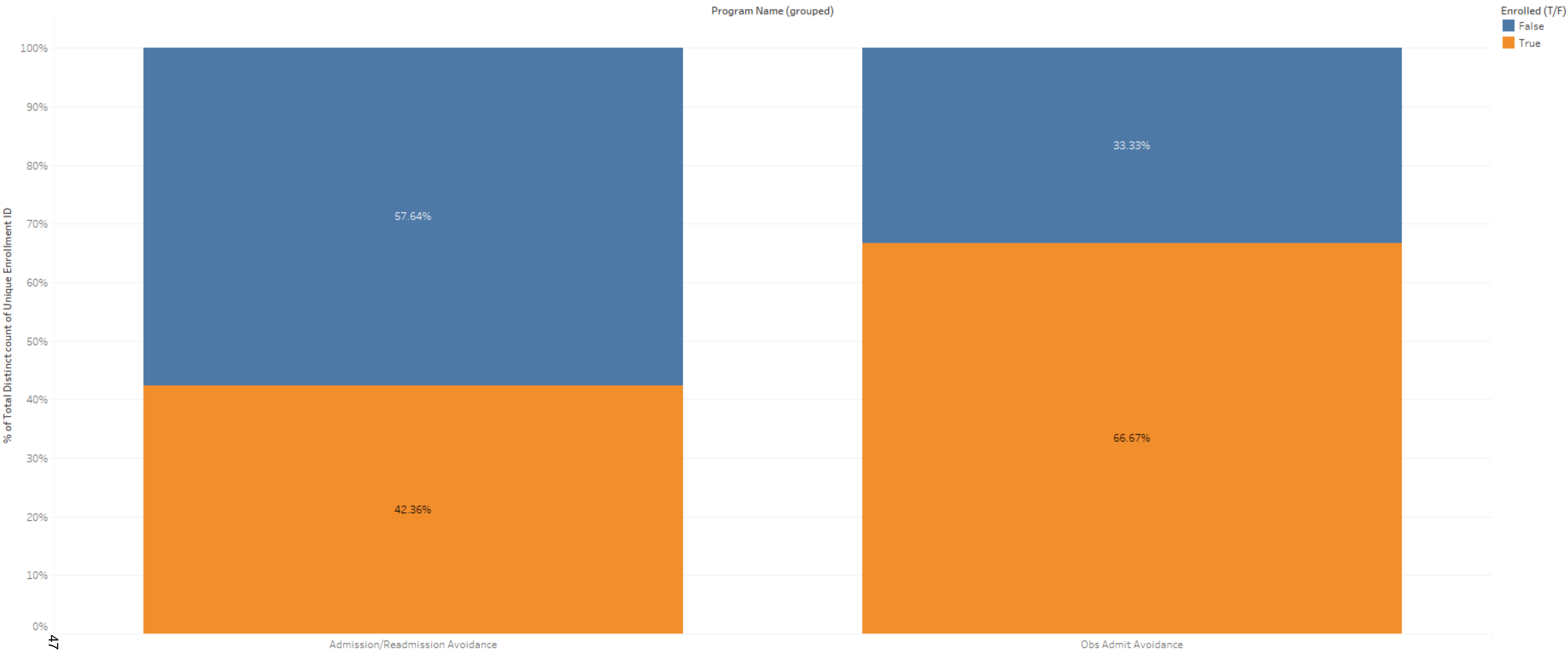
Referrals: October 2021 – September 2022

Referral Count

Enrollments: October 2021 – September 2022

Enrollment Count

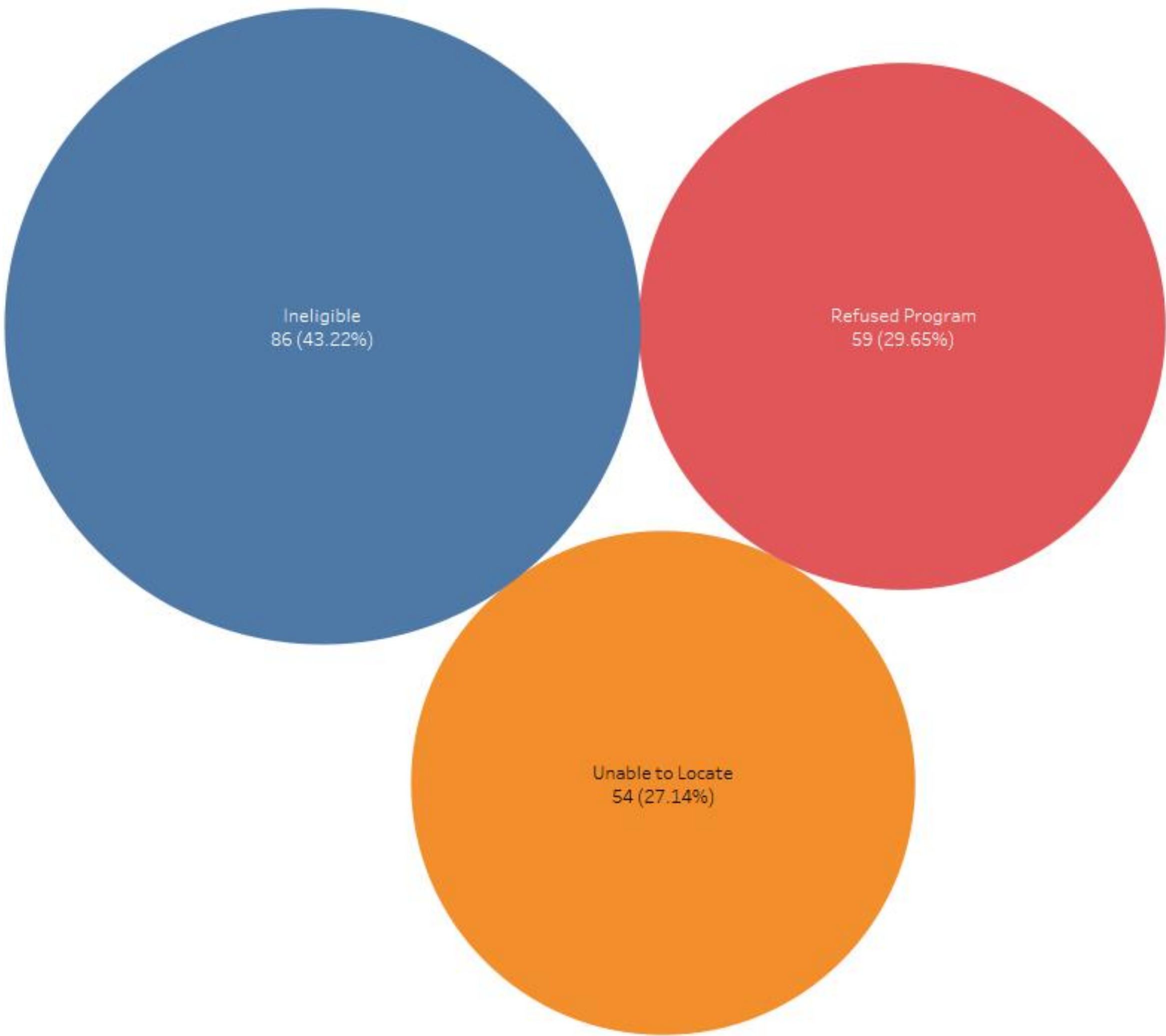
Referral to Enrollment Ratio



MEDSTAR MOBILE HEALTHCARE

Texas Health Harris Methodist Hospital FORT WORTH

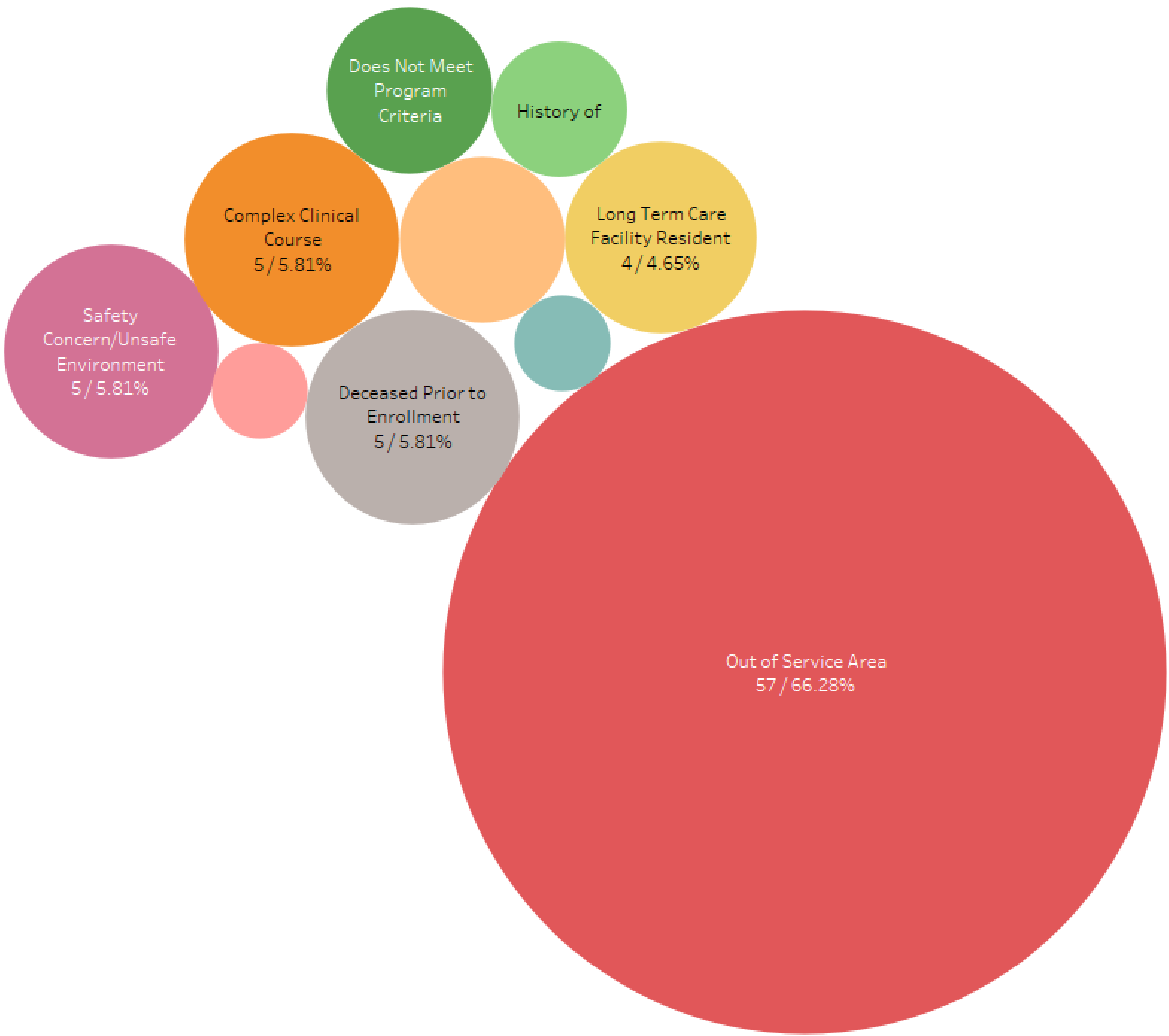
Not Enrolled Reasons



MEDSTAR MOBILE HEALTHCARE

Texas Health Harris Methodist Hospital FORT WORTH

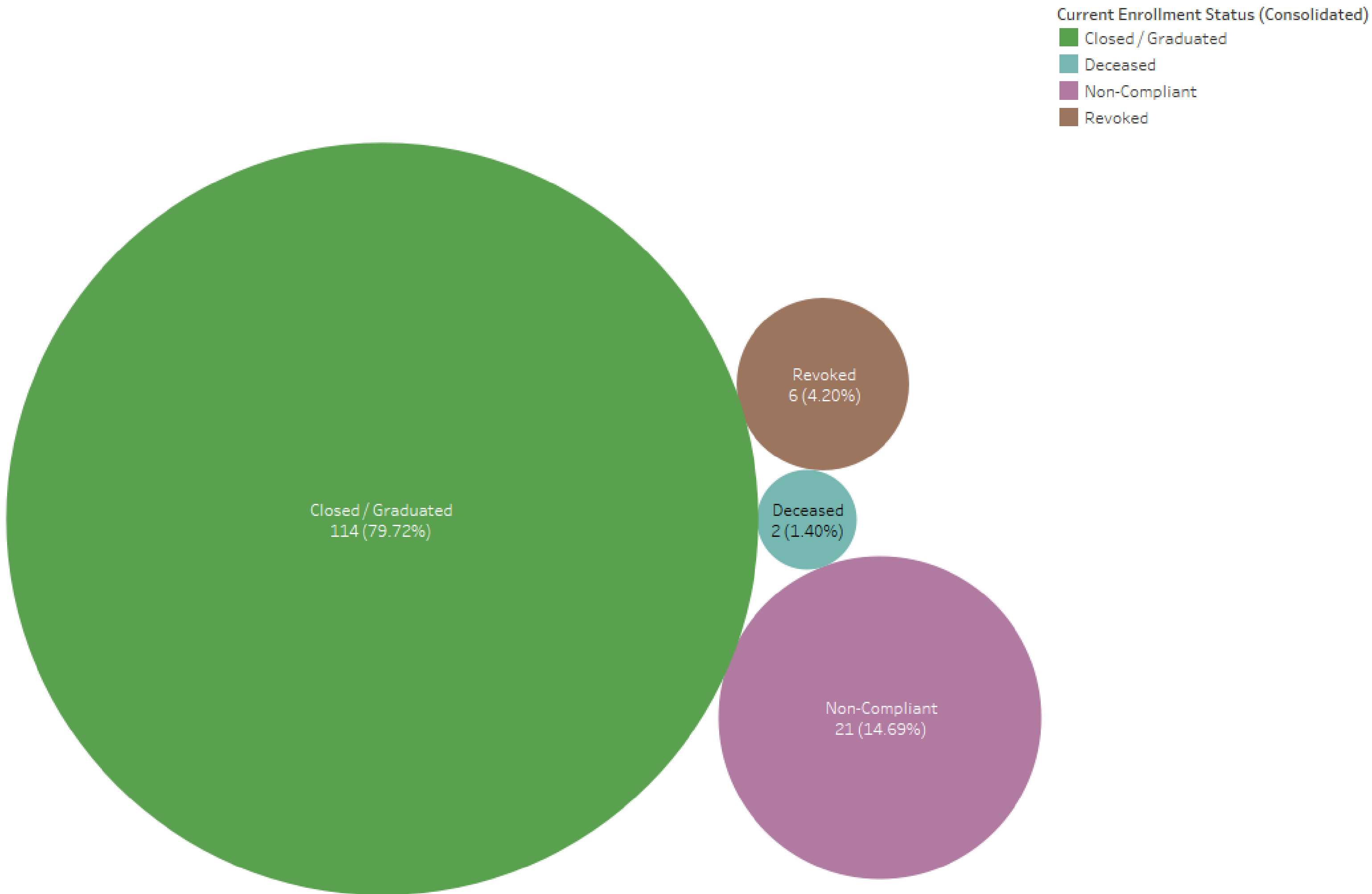
Ineligible Reasons



MEDSTAR MOBILE HEALTHCARE

Texas Health Harris Methodist Hospital FORT WORTH

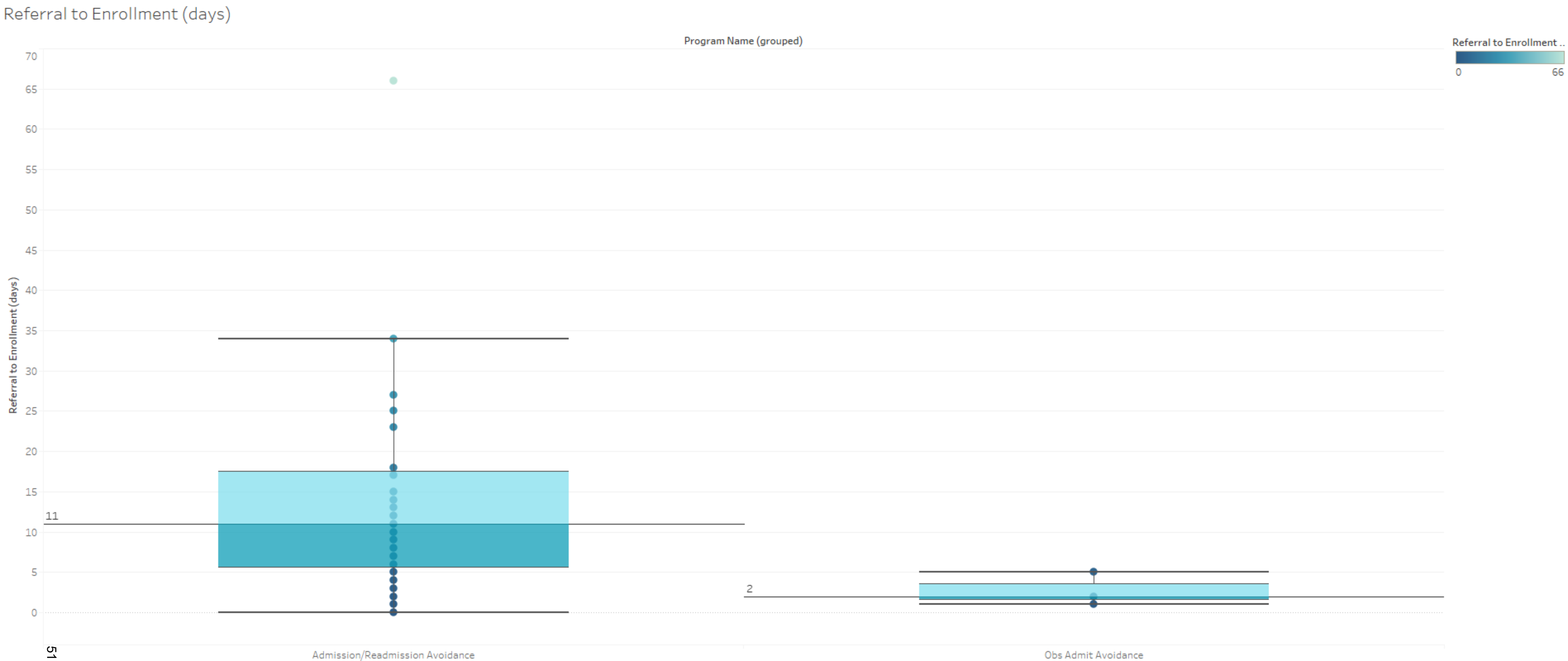
Enrolled Dispositions



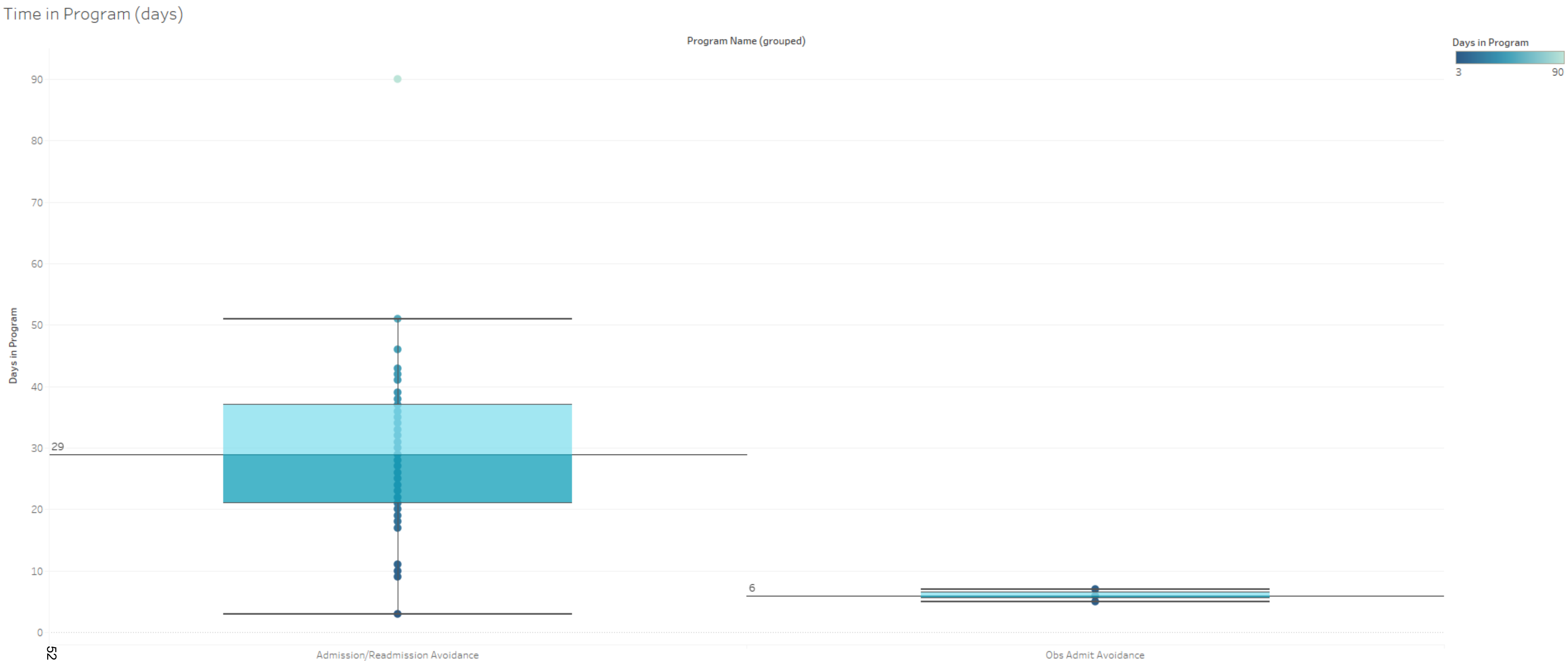
MEDSTAR MOBILE HEALTHCARE

Texas Health Harris Methodist Hospital FORT WORTH

Referrals to Enrollment Time (days)



Time in Program (days)



MEDSTAR MOBILE HEALTHCARE

Texas Health Harris Methodist Hospital FORT WORTH

Hospital Utilization

Hospital Utilization	THFW	Admission/Readmission Avoidance		
As of:	9/30/2022			
	Before Enrollment (1)	After Graduation (2)	Change	30-Day Readmission (3)
Sample Size (4)	**103**			**225**
ED Utilization	128	101	**-21.09%**	**16.44%**
Unplanned Admission	319	156	**-51.10%**	

Notes:

1. Count of ED admissions/IP admissions during the 12 months prior to enrollment

2. Count of ED admissions/IP admissions during the 12 months after graduation

3. Anticipated readmission rate of 100%

4. Patient enrollment criteria requires a prior 30-day readmission and/or the referral source expects the patient to have a 30-day readmission

Hospital Utilization	THFW	Obs Admit Avoidance			
As of:	9/30/2022				
	Before Enrollment (1)	After Graduation (2)	Change	ED Visit During Enrollment	30-Day Readmission
Sample Size (4)	**50**				
ED Utilization	141	**106**	**-24.82%**	**7.27%**	**7.27%**
Unplanned Admission	112	**75**	**-33.04%**		

Notes:

1. Count of ED admissions/IP admissions during the 12 months prior to enrollment

2. Count of ED admissions/IP admissions during the 12 months after graduation

MEDSTAR MOBILE HEALTHCARE

Texas Health Harris Methodist Hospital FORT WORTH

Patient Self-Assessment of Health Status

Patient Self-Assessment of Health Status (1)

As of: **9/30/2022**

	Admission/Readmission Avoidance			**Obs Admit Avoidance**		
	Enrollment	**Graduation**	**Change**	**Enrollment**	**Graduation**	**Change**
Sample Size	**206**			**44**		
Mobility (2)	2.37	2.54	7.2%	2.36	2.52	6.7%
Self-Care (2)	2.56	2.74	6.8%	2.55	2.70	6.3%
Perform Usual Activities (2)	2.36	2.58	9.0%	2.36	2.52	6.7%
Pain and Discomfort (2)	2.23	2.51	**12.6%**	2.14	2.41	**12.8%**
Anxiety/Depression (2)	2.42	2.71	**12.2%**	2.48	2.73	**10.1%**
Overall Health Status (3)	**5.72**	**7.32**	**27.9%**	**5.05**	**7.68**	**52.3%**

Notes:

1. Average scores of pre and post enrollment data from EuroQol EQ-5D-3L Assessment Questionnaire

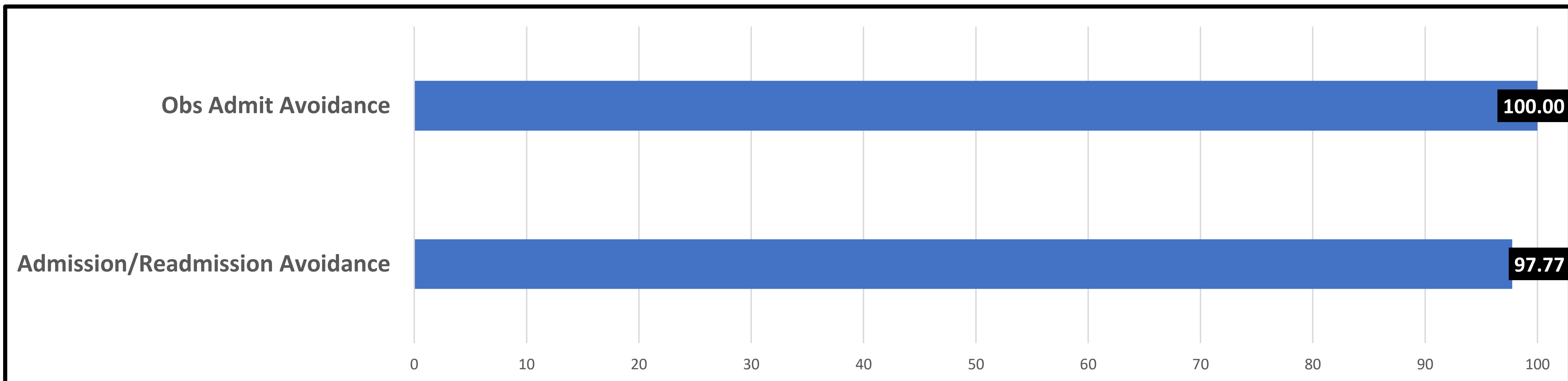
2. Score 1 - 3 with 3 most favorable

3. Score 1 - 10 with 10 most favorable

MEDSTAR MOBILE HEALTHCARE

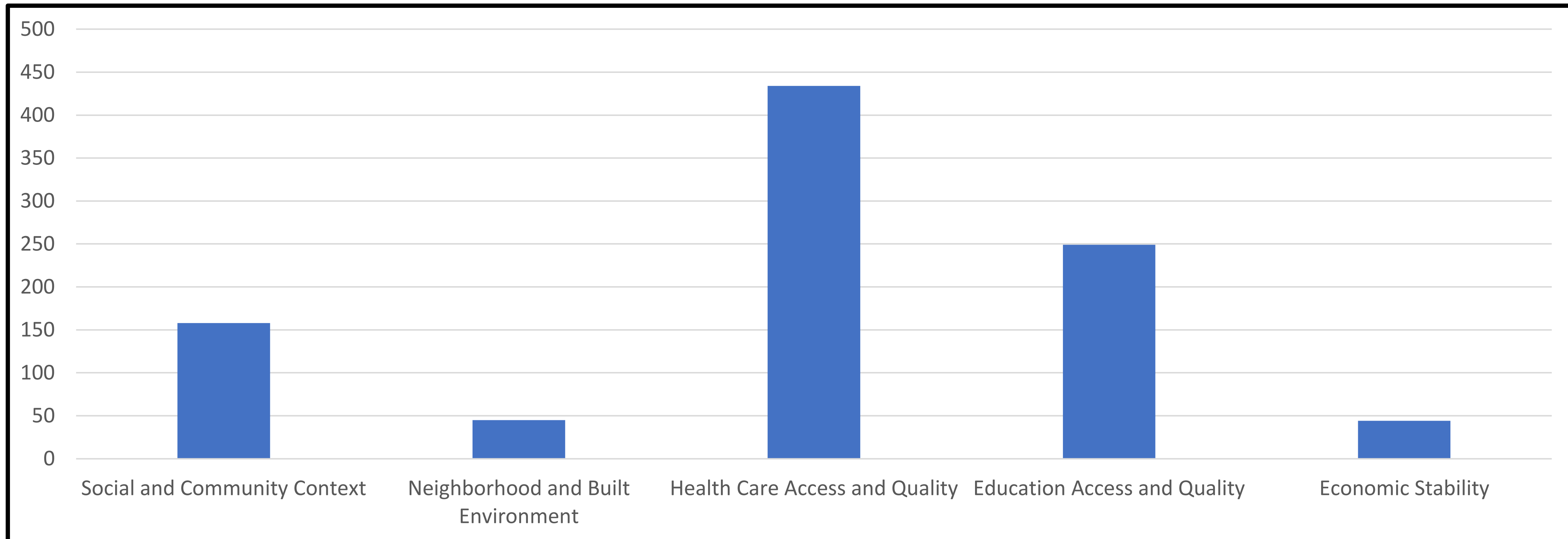
Texas Health Harris Methodist Hospital FORT WORTH

Patient Experience Score



MEDSTAR MOBILE HEALTHCARE
Texas Health Harris Methodist Hospital FORT WORTH

Determinants of Health



MEDSTAR MOBILE HEALTHCARE

Texas Health Harris Methodist Hospital FORT WORTH

Tab D – Chief Financial Officer

Metropolitan Area EMS Authority dba MedStar Mobile Healthcare
Finance Report – October 31, 2022

The following summarizes significant items in the October 31, 2022 Financial Reports:

Statement of Revenues and Expenses:

Month to Date: Net Income for the month of October 2022 is a gain of $62,105 as compared to a budgeted gain of $148,735 for a negative variance of ($86,630). EBITDA for the month of October 2022 is a gain of $436,562 compared to a budgeted gain of $531,410 for a negative variance of ($94,848).

- Transport volume in October ended the month 100% to budget.
- Net Revenue in October is $19K under budget.
- Total Expenses ended the month 101% to budget or $67K over budget. In October, MedStar incurred additional expenses in Salaries and Overtime of $9K, Benefits and Taxes of $69K (all in health insurance claims paid) and Fuel of $25K. The total of all other line items is below budget by $35K.

Key Financial Indicators:

- Current Ratio – MedStar has $4.79 in current assets (Cash, receivables) for every dollar in current debt. (Goal: a score of $1.00 would mean sufficient current assets to pay debts.)
- Cash Reserves – The Restated Interlocal Cooperative Agreement mandates 3 months of operating capital. As of October 31, 2022, there is 4 months of operating capital.
- Accounts Receivable Turnover – This statistic indicates MedStar's effectiveness in extending credit and collecting debts by indicating the average age of the receivables. MedStar's goal is a ratio greater than 3.0 times; current turnover is 10.24 times.
- Return on Net Assets – This ratio determines whether the agency is financially better off than in previous years by measuring total economic return. An improving trend indicates increasing net assets and the ability to set aside financial resources to strengthen future flexibility. Through October, the return is 0.12%.

MAEMSA/EPAB cash reserve balance as of October 31, 2022 is $475,470.69.

Metropolitan Area EMS Authority dba MedStar Mobile Healthcare

Balance Sheet By Character Code

For the Period Ending October 31, 2022

Assets	Current Year	Last Year
Cash	$19,781,295.66	$22,223,845.83
Accounts Receivable	$5,813,874.21	$7,803,199.96
Inventory	$409,910.36	$383,481.43
Prepaid Expenses	$2,091,036.14	$1,214,325.30
Property Plant & Equ	$68,239,240.85	$63,814,632.18
Accumulated Deprecia	($27,801,118.76)	($25,986,722.46)
Total Assets	$68,534,238.46	$69,452,762.24
Liabilities		
Accounts Payable	($1,786,638.88)	($348,530.47)
Other Current Liabil	($2,265,020.07)	($2,176,028.90)
Accrued Interest	($7,781.31)	($7,781.31)
Payroll Withholding	($4,192.19)	($104,889.04)
Long Term Debt	($3,299,651.73)	($3,658,125.21)
Other Long Term Liab	($8,863,361.38)	($10,417,890.03)
Total Liabilities	($16,226,645.56)	($16,713,244.96)
Equities		
Equity	($52,500,769.40)	($52,884,378.49)
Control	$193,176.50	$144,861.21
Total Equities	($52,307,592.90)	($52,739,517.28)
Total Liabilities and Equities	($68,534,238.46)	($69,452,762.24)

Metropolitan Area EMS Authority dba MedStar Mobile Healthcare
Statement of Revenue and Expenditures
October 31, 2022

Revenue	Current Month Actual	Current Month Budget	Current Month Variance	Year to Date Actual	Year to Date Budget	Year to Date Variance
Transport Fees	$20,378,033.81	$20,346,161.47	$31,872.34	$20,378,033.81	$20,346,161.47	$31,872.34
Contractual Allow	($10,649,911.27)	($8,838,226.55)	($1,811,684.72)	($10,649,911.27)	($8,838,226.55)	($1,811,684.72)
Provision for Uncoll	($5,106,136.93)	($6,832,469.00)	$1,726,332.07	($5,106,136.93)	($6,832,469.00)	$1,726,332.07
Education Income	$190.00	$1,690.00	($1,500.00)	$190.00	$1,690.00	($1,500.00)
Other Income	$95,116.42	$98,823.00	($3,706.58)	$95,116.42	$98,823.00	($3,706.58)
Standby/Subscription	$204,818.25	$165,161.50	$39,656.75	$204,818.25	$165,161.50	$39,656.75
Pop Health PMPM	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
interest on Investme	$4.95	$500.00	($495.05)	$4.95	$500.00	($495.05)
Gain(Loss) on Dispos	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Revenue	$4,922,115.23	$4,941,640.42	($19,525.19)	$4,922,115.23	$4,941,640.42	($19,525.19)
Expenditures						
Salaries	$2,932,304.94	$2,923,177.33	$9,127.61	$2,932,304.94	$2,923,177.33	$9,127.61
Benefits and Taxes	$382,625.49	$313,131.00	$69,494.49	$382,625.49	$313,131.00	$69,494.49
Interest	$31,146.26	$33,500.00	($2,353.74)	$31,146.26	$33,500.00	($2,353.74)
Fuel	$192,242.80	$167,165.00	$25,077.80	$192,242.80	$167,165.00	$25,077.80
Medical Supp/Oxygen	$170,183.20	$221,436.00	($51,252.80)	$170,183.20	$221,436.00	($51,252.80)
Other Veh & Eq	$46,066.25	$45,331.01	$735.24	$46,066.25	$45,331.01	$735.24
Rent and Utilities	$52,400.09	$59,711.92	($7,311.83)	$52,400.09	$59,711.92	($7,311.83)
Facility & Eq Mtc	$60,603.51	$77,162.78	($16,559.27)	$60,603.51	$77,162.78	($16,559.27)
Postage & Shipping	$450.53	$2,591.33	($2,140.80)	$450.53	$2,591.33	($2,140.80)
Station	$68,496.85	$47,385.25	$21,111.60	$68,496.85	$47,385.25	$21,111.60
Comp Maintenance	$65,679.74	$52,245.52	$13,434.22	$65,679.74	$52,245.52	$13,434.22
Insurance	$83,248.21	$53,654.66	$29,593.55	$83,248.21	$53,654.66	$29,593.55
Advertising & PR	$4,135.20	$5,792.00	($1,656.80)	$4,135.20	$5,792.00	($1,656.80)
Printing	$3,336.55	$2,117.43	$1,219.12	$3,336.55	$2,117.43	$1,219.12
Travel & Entertain	$4,446.78	$13,792.00	($9,345.22)	$4,446.78	$13,792.00	($9,345.22)
Dues & Subs	$118,588.68	$120,848.00	($2,259.32)	$118,588.68	$120,848.00	($2,259.32)
Continuing Educ Ex	$5,240.00	$28,524.00	($23,284.00)	$5,240.00	$28,524.00	($23,284.00)
Professional Fees	$294,247.43	$272,582.34	$21,665.09	$294,247.43	$272,582.34	$21,665.09
Education Expenses	$575.61	$1,945.00	($1,369.39)	$575.61	$1,945.00	($1,369.39)
Miscellaneous	$680.99	$1,637.00	($956.01)	$680.99	$1,637.00	($956.01)
Depreciation	$343,310.92	$349,175.00	($5,864.08)	$343,310.92	$349,175.00	($5,864.08)
Total Expenditures	$4,860,010.03	$4,792,904.57	$67,105.46	$4,860,010.03	$4,792,904.57	$67,105.46
Net Rev in Excess of Expend	$62,105.20	$148,735.85	($86,630.65)	$62,105.20	$148,735.85	($86,630.65)
EBITDA	$436,562.38	$531,410.85	($94,848.47)	$436,562.38	$531,410.85	($94,848.47)

Metropolitan Area EMS Authority dba MedStar Mobile Healthcare
Key Financial Indicators
October 31, 2022

	Goal	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Current Ratio	**> 1**	**9.49**	**11.59**	**10.48**	**8.43**	**6.04**	**4.79**

of debt. Ratio should be greater than 1, so that assets are available to
retire debt when due.

	Goal	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Cash as % of Annual Expenditures	**> 25%**	**47.07%**	**42.95%**	**51.76%**	**44.45%**	**33.49%**	**34.31%**

Indicates compliance with Ordinance which specifies 3 months cash on hand.

	Goal	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Accounts Receivable Turnover	**>3**	**4.28**	**3.65**	**5.44**	**6.34**	**9.06**	**10.24**

A measure of how these resources are being managed. Indicates how long accounts receivable
are being aged prior to collection. Our goal is a turnover rate of greater than 3 .

	Goal	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Return on Net Assets	**-1.00%**	**10.11%**	**4.04%**	**0.00%**	**-4.03%**	**-0.07%**	**0.12%**

Reveals management's effectiveness in generating profits from the assets available.

Emergency Physicians Advisory Board

Cash expenditures Detail

	Date	Amount	Balance
Balance 1/1/17			$ 609,665.59
J29 Associates, LLC	2/27/2017	$ 1,045.90	$ 608,619.69
Bracket & Ellis	10/30/2017	$ 12,118.00	$ 596,501.69
Brackett & Ellis	11/19/2018	$ 28,506.50	$ 567,995.19
FWFD Grant	4/3/2019	$ 56,810.00	$ 511,185.19
Brackett & Ellis	4/3/2019	$ 20,290.50	$ 490,894.69
Brackett & Ellis	11/27/2019	$ 9,420.00	$ 481,474.69
Bracket & Ellis	2/6/2020	$ 1,382.50	$ 480,092.19
Bracket & Ellis	2/29/2020	$ 4,621.50	$ 475,470.69
Balance 10/31/2022			$ 475,470.69

Metropolitan Area EMS Authority dba MedStar Mobile Healthcare
Finance Report – September 30, 2022

The following summarizes significant items in the September 30, 2022 Financial Reports:

Statement of Revenues and Expenses:

Month to Date: Net Income for the month of September 2022 is a gain of $1,797,981 as compared to a budgeted gain of 525,278 for a positive variance of $1,272,703. EBITDA for the month of September 2022 is a gain of $2,196,342 compared to a budgeted gain of $858,806 for a positive variance of 1,337,536.

- Transport volume in September ended the month 108% to budget.
- Net Revenue in September is 143% to budget or $2,242,727 above budget.
- Net Revenue for the month is impacted by transport volume above budget by 8%, a payment of $150K from EMSMC for trips denied due to timely filing, and a year-end adjustment to Provision for Uncollectable of $1,250,000. This year end adjustment is made to decrease the Provision for Uncollectable due to a higher collection percentage of cash than previously booked in FY2022.
- Total Expenses ended the month 120% to budget or $970K over budget. In September, MedStar incurred additional expenses in Salaries and Overtime of $627K, Benefits and Taxes of $164K, Fuel of $98K, and Professional Fees of $146K. The total of all other line items is below budget by $65K.

Year to Date: EBITDA is $3,705,676 as compared to a budget of $4,015,081 for a negative variance of ($309,405)

- The main drivers for this variance are YTD patient encounters are 104% to budget and YTD net revenue is 1.09% to budget. Year to date expenses is 1.09% to budget. The main driver for this overage is salaries and overtime, health insurance claims, fuel, medical supplies and professional fees. The total of all other expense lines is below budget by ($342K) for the year.

Key Financial Indicators:

- Current Ratio – MedStar has $6.04 in current assets (Cash, receivables) for every dollar in current debt. (Goal: a score of $1.00 would mean sufficient current assets to pay debts.)
- Cash Reserves – The Restated Interlocal Cooperative Agreement mandates 3 months of operating capital. As of September 30, 2022, there is 4 months of operating capital.
- Accounts Receivable Turnover – This statistic indicates MedStar's effectiveness in extending credit and collecting debts by indicating the average age of the receivables. MedStar's goal is a ratio greater than 3.0 times; current turnover is 9.06 times.
- Return on Net Assets – This ratio determines whether the agency is financially better off than in previous years by measuring total economic return. An improving trend indicates increasing net assets and the ability to set aside financial resources to strengthen future flexibility. Through September, the return is -0.72%.

MAEMSA/EPAB cash reserve balance as of September 30, 2022 is $475,470.69.

Metropolitan Area EMS Authority dba MedStar Mobile Healthcare

Balance Sheet By Character Code

For the Period Ending September 30, 2022

Assets	Current Year	Last Year
Cash	$19,214,018.91	$23,478,246.61
Accounts Receivable	$7,789,454.77	$8,606,323.97
Inventory	$409,910.36	$383,481.43
Prepaid Expenses	$1,408,122.55	$473,354.22
Property Plant & Equ	$68,239,240.85	$63,814,632.18
Accumulated Deprecia	($27,457,807.84)	($25,659,926.52)
Total Assets	$69,602,939.60	$71,096,111.89
Liabilities		
Accounts Payable	($2,612,099.27)	($493,928.37)
Other Current Liabil	($2,092,792.86)	($3,415,440.42)
Accrued Interest	($7,781.31)	($7,781.31)
Payroll Withholding	($58,693.87)	($1,413.59)
Long Term Debt	($3,330,096.14)	($3,687,609.48)
Other Long Term Liab	($9,000,706.75)	($10,552,676.23)
Total Liabilities	($17,102,170.20)	($18,158,849.40)
Equities		
Equity	($52,884,378.49)	($55,208,105.09)
Control	$383,609.09	$2,270,842.60
Total Equities	($52,500,769.40)	($52,937,262.49)
Total Liabilities and Equities	($69,602,939.60)	($71,096,111.89)

Metropolitan Area EMS Authority dba MedStar Mobile Healthcare
Statement of Revenue and Expenditures
September 30, 2022

Revenue	Current Month Actual	Current Month Budget	Current Month Variance	Year to Date Actual	Year to Date Budget	Year to Date Variance
Transport Fees	$22,115,746.66	$18,302,631.11	$3,813,115.55	$234,701,280.96	$209,658,204.94	$25,043,076.02
Contractual Allow	($9,525,406.42)	($7,541,767.52)	($1,983,638.90)	($91,767,574.24)	($90,955,249.42)	($812,324.82)
Provision for Uncoll	($5,399,118.48)	($5,625,879.61)	$226,761.13	($88,680,132.33)	($67,849,247.56)	($20,830,884.77)
Education Income	$102,471.30	$1,690.00	$100,781.30	$199,156.60	$81,650.00	$117,506.60
Other Income	$135,415.59	$43,760.75	$91,654.84	$1,547,775.20	$807,729.00	$740,046.20
Standby/Subscription	$174,732.08	$60,973.79	$113,758.29	$1,115,059.56	$775,829.08	$339,230.48
Pop Health PMPM	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
interest on Investme	$324.09	$500.00	($175.91)	$5,341.33	$6,000.00	($658.67)
Gain(Loss) on Dispos	($119,528.84)	$0.00	($119,528.84)	($90,033.57)	$4,626.00	($94,659.57)
Total Revenue	$7,484,635.98	$5,241,908.52	$2,242,727.46	$57,030,873.51	$52,529,542.04	$4,501,331.47
Expenditures						
Salaries	$3,213,574.88	$2,586,423.66	$627,151.22	$33,955,145.44	$31,121,465.59	$2,833,679.85
Benefits and Taxes	$1,063,004.40	$898,654.00	$164,350.40	$6,793,329.50	$6,203,442.00	$589,887.50
Interest	$32,305.81	$33,500.00	($1,194.19)	$408,223.22	$402,000.00	$6,223.22
Fuel	$208,349.03	$110,038.92	$98,310.11	$1,952,896.35	$1,221,198.04	$731,698.31
Medical Supp/Oxygen	$152,116.58	$187,776.40	($35,659.82)	$2,386,136.98	$2,264,066.00	$122,070.98
Other Veh & Eq	$59,164.86	$39,897.00	$19,267.86	$604,998.62	$478,310.00	$126,688.62
Rent and Utilities	$61,443.51	$66,409.52	($4,966.01)	$700,096.04	$794,764.24	($94,668.20)
Facility & Eq Mtc	$89,241.84	$67,211.26	$22,030.58	$848,199.51	$894,385.12	($46,185.61)
Postage & Shipping	$229.21	$3,521.55	($3,292.34)	$23,875.50	$42,258.60	($18,383.10)
Station	($105,652.72)	$45,130.05	($150,782.77)	$309,799.13	$587,783.16	($277,984.03)
Comp Maintenance	$79,906.16	$62,275.11	$17,631.05	$872,124.31	$747,300.00	$124,824.31
Insurance	$43,637.12	$44,026.52	($389.40)	$595,405.00	$528,318.24	$67,086.76
Advertising & PR	$2,024.26	$292.00	$1,732.26	$14,032.65	$39,604.00	($25,571.35)
Printing	$334.22	$3,615.41	($3,281.19)	$42,026.82	$43,384.92	($1,358.10)
Travel & Entertain	$10,858.30	$2,363.00	$8,495.30	$69,877.33	$108,306.00	($38,428.67)
Dues & Subs	$113,528.53	$129,741.00	($16,212.47)	$1,352,770.93	$1,613,110.00	($260,339.07)
Continuing Educ Ex	$15,611.24	$7,923.00	$7,688.24	$149,231.11	$223,049.00	($73,817.89)
Professional Fees	$271,813.73	$125,860.04	$145,953.69	$2,542,078.98	$1,580,187.85	$961,891.13
Education Expenses	$7,356.65	$0.00	$7,356.65	$26,485.43	$0.00	$26,485.43
Miscellaneous	$1,752.09	$1,944.00	($191.91)	$86,687.79	$23,528.00	$63,159.79
Depreciation	$366,055.06	$300,028.00	$66,027.06	$3,680,360.56	$3,600,336.00	$80,024.56
Total Expenditures	$5,686,654.76	$4,716,630.44	$970,024.32	$57,413,781.20	$52,516,796.76	$4,896,984.44
Net Rev in Excess of Expend	$1,797,981.22	$525,278.08	$1,272,703.14	($382,907.69)	$12,745.28	($395,652.97)
EBITDA	$2,196,342.09	$858,806.08	$1,337,536.01	$3,705,676.09	$4,015,081.28	($309,405.19)

/Custom Reports StatementofRevenueandExpensesByCategory
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FOR MANAGEMENT USE ONLY

Metropolitan Area EMS Authority dba MedStar Mobile Healthcare
Key Financial Indicators
September 30, 2022

	Goal	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Current Ratio	**> 1**	**8.97**	**9.49**	**11.59**	**10.48**	**8.43**	**6.04**

Indicates the total short term resources available to service each dollar of debt. Ratio should be greater than 1, so that assets are available to retire debt when due.

	Goal	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Cash as % of Annual Expenditures	**> 25%**	**55.06%**	**47.07%**	**42.95%**	**51.76%**	**44.45%**	**33.49%**

Indicates compliance with Ordinance which specifies 3 months cash on hand.

	Goal	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Accounts Receivable Turnover	**>3**	**4.96**	**4.28**	**3.65**	**5.44**	**6.34**	**9.06**

A measure of how these resources are being managed. Indicates how long accounts receivable are being aged prior to collection. Our goal is a turnover rate of greater than 3 .

	Goal	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Return on Net Assets	**-1.00%**	**10.35%**	**10.11%**	**4.04%**	**0.00%**	**-4.03%**	**-0.07%**

Reveals management's effectiveness in generating profits from the assets available.

Emergency Physicians Advisory Board
Cash expenditures Detail

	Date		Amount	Balance
Balance 1/1/17				$ 609,665.59
J29 Associates, LLC	2/27/2017	$	1,045.90	$ 608,619.69
Bracket & Ellis	10/30/2017	$	12,118.00	$ 596,501.69
Brackett & Ellis	11/19/2018	$	28,506.50	$ 567,995.19
FWFD Grant	4/3/2019	$	56,810.00	$ 511,185.19
Brackett & Ellis	4/3/2019	$	20,290.50	$ 490,894.69
Brackett & Ellis	11/27/2019	$	9,420.00	$ 481,474.69
Bracket & Ellis	2/6/2020	$	1,382.50	$ 480,092.19
Bracket & Ellis	2/29/2020	$	4,621.50	$ 475,470.69
Balance 09/30/2022				$ 475,470.69

Human Resources - October 2022

As a department we are focusing on recruitment, retention, and engagement. Our first NEOP for this fiscal year started on 10/24/2022 with 17 field operations employees. We have a total of 10 planned NEOPs this fiscal year.

Turnover:

- October turnover – 1.88%
  - FT – 1.89%
  - PT – 1.82%
- Year to date turnover –1.88%
  - FT – 1.89%
  - PT – 1.82%

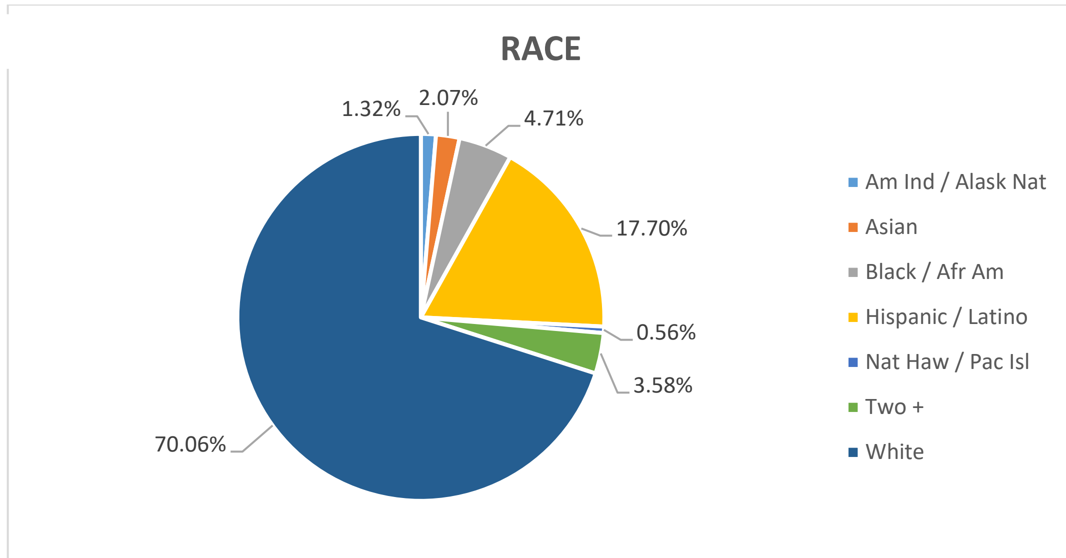
Leaves:

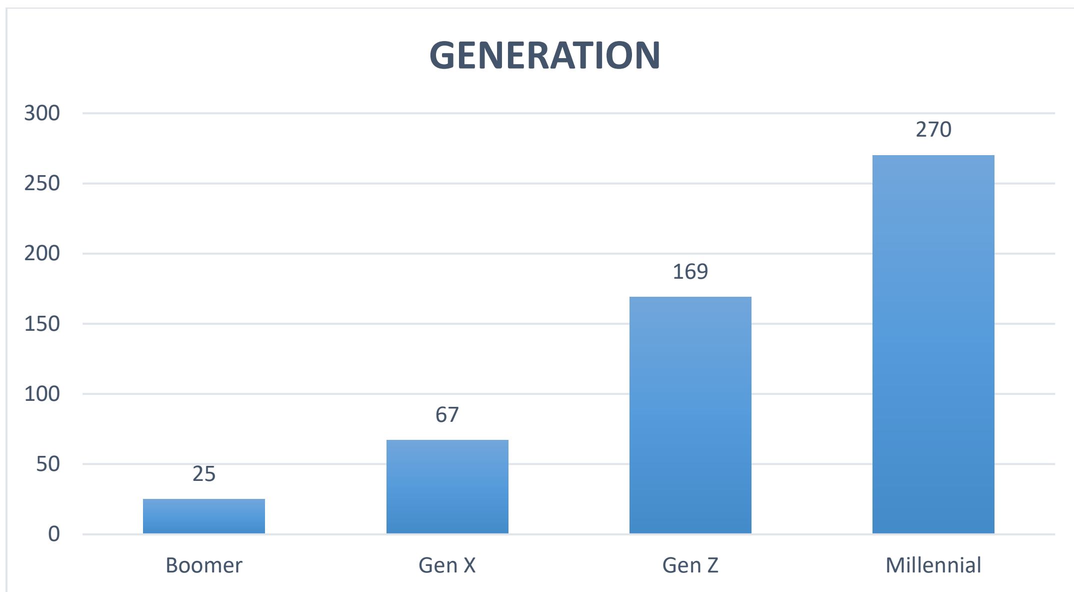
- 25 employees on FMLA / 5.25% of eligible workforce
  - 16 cases on intermittent
  - 9 cases on a block
- Top FMLA request reasons/conditions
  - Internal Medicine (5)
  - Mental Health (4)
  - Neurological (4)

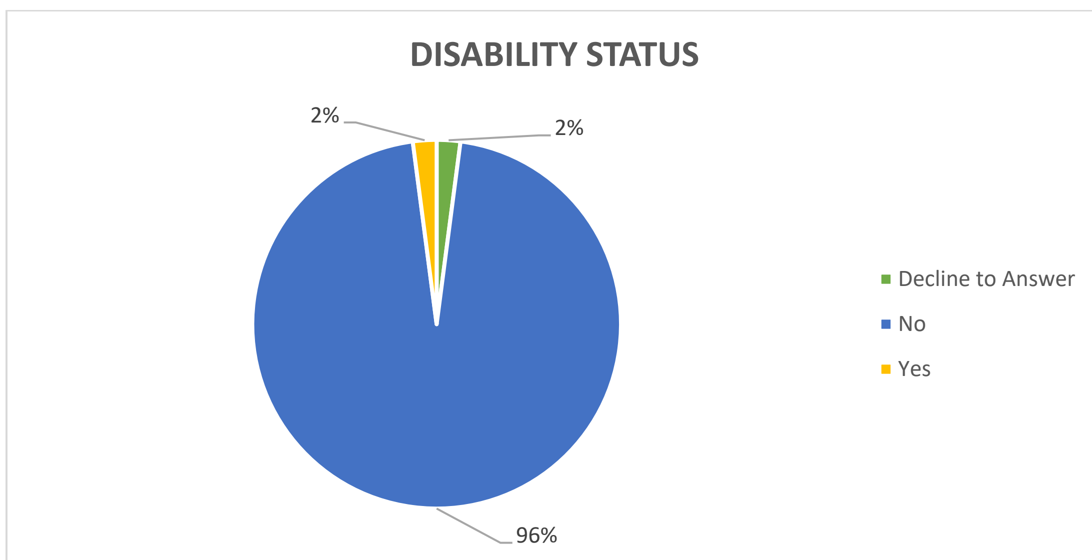
Staffing

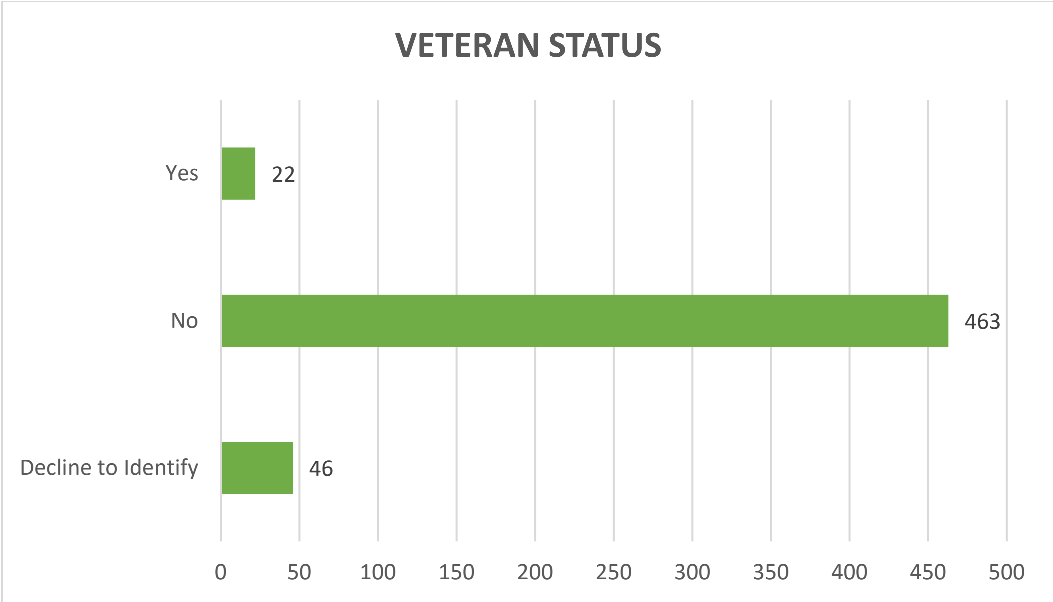
- 14 hires in October
- 14 hires FYTD

OCTOBER 2022 DIVERSITY STATISTICS








VETERAN STATUS
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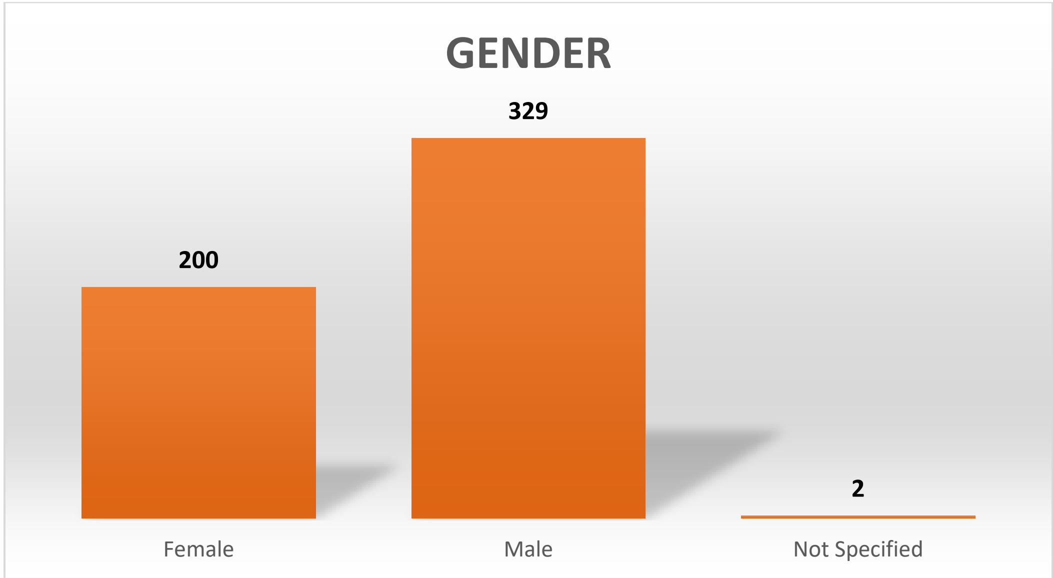
No
463
Decline to Identify
46
0
50
100
150
200
250
300
350
400
450
500


GENDER
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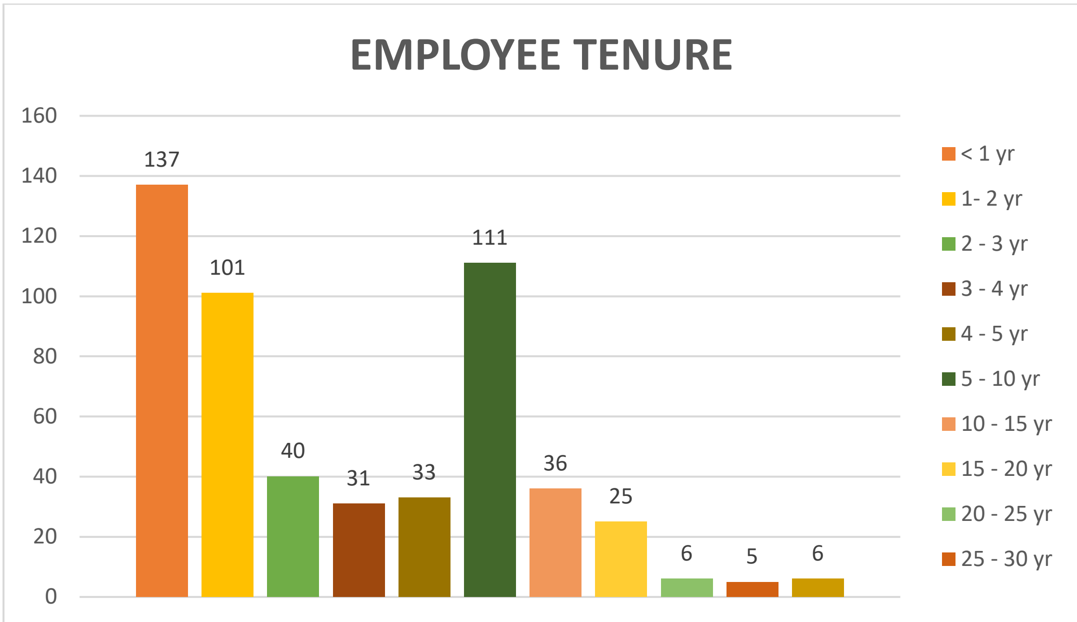
329
2
Female
Male
Not Specified


EMPLOYEE TENURE
160
140
120
100
80
60
40
20
0
137
101
40
31
33
111
36
25
6
5
6
< 1 yr
1- 2 yr
2 - 3 yr
3 - 4 yr
4 - 5 yr
5 - 10 yr
10 - 15 yr
15 - 20 yr
20 - 25 yr
25 - 30 yr

FMLA Leave of Absence (FMLA Detailed Report)
Fiscal Year 10/1/2022 thru 10/31/2022
Percentages by Department/Conditions

Conditions	
Bonding	1
FMLA - Child	2
FMLA - Parent	2
FMLA - Spouse	2
General Surgery	1
Internal Medicine	5
Mental Health	4
Neurological	4
Obstetrics	1
Oncology	1
Orthopedic	2
Grand Total	**25**

Percentage by Department					
Department	**# of Ees**	**# on FMLA**	**% by FTE**	**% by FMLA**	**% by Dept HC**
Advanced	123	8	1.68%	32.00%	6.50%
Basic	185	8	1.68%	32.00%	4.32%
Communications	40	4	0.84%	16.00%	10.00%
Controller - Payroll, Purchasing, A/P	6	1	0.21%	4.00%	16.67%
Human Resources	6	1	0.21%	4.00%	16.67%
Information Technology	7	1	0.21%	4.00%	14.29%
Support Services - Facilities, Fleet, S.E., Logistics	31	2	0.42%	8.00%	6.45%
Grand Total	**398**	**25**			
Total # of Full Time Employees - October 2022	476				
% of Workforce using FMLA	5.25%				

TYPE OF LEAVES UNDER FMLA	# of Ees	% on Leave
Intermittent Leave	16	64.00%
Block of Leave	9	36.00%
Total	**25**	100.00%

MedStar Mobile Health Care Separation Statistics October 2022

	Current Month			Year to Date			YTD Compared to Aug'21		Headcount
	Vol	Invol	Total	Vol	Invol	Total	Oct'21	%	Oct-21
Full Time Separations	7	2	9	7	2	9	5	1.05%	475
Part Time Separations	1	0	1	1	0	1	3	6.98%	43
Total Separations	8	2	10	8	2	10	8	1.54%	518
							Difference	0.343%	

	Current Month			Year to Date		
	Full Time	Part Time	Total	Full Time	Part Time	Total
Total Turnover %	1.89%	1.82%	1.88%	1.89%	1.82%	1.88%

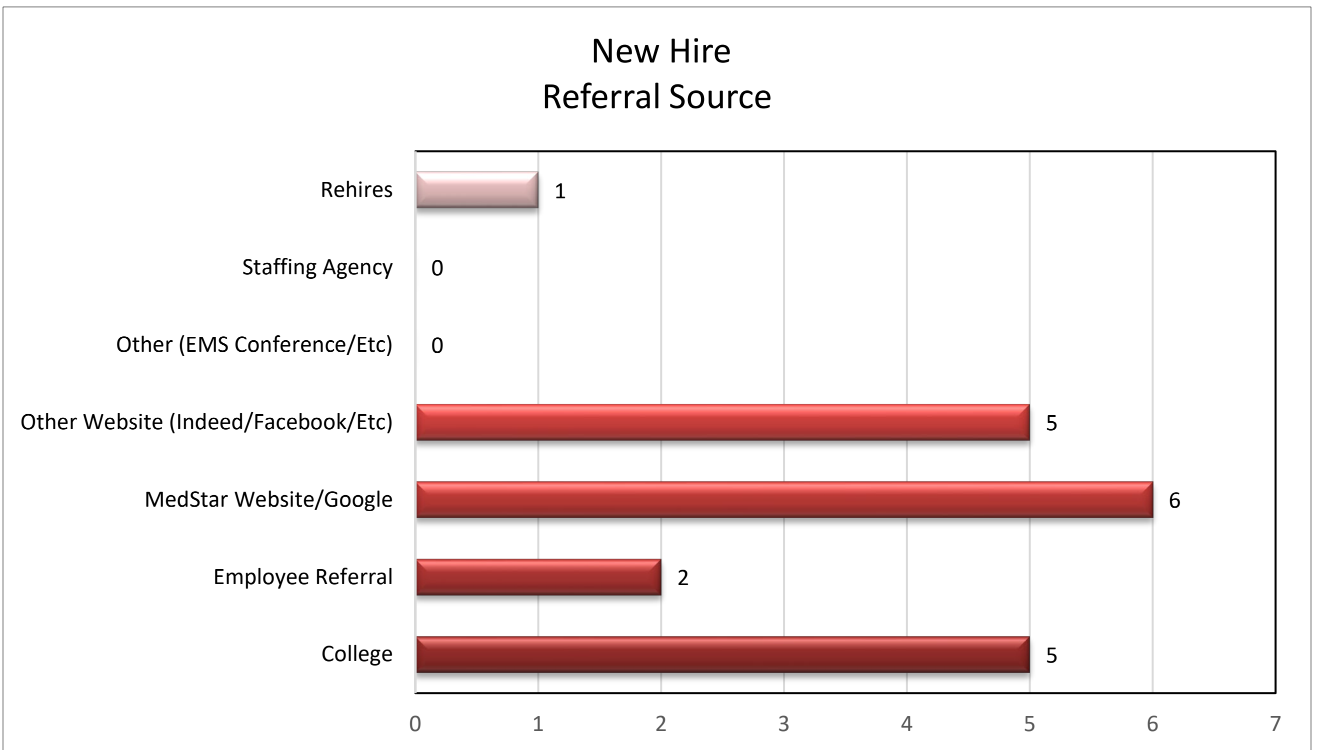
Separations by Department

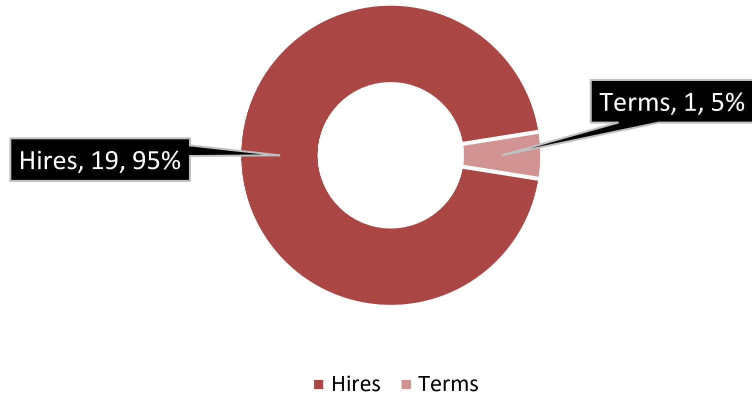
Full Time	Current Month			Year to Date			Headcount
	Vol	Invol	Total	Vol	Invol	Total	Oct-21
Advanced	3	0	3	3	0	3	123
Basics	4	2	6	4	2	6	185
Business Office							12
Communications							40
Controller - Payroll, Purchasing, A/P							6
Executives							8
Field Manager/Supervisors - Operations							23
Field Operations Other							7
Health Information Systems							3
Human Resources							6
Information Technology							7
Legal/Compliance							2
Mobile Integrated Health							9
Office of the Medical Director							13
Public Information							1
Support Services - Facilities, Fleet, S.E., Logistics							31
Total	**7**	**2**	**9**	**7**	**2**	**9**	**476**

Part Time	Current Month			Year to Date			Headcount
	Vol	Invol	Total	Vol	Invol	Total	Oct-21
Advanced							22
Basics	1	0	1	1	0	1	25
Business Office							
Communications							5
Controller - Payroll, Purchasing, A/P							
Executives							
Field Manager/Supervisors - Operations							
Field Operations Other							
Health Information Systems							
Human Resources							
Information Technology							
Legal/Compliance							
Mobile Integrated Health							
Office of the Medical Director							
Public Information							
Support Services - Facilities, Fleet, S.E., Logistics							3
Total	**1**	**0**	**1**	**1**	**0**	**1**	**55**

Recruiting & Staffing Report

Fiscal Year 2022-2023



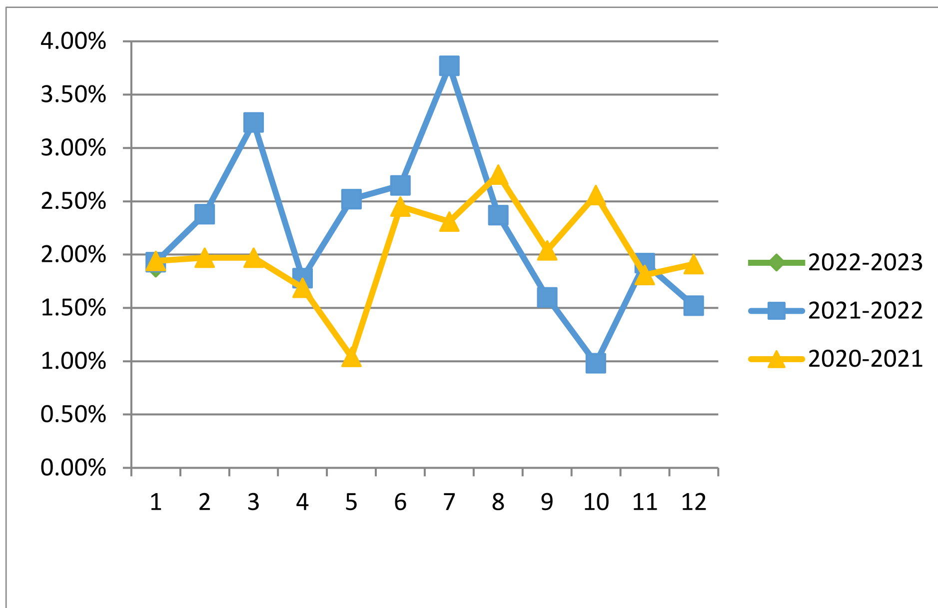


Fiscal Year Statistics
Total hires to date 20
Total separations from hires 1

Separation Reasons:
Better Opportunity – 1

MedStar Mobile Healthcare Turnover
Fiscal Year 2022 - 2023

	Full & Part Time Turnover			**Full Time Only**
	2022-2023	**2021-2022**	**2020-2021**	**2022-2023**
October	1.88%	1.93%	1.94%	1.89%
November		2.38%	1.97%	
December		3.24%	1.97%	
January		1.78%	1.69%	
February		2.52%	1.04%	
March		2.65%	2.45%	
April		3.77%	2.31%	
May		2.37%	2.75%	
June		1.60%	2.04%	
July		0.98%	2.56%	
August		1.92%	1.81%	
September		1.52%	1.91%	
Actual Turnover	1.88%	24.57%	16.17%	1.89%



Tab F – FRAB

Tab G – Operations

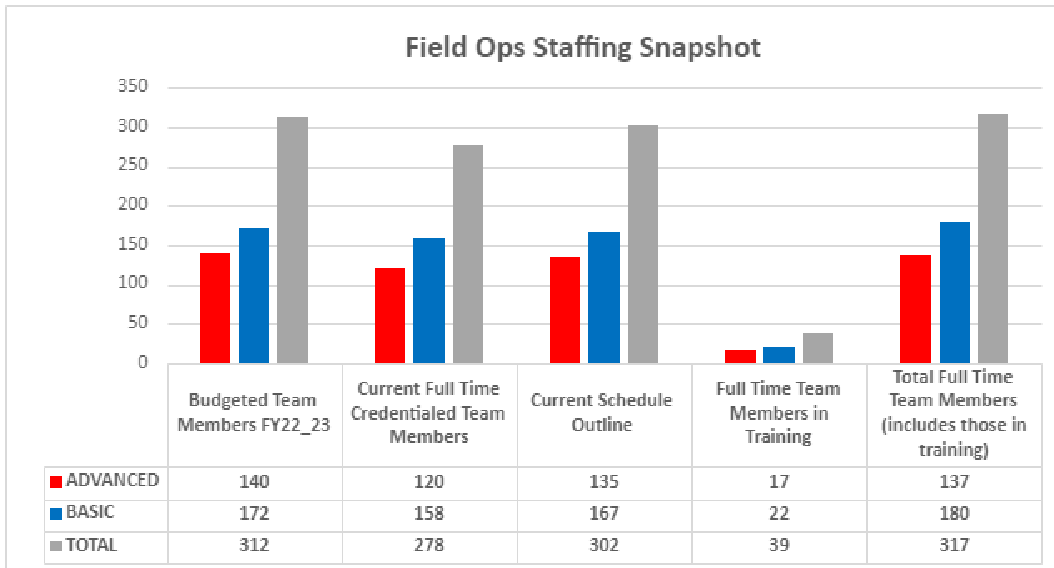
Metropolitan Area EMS Authority dba MedStar Mobile Healthcare

Operations Report- October 2022

The following summarizes significant operational items through October 31st, 2022:

Overall, the team performed well during our recent cyber incident. It was great to see all the departments come together to combat the effects of this event on our daily operations. We look forward to the continued learning from this event and how to improve.

Field Operations:



	Budgeted Team Members FY22_23	Current Full Time Credentialed Team Members	Current Schedule Outline	Full Time Team Members in Training	Total Full Time Team Members (includes those in training)
ADVANCED	140	120	135	17	137
BASIC	172	158	167	22	180
TOTAL	312	278	302	39	317

- Next 2 NEOP's are scheduled for Jan 2023 which should place field ops above on our FY22_23 staffing goals.
- Continued work on restoration efforts from cyber incident to include AAR activities

Fleet/Logistics/Building Maintenace:

- HVAC projects are in process
- New ambulance units are arriving and being placed in service

Special Operations:

- Currently in peak fall events season
- Completed 197 special events for the month of October 2022

Mobile Integrated Health:

- Sustained increase in MHP referrals from existing program partners.
    - 2,002 clients are currently enrolled.
- October 2022 MIH Encounters:
    - Scheduled Visits: 350
    - Unscheduled Visits: 25

    - 911 Encounters on Enrolled Clients: 52
- Specialty Care Transports have increased by 32.2% compared to last year.
- Hired additional part time CCP and MHP team members to assist with being able to flex to meet increasing demands from contracted providers and SCT volume.
- Completed hiring process for Mobile Health EMT.

Information Technology:

The team continues to work through the restoration process. All mission-critical systems are fully functional. Working with department leaders to reprioritize projects which were scheduled prior to the incident.

Business Intelligence:

- Cooperated with IT in restoration efforts.
- Analyzed loss of data and plans for data restoration efforts.
- Trained newcomers to department techniques.
- Working on replacement for FTO forms and VLI.
- Sharepoint conversion/data storage is gearing up to start.

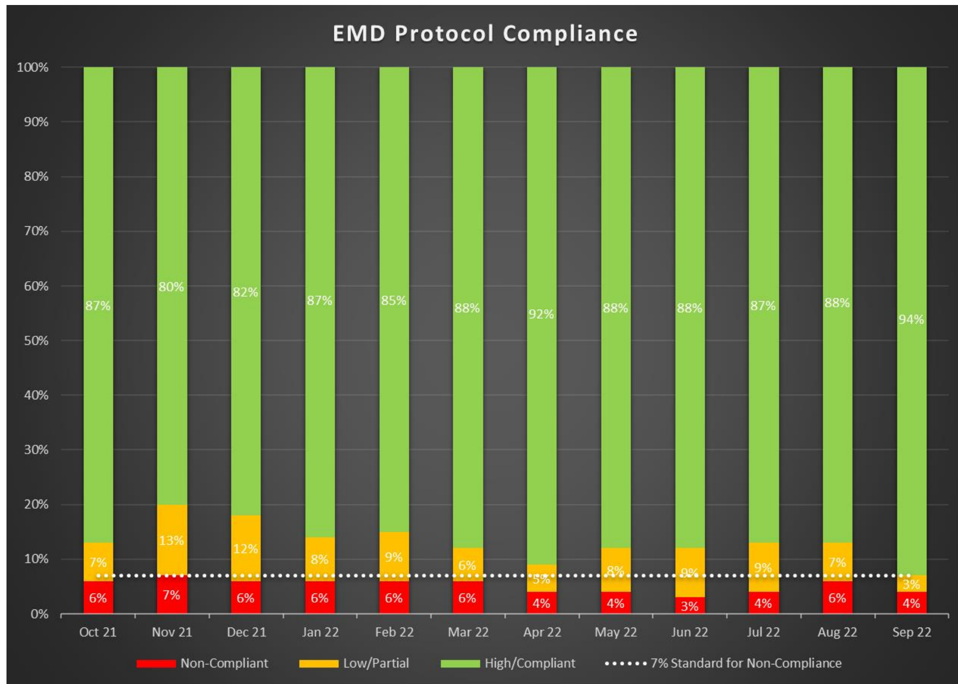
Communications:

- The Training Coordinator has moved into the position and begun the process of evaluating and updating the training program.
- Fourteen (14) controllers in various stages of training.
- Recruiting efforts are being made to fill one (1) supervisor, one (1) CTO, and four (4) controller positions.
- Continue to focus on meeting Organization Standards: 90% of 9-1-1 calls answered within 15 seconds or less; 95% of 9-1-1 calls answered within 20 seconds or less.
    - Have had marked improvement over the past 12 months.

Month	# 911 Calls	# Admin Calls	Total Calls	Avg Dur	% 911 Answered	
					≤ 15 sec	≤ 20 sec
Oct-21	8,891	14,552	23,443	283.3	81.67%	85.61%
Oct-22	11,458	12,642	24,100	283.1	90.31%	92.28%

Answer Time Compliance
95.00%
92.50%
90.00%
87.50%
85.00%
82.50%
80.00%
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
≤ 15 sec
≤ 20 sec

E911 Call Volume
12,500
12,000
11,500
11,000
10,500
10,000
9,500
9,000
8,500
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
911



EMD Protocol Compliance
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
87%
80%
82%
87%
85%
88%
92%
88%
88%
87%
88%
94%
7%
13%
12%
8%
9%
6%
5%
8%
9%
9%
7%
3%
6%
7%
6%
6%
6%
6%
4%
4%
3%
4%
6%
4%
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Non-Compliant
Low/Partial
High/Compliant
7% Standard for Non-Compliance

Tab H – Compliance and Legal

Legal Team Report
October 19, 2022- November 30, 2022

Compliance Officer Duties

- Submitted EMS provider roster changes to the DSHS as required by TX Admin Code 157.11.
- Assisted MAEMSA jurisdiction Police departments with multiple criminal investigations, records requests, missing persons investigations, and crew member statements, witness interviews as needed.
- Assisted Tarrant County Medical Examiner's office with multiple death investigations, and records requests.
- 1 narcotic Anomalies occurred during this reporting period:
  - Cap on a vial of Midazolam inadvertently came off during shift.
    The anomaly process was followed, and no foul play was suspected.
- Reviewed multiple legal & privacy matters for compliance and provided guidance as needed.

Paralegal Duties

- 10 Subpoenas(s) for witness appearance processed and served.
- 6 Pre-Trial meeting were held with the Tarrant Co. District Attorney's Office.
- 20 DFPS reports were made for suspected abuse, neglect, or exploitation.
- 6 court appearance was made as a state's witness.
- Conducted multiple employee internal investigations regarding various legal matters.
- Drafted, reviewed, negotiated, and executed agreements with outside parties as needed.
- Worked with outside counsel regarding ongoing active litigation.

Chad Carr

Compliance Officer
General Counsel Paralegal
ACO, CAPO, CRC, EMT-P

Tab I – EPAB

COMMONLY USED ACRONYMS

A

ACEP – American College of Emergency Physicians
ACEP – American Academy of Pediatrics
ACLS – Advanced Cardiac Life Support
AED – Automated External Defibrillator
ALJ – Administrative Law Judge
ALS – Advance Life Support
ATLS – Advanced Trauma Life Support

B

BLS – Basic Life Support
BVM – Bag-Valve-Mask

C

CAAS – Commission on Accreditation of Ambulance Services (US)
CAD – Computer Aided Dispatch
CAD – Coronary Artery Disease
CCT – Critical Care Transport
CCP – Critical Care Paramedic
CISD – Critical Incident Stress Debriefing
CISM – Critical Incident Stress Management
CMS – Centers for Medicare and Medicaid Services
CMMI - Centers for Medicare and Medicaid Services Innovation
COG – Council of Governments

D

DFPS – Department of Family and Protective Services
DSHS – Department of State Health Services
DNR – Do Not Resuscitate

E

ED – Emergency Department
EKG – ElectroCardioGram
EMD – Emergency Medical Dispatch (protocols)
EMS – Emergency Medical Services
EMT – Emergency Medical Technician
EMTALA – Emergency Medical Treatment and Active Labor Act
EMT – I – Intermediate
EMT – P – Paramedic
ePCR – Electronic Patient Care Record
ER – Emergency Room

F

FFS – Fee for service
FRAB – First Responder Advisory Board
FTE – Full Time Equivalent (position)
FTO – Field Training Officer
FRO – First Responder Organization

G

GCS – Glasgow Coma Scale
GETAC – Governor's Emergency Trauma Advisory Council

H

HIPAA – Health Insurance Portability & Accountability Act of 1996

I

ICD – 9 – International Classification of Diseases, Ninth Revision
ICD -10 – International Classification of Diseases, Tenth Revision
ICS – Incident Command System

J

JEMS – Journal of Emergency Medical Services

K

L

LMS – Learning Management System

M

MAEMSA – Metropolitan Area EMS Authority
MCI – Mass Casualty Incident
MI – Myocardial Infarction
MICU – Mobile Intensive Care Unit
MIH – Mobile Integrated Healthcare

COMMONLY USED ACRONYMS

N

NAEMSP – National Association of EMS Physicians
NAEMT – National Association of Emergency Medical Technicians
NEMSAC – National EMS Advisory Council (NHTSA)
NEMSIS – National EMS Information System
NFIRS – National Fire Incident Reporting System
NFPA – National Fire Protection Association
NIMS – National Incident Management System

O

OMD – Office of the Medical Director

P

PALS – Pediatric Advanced Life Support
PHTLS – Pre-Hospital Trauma Life Support
PSAP – Public Safety Answering Point (911)
PUM – Public Utility Model

Q

QRV – Quick Response Vehicle

R

ROSC – Return of Spontaneous Circulation
RFQ – Request for Quote
RFP – Request for Proposal

S

SSM – System Status Management
STB – Stop the Bleed
STEMI – ST Elevation Myocardial Infarction

T

U

V

VFIB – Ventricular fibrillation; an EKG rhythm

W

X/Y/Z