Metropolitan Area EMS Authority (MAEMSA)

dba MedStar Mobile Healthcare

Board of Directors

February 23, 2022

METROPOLITAN AREA EMS AUTHORITY
DBA MEDSTAR MOBILE HEALTHCARE
NOTICE OF MEETING

Date and Time: February 23, 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/1492144779 or by phone at (469) 445-0100 (**meeting** ID: 149 214 4779).

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. February 22, 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 – 1500	Approval of Board Minutes for January 26, 2021	Dr. Janice Knebl Pg. 5
	BC – 1501	Approval of Check Register for January 2022	Dr. Janice Knebl Pg. 10

V. NEW BUSINESS

IR – 223	Report and Certification of Results of Election of Suburban Cities Representatives to Board of Directors	Dr. Janice Knebl
IR – 224	Preliminary Discussion of Bylaws Revision	Kristofer Schleicher
BC – 1502	Approval of 911-Tiered Ambulance Deployment	Kenneth Simpson
BC – 1503	Medical Director Search Process	Dr. Janice Knebl
BC -1504	Approval of Medical Director Job Description	Dr. Janice Knebl

VI. MONTHLY REPORTS

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

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:

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;
2. Section 551.072: To deliberate the purchase, exchange, lease, or value of real property if deliberation in an open meeting would have a detrimental effect on the position of the Authority in negotiations with a third person;
3. Section 551.074: To (1) deliberate the appointment, employment, evaluation, reassignment, duties, discipline, or dismissal of an Authority officer or employee; or (2) to hear a complaint or charge against an officer or employee; or
4. 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.

The Board may act on any agenda item discussed during the Closed Session.

IX ADJOURNMENT

MAEMSA
BOARD COMMUNICATION

Date: 02.23.2022	**Reference #:** BC-1500	**Title:** Approval of Board of Directors Minutes

RECOMMENDATION:

It is recommended that the Board of Directors approve the board minutes for January 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

Meeting Date and Time: January 26, 2022, at 10:00am

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 10:00 a.m.

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

Guests on phone or in person as attendees: Fire Chief Brian Jacobs, Division Chief Jeremy Blackwell, Fire Chief Ryan Arthur, Fire Chief Brandon Logan, Fire Chief Kirt Mays, Bettina Martin, Bob Strickland, Bradley Crenshaw, Chris Cunningham, Chris Roberts, Desiree Partain, Elizabeth Paoli, Heath Stone, Jeramie Davidson, Joleen Quigg, Kristine Valenti, Lindy Curtis, Maerissa Thomas, Matthew Willens, Misti Skinner, Nancy Cychol, Pete Rizzo, Ricky Hyatt, Shaun Curtis, Susan Swagerty, and William Gleason.

Dr. Veer Vithalani introduced Dr. Angela Cornelius, the new Assistant Medical Director.

II. CONSENT AGENDA

BC-1494 Approval of Board minutes for December 15, 2021
BC-1495 Approval of Board minutes for December 22, 2021
BC-1496 Approval of Check Register for November 2021
BC-1497 Approval of Check Register for December 2021

The motion to approve all items on the Consent Agenda was made by Doug Spears and seconded by Susan Alanis. The motion carried unanimously.

III. NEW BUSINESS

IR - 222 Whitley Penn 2021 Audit Review
Dr. Janice Knebl introduced the Authority's auditors from Whitney Penn, Jenni Barnett and Josh Anagen, who reported that the 2021 audit was clean with no issues of concern after a very

thorough review of MedStar's significant accounting policies, accounting estimates, and financial statements. The Federal Single Audit report was also included this year.

BC – 1498 Approval of MedStar Foundation Board Appointment
The motion to approve the nomination of Councilmen Flores and Teneisha Kennard as MedStar appointees to MedStar Foundation Board of Directors was made by Doug Spears and seconded by Dr. Chris Bolton. The motion carried unanimously.

BC – 1499 Approval of Stretcher Purchase
The motion to approve was made by Doug Spears and seconded by Dr. Brad Commons. The motion carried unanimously.

IV. MONTHLY REPORTS

A. Chief Executive Officer- Ken Simpson noted that Maerissa Thomas has sent out placeholders for all of the Board of Directors meetings thru October 26, 2022. Mr. Simpson referred to Tab A in the packet and reported that. MedStar received full CAAS accreditation for another three-year term. A draft of the tiered response program was included in the board packet. The FRAB will be discussing this on Thursday, January 27th and the final document will be presented to MAEMSA Board at the February meeting. The Burleson City Council met on January 18th, and voted to provide formal notice of their intent to withdraw from the Authority on October 1, 2023. Board training will be held on Friday, January 28th at MedStar Mobile Healthcare, the training will cover a variety of topics including board responsibilities, board functions and obligations, etc. We are reviewing our compensation rates for our frontline employees. All Board members now have access to Board Source using the link that was provided via email.

B. Office of the Medical Director- Dr. Vithalani informed the Board of the OMD's continuous work, including the completion of the most recent continuing education sessions, which were cadaver labs hosted at UNT Health Science Center. The Office of the Medical Director is implementing a standardized airway checklist. A new process has been implemented to decrease credentialing time. One of the changes in the process creates time for all trainees to come in and complete simulated patient encounters once per week. The Office of the Medical Director continues to evaluate the Tiered Response Program with the rest of the system performance committee and is confident that it is more effectively matching the level of care with the patient's medical condition rather than automatically sending ALS responses to all calls. During the EPAB board meeting tomorrow, there will be a discussion about ECMO-facilitated CPR. Dr. Vithalani referred to Tab B in the Board packet for additional information.

C. Chief Financial Officer- Steve Post informed the Board that MedStar has completed the end of year audit and will be starting on the annual cost reporting this week. He referred to Tab C for monthly reports.

D. Chief Human Resources Officer- Leila Peeples informed the Board, MedStar is working through the ADP implementation; there were a few setbacks with the scheduling software and HR is now evaluating some other partners with ADP. It has been a challenge to recruit and retain employees due to the salaries, so HR and the Executive Team are regularly evaluating to ensure MedStar

remains competitive within the market. COVID leave has increased for the month of December. FMLA absences have decreased, and turnover has increased slightly. Leila referred the Board to Tab D in the packet for additional reports.

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

F. Operations – Ken Simpson referred to Tab F and provided some highlights to the Board- COVID leave and increase in call volume. It has been a challenge maintain staffing and add ambulances to address the volume, but Operations Management has offered some shift incentives to improve staffing. MedStar continues to offer the opportunity for vaccines and boosters. Ring to answer time in Communications Department is coming down due to the efforts of the Communications Managers and department staff. Lindy Curtis and Joleen Quigg have taken over as the Communications Managers, and they have done a tremendous job ensuring we are getting to the incoming calls faster. Ken informed the Board that election ballots went out to the suburban cities to replace Board member Matt Aiken. One nomination has been received - Bryce Davis, who is the Emergency Manager for Haltom City.

G. FRAB- Chief Spears informed the Board about the upcoming FRAB meeting on Thursday, January 27th.

H. EPAB- Dr. Brad Commons informed the Board that both Harris Fort Worth and Southwest Hospital have broken multiple emergency room records over the past couple of weeks including their one-day highs. The hospitals are seeing different patient conditions as the COVID variants have changed.

I. Chief Transformation Officer- Matt Zavadsky referred to Tab I and provided the Board with the following highlights- the alternative-payment models and expanded service lines are a large focus for MedStar as they bring more value to the community. In the last quarter, Medicare has been creating what is referred to as "Affinity Groups" for ET3. These groups are intended to help work with ET3 applicants that have applied for the ET3 program but haven't implemented yet. Medicare has reached out to a couple of agencies to host and share their experiences. MedStar has been included in two of those. The commercial agreement referenced in the Board packet is very significant for MAEMSA because it is our first commercial payor contract that provides payment for treatment on scene rather than just payment for transport. The payment rate and economic model is mutually beneficial for MAEMSA and for the payor. The team is working diligently this week to put a model together to submit to Medically Home, a venture capital firm that is partnering with hospitals, including THR, to do hospital in home programs. MAEMSA management is carefully tracking the balance billing issue. One of the MedStar representatives, Matt Zavadsky, was nominated by several national associations to work with the congressional committee for evaluating ground ambulance balance billing process.

V. REQUEST FOR FUTURE AGENDA ITEMS

There were no requests for future agenda items.

VI. CLOSED SESSION

Dr. Knebl called the meeting into a closed session at 11:01 a.m. under Section 551.071 of the Texas Government Code. The Board returned from closed session at 11:14 p.m. and took no further action.

VII. ADJOURNMENT

The board stood adjourned at 11:14 p.m.

Respectfully submitted,

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Douglas Spears
Secretary

MAEMSA
BOARD COMMUNICATION

Date: 02.23.2022	**Reference #:** BC-1501	**Title:** Approval of Check Register for January

RECOMMENDATION:

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

DISCUSSION:

N/A

FINANCING:

N/A

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

AP Check Details Over 5000.00
For Checks Between 1/1/2022 and 1/31/2022

Check Number	CK Date	Vendor Name	Check Amount	Description
107060	1/6/2022	Abbott Point of Care	6,427.12	ISTAT service contract 12/14/2
107072	1/6/2022	Bound Tree Medical LLC	54,081.94	Various Medical Supplies
107077	1/6/2022	Direct Energy Business	7,918.99	Electric Services
107082	1/6/2022	Maintenance of Ft Worth, Inc.	6,690.54	Janitorial Supplies and Services
107084	1/6/2022	Medline Industries, Inc.	73,911.25	Various Medical Supplies
107093	1/6/2022	Public Consulting Group, Inc.	66,820.15	Ambulance Supplemental Payment
107096	1/6/2022	ReCept Pharmacy	13,066.97	Various Medical Supplies
107103	1/6/2022	Teleflex Medical	7,664.95	Various Medical Supplies
107105	1/6/2022	Texas Wrap Studios LLC	15,232.00	Decals for code 100s
107108	1/6/2022	XL Parts	7,352.30	Various Parts
107119	1/13/2022	Bound Tree Medical LLC	6,070.60	Various Medical Supplies
107130	1/13/2022	Logis Solutions	17,559.34	Standard Scheduling/HERE Licenses
107132	1/13/2022	Masimo Americas, Inc	8,130.72	Various Medical Supplies
107135	1/13/2022	MetLife - Group Benefits	42,627.22	Dental/Vision/STD/Life/Supp Life
107137	1/13/2022	Mutual of Omaha	11,036.41	Critical Care/Accident
107149	1/13/2022	Stryker	14,554.52	cot parts
107152	1/13/2022	Teleflex Medical	9,389.95	Various Medical Supplies
107153	1/13/2022	Texas Medical Liability Trust	17,797.00	Liability Insurance
107162	1/21/2022	Airgas USA, LLC	5,186.48	Cylinders and Rental
107185	1/21/2022	ImageTrend	24,272.00	Elite EMS - Monthly Fee
107188	1/21/2022	M Davis and Company Inc	5,240.00	Detection of Elder Abuse Service
107192	1/21/2022	Medline Industries, Inc.	13,303.48	Various Medical Supplies
107193	1/21/2022	NRS	26,704.18	Collection agency fees
107209	1/21/2022	PERCOMOnline	6,500.00	Paramedic Tuition - B Michaels
107210	1/21/2022	Paranet Solutions	5,111.25	Proj#903 / ISE Refresh
107336	1/27/2022	All-Pro Construction & Commerical	5,305.60	Smoke Detectors in Bay
107349	1/27/2022	AT&T	18,557.60	Cell Phone / Aircards
107351	1/27/2022	Bound Tree Medical LLC	28,541.65	Various Medical Supplies
107352	1/27/2022	Bruce Lowrie Chevrolet	5,948.02	Various Parts
107358	1/27/2022	CyrusONe	7,717.68	Colocation Charges
107366	1/27/2022	HF Custom Solutions	30,000.00	Christmas gifts
107374	1/27/2022	Medic Built LLC	213,984.00	New Ram Chassis
107375	1/27/2022	Medline Industries, Inc.	45,534.75	Various Medical Supplies
107377	1/27/2022	NRS	13,179.79	Collection Services
107385	1/27/2022	ReCept Pharmacy	11,281.04	Various Medical Supplies
107394	1/27/2022	Teleflex Medical	9,425.00	Various Medical Supplies
107398	1/27/2022	Whitley Penn, LLC	21,000.00	Professional Services
1032022	1/3/2022	Frost	61,053.88	Frost Loan #30001
1042022	1/4/2022	Frost	38,540.62	Frost Loan #4563-001
1192022	1/19/2022	JP Morgan Chase Bank, N.A.	19,049.33	MasterCard Bill

AP Check Details Over 5000.00
For Checks Between 1/1/2022 and 1/31/2022

Check Number	CK Date	Vendor Name	Check Amount	Description
1252022	1/25/2022	Frost	52,993.77	Frost Loan #4563-002
1610758	1/19/2022	Frost	39,363.52	Frost Loan #39001
1628903	1/7/2022	UMR Benefits	47,941.10	Health Insurance
1667067	1/20/2022	WEX Bank	118,516.53	Fuel
1695526	1/28/2022	UT Southwestern Medical Center	12,833.33	Contract Services - B Miller
2095447	1/24/2022	Direct Energy Business	7,638.78	Electric Service
209544701	1/24/2022	Direct Energy Business	8,165.57	Electric Service
772701072	1/7/2022	AT&T	18,210.61	Cell Phones & Aircards

MAEMSA
BOARD COMMUNICATION

Date: 02.23.2022	**Reference #:** BC- 1502	**Title:** Approval of 911 Tiered Ambulance Deployment

RECOMMENDATION:

It is recommended that the Board of Directors approve the utilization of tiered ambulance deployment in the 911 system.

DISCUSSION:

Starting in February 2021 a tiered ambulance deployment pilot program was implemented in the MedStar system. Traditionally MedStar has utilized an all-Advanced Life Support ("ALS") system, meaning that each ambulance is staffed by at least one paramedic, but paramedic care is unnecessary for many of the calls that come through the 911 system. A Basic Life Support ("BLS") ambulance is made up of at least one Emergency Medical Technician (EMT), who is trained in basic life support interventions like airway assessment and stabilization, bandaging, splinting, and CPR. BLS ambulances can safely and effectively manage many of the patients that come through the 911 system.

Allowing the utilization of BLS ambulances in the MedStar system will provide the ability to more easily staff ambulances that can provide clinically appropriate care to our 911 patients. Likewise, there is a slight cost savings associated with utilizing BLS ambulances instead of all ALS ambulances. There is also a clinical advantage to by allowing ALS ambulance to respond to more ALS appropriate calls through increased utilization of ALS skills. The eligible BLS emergency medical dispatch ("EMD") codes are identified through a retrospective analysis of EMD chief complaints, which factors in variables such as the percentage of patients with unstable vital signs, the percentage of patients receiving ALS interventions, and the percentage of patients that received critical interventions. A more detailed outline of the BLS program has been included, which was also included last month as a draft document.

The tiered ambulance deployment pilot program has gone very well with positive feedback from the system stakeholders. The Emergency Physician's Advisory Board ("EPAB") agreed to support this approval request at their December meeting, and the First Responder Advisory Board ("FRAB") also indicated their support for this approval request at their January meeting.

FINANCING:

N/A

Submitted by: **Kenneth J. Simpson** **Board Action:**

_____Approved
_____Denied
_____Continued until _____

TIERED AMBULANCE DEPLOYMENT

PROGRAM OVERVIEW

MedStar Mobile Healthcare

Metropolitan Area EMS Authority

Contents

Executive Summary

The current all ALS deployment model presents operational challenges related to staffing, response, outcomes, and cost-effectiveness. The EMS System Performance Committee, established through the interlocal agreement between MAEMSA member jurisdictions, created a Tiered Response Task Force to assess the potential clinical, operational, experiential, and fiscal value of shifting from an all-Advanced Life Support ("ALS") ambulance deployment model to an ALS and Basic Life Support ("BLS") ambulance deployment model. The Task Force was comprised of representatives from first response agencies, the Office of the Medial Director, and MedStar.

The Tiered Response Task Force proposed a six-month pilot project to evaluate a Tiered Deployment Model, where a combination of ALS and BLS ambulances respond to 9-1-1 medical calls in the MAEMSA service area. Included in the pilot were five specific goals to be evaluated, with success evaluation methodology. The pilot project was approved by the MAEMSA Board and launched on February 1st, 2021.

The outcomes of the five goals were presented at the October 2021 meeting of the EMS System Performance Committee. The evaluation indicated that the pilot project met or exceeded all five goals (see Appendix 1).

Recognizing the benefit to the EMS response system and the patients the System serves, the EMS System Performance Committee submits to the MAEMSA Board of Directors this plan outlining the deployment and utilization of resources tailored to better meet the specific needs of callers through the 911 system in the MAEMSA's member jurisdictions. Specifically, utilization of BLS ambulances to respond to BLS response determinants, identified through an analysis of the actual care provided to patients from responses triaged to those determinants provides the MAEMSA system with the flexibility to deploy resources which more closely match the medical needs of patients accessing the 911 system. Approval of this plan would transition the Tiered Ambulance Deployment Model from pilot to permanent.

Background

Utilization of the 911 system for emergency medical care has expanded significantly since the introduction of the three-digit number. While some medical emergencies require ALS care, it is also common to find individuals who utilize the emergency medical system for low acuity medical complaints that do not rise to the level of necessitating advance life support care and intervention.

Utilizing paramedics to respond to low acuity calls with a very low likelihood of requiring ALS care diminishes the opportunity for paramedics to administer ALS care, potentially leading to ALS skill degradation throughout the system. It also adds to paramedic burnout and job dissatisfaction. Likewise, utilizing ALS resources to respond to calls that are determined, through emergency medical dispatch ("EMD") criteria, to be low acuity unnecessarily adds cost to the EMS system, when a more clinically appropriate, lower cost response is more effective. Fully utilizing the EMD process to better match ALS calls with ALS providers and allowing BLS providers to care for the lower acuity calls may result in more proficient ALS providers as the frequency and intensity of patient care experiences are honed with even more repetition of ALS skills than what is seen in an all-ALS system.[1]

Furthermore, utilizing multiple providers at different certification levels, with different specialties, provides the added benefit of producing more resources to respond to, and support, the healthcare systems in the community.

Methodology to Identify BLS Eligible EMD Codes

The optimal response plan is evaluated by conducting a retrospective analysis of the previous 12 months of EMD determinants and the patient condition as represented in the electronic patient care report ("ePCR") data. The criteria evaluated include the percentage of incidents for each EMD determinant where the ePCR indicated ALS criteria, the percentage with unstable vital signs, the percentage with critical interventions such as defibrillation or advanced airway management, the percentage of lights-and-sirens ("Hot") transport to the hospital, and the percentage of patients transported.

[1] https://www.jems.com/operations/too-many-medics-debating-a-tiered-response-vs-all-als-ems-system/

The threshold percentages and minimum quantity of incidents are established by the system's determination regarding the likelihood that ALS care is necessary on arrival of a BLS ambulance. There is a natural correlation between a higher threshold of ALS interventions, unstable vital signs, or critical interventions, and an increased number of calls that could require a subsequent dispatch of an ALS upgrade. It is important to note that, of the four criteria, the ALS criteria measurement may be elevated, as some of the historical interventions may have been permissible, but not necessarily *required*, to improve the patient's outcome. For this reason, based on feedback from the Performance Standards Committee, the ALS criteria threshold was increased from an initial level of 3% during the pilot to 5% in this recommendation.

ALS upgrade is a data point that will be captured and reported. It is important to note that BLS interventions make up the initial steps of all medical protocols and correlates with industry best practices. While an ALS upgrade may make their way to a scene, the clinicians on scene will continue to provide vital care to the patient.

Thresholds for BLS

For an EMD determinant to be included as a BLS eligible, it will have, over the prior 12 months:

- A minimum of 50 dispatches;
- An ALS criteria rate < 5%;
- Unstable vital signs < 5%;
- Critical incident criteria < 1%.

The BLS-eligible EMD determinates may be updated as needed by MedStar's CEO and the MAEMSA Medical Director, in collaboration with the EMS System Performance Committee, and shall be reported to the MAEMSA Board of Directors.

Based on the proposed EMD determinants the number of BLS eligible incidents received through the 911 system is anticipated to be ~29,000, which constitutes ~17% of the total call volume. Initial response volume targets will be 15-25% of the total call volume for BLS eligibility. It is anticipated that the overall deployment should represent a corresponding percentage of BLS ambulances to anticipated BLS EMD codes. The proposed BLS determinates are found in Appendix 2.

BLS Ambulance Deployment Methodology

MedStar utilizes dynamic posting of medical resources based on the historical demand for time of day and day of week. It is recommended that the same deployment criteria be utilized to position BLS resources throughout the system.

The BLS eligible determinants will be programmed into the computer aided dispatch ("CAD") software so that the machine learning can begin to build a history of ALS and BLS call types by time of day and day of week. The dynamic deployment of the resources will improve as more data is added to the analysis, and the CAD will position both ALS and BLS ambulances to best meet the desired response time targets.

The CAD will be being set up to make responding ambulance determinations based on the requirements of the EMD code, applicable response time guidelines, and resource availability. The CAD is programmed to apply the following methodology:

1.) If a BLS EMD determinant, find a BLS ambulance that can meet the response time. (Recommended Priority 3).
    a. If no BLS ambulance can meet the response time goal, dispatch an ALS ambulance.
    b. If no ALS ambulance can meet response time goal, evaluate mutual aid response.

2.) If an ALS EMD determinant, find an ALS ambulance that can meet the response time goal.
    a. If no ALS ambulance can meet the response time goal, dispatch BLS ambulance and find an ALS resource to co-respond.

As mentioned above, BLS ambulance deployment is anticipated to be 15-25%. MedStar utilizes a deployment methodology more aligned with healthcare's census-based staffing models, which takes into consideration previous demand and current conditions. This means we try to assure 85-100% of the scheduled unit hours are filled. If staffing percentages drop below that our practice is to shift administrative positions down to the field to provide additional ambulance coverage. Utilization of BLS ambulance will allow us to staff a greater percentage of the projected schedule and add additional unit hours to the schedule for BLS coverage.

To accomplish the proportion of BLS ambulance to ALS the number of EMT positions was increased to a greater magnitude than paramedic positions. Specifically, this year we are budgeted for 169 full time EMT positions and 135 full time paramedic positions. Both of which represent an increase over the previous year and a peak deployment of 52 ambulances.

Response Priority and FRO Response

The criteria through which specific EMD codes are identified as being BLS eligible also aids in identifying these calls as likely low acuity incidents. It is recommended that these calls be classified as priority three (P3) responses, and, except for potential scenes that may require Fire or Police response for fire or hazardous situations, BLS eligible calls should not require the deployment of first response resources. As has been the practice in the MAEMSA system, if a city or first response agency wishes to be sent on these calls, MedStar's Communications Department can adjust their specific response plan accordingly.

ALS Quick Response Vehicle (QRV)

A Quick Response Vehicle ("QRV") is a non-transport capable response vehicle, staffed with a paramedic or higher credentialed provider, that can be deployed as additional support to BLS or ALS calls. The MedStar system has historically deployed these resources as supervisor and critical care vehicles.

The utilization of QRVs is separate from the BLS pilot project. The inclusion of them in this document is to address some questions that have been raised around how they are reported. These units are not included in either the number of ALS or BLS unit hours as it relates to ambulances.

These units are also not included in the unit hour costs since they are not part of the unit hours. Additional information may be found in the section heading "Response Time Compliance for BLS."

Response Time Compliance for BLS

The response time guidelines will remain unchanged from those recommended by the EMS System Performance Committee and adopted by the MAEMSA Board of Directors on December 14, 2016. (See Appendix 3). After some initial confusion, feedback from the System Performance Committee, including some FRAB members, produced the following suggestions regarding response time requirements for BLS ambulances:

1. If a BLS ambulance and an ALS resource are dispatched to an ALS determinant:
    a. The response time clock will not stop until both the BLS ambulance and the ALS resource are on scene.
    b. If the BLS ambulance arrives on scene and the BLS ambulance or any co-responder cancels the responding ALS resources, the on-scene time for the BLS ambulance shall be the response clock stop time.
    c. If an ALS resource cancels the BLS ambulance the on-scene time for the ALS resource shall be the response clock stop time.
    d. As has been the practice within the system with all other apparatus a BLS ambulance or a QRV may upgrade, downgrade, or cancel additional responding apparatus and/or agencies.

ALS Co-responders

Several first response agencies have elected to provide ALS level service. The System Medical Director has provided criteria to assist in identifying when a call may need to be upgraded to an ALS level of care. (See Appendix 4) BLS deployment is not intended to necessitate the utilization of the first responder paramedics for continued patient care and transport. Through ALS ambulance deployment and QRV deployment, MedStar intends to be able to provide ALS intervention to any calls that may need to be upgraded.

Nothing in this deployment model is intended to prevent a first response paramedic from electing to ride into the hospital with a BLS ambulance, nor is this program intended or designed to force a first response paramedic to ride into the hospital with a BLS crew. The BLS checklist should help guide this determination as well as other factors, as applicable, such as the estimated time of arrival of additional responding ALS units and the patient condition. In coordination with the on-scene MedStar crew, a determination may be made that the FRO paramedic prefers to ride into the hospital as opposed to waiting for the ALS resource or sending the patient with the BLS ambulance. Based on the design of the BLS deployment system there should be few cases requiring a first response paramedic to accompany a BLS ambulance to the hospital.

Quality assurance ("QA") will be conducted on calls within the MAEMSA system according to standard QA processes. Should an agency have concern with any instances of first response paramedics riding in with BLS ambulances, it is expected that this be voiced to MedStar's leadership as a concern. Upon receipt of such concern the respective leadership teams will review the results of the quality reviews for calls in which first response paramedics rode in with BLS ambulances. Additionally, operational components such as ALS and BLS staffing numbers, call volume and location of responding ALS resources will be evaluated to identify and mitigate any applicable root cause.

Documentation For ALS Co-Responders

If an FRO paramedic rides in with a BLS crew and the patient condition and FRO paramedic's interventions make the call eligible to be billed as an ALS call the call will NOT be billed as an ALS call. Instead, it will be billed as a BLS level of service. The reason for this is that this could be looked at as a double charge to the patient in that the FRO paramedic is provided through tax dollars, and they would be paying for that paramedic's service again through an ALS charge.

In this scenario, the FRO paramedic should document the care provided to the patient in their ImageTrend chart and sync the chart in the cloud. The MedStar BLS crew should document the care provided in their chart and pull the FRO paramedic's chart into theirs where they will both be sent to the hospital as a comprehensive patient care report.

Data Analytics for BLS Deployment

BLS deployment data will include the metrics listed below. It is anticipated that this will be developed into dashboards to be shared with the System Performance Committee and included in the monthly report to the Board of Directors as the pilot program goals, shown in Appendix 1, have been. Given the recent requests for information, data, reporting and explanation MedStar's management is evaluating the most efficient and economical ways to provide and maintain data and metrics moving forward.

1. **ALS Upgrades**- total number of BLS eligible dispatched calls which result in a request for an ALS intercept.
2. **BLS Unit Hour Deployment**- The total number of BLS unit hours deployed vs. the total number of unit hours deployed.
3. **BLS Capture Rate**- The total number of BLS eligible incidents dispatched and the total number of BLS eligible calls receiving a BLS ambulance.
4. **ALS Skills Utilization**- The percentage of calls responded to by an ALS ambulance which meet ALS criteria.
5. **Co-Responder Ride In**- The number of calls an ALS co-responder rode into the hospital with a BLS ambulance.

Communication

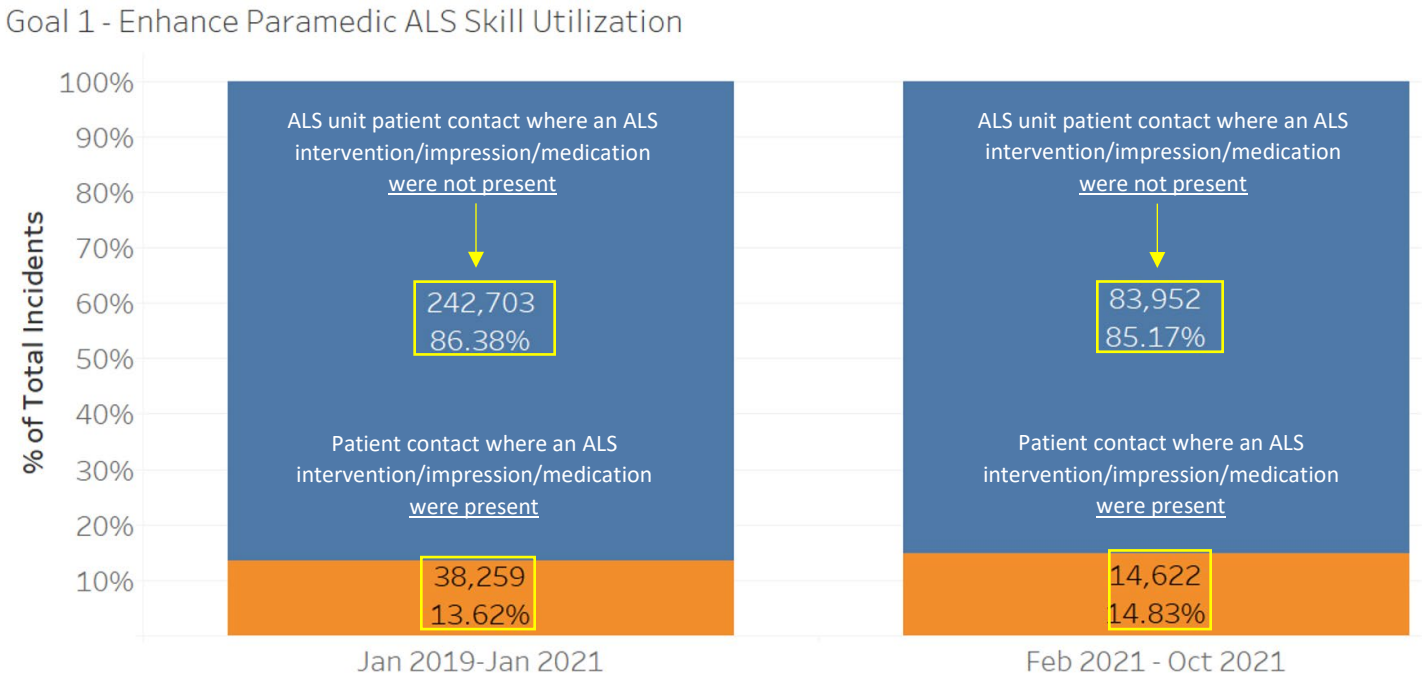
The initial BLS pilot project was discussed and developed at the System Performance Committee. First Responder Advisory Board and Emergency Physician's Advisory Board input was then gathered, and then it was submitted to the MAEMSA Board of Directors for review and approval. This document has followed the same process.

It is understood that BLS deployment is permitted by the Interlocal agreement, but it is a new service line available to the cities 911 markets. To assure the program is communicated to the member cities, with approval of the program from the MAEMSA Board the program details will be presented to the member jurisdiction's City Managers in collaboration with the leadership of the first response agency for that city.

Appendix 1: Tiered Ambulance Deployment Pilot Goals and Evaluation

Goal – Enhance Paramedic ALS Skill Utilization

- Measure
  - % Of calls assigned to an ALS unit that result in an ALS intervention
    - Cohort 1: % of ALS unit patient contacts that resulted in an ALS intervention post-implementation
    - Control group: % of ALS unit patient contacts that resulted in an ALS intervention Pre-implementation



Goal - Increase staffed ambulance unit hours available for 9-1-1 response

- Measure
  - Number of staffed ambulance Unit Hours (UH) available for 9-1-1 response
    - Cohort 1: Number of staffed 9-1-1 ambulance UHs post-implementation
    - Control Group: Number of staffed 9-1-1 ambulance UHs pre-implementation

Unit Hours Produced:

May '20 - Jan '21 (9 months (276 days)) 194,724, average per day = 705.5

Feb - Oct '21 (9 months (269 days)) 204,041, average per day = 747.4 (**5.9% increase**)

Aug - Oct '21 (3 months (92 days)) 70,128, average per day = 762.3 (**8.0% increase**)

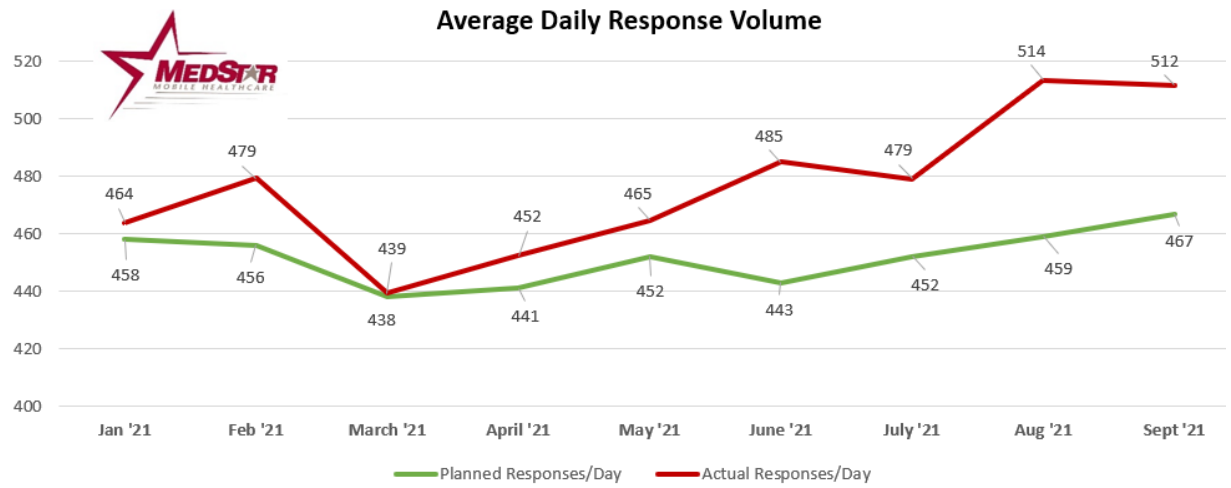
Goal - Reduce or maintain overall ambulance response times

- Measure
  - Cohort 1: System-Wide average and fractile response times for P1, P2 and P3 calls post-implementation
  - Control Group: System-Wide average and fractile response times for P1, P2 and P3 calls pre-implementation

	P1		P2		P3				
	Avg	**%**	**Avg**	**85%**	**Avg**	**85%**			
Apr '20	8:33	83.8%	9:22	88.9%	10:55	92.2%			
May '20	8:59	80.1%	9:50	85.4%	11:24	89.0%			
Jun '20	9:10	78.1%	10:02	83.7%	11:40	87.0%			
Jul '20	9:17	76.8%	10:29	80.1%	12:33	82.3%			
Aug '20	9:05	78.0%	10:03	83.2%	11:51	85.6%			
Sep '20	8:39	83.0%	9:30	86.9%	11:21	88.5%			
Oct '20	9:11	77.0%	10:17	81.7%	12:15	83.6%			
Nov '20	9:09	76.9%	9:57	83.5%	12:12	84.0%			
Dec '20	9:31	73.1%	10:42	77.1%	13:20	77.6%			
Jan '21	9:27	73.4%	10:42	77.8%	13:05	79.8%			
Overall	**9:06**	**78.0%**	**10:05**	**82.8%**	**12:03**	**85.0%**			
Feb '21	11:38	77.9%	13:05	83.6%	16:17	84.1%	*(Not included in the analysis)*		
Mar '21	9:23	75.5%	10:17	81.6%	12:18	83.4%			
Apr '21	9:27	75.2%	10:20	80.9%	12:37	81.6%			
May '21	9:06	77.4%	9:53	82.7%	11:44	84.7%			
Jun '21	8:52	78.0%	9:50	82.4%	12:06	82.6%			
Jul '21	8:11	83.2%	9:11	86.7%	11:19	86.3%			
Aug '21	9:19	74.0%	10:05	79.7%	12:49	79.0%			
Sep '21	9:33	72.4%	10:26	77.3%	13:04	77.3%			
Oct '21	8:51	78.4%	9:36	83.7%	10:58	86.3%			
Nov '21	8:22	83.5%	9:01	87.3%	10:25	89.7%			
Overall	**9:03**	**77.6%**	**9:56**	**82.6%**	**12:08**	**83.5%**			
Change	**0:03**	**-0.47%**	**0:09**	**-0.24%**	**0:05**	**-1.46%**			

Notes:

- *February 2021 not included in the analysis due to Winter Storm Uri response volume and weather conditions anomaly.*
- *August '21 response volume at record level w/average of 514 responses/day vs. 459 planned.*



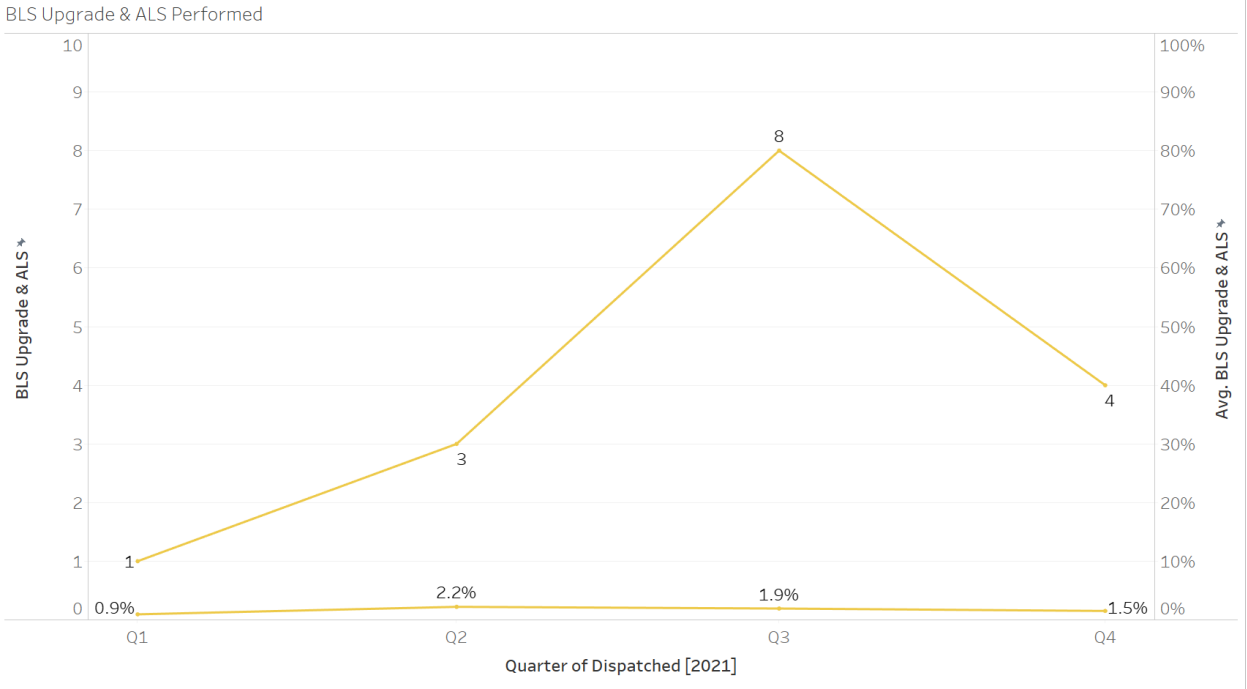
Goal - Reduce overall unit hour expense

- Measure
  - Cohort 1: Average operational cost per unit hour post-implementation (*field ops, comm, fleet, logistics costs*)
  - Control Group: Average operational cost per unit hour pre-implementation (*field ops, comms, fleet, logistics costs*)
  - Note that these costs below compare the costs of a BLS unit hour to an ALS unit hour. Due to increases in demand more unit hours have been added. The table below displays the cost savings achieved by increasing BLS unit hours rather than increasing ALS unit hours. This does not account for additional training costs associated with advanced credentialing or benefit costs.

	Avg. Hrly	Regular Hour Equivalents	Annual Salary	Annual Hours	Weighted		ALS UH Cost	BLS UH Cost	Savings Per UH	Staffed BLS UH Feb - Oct 2021	Total UH Savings
Advanced	$ 25.99	2,288	$ 59,465.12	2,184	$ 27.23		$ 46.13	$ 37.80	$ 8.33	9,215.56	**$ 76,752.45**
Basic	$ 18.04	2,288	$ 41,275.52	2,184	$ 18.90						

Goal – Dispatched response level accuracy

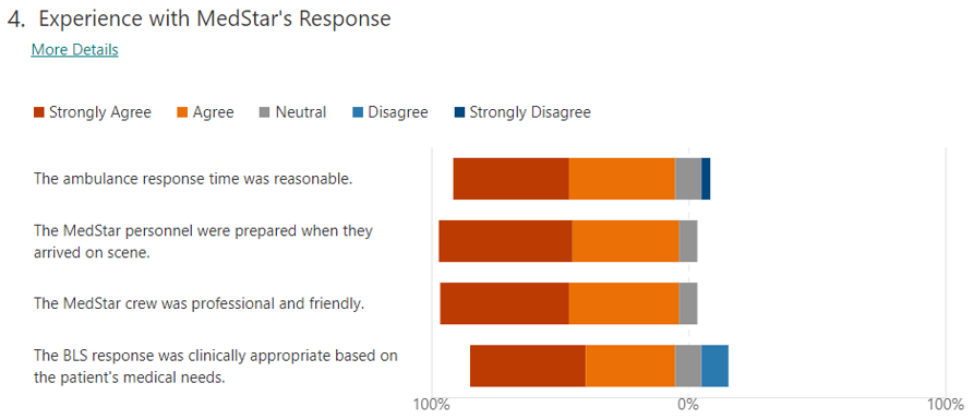
- Measure
    - # and % of 9-1-1 calls dispatched to a BLS ambulance that resulted in an ALS unit response request *AND* resulted in an ALS intervention
    - # and % of calls in which an ALS first responder was required to ride-in with the patient due to a BLS unit on scene and an ALS first responder-initiated ALS care



Goal – Provider Experience

The Tiered System Response Task force will develop a brief experiential survey that will be provided to the lead EMS official in each member jurisdiction, along with a report detailing the date, time and address for every call receiving a BLS response and transport. The EMS Lead will determine which of the agency's personnel were assigned to the BLS call for feedback.

Co-Response Agency Surveys *(29 responses)*

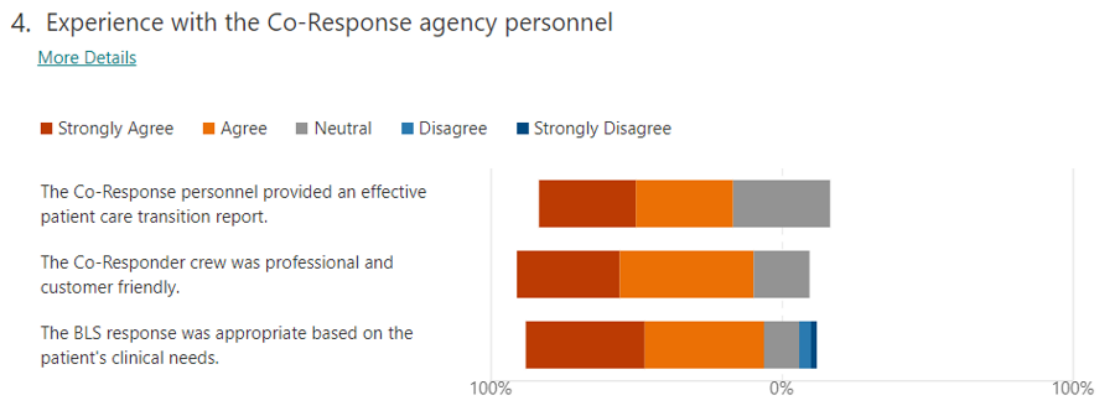


Co-Responder Comments Submitted:

- Medstar's crew was great as always. Carrington Steward's crew is always awesome to work with!
- Worked well for an MVA with no injuries.
- "The crew did a great job. Thank you for all that you do.
  Sgt. A. Sheehan, EMT-P, Westover Hills Police Department"
- Everything went well.
- ALS ambulance was requested due to the high velocity head on impact and due to the patient's condition. This ALS unit was requested by the MedStar EMT on scene.
    - *NOTE: Does not appear any ALS was administered to either of the two patients during this response. 2nd ambulance was requested. Sent to OMD and Comms Center Manager for QA review*
- This was a welfare check called in by the residents Doctor's office. The resident was not home and no care administered.
- Good crew!
- We had 2 ambulances respond and arrive on scene at the same time from 2 different directions.
    - BLS unit did not have same dispatch call note info as Q472 and the ALS unit.
    - It was a child seizure.

    - Obviously, the child patient went with the ALS Medstar unit to hospital.
    - Q472 crew was confused on why 2 ambulances responded, other than that issue they were quick response and no complaints.
- On this call we got both an ALS unit and a BLS unit.
    - They arrived simultaneously, but this was an ALS call so the ALS unit cared for and transported the patient.
- The response time was longer than normal.
    - The injuries to the Pt. were minimal and suitable for the crew arriving.
    - FRO's will probably need to give dispatch better updates while on-scene to assist in determining if the BLS response is appropriate.
- No ALS needed on this call. Crew was very friendly and cooperative.

MedStar Crew Surveys – (51 completed)



MedStar Survey Response Comments:

- This call was exactly what the BLS units need to be responding to so that ALS trucks aren't tied up on calls like this.
- Good job by all parties.
- P3 psych, no FD, no staging, PD arrived and stayed till we transported.
- Patient was transported safely without other interventions for the care he needed.
- Call was check on the welfare and the patient was not home. All units cleared. No patient contact.

- I love the idea of 911 BLS. I think it's a great way to help out our community get the appropriate health care by keeping the ALS units available for calls that require more ALS interventions. I think an EMT-B at Medstar has had the appropriate training by our amazing OMD team to handle BLS calls. I also think it's a great way to help with staffing.
- FD was on scene flushing eyes, patient symptoms resolved enough that mother refused any further care from EMS, we took the refusal as transport unit. Resupplied FD to be available. Worked and communicated well!
- FRO OS provide vitals and info to help expedite clearing.
- Went very well fire assisted with movement of patient and transported in a timely manner. ALS was put on the ticket but canceled on scene due to patient being stable.
- No one complained of any pain, it was 100% BLS. Love the idea of 911 BLS.
- I believe it will be a good system, less busy when there are more trucks at once.
- I think the BLS response was appropriate.
- Great working with BFD, no ALS interventions required, Paramedic on scene.
- Medstar was first on scene, gathered scene size up and responded to dispatch with 3 green PTs and no additional resources needed. Fort Worth Fire assisted with blocking traffic and obtaining 1 RAS while Medstar obtained 2 AMAs.
- 1 AMA and 1 RAS we arrived 1st and assessed patient priority. Fire did come and ask if we needed help.
- We were able to treat the patient and complete documentation prior to departure but although the call did not require the need for ALS intervention it would have been preferable for stronger pain management options due to the patient being noticeably in severe pain
- It was a 3rd party call regarding an unknown/possible person inside of a bedsheet near the train tracks. Nothing was found by either M558 or E04, neither crew made personal contact, and cleared by dispatch, False Call.
- Highway MVC with three 'green' patients. Call ran smoothly with FWFD and FWPD assist, M559 transported two patients with minor injuries, no ALS intercept was needed. BLS response seemed appropriate.
- This was very appropriate for a BLS response.
- This patient was initially hypertensive in the 210s with a head injury. We considered ALS, then canceled it and transported when the BP came down.

- The chief complaint from what I remember was nausea, vomiting, & dizziness. Due to that and the age of the patient I don't believe that the BLS unit should have been placed on the call at all. The PT ended up getting IV fluids, IV meds, & a 12 lead was done.

BLS Response Report Summary - BLS Eligible Determinants				
Through:	**10/31/2021**			
**BLS Response Determinants w/BLS Unit Response*				
Determinant	**Responses**	**Patients Assessed**	**Transports**	**Transport Ratio**
01A03 - Abdominal Pain / Problems - P3	10	8	7	70.0%
04B01 - A - Assault - Assault - P2	69	60	33	47.8%
04B03 - A - Assault / Sexual Assault / Stun Gun - Assault - P2	10	9	7	70.0%
04D05 - A - Assault - Assault - P1	14	12	6	42.9%
05A01 - Back Pain (Non-Traumatic or Non-Recent Trauma) - P3	6	6	6	100.0%
16A01 - Eye Problems / Injuries - P3	4	4	3	75.0%
20B02 - H - Heat / Cold Exposure - Heat exposure - P2	24	11	5	20.8%
20O01 - H - Heat exposure - Heat exposure - P3	4	2	1	25.0%
23B01 - Overdose/Poisoning/Ingestion	1	1	1	100.0%
24B02 - Pregnancy/Childbirth/Miscarriage	0	0	0	
24C03 - Pregnancy/Childbirth/Miscarriage	2	2	2	100.0%
24D03 - Pregnancy/Childbirth/Miscarriage	3	3	3	100.0%
25A02 - Psychiatric / Abnormal Behavior / Suicide Attempt - P3	20	18	13	65.0%
25B03 - Psychiatric / Abnormal Behavior / Suicide Attempt - P2	50	40	37	74.0%
25O01 - Psychiatric / Abnormal Behavior / Suicide Attempt - P3	36	33	27	75.0%
25O02 - Psychiatric / Abnormal Behavior / Suicide Attempt - P3	28	25	23	82.1%
26A06 - Sick Person (Specific Diagnosis) - P3	14	12	10	71.4%
26A10 - Sick Person (Specific Diagnosis) - P3	68	54	43	63.2%
26C02 - C - Sick Person (Specific Diagnosis) - Suspected coronavirus illness - P2	23	20	12	52.2%
26O28 - Sick Person (Specific Diagnosis) - P3	13	12	12	92.3%
29A02 - V - Traffic Collision / Transportation Incident - Multiple patients - P3	60	21	13	21.7%
29B01 - V - Vehicle vs. vehicle - Multiple patients - P2	271	141	88	32.5%
29B02 - V - Vehicle vs. vehicle - Multiple patients - P2	4	1	1	25.0%
29B03 - V - Vehicle vs. vehicle - Multiple patients - P2	56	18	9	16.1%
29B05 - Traffic Collision / Transportation Incident - P2	322	116	82	25.5%
32B03 - Unknown Problem (Person Down) - P2	109	37	16	14.7%
Total	**1221**	**666**	**460**	**37.7%**

BLS Unit Responses By Member Jurisdiction

CAD Data - BLS Unit Responded

As of: 10/31/2021

Member City	BLS Unit Responses	BLS Unit to BLS EMD
Blue Mound	3	1
Burleson	29	9
Edgecliff Village	2	0
Forest Hill	16	4
Fort Worth	1822	637
Haltom City	28	5
Haslet	1	1
Lake Worth	8	3
River Oaks	1	0
Saginaw	3	0
Westworth Village	1	0
White Settlement	8	1
Other	42	29
Blank	4	26
Total	**1965**	**715**

Appendix 2 Proposed BLS EMD Codes

Current and Proposed	EMD Determinant	Incidents	Patients	% of Total Calls	Transported?	L&S?	ALS Incident %	Critical Incident %	Vital Incident %	Expected BLS Fallout	BLS Assigned First on Call?	Avg. BLS Upgrade?
Current Code	4B01	1,384	1,457	0.9%	41.7%	3.1%	3.0%	0.0%	2.7%	5.1%	69	4.2%
	4D05	148	200	0.1%	23.5%	2.8%	2.0%	0.0%	4.7%	6.1%	9	10.0%
	16A01	86	89	0.1%	44.3%	5.1%	3.5%	0.0%	0.0%	3.5%	4	0.0%
	25A02	373	378	0.2%	65.3%	0.4%	2.1%	0.0%	1.9%	3.5%	19	10.0%
	25B03	1,473	1,490	1.0%	56.2%	2.6%	2.6%	0.2%	2.2%	4.2%	57	3.5%
	25O01	572	590	0.4%	69.0%	0.7%	2.3%	0.2%	1.0%	3.3%	31	12.9%
	25O02	325	331	0.2%	76.7%	1.2%	1.8%	0.0%	1.8%	3.7%	30	3.2%
	26O28	130	134	0.1%	81.1%	0.9%	1.5%	0.0%	4.6%	5.4%	13	0.0%
	29A02	757	1,354	0.5%	24.3%	2.1%	1.6%	0.1%	1.5%	2.9%	40	19.5%
	29B01	3,194	5,646	2.1%	35.1%	3.8%	3.8%	0.1%	2.3%	5.7%	173	7.4%
	29B05	5,232	8,349	3.5%	24.7%	5.4%	3.0%	0.2%	1.9%	4.3%	243	9.2%
Remove Code	20B02	214	222	0.1%	44.7%	2.1%	4.7%	0.0%	6.1%	8.9%	23	8.7%
	23B01	289	292	0.2%	74.4%	2.4%	2.1%	0.3%	5.9%	7.6%	1	0.0%
	26A06	147	154	0.1%	75.0%	0.9%	4.1%	0.0%	8.2%	10.9%	16	12.5%
	29B03	694	1,266	0.5%	36.4%	4.4%	5.6%	0.3%	2.4%	7.5%	35	13.9%
	32B03	1,827	1,873	1.2%	23.3%	2.1%	3.6%	1.4%	2.2%	5.1%	114	11.1%
New Code	3B03	84	87	0.1%	38.4%	0.0%	4.8%	0.0%	3.6%	6.0%	0	
	4A02	74	74	0.0%	44.4%	3.1%	2.7%	0.0%	4.1%	6.8%	0	
	4A03	105	108	0.1%	66.4%	0.0%	1.0%	0.0%	1.9%	2.9%	2	0.0%
	4B03	1,527	1,642	1.0%	38.6%	2.5%	3.8%	0.3%	2.6%	5.6%	14	0.0%
	4D04	126	130	0.1%	58.7%	8.1%	4.8%	0.0%	1.6%	6.3%	3	0.0%
	4O01	50	50	0.0%	54.0%	3.7%	2.0%	0.0%	4.0%	6.0%	0	
	13A01	218	230	0.1%	63.0%	0.7%	4.6%	0.0%	4.1%	8.3%	1	0.0%
	18B01	132	139	0.1%	64.9%	2.3%	2.3%	0.0%	3.0%	4.5%	3	33.3%
	18O01	158	168	0.1%	66.3%	0.9%	3.8%	0.0%	3.8%	7.6%	1	0.0%
	20A01	60	65	0.0%	50.8%	3.1%	3.3%	0.0%	5.0%	8.3%	2	0.0%
	20O01	139	146	0.1%	57.3%	1.2%	2.9%	0.0%	4.3%	6.5%	3	33.3%
	21A02	54	56	0.0%	53.7%	3.4%	1.9%	0.0%	1.9%	3.7%	0	
	21O03	62	63	0.0%	56.5%	2.9%	4.8%	0.0%	3.2%	8.1%	0	
	23C05	97	101	0.1%	63.9%	1.6%	3.1%	1.0%	4.1%	6.2%	2	50.0%
	24B01	109	112	0.1%	90.0%	9.1%	0.0%	0.0%	1.8%	1.8%	1	0.0%
	24B02	102	107	0.1%	70.9%	4.1%	2.0%	0.0%	2.0%	3.9%	0	
	24C01	55	60	0.0%	89.5%	3.9%	1.8%	0.0%	1.8%	3.6%	0	
	24C03	142	146	0.1%	89.5%	0.0%	4.9%	0.7%	3.5%	8.5%	1	0.0%
	24D03	319	334	0.2%	91.6%	7.8%	1.9%	0.3%	4.7%	6.3%	2	0.0%
	24D04	51	53	0.0%	92.3%	6.3%	2.0%	0.0%	3.9%	3.9%	0	
	26A01	70	75	0.0%	67.6%	0.0%	4.3%	0.0%	2.9%	7.1%	0	
	26A08	2,083	2,193	1.4%	77.7%	1.3%	4.8%	0.0%	3.6%	7.9%	37	17.5%
	26A10	4,277	4,495	2.8%	58.8%	2.0%	3.8%	0.2%	4.9%	7.9%	77	6.0%
	26O06	60	61	0.0%	77.0%	0.0%	0.0%	0.0%	5.0%	5.0%	2	0.0%
	28C08	52	53	0.0%	81.1%	2.3%	1.9%	0.0%	1.9%	3.8%	0	
	29O01	135	237	0.1%	29.7%	0.0%	0.7%	0.0%	2.2%	3.0%	7	22.2%
	30O02	118	125	0.1%	74.8%	1.1%	4.2%	0.0%	0.8%	5.1%	2	0.0%
	32B01	189	195	0.1%	37.8%	0.0%	2.1%	0.5%	2.6%	4.2%	4	0.0%
	32B02	52	52	0.0%	17.3%	11.1%	1.9%	0.0%	3.8%	3.8%	0	
	33A03	1,488	1,552	1.0%	91.7%	0.9%	2.1%	0.1%	5.0%	6.8%	12	0.0%
Grand Total		**25,862**	**32,927**	**17.1%**	**48.3%**	**2.5%**	**3.3%**	**0.2%**	**3.0%**	**5.8%**	**1,052**	**8.8%**

Appendix 3 Performance Standards

Adopted by Board of Directors 12-14-16

Metropolitan Area EMS Authority

Recommended EMS System Performance Measures

Background: The Metropolitan Area EMS Authority (MAEMSA) sets operational and clinical performance measures for the emergency medical services system operating in the jurisdictions that are part of the MAEMSA. As part of the performance measures adoption process, the MAEMSA established a System Performance Task Force (comprised of representatives of area First Responders, MedStar and the Office of the Medical Director) to continuously review system performance, advise the MAEMSA Board, and recommend system performance measures that are focused on patient outcomes.

The initial project undertaken by the Task force was to formulate recommended ambulance response time goals. Additional system performance measures will be added over time. For 2017, through the QA/QI process, the Office of the Medical Director will be focusing on outcomes in cases involving cardiac arrests, airway management, and patient refusals and releases. The determination of ambulance response priorities will be reviewed by the Office of the Medical Director, based on the clinical effectiveness of time-sensitive responses and interventions.

PHASE ONE: **Initial Response Time Performance Measures Recommendations (Ambulance):** The Task Force collected and reviewed response time data from MAEMSA system participants, as well from numerous ambulance agencies across the country in developing these recommendations. The Task Force also agreed on several principles for response time performance measures:

- Measures should be from the perspective of the patient
- All EMS system response agencies should track and report response times
- Fractile response times will be used for system response time performance measure accountability
- Average response times should be reported for simplicity and understanding, with the goal of minimizing extended response times
- Extended response times should be minimized
  - Defined as 1 and ½ times the response time goal for the response mode (P1, P2, P3, P4)
  - Measured as a percentage to call volume with the goal not to exceed 1.5%
- Response Time for ambulances will be defined as:
  - Clock Start: "First Key Stroke"
    - The time at which the dispatch center responsible for dispatching response units to the scene of a medical response answers the incoming call
  - Clock Stop: "On-Scene"
    - Defined as vehicle wheel stop at the scene of the response
- All EMS responses will be measured using these definitions of clock start and stop

Additionally, the Task Force recommends that agencies promote the tracking and reporting of 'patient contact' times, defined as the time that the responding crew is able to initiate an assessment of the patient.

Ambulance Response Time Goals –

Response Mode	Response Time	Fractile Reliability	Extended Responses
Priority 1	11 Minutes	85%	1.5%
Priority 2	13 Minutes	85%	1.5%
Priority 3	17 Minutes	85%	1.5%
Priority 4	60 Minutes	85%	1.5%

Appendix 4: BLS Handoff Medical Directive

Medical Directive # 202109001
FOR IMMEDIATE DISTRIBUTION
Date 09/13/2021

OFFICE OF THE MEDICAL DIRECTOR
EMERGENCY PHYSICIANS ADVISORY BOARD

Medical Oversight for the MedStar System

Effective: 09/13/2021 Expiration:

Replaces Medical Directive #:

Subject: BLS Ambulance Transport Criteria

In the interest of patient safety and to streamline decision-making in BLS vs. ALS ambulance transport, a checklist has been created and added to the assessment section of ImageTrend documentation. This BLS Ambulance Transport Criteria form should be completed whenever a BLS Ambulance responds to a 911 patient.

When a BLS ambulance is the only ambulance responding to a 911 patient, the criteria will guide the Basic crew regarding when to request an ALS resource (ALS Ambulance, QRV, or ALS FRO). When a BLS ambulance co-responds with a QRV or ALS FRO, the BLS crew may complete the transport alone if the patient does not meet any of the criteria listed. System FRO providers may also utilize the form in the decision-making process for additional or alternate resources when responding with a BLS Ambulance.

With any handoff from an ALS resource to a BLS ambulance, both crews must agree with the decision and sign the ePCR in the appropriate locations. If a BLS ambulance requests an ALS resource using the criteria, the arriving ALS clinician should not attempt to hand the care back to the BLS ambulance.

In the rare instance that an ALS resource is requested and there is none available in a timely manner, the Communication Center will advise regarding transport to the closest appropriate facility.

The BLS Transport Criteria are listed below. Please reach out if there are any questions or concerns.

Veer D. Vithalani MD, FACEP, FAEMS
System Medical Director | Metropolitan Area EMS Authority
Chief Medical Officer | MedStar Mobile Healthcare

BLS Transport Criteria

BLS UNIT CANNOT TRANSPORT PATIENTS WITH ANY OF THE FOLLOWING:

- **Crashing patient**
  - *Provider impression of extremis, including new-onset altered mental status, airway issues, severe respiratory distress/failure, signs and symptoms of shock/poor perfusion, or imminent cardiac or respiratory arrest*
- Airway
  - Current or anticipated need for airway management
- Breathing
  - Respiratory failure or distress (RR < 8 or > 20)
  - Hypoxia (SpO2 < 94%) despite NRB (or higher)
- Circulation
  - Cardiac chest pain or anginal equivalent
  - EKG with ischemia or infarct
  - EKG with new or concerning dysrhythmia
  - Current or anticipated need for IV fluids, vasopressors, or other IV medication
  - Unstable bradycardia/tachycardia
  - Hypotension (SBP < 90)
- Disability
  - Acute change in mental status (GCS ≤ 13)
  - Positive stroke screen (or new neurologic deficit)
  - Seizure not returned to baseline or multiple seizures
  - Syncope
  - Acute Agitation
  - Severe intoxication/overdose
- Everything Else
  - Significant injuries or high mechanism trauma
  - Hypoglycemia with AMS
  - Hyperglycemia with AMS
  - Pediatric patients with a high-risk complaint (e.g., BRUE) or complex medical history
  - Basic Provider Clinical Concern
  - ALS Procedure Performed
    (not including IV placement or 12-lead EKG interpretation)
  - ALS Medication Administered

MAEMSA
BOARD COMMUNICATION

Date: 02.23.2022	**Reference #:** BC-1503	**Title:** Medical Director Search Process

RECOMMENDATION:

It is recommended that the Board of Directors review, revise, and adopt a proceess for selecting a new Medical Director.

DISCUSSION:

N/A

FINANCING:

N/A

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

BOARD POLICY

SELECTION OF CHIEF MEDICAL OFFICER / SYSTEM MEDICAL DIRECTOR

Whereas, Section 2.9 of the Restated and Amended Interlocal Cooperative Agreement (2020) requires that the Board establish written protocols and procedures for the hiring, employment, direction and discharge of Executive Personnel, the Board adopts the following policy regarding the selection of a Chief Medical Officer / System Medical Director ("Medical Director").

I. BACKGROUND.

Section 2.9.3 of the Restated and Amended Interlocal Cooperative Agreement ("ICA") provides that the Medical Director shall:

1. (i) be hired by a majority affirmative vote of the Board.
2. (ii) be the independent medical director for the System, in accordance with state law, and as further set forth in Article VII;
3. (iii) if an employee of Authority, hire, employ, direct, manage, and discharge employees who report to the Medical Director and assist the Medical Director in the performance of his or her duties, and ensure all such employees follow the written policies, rules, and procedures applicable to all Authority employees as set forth or approved by the Board; if a contractor of Authority, the Board shall, for the purpose of independent medical direction, ensure that the employees of the OMD report directly to the Board through an alternate structure adopted by the Board, and do not report to the Chief Executive Officer of the Authority; and
4. (iv) perform other duties as assigned by the Board.

II. SELECTION PROCESS

Whenever there is a need to select a new Medical Director, the following process will be initiated. When there is advance notice of a vacancy, such as a planned retirement, the Board may initiate the selection process prior to the expected date of the opening, with the goal of having a new Medical Director in place on or soon after the date the position becomes open.

A. Recruiting Committee: The Board shall appoint a Recruiting Committee to work with Human Resources to oversee and direct the selection process. Members of the Recruiting Committee shall be nominated by the Chair and shall include the Chair (or the Chair's Designee), the Fort Worth Fire Chief (or at the Fort Worth Chief's option, the other FRAB representative on the Board), one EPAB appointee member (who shall chair the Recruiting Committee), and one additional Member Jurisdiction-appointed Board member. The Recruiting Committee will establish the timeline for process milestones, in consultation with the Human Resources Manager. The Committee shall make regular reports to the entire Board and keep stakeholders apprised of its progress. The General Counsel shall be the staff liaison for the Recruiting Committee and will oversee the

process internally on behalf of the Board with the assistance of the Chief Human Resources Officer.

B. Outside Recruiting Services: The Board may, in its discretion, retain the services of an executive search firm or other consultants to perform any or all of the tasks set forth in paragraphs C, D, E, G and I below, in coordination with the Recruiting Committee and either in place of or in coordination with Human Resources.

C. Job Description and Salary: Human Resources will develop a job description for the Medical Director position, which must be approved by the Board. Human Resources and the Chief Financial Officer shall also recommend a salary range and benefit package to the Board, based on industry research. Any amendments to the job description or departure from the approved salary range and benefits must be approved by the Board before or at the time a contract has been negotiated with the final candidate.

D. Recruitment of Candidates: Human Resources will distribute notice of the job opening to industry publications, bulletin boards, blogs, and other job posting sites. The opening shall also be posted on the MedStar Mobile Healthcare website.

E. Screening of Candidates: Human Resources will screen applicants for those meeting the minimum qualifications for the Medical Director position and for employment eligibility (credit checks, exclusion from government healthcare programs, background checks, etc.). Human Resources may also qualify candidates who may not meet all the minimum requirements but have exceptional experience or expertise (if such a candidate becomes the finalist, the minimum qualification would need to be amended to reflect the finalist's experience and expertise).

F. Preliminary Screening Panel: The Recruiting Committee shall serve as a preliminary screening panel ("Panel") to narrow the field of candidates for preliminary interviews and/or to participate in preliminary interviews of candidates. At least three Recruiting Committee members shall participate in each interview. The Committee may also invite MedStar employees and other stakeholders, including members of EPAB and or FRAB who are not Authority Board Members to serve on the Panel or otherwise assist in the preliminary screening of candidates and/or in the preliminary interviews. Such employees shall include the Chief Executive Officer and General Counsel and may include up to two other employee representatives selected by the Chief Human Resources Officer.

G. Screening for Interviews: When there are more than ten qualified candidates, the Panel will first review the applications and resumes of all qualified candidates. Each Panel member will select their ten most qualified candidates, after which the Panel will meet and jointly identify a final list of up to ten candidates for preliminary interviews.

H. Preliminary Interviews: The Panel shall interview up to ten candidates. Interviews may be conducted in person or by video conference. Candidates will be evaluated by each Panel member using a scoring and comment sheet developed by Human Resources or the outside search firm.

I. Selection of Finalists: After all interviews have been completed, Human Resources shall create a spreadsheet showing the individual and the aggregate scores received by each candidate and the comments of Panelists, but without identifying individual scorers or

commenters. The Recruiting Committee shall meet and review the scoring of candidates and Panelist's comments and shall then identify the most qualified candidates for consideration by the Board. In the event the Recruiting Committee determines there are less than three suitable candidates, the Committee shall report this fact to the Board and the Board shall decide whether to:

(1) proceed with only the candidates deemed suitable by the Recruiting Committee;
(2) direct the Committee to revisit the process to identify additional suitable candidates; or
(3) direct Human Resources or the search firm to take additional steps to enlarge the candidate pool.

J. Final Interviews and Selection by Board: Human Resources and the Recruiting Committee shall prepare a report for the Board at the conclusion of the Panel interviews, identifying the suitable candidates recommended for final interviews with the Board. The Board shall interview each finalist in person or by video conference using a scoring and comment sheet developed by Human Resources or the outside search firm. The Board shall discuss the interviews and, if it deems appropriate, select a final candidate by majority vote, subject to the negotiation of an acceptable contract and salary and benefits.

K. Contract of Employment: The General Counsel, in consultation with the Board Chair, Chief Financial Officer, and Human Resources Manager, shall negotiate a proposed contract with the candidate selected by the Board. Human Resources shall recommend the amount of salary based on industry standards and the candidate's expertise and experience. Upon Board approval of an employment contract and salary, the Board shall authorize the Chair to execute the contract.

Adopted by Board of Directors on _____.

Attest: _____

Dr. Janice A. Knebl
Secretary, Board of Directors
Metropolitan Area EMS Authority

MAEMSA
BOARD COMMUNICATION

Date: 02.23.2022	**Reference #:** BC-1504	**Title:** Approval of Medical Director Job Description

RECOMMENDATION:

It is recommended that the Board approve the attached job description for the Chief Medical Officer/ System Medical Director with the changes indicated.

DISCUSSION:

N/A

FINANCING:

N/A

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

JOB TITLE: **Chief Medical Officer and Medical Director**
REPORTS TO: MAEMSA Board of Directors
DATE CREATED: 06/12/20
DATE REVISED: **N/A**

SUMMARY:
The mission and purpose of this position is to serve as the Chief Medical Officer for the Metropolitan Area EMS Authority ("Authority") and Medical Director for the Authority and the First Responders of the Authority's member jurisdictions (including the regulated prehospital emergency medical services, mobile integrated healthcare, medical transportation system, and any other medical services provided by the Authority or the Member Jurisdictions' First Responders, whether in or out of the service area; collectively, the "System"). As Chief Medical Officer, the employee participates in the Authority's executive team, provides oversight and direction for all of the Authority's clinical activities and programs; and directs and manages the Office of the Medical Director. As Medical Director, the employee provides medical direction and oversight, consultation, training, and education, for the System, including the participating First Responder Organizations (FROs). The Medical Director performs all duties required of EMS Medical Directors by the State of Texas and performs the duties set forth in the Interlocal Agreement between the Authority's member jurisdictions. This is a fulltime position.

SPECIAL NOTE: This job has been designated as **a Safety Sensitive Position** by the Authority. Public safety requires that the employee be able to perform all essential functions at the highest levels at all times. Therefore, this position is subject to frequent drug testing and requires reporting of all employee use of High Risk Medications identified by the Authority and certification from the employee's physician that such medications can be safely used while working. Because the System's ability to deliver emergency medical response depends on having a workforce that can be reliably scheduled, this job also requires regular and reliable attendance. This job requires focus, engagement, and high performance in responding to traumatic, emotionally charged, and life-threatening situations. A high level of physical, mental, and emotional health is an essential requirement.

ESSENTIAL FUNCTIONS:
- Work effectively and collaboratively as a member of the Authority's executive team.
- Work effectively and collaboratively with Authority member jurisdictions and FROs.
- Effectively and professionally represent the System in the community and with partners and customers.
- Provide all independent medical direction and function as the exclusive source of medical direction and oversight for the System.
- Maintain qualification as and perform duties required of EMS Medical Directors by the State of Texas (See 22 TX ADC § 197).
- Be available to System field personnel for medical consultation and direction on a 24-hour basis, either directly or through delegation to other qualified individuals, including through on-line medical directors as described in 22 TX ADC § 197.2
- Function as the Authority's Chief Medical Officer and advise its Board of Directors and executive team on clinical matters.
- Maintain current awareness of EMS developments on a local, state, and national level.
- Maintains appropriate physical and mental health required to perform the essential functions of this job.
- As a member of Leadership team, set proper example for subordinate employees to follow.

JOB DUTIES:

- Implement the Authority's mission of providing the highest quality customer service and clinical excellence in a fiscally responsible manner.
- Manage the Office of the Medical Director and hire, employ, direct, manage, and discharge employees who report to the Medical Director and assist the Medical Director in the performance of his or her duties, and ensure all such employees follow the written policies, rules, and procedures applicable to all Authority employees as set forth or approved by the Board.
- Direct and supervise any Associate Medical Directors.
- Participate in the Authority's budgeting process in consultation with EPAB and in coordination with the Authority's Executive Team; prepare and oversee the budget for the OMD.
- Attend MAEMSA and EPAB Board meetings and oversee the reporting of the Office of the Medical Director to those Boards.
- Collaborate with, and participate in, the System Performance Task Force
- Recommend to the Authority medically appropriate performance measures and standards for the Service Area, including but not limited to standards for equipment on System vehicles
- Provide direct prehospital patient care, as appropriate.
- Maintain clinical skills and field employee interaction by providing clinical services to local hospitals, as appropriate.
- Participate in MAEMSA's Executive Team and collaborate with all MAEMSA departments.
- Establish patient care standards for all medical services provided by the System
- Develop Medical Protocols for the System and revise the same as appropriate.
- Provide necessary training to System personnel regarding the Medical Protocols.
- Develop and periodically revise and administer both written and practical tests for the credentialing of System personnel.
- Provide training for purposes of credentialing, and credential qualified personnel in the System.
- Develop, implement, and monitor the effectiveness of continuing education (CE) programs for the System.
- Develop, direct, and conduct the System's quality assurance and medical review programs of the delivery of medical transportation, MIH, and prehospital emergency medical service and review individual cases as appropriate.
- Represent the System regarding clinical issues at meetings and functions with community partners and other healthcare providers.
- To the extent feasible, in coordination and collaboration with the participating organization's administration, develop, implement, and oversee an organized, ongoing program of EMS research to improve the System and contribute to the EMS knowledge base.
- Provide Medical Direction & Oversight to the Authority's EMS Communication Center, including quality assurance and protocol review
- Provide Medical Direction to the System's clinical education and training programs
- Monitor the clinical performance of the System
- Approve standards governing the operation of Specialized Mobile Intensive Care units within the System, including standards limiting the types of patients which may be transported thereby
- Approve standards governing the operation of Aeromedical Transportation Units within the System, including standards defining the circumstances under which such units may be deployed to emergency scenes
- Conduct inspections of System vehicles, equipment, and supplies
- Maintain responsibility for all aspects of the operation of the System concerning provision of medical care
- Function as the primary liaison between the System and the local medical community
- Perform other duties as described in State law pertaining to EMS Medical Director, including but not limited to:
    - Suspending a certified EMS individual from medical care duties for due cause pending review and evaluation;
    - Establishing the circumstances under which a patient might not be transported;

- Establishing the circumstances under which a patient may be transported against his or her will in accordance with state law, including approval of appropriate procedures, forms, and a review process
- Establishing criteria for selection of a patient's destination;

- Perform other duties as assigned by the Authority's Board of Directors
- Perform other duties as described in the Restated and Amended Interlocal Cooperative Agreement

WORKING CONDITIONS:

Routinely:

- An air-conditioned office environment.

Occasionally:

- Confined areas, extreme hot and cold, wet and/or humid conditions, noise, vibration, mechanical and electrical equipment, moving objects, high places, fumes/odors/mists, dirt and dust, gasses, toxic conditions, human excrement, blood, urine, mucous, tissue. Frequently works alone, with and around others, face-to-face and verbal contact, inside and outside temperature changes. Work hours may vary due to office needs.

PHYSICAL DEMANDS:

Typing (30 wpm), climbing, balancing, kneeling, stooping, bending, leaning, upper and lower body flexibility, running distance, driving ambulance, car or truck, multiple physical activities performed at the same time (driving, talking and seeing). Constantly seeing. Frequently hearing/listening, clear speech, touching, walking inside and outside, sitting.

MINIMUM REQUIREMENTS:

- Graduation from an accredited School of Medicine
- Board Certification in Emergency Medicine
- Experience in Medical Direction & oversight of EMS programs
- Possession of a current, unrestricted license to practice medicine in the State of Texas
- Understanding of Emergency Medical Services operations
- Excellent communication/presentation skills
- Valid Texas driver's license

PREFERRED REQUIREMENTS:

- Board Certification in Emergency Medical Services
- Demonstrated experience in quality assurance, research and quantitative data analysis.
- Experience in EMS program design & management.

Tab A – Chief Executive Officer

Metropolitan Area EMS Authority dba MedStar Mobile Healthcare

Chief Executive Officer's Report- January 31, 2021

Reprioritization- We are evaluating the current response plans for the system with the EMS system performance committee. The objective of this analysis is to define the subset of patients in the 911 system that are experiencing time sensitive emergencies while also triaging those complaints with a low risk of having a time sensitive compliant.

With effective triage and classification of these calls one objective of this analysis will be to define what apparatus are necessary to respond to what conditions to provide the most effective and efficient utilization of system resources. For example, time sensitive, life-threatening conditions typically require more healthcare providers so they would likely benefit from both a first responder organization and an ambulance while those with conditions representing a low likelihood of time sensitive, life threatening conditions may require only an ambulance response or, in cases such as minor motor vehicle accidents, a FRO response since they already have to respond.

With this analysis it has also been requested that the response time goals be evaluated as some systems tout a 90% fractile response whereas MedStar utilizes an 85% fractile response. There are many variables that come into play with response time standards such as what, if any, calls may be excluded from response time compliance, when are clock start and stop times, what time standard is utilized, and are calls grouped into priorities, just to name a few.

Finally, as we discuss how emergency medical dispatch codes are analyzed and prioritized we are also going to be discussing the appropriate type of ambulance response for each priority. There are several studies that indicate red lights and sirens may be unnecessary for a large percentage of 911 calls because they may put both the public and emergency responders at greater risk of harm without a corresponding benefit in patient outcome.

While we feel the above topics are relevant and deserve attention and discussion we also understand that some first response agencies provide service in cities where the FROs understand there to be an expectation as to what calls they respond to and how they respond. This initiative is not intended to override the inherent ability of each member city to elect to respond to any or all calls in their city in any way they feel is necessary. The intent is to better define those complaints with a higher correlation between improved outcomes and faster response thereby benefiting the patient and potentially increasing the efficiency and effectiveness of the MAEMSA system for those agencies interested in participating in these changes.

Communications- Our communications leadership continues to make improvements in performance. Our communications leadership team has continued to improve ring to answer times, as you will see in the operations section, while also assuring the adequacy of call gathering information.

This team has also been verifying the accuracy of the response plans for each municipality as well as response plans that integrate the tier response plans.

Burleson's Departure- Official notification was received from the Burleson City Manager that Burleson will withdraw from the MAEMSA system October 1, 2023. We received a couple inquiries from other member cities about what this means for MAEMSA and whether MAEMSA would be sending something

out in response to the notification. A document was e-mailed to the member cities on Friday February 11, 2022 stating that MAEMSA did not anticipate having any reductions as growth should replace the Burleson volume. The correspondence also confirmed that we would continue providing service to Burleson through the date they leave the MAEMSA system.

Fort Worth Study- Fort Worth will be using a consulting firm from California called City Gate. We have been working with Fort Worth's data analytics team to help them aggregate and analyze the data, and we look forward to working with City Gate as they work through their study.

HRIS/ADP- We are continuing to implement the ADP system. Their native scheduling module has some challenges that will probably not make it useful. Instead we are looking at a replacement module ADP has found for us. This change has slowed this this phase of the ADP implementation, but we are hopeful we will soon be back on schedule as it will remove additional manual steps in the payroll process. Overall, the implementation has been slow and painstaking, but once it is set up it does seem to help streamline some of our internal processes.

Billing/EMS|MC- The billing project continues to advance. EMS|MC started billing on December 1, 2021. Due to the nature of EMS billing and the lag in collection data it is still too early to evaluate the outcome. An early indication is payor mix data, and we have been working with EMS|MC to identify processes that will help to pull up some initially low payor mix numbers. The EMS|MC team has been open to feedback and they have implemented some process changes to identify insurance earlier in their process. We are hopeful that these changes will help to drive better collections.

Incentive Committee- We sent an e-mail out to the organization looking for individuals interested in proposing a program to replace the annual incentive program. The task force will propose the frequency with which the objectives will be evaluated, what measures will be evaluated, and how incentive amounts should be calculated. The proposal will then be submitted to the executive team and then submitted to the MAEMSA Board of Directors for review and discussion.

Strategic Planning- An e-mail was sent out to Board members and the management team about dates for strategic planning. We have found a facilitator and intend on hosting this at Rough Creek for an afternoon and morning session. We are also open to members of member city leadership that are interested in attending as it is important that we continue to provide value and implement positive change that benefits our patients, healthcare systems, and our member cities.

Tab B –Office of the Medical Director

Discussion

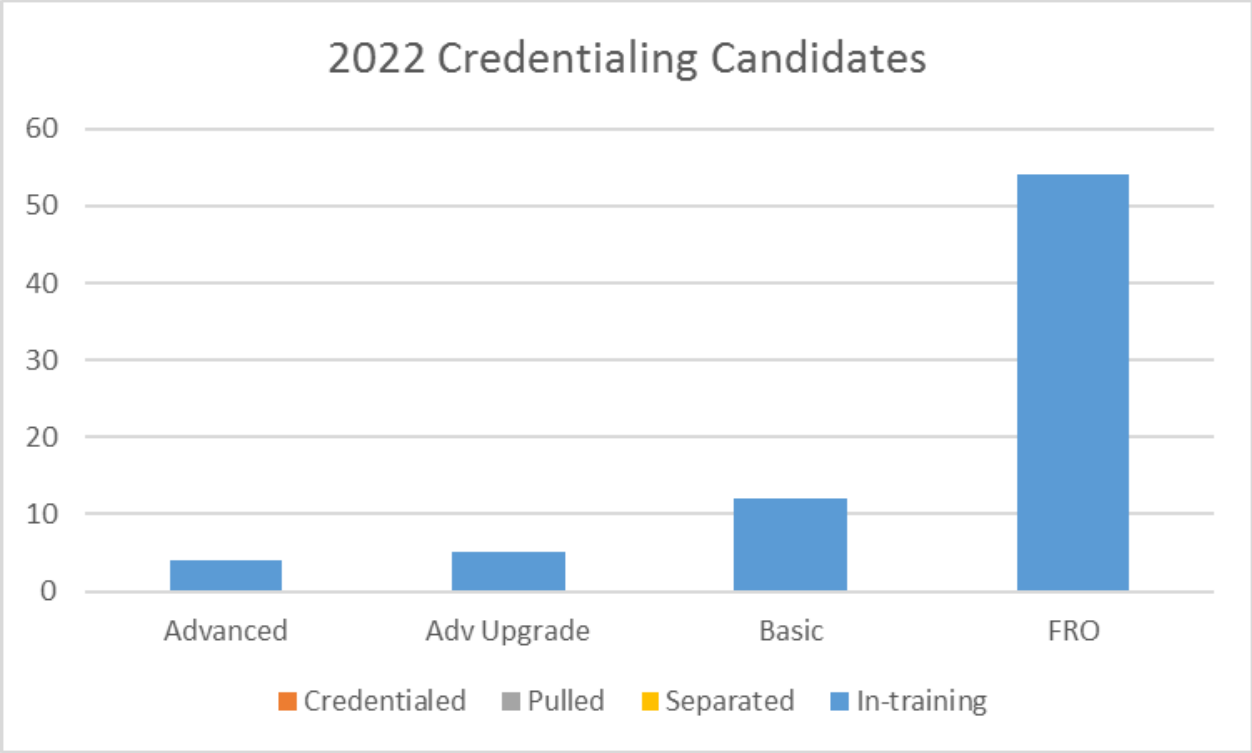
- ET3
- Credentialing Committee
- System Education Committee
- ECPR Center Project

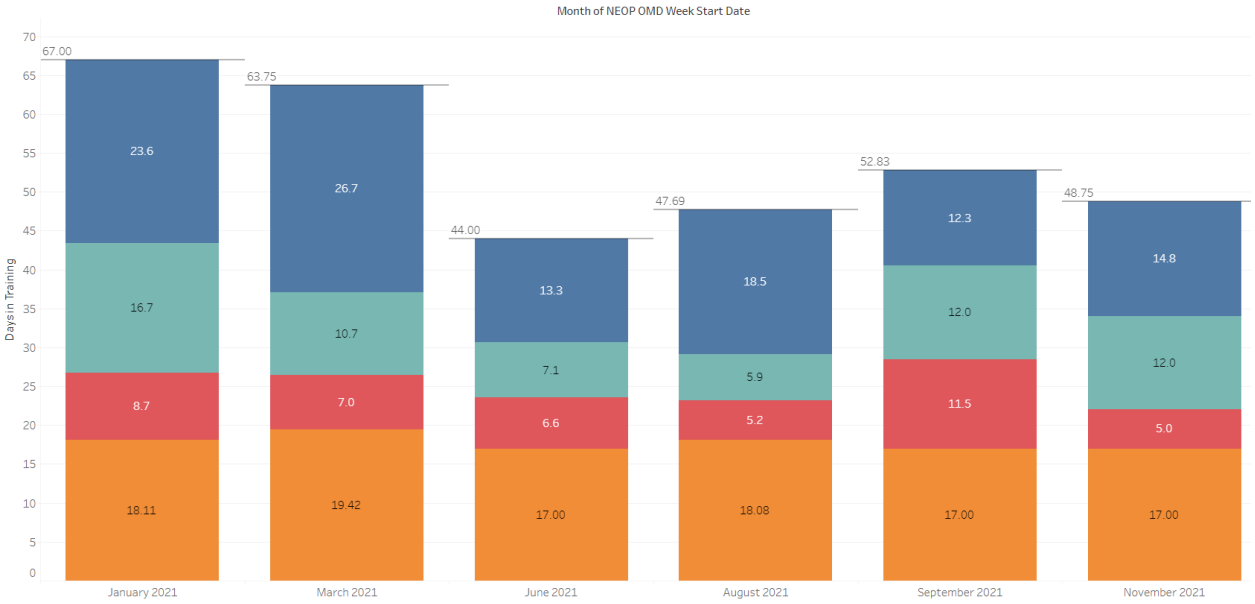
Education and Training

- OMD 22Q1CE – March
  - 4-hour Physician led recorded session
    - STEMI and Stroke Bundles of Care
    - Opiate Use Disorder Spectrum
    - Behavior Emergencies
    - Pediatric Respiratory Spectrum
    - ECMO Facilitated CPR
- MIH Provider Course #2
  - Attendees from Florida to Hawaii and Texas up to Montana

Course Attendance	BCLS	ACLS	Pedi	AMLS	PHTLS	Additional Course Challenges
MedStar	12	7	0	18	4	3
FRO	0	2	0	4	2	0
External	0	0	0	0	2	0
2021 Totals	122	49	40	93	131	32

Credentialing





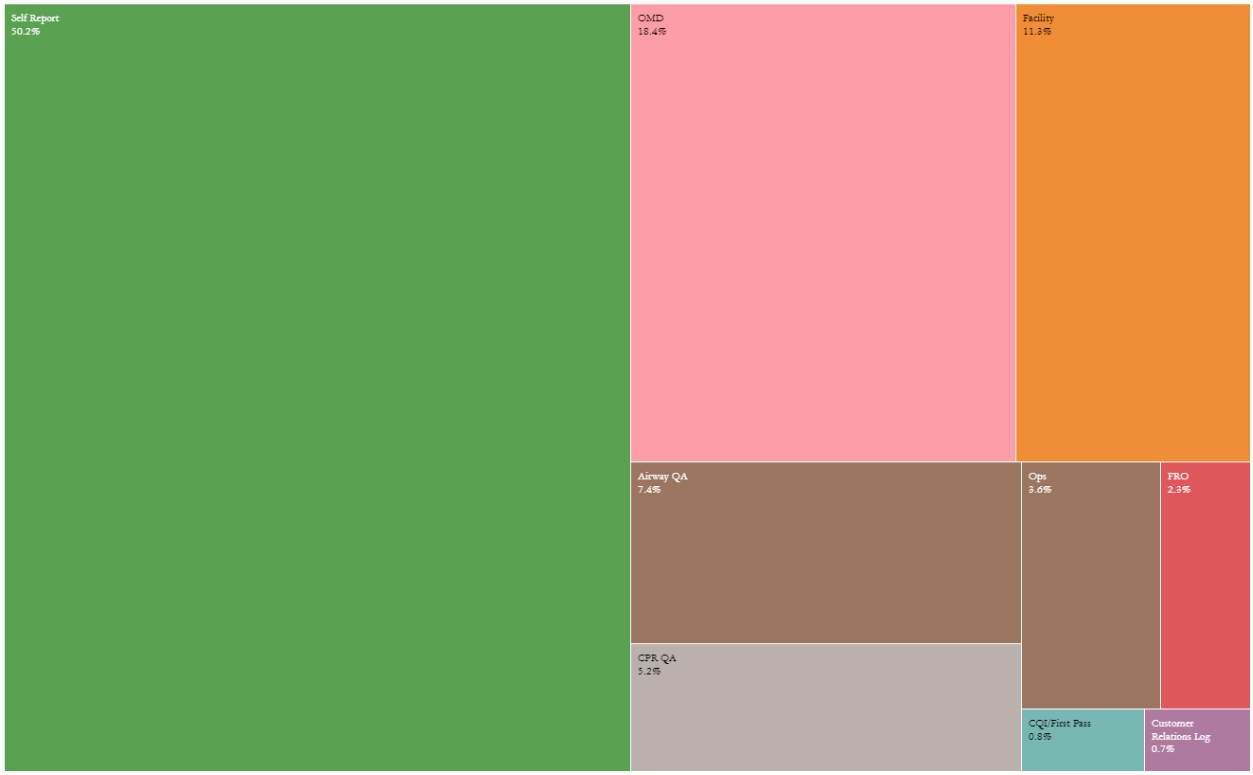
* Begins with first day of clinical NEOP through credentialing.

Quality Assurance

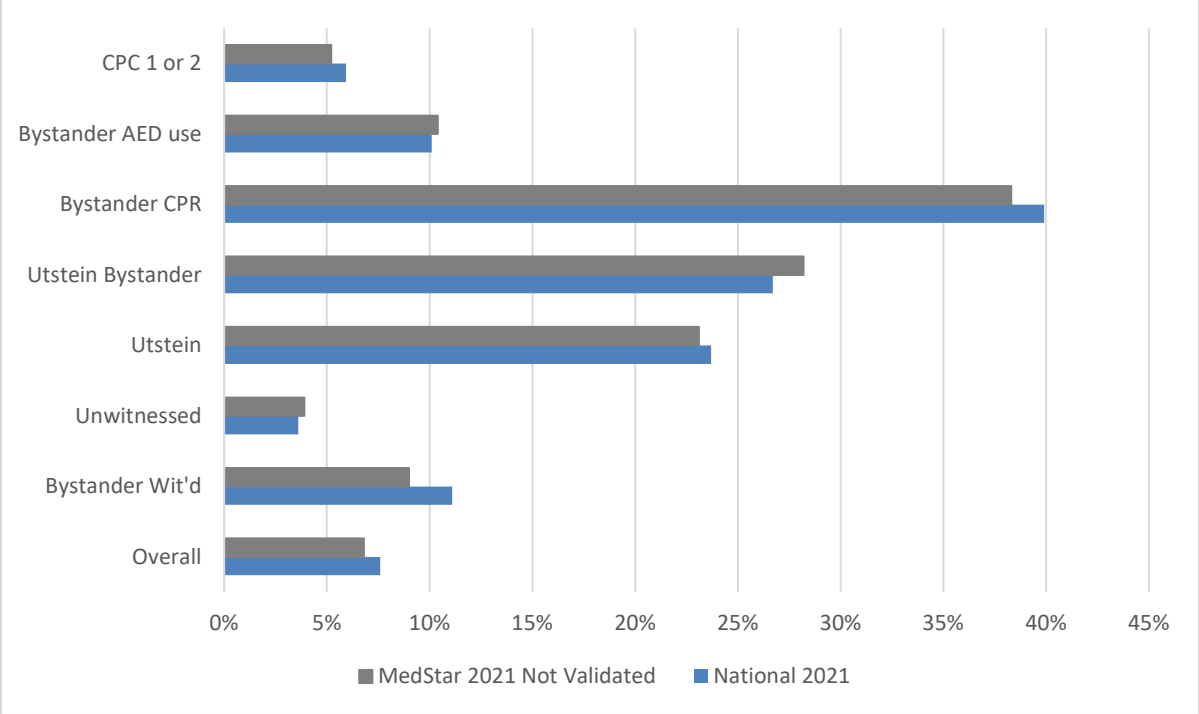
Case Acuity	December 2021	January 2022
High	3 (4.3%)	9 (12.7%)
Moderate	21 (30.0%)	11 (15.5%)
Low	37 (52.9%)	47 (66.2%)
Non QA/QI	9 (12.9%)	4 (5.6%)
Grand Total	70 (100.0%)	71 (100.0%)

Case Disposition	December 2021	January 2022
Needs Improvement	49 (70.0%)	52 (73.2%)
Clinically Inappropria..	2 (2.9%)	
Forwarded	2 (2.9%)	
No Fault	13 (18.6%)	17 (23.9%)
Pending	4 (5.7%)	2 (2.8%)
Grand Total	70 (100.0%)	71 (100.0%)

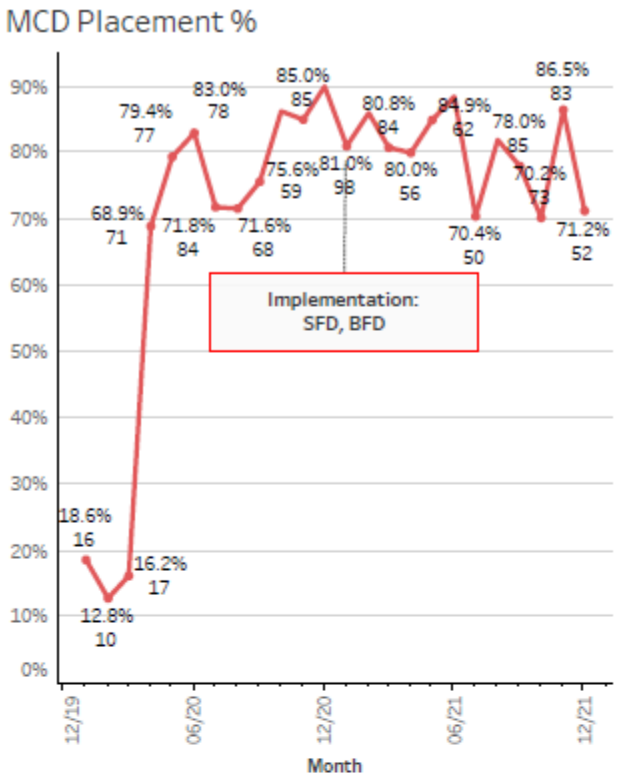
Cases by Origin

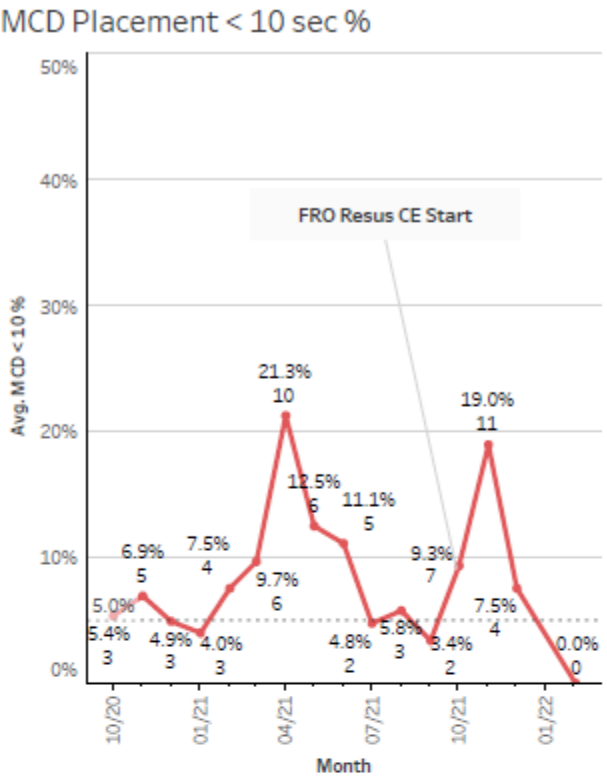


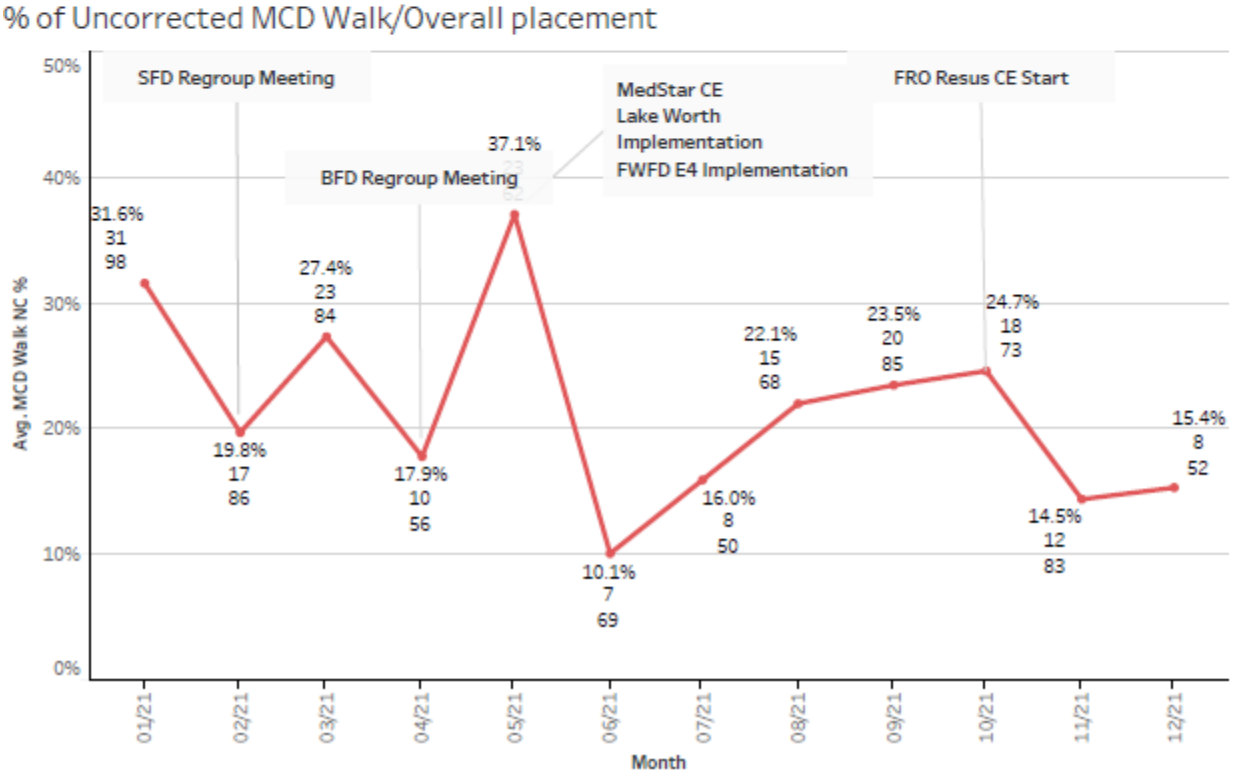
- CARES



- 2021 (Not Validated)
  - Validated report in March 2022
  - 1056-cases of non-traumatic OHCA
  - 19-outcomes still pending





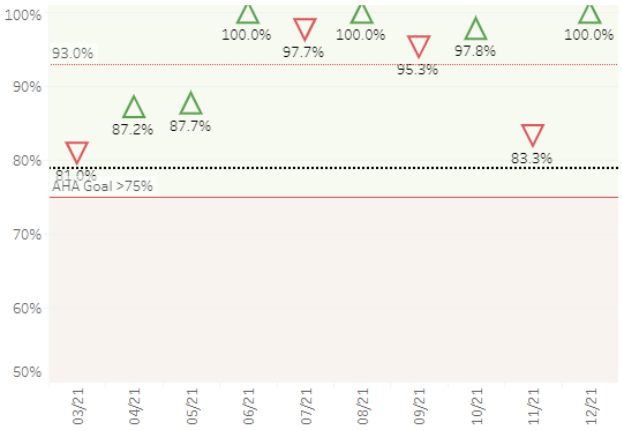


The Office of the Medical Director provides medical direction for the MedStar System and First Responder Organizations in the Fort Worth, Texas area.

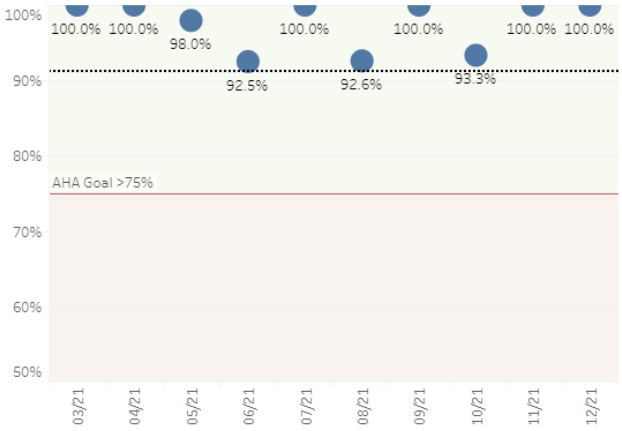
www.fwomd.org

- T-CPR

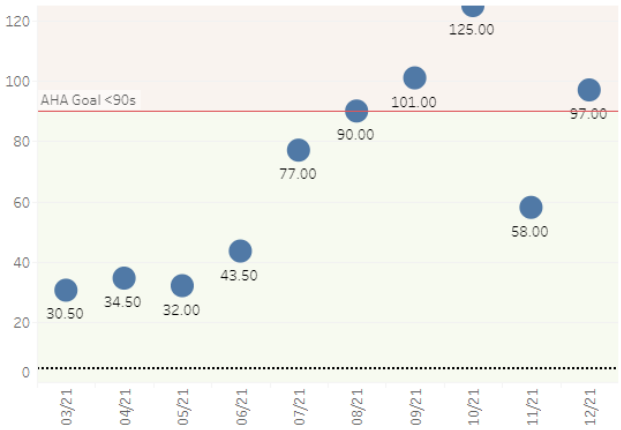
Percentage of OHCA Identified by PSAP



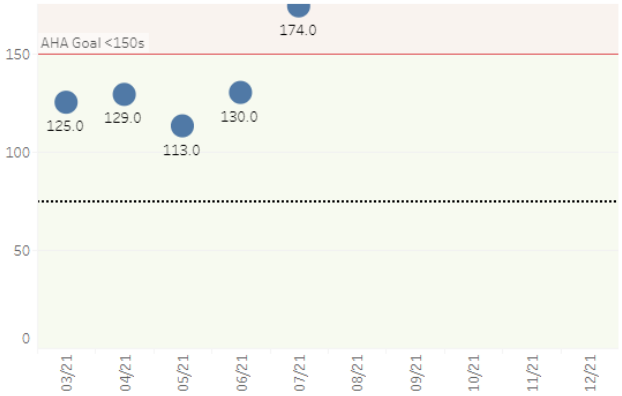
Percentage of Recognized OHCA Receiving T-CPR

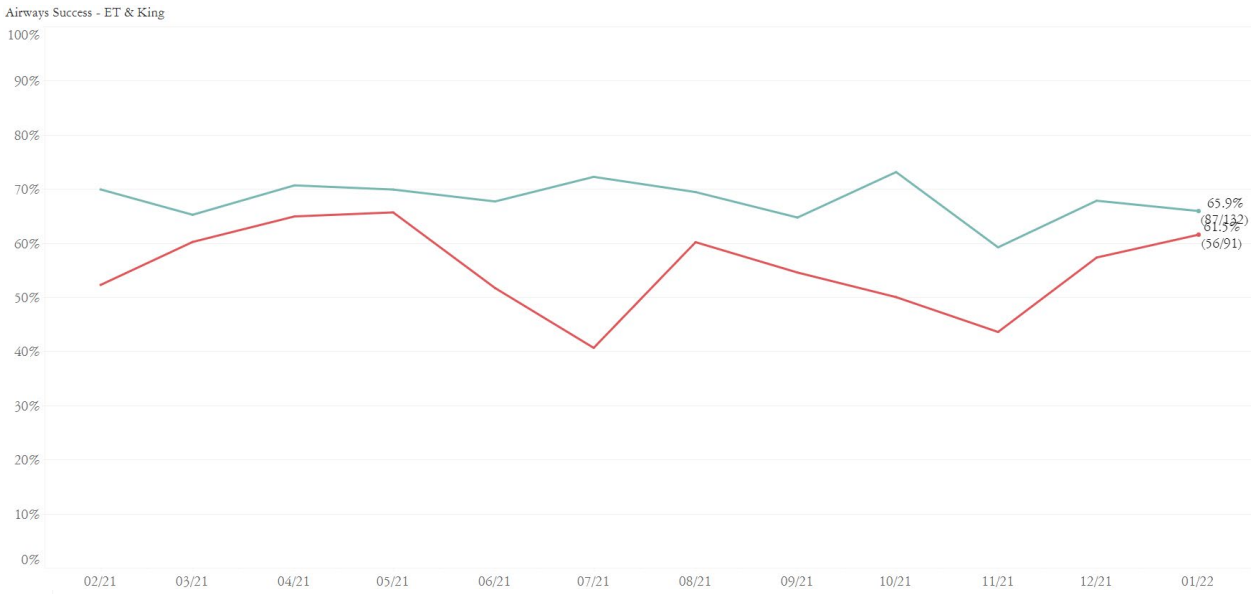


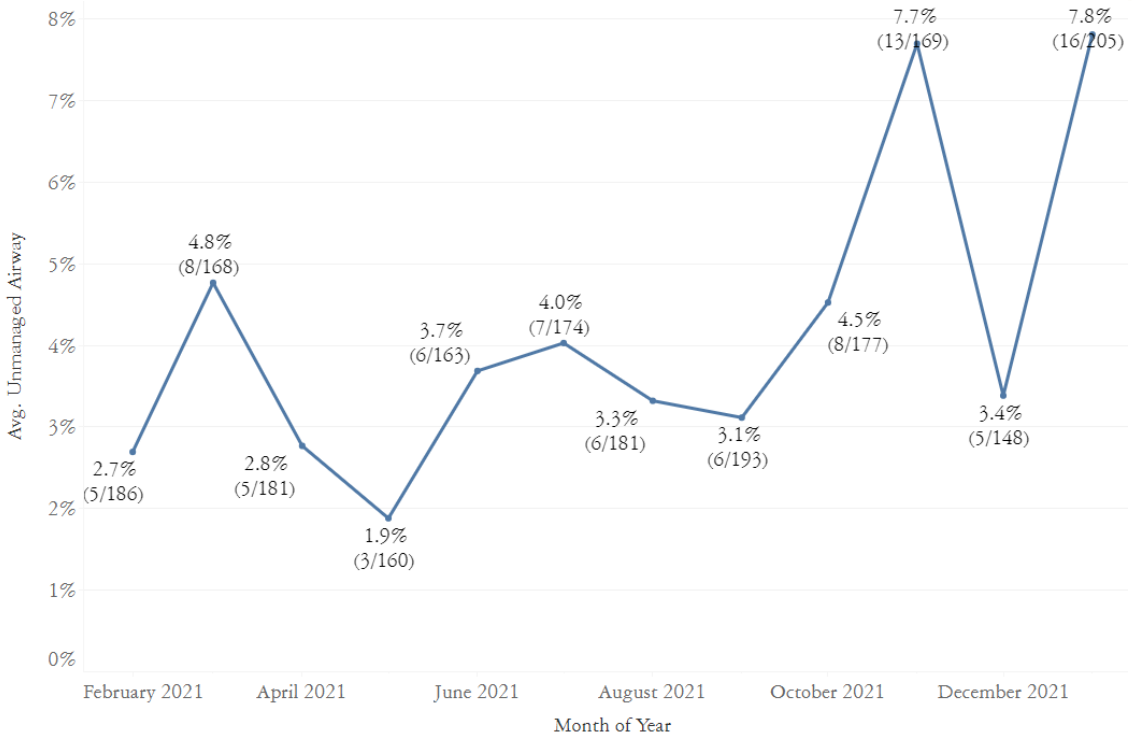
Median Time Between 9-1-1 Call and OHCA Recognition



Median Time Between 9-1-1 Call and First T-CPR–Directed Compression







The Office of the Medical Director provides medical direction for the MedStar System and First Responder Organizations in the Fort Worth, Texas area.

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System Diagnostics

Cardiac Arrest	Goal	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Current Avg.
% of recognizable Out-of-Hospital Cardiac Arrests (OHCA) cases correctly identified by Dispatch	x	87.7%	100.0%	97.7%	100.0%	95.3%	97.8%			86.0%
Median time between 9-1-1 call and OHCA recognition		0:00:32	0:00:43	0:01:17	0:01:30	0:01:33	0:02:05			0.0%
% of recognized 2nd party OHCA cases that received tCPR	x	98.0%	92.5%	100.0%	89.3%	100.0%	93.6%			98.6%
Median time between 9-1-1 Access to tCPR hands on chest time for OHCA cases		0:01:53	0:01:53	0:02:10	0:02:54					0.1%
% of cases with time to tCPR < 180 sec from first key stroke		72.9%	89.1%	79.2%	75.7%	68.8%	80.0%			71.3%
% of cases with CCF ≥ 90%		88.0%	76.0%	72.0%	74.0%	84.0%	67.0%			79.9%
% of cases with compression rate 100-120 cpm 90% of the time		95.5%	97.3%	87.5%	90.9%	93.3%	92.9%			89.7%
% of cases with compression depth that meet appropriate depth benchmark 90% of the time		37.9%	45.9%	90.9%	42.9%	46.1%	47.6%			33.7%
% of cases with mechanical CPR device placement with < 10 sec pause in chest compression		13.3%	13.9%	9.5%	8.1%	3.4%	9.3%			19.9%
% of cases with Pre-shock pause < 10 sec	x									89.2%
% arrive at E/D with ROSC	x	15.1%	6.9%	14.8%	18.7%	13.3%	15.7%	10.3%	15.8%	16.7%
% discharged alive	x	8.1%	5.5%	4.8%	7.9%	7.1%	3.8%	5.2%	2.1%	7.1%
% neuro intact at discharge (Good or Moderate Cognition)	x	8.1%	2.8%	3.7%	6.6%	4.7%	3.8%	4.1%	2.1%	5.3%
% of cases with bystander CPR		53.5%	58.3%	39.5%	44.0%	41.0%	45.7%			48.7%
% of cases with bystander AED use		20.9%	29.2%	27.2%	26.7%	24.1%	2.9%			19.8%

STEMI	Goal	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	
% of suspected STEMI patients correctly identified by EMS		52.2%	52.0%	57.1%	66.7%	44.1%	63.4%	33.3%	52.4%	62.0%
% of suspected STEMI patients w/ASA admin (*in the absence of contraindications)*		96.9%	90.6%	87.5%	92.9%	94.7%	95.8%	100.0%	88.0%	94.5%
% of suspected STEMI patients w/NTG admin (*in the absence of contraindications)*		84.4%	87.5%	87.5%	85.7%	81.6%	81.3%	80.0%	84.0%	87.7%
% of suspected STEMI patients with 12L acquisition within 10 minutes of patient contact		59.4%	81.3%	65.6%	71.4%	63.2%	72.9%	66.7%	56.0%	72.1%
% of suspected STEMI patients with 12L transmitted within 5 minutes of transport initiation		71.9%	71.9%	59.4%	46.4%	60.5%	64.6%	60.0%	56.0%	62.4%
% of suspected STEMI patients with PCI facility notified of suspected STEMI within 10 minutes of EMS patient contact		18.8%	21.9%	12.5%	25.0%	23.7%	10.4%	20.0%	12.0%	18.5%
% of patients with Suspected STEMI Transported to PCI Center		96.9%	96.9%	100.0%	100.0%	94.7%	100.0%	100.0%	100.0%	99.6%
% of suspected STEMI patients with EMS activation to Cath Lab intervention time < 90 minutes		18.2%	54.6%	8.3%	50.0%	28.6%	33.3%	0.0%	30.0%	32.7%
STEMI BUNDLE COMPLIANCE		33.3%	33.3%	16.7%	33.3%					25.0%

Tab C – Chief Financial Officer

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

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

Statement of Revenues and Expenses:

Month to Date: Net Income for the month of January 2022 is a loss of ($285,340) as compared to a budgeted gain of $141,734 for a negative variance of ($427,074). EBITDA for the month of January 2022 is a gain of $56,003.15 compared to a budgeted gain of $475,258 for a negative variance of ($419,259).

- Transport volume in January ended the month 101.8% to budget.
- Net Revenue in January is 98.7% to budget or ($58,741) below budget.
- Total Expenses ended the month 108% to budget or $368,333 over budget. In January, MedStar incurred additional expenses in Salaries and Overtime of $210,193, Benefits and Taxes $53K, Fuel of $23.7K, Medical Supp/Oxygen $82K and Other Vehicle Expense of $11.8K. This expense overage was offset by lower than expected expenses in all other expense lines by a total of (12K).

Year to Date: EBITDA is $1,070,910 as compared to a budget of $1,510,777 for a negative variance of ($534,605)

- The main drivers for this variance are YTD patient encounters are 102.3% to budget and YTD net revenue is 1.02% to budget. Year to date expenses are 1.05% to budget. The main driver for this overage is salaries, overtime and shift incentives. All non-Salary and Benefits/Taxes expenses are under budget by .01%.

Key Financial Indicators:

- Current Ratio – MedStar has $7.30 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 January 31, 2022, there is 4.32 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 5.10 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 January, the return is -1.01%.

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

Metropolitan Area EMS Authority dba MedStar Mobile Healthcare

Balance Sheet By Character Code

For the Period Ending January 31, 2022

Assets	Current Year	Last Year
Cash	$19,973,041.81	$23,458,892.42
Accounts Receivable	$10,254,733.08	$8,686,396.16
Inventory	$383,481.43	$358,989.75
Prepaid Expenses	$1,144,302.24	$1,026,561.13
Property Plant & Equ	$63,836,802.18	$59,411,026.93
Accumulated Deprecia	($26,946,248.03)	($23,180,142.81)
Total Assets	$68,646,112.71	$69,761,723.58
Liabilities		
Accounts Payable	($571,038.15)	($489,204.80)
Other Current Liabil	($2,496,965.38)	($2,340,470.19)
Accrued Interest	($7,781.31)	($7,781.31)
Payroll Withholding	($6,673.12)	($11,061.07)
Long Term Debt	($3,569,839.58)	($3,919,665.56)
Other Long Term Liab	($10,056,218.65)	($8,289,852.45)
Total Liabilities	($16,708,516.19)	($15,058,035.38)
Equities		
Equity	($52,884,378.49)	($55,208,105.09)
Control	$946,781.97	$504,416.89
Total Equities	($51,937,596.52)	($54,703,688.20)
Total Liabilities and Equities	($68,646,112.71)	($69,761,723.58)

Metropolitan Area EMS Authority dba MedStar Mobile Healthcare
Statement of Revenue and Expenditures
January 31, 2021

Revenue	Current Month Actual	Current Month Budget	Current Month Variance	Year to Date Actual	Year to Date Budget	Year to Date Variance
Transport Fees	$18,922,341.20	$18,264,264.96	$658,076.24	$73,260,977.85	$69,555,512.65	$3,705,465.20
Contractual Allow	($2,390,424.54)	($7,967,060.71)	$5,576,636.17	($13,395,257.69)	($30,319,644.94)	$16,924,387.25
Provision for Uncoll	($12,264,924.15)	($5,943,132.59)	($6,321,791.56)	($43,237,258.85)	($22,617,333.62)	($20,619,925.23)
Education Income	$12,340.00	$1,050.00	$11,290.00	$65,563.60	$47,480.00	$18,083.60
Other Income	$76,930.18	$113,760.75	($36,830.57)	$536,934.39	$317,643.00	$219,291.39
Standby/Subscription	$97,467.18	$43,631.15	$53,836.03	$355,026.71	$277,071.40	$77,955.31
Pop Health PMPM	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
interest on Investme	$542.25	$500.00	$42.25	$2,761.74	$2,000.00	$761.74
Gain(Loss) on Dispos	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Revenue	$4,454,272.12	$4,513,013.56	($58,741.44)	$17,588,747.75	$17,262,728.49	$326,019.26
Expenditures						
Salaries	$2,870,318.75	$2,660,125.66	$210,193.09	$11,297,909.05	$10,467,714.64	$830,194.41
Benefits and Taxes	$453,407.09	$400,285.00	$53,122.09	$1,547,260.47	$1,489,192.00	$58,068.47
Interest	$35,464.70	$33,500.00	$1,964.70	$142,528.39	$134,000.00	$8,528.39
Fuel	$125,317.83	$101,599.92	$23,717.91	$480,999.38	$405,901.68	$75,097.70
Medical Supp/Oxygen	$279,858.71	$197,845.05	$82,013.66	$797,631.52	$754,717.75	$42,913.77
Other Veh & Eq	$51,213.09	$39,398.00	$11,815.09	$180,788.61	$163,377.00	$17,411.61
Rent and Utilities	$58,021.53	$66,269.52	($8,247.99)	$254,877.17	$264,828.08	($9,950.91)
Facility & Eq Mtc	$82,893.62	$82,526.26	$367.36	$299,447.69	$301,885.04	($2,437.35)
Postage & Shipping	$1,420.93	$3,521.55	($2,100.62)	$12,408.41	$14,086.20	($1,677.79)
Station	$51,836.39	$47,699.01	$4,137.38	$166,983.27	$193,898.04	($26,914.77)
Comp Maintenance	$60,449.77	$62,274.99	($1,825.22)	$193,244.73	$249,099.96	($55,855.23)
Insurance	$46,340.46	$44,026.52	$2,313.94	$205,659.36	$176,106.08	$29,553.28
Advertising & PR	($199.00)	$3,892.00	($4,091.00)	$302.67	$11,768.00	($11,465.33)
Printing	$3,717.92	$3,615.41	$102.51	$13,705.86	$14,461.64	($755.78)
Travel & Entertain	$4,843.04	$11,863.00	($7,019.96)	$8,839.37	$39,327.00	($30,487.63)
Dues & Subs	$124,600.77	$148,352.00	($23,751.23)	$452,963.14	$537,939.00	($84,975.86)
Continuing Educ Ex	$6,956.60	$22,198.00	($15,241.40)	$36,358.43	$83,906.00	($47,547.57)
Professional Fees	$165,698.62	$140,315.71	$25,382.91	$522,432.48	$575,767.84	($53,335.36)
Education Expenses	$1,167.61	$0.00	$1,167.61	$14,032.01	$0.00	$14,032.01

Metropolitan Area EMS Authority dba MedStar Mobile Healthcare
Statement of Revenue and Expenditures
January 31, 2021

Revenue	Current Month Actual	Current Month Budget	Current Month Variance	Year to Date Actual	Year to Date Budget	Year to Date Variance
Miscellaneous	$10,405.24	$1,944.00	$8,461.24	$31,994.28	$7,976.00	$24,018.28
Depreciation	$305,878.59	$300,028.00	$5,850.59	$1,286,321.51	$1,200,112.00	$86,209.51
Total Expenditures	$4,739,612.26	$4,371,279.60	$368,332.66	$17,946,687.80	$17,086,063.95	$860,623.85
Net Rev in Excess of Expend	($285,340.14)	$141,733.96	($427,074.10)	($357,940.05)	$176,664.54	($534,604.59)
EBITDA	$56,003.15	$475,261.96	($419,258.81)	$1,070,909.85	$1,510,776.54	($439,866.69)

/Custom Reports StatementofRevenueandExpensesByCategory
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FOR MANAGEMENT USE ONLY

Metropolitan Area EMS Authority dba MedStar Mobile Healthcare
Key Financial Indicators
January 31, 2021

	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**	**7.30**

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.

Cash as % of Annual Expenditures	**> 25%**	**55.06%**	**47.07%**	**42.95%**	**51.76%**	**44.45%**	**36.00%**

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

Accounts Receivable Turnover	**>3**	**4.96**	**4.28**	**3.65**	**5.44**	**6.34**	**5.10**

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 .

Return on Net Assets	**-1.00%**	**10.35%**	**10.11%**	**4.04%**	**0.00%**	**-4.03%**	**-1.01%**

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 01/31/2021			$ 475,470.69

Tab D – Chief Human Resources Officer

Human Resources - January 2022

Turnover:

- January turnover –1.38%
    - FT – 1.53%
    - PT – 0.00%
- Year to date turnover –8.89%
    - FT – 8.28%
    - PT – 14.89%

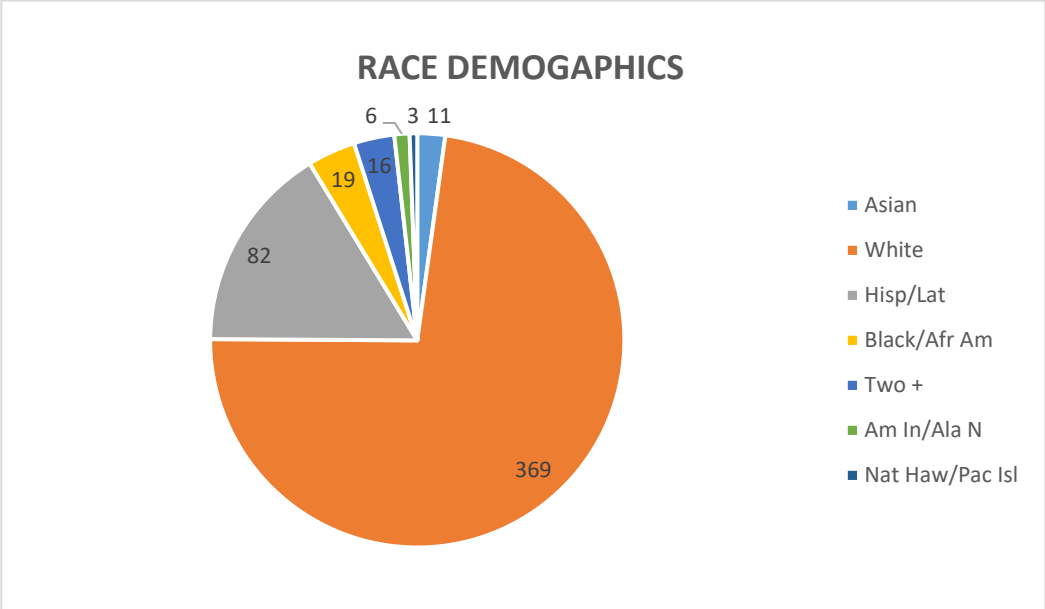
Leaves:

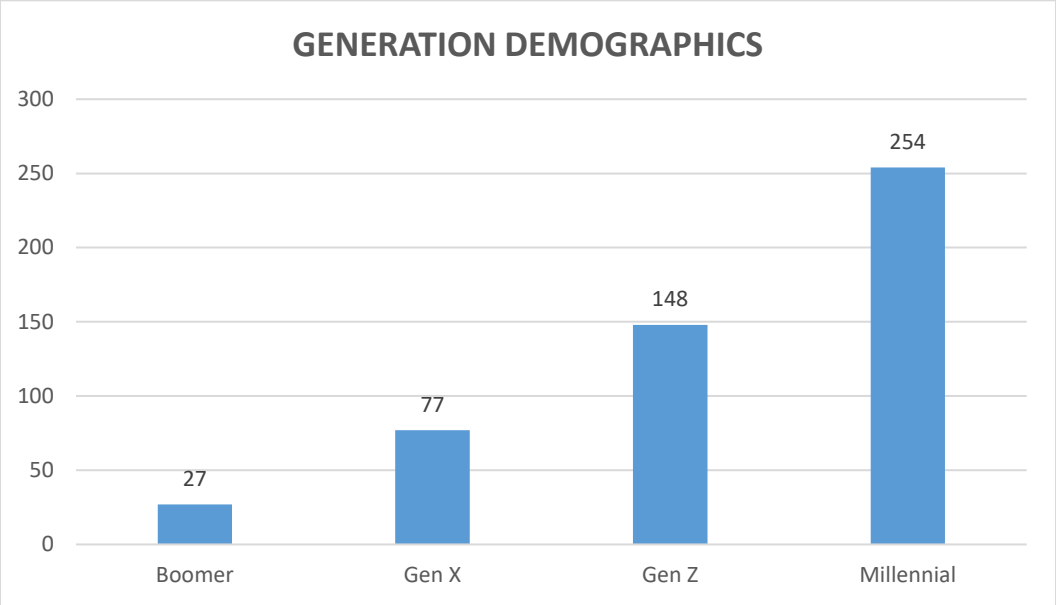
- 31 employees on FMLA / 6.75% of workforce
    - 28 cases on intermittent
    - 3 cases on a block
- Top FMLA request reasons/conditions
    - FMLA Child (8)
    - Neurological (7)
    - FMLA Parent (5)
    - Mental Health (8)
- COVID Administrative Leave
    - 2147:50 hours in January
    - 18409:08 hours to date

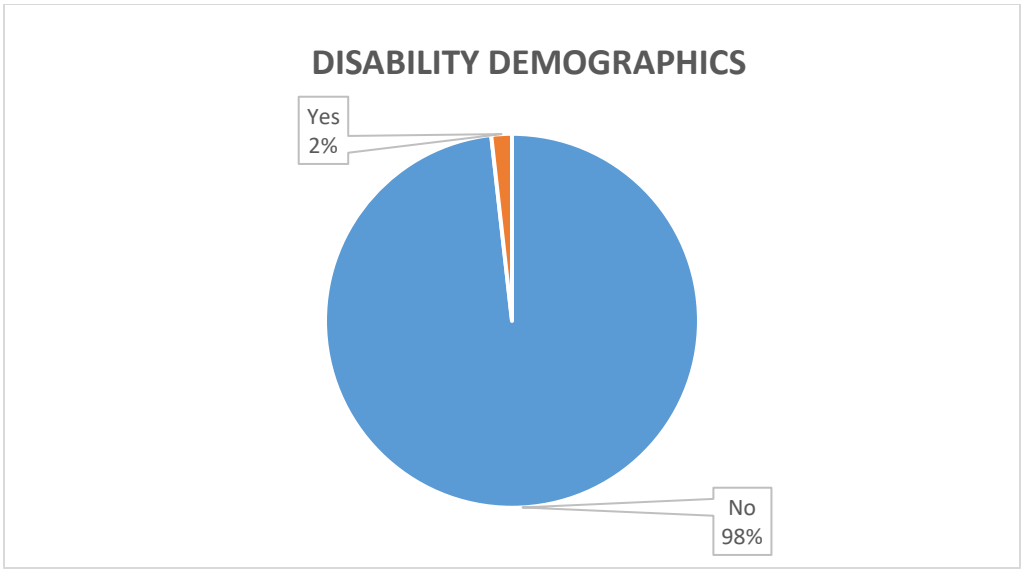
Staffing

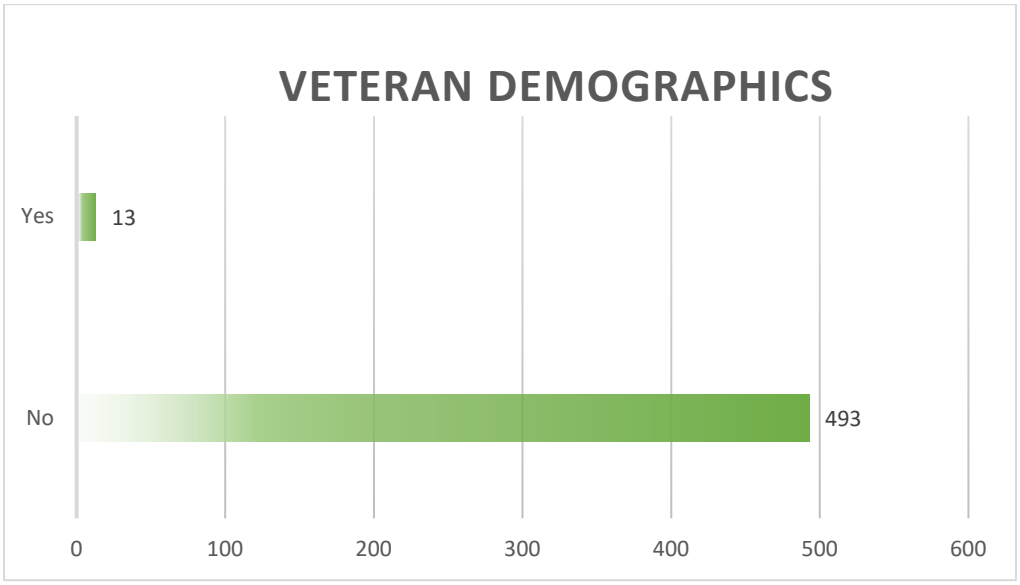
- 24 hires in January
- 42 hires FYTD

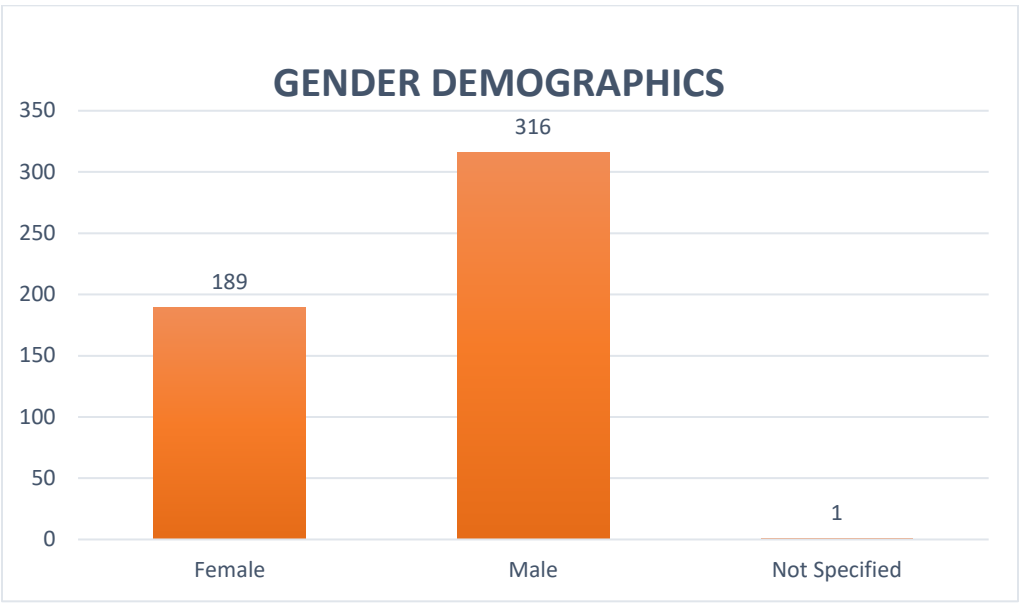
JANUARY 2022 DIVERSITY STATISTICS






DISABILITY DEMOGRAPHICS
Yes
2%
No
98%


VETERAN DEMOGRAPHICS
Yes
13
No
493
0
100
200
300
400
500
600


GENDER DEMOGRAPHICS
350
300
250
200
150
100
50
0
189
316
1
Female
Male
Not Specified

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

Conditions	
Row Labels	**Count of Reason**
Cardiology	2
FMLA - Child	6
FMLA - Parent	5
FMLA - Spouse	2
Internal Medicine	1
Mental Health	5
Neurological	6
Obstetrics	2
Orthopedic	1
Pulmonary	1
Grand Total	**31**

Percentage by Department					
Department	**# of Ees**	**# on FMLA**	**% by FTE**	**% by FMLA**	**% by Dept HC**
Administration	6	1	0.22%	3.23%	16.67%
Advanced	142	8	1.74%	25.81%	5.63%
Basic	191	8	1.74%	25.81%	4.19%
Business Office	12	4	0.87%	12.90%	33.33%
Communications	45	3	0.65%	9.68%	6.67%
Executive	7	2	0.44%	6.45%	28.57%
Human Resources	5	1	0.22%	3.23%	20.00%
Support Services - Facilities, Fleet, S.E., Logistics	37	4	0.87%	12.90%	10.81%
Grand Total	**445**	**31**			

Total # of Full Time Employees - January 2022	459	
% of Workforce using FMLA	6.75%	
TYPE OF LEAVES UNDER FMLA	**# of Ees**	**% on Leave**
Intermittent Leave	28	90.32%
Block of Leave	3	9.68%
Total	**31**	100.00%

MedStar Mobile Healthcare

Leave of Abscence Report - Fiscal Year 2013-2014

Light Duty WC for Fiscal Year 2021 - 2022													
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Goal
Hours/Mo	634:59	317:41	583:37	431:23	0:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	
FY 21-22	634:59	952:40	1536:17	1967:40	1967:40	1967:40	1967:40	1967:40	1967:40	1967:40	1967:40	1967:40	3254:00
FY 20-21	337:52	794:12	1368:03	1498:06	1650:25	1883:54	1898:19	1898:19	1983:33	2406:36	3143:20	3615:34	

GOAL: Reduce number of lost hours due to job-related injuries by 10%

Light Duty HR for Fiscal Year 2021 - 2022													
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Goal
Hours/Mo	46:20	154:26	57:15	60:31	0:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	
FY 21-22	192:17	228:32	228:32	228:32	431:44	1102:08	1649:08	1876:05	1889:04	2029:09	2189:44	2272:36	2162:30
FY 20-21	674:38	940:59	1106:34	1106:34	1106:34	1154:34	1571:41	1761:31	1971:08	2103:08	2180:38	2402:47	

GOAL: Reduce number of lost hours due to job-related injuries by 10%

Worker's Comp LOA for Fiscal Year 2021 - 2022													
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Goal
Hours/Mo	0:00	24:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	
FY 21-22	0:00	24:00	24:00	24:00	24:00	24:00	24:00	24:00	24:00	24:00	24:00	24:00	0:00
FY 20-21	0:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	

GOAL: Reduce number of lost hours due to job-related injuries by 10%

FMLA LOA for Fiscal Year 2021 - 2022													
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	AVG
Hours/Mo	852:24	799:07	444:27	461:04	0:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	255:42
FY 21-22	852:24	1651:31	2095:58	2557:02	2557:02	2557:02	2557:02	2557:02	2557:02	2557:02	2557:02	2557:02	
FY 20-21	1700:39	3182:09	5037:34	7148:44	8734:36	10113:23	11390:09	12350:11	13660:26	14959:46	16303:24	17497:06	10173:10:35

All Other Leave for Fiscal Year 2021 - 2022*													
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	AVG
Hours/Mo	7250:27	7460:58	9810:21	7431:02	0:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	3195:16
FY 21-22	7250:27	14711:25	24521:46	31952:48	31952:48	31952:48	31952:48	31952:48	31952:48	31952:48	31952:48	31952:48	
FY 20-21	6258:06	11345:22	17676:28	21636:11	25998:39	32058:12	37543:40	44215:57	51059:14	57964:04	63772:29	69441:53	36580:51:15

*includes all other leaves (LOA, MLOA, Vacation, Sick, Jury, etc.)

Military Leave for Fiscal Year 2021 - 2022													
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	AVG
Hours/Mo	166:00	206:00	46:00	12:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	43:00
FY 21-22	166:00	372:00	418:00	430:00	430:00	430:00	430:00	430:00	430:00	430:00	430:00	430:00	
FY 20-21	144:00	216:00	276:00	373:00	645:55	888:55	1158:55	1239:55	1291:55	1291:55	1382:55	1442:55	18086:55:00

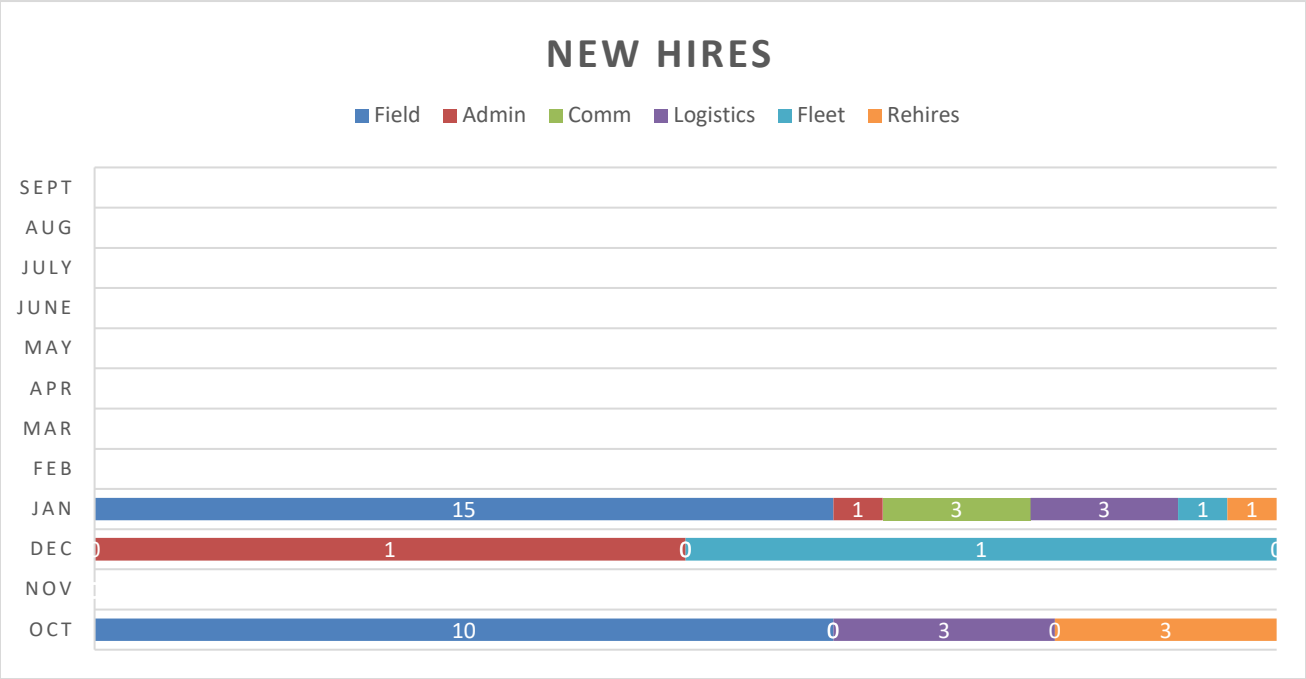
Total Leave Hours													
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	AVG
Hours/Mo	1653:23	1346:48	1074:04	904:27	0:00	0:00	0:00	0:00	0:00	0:00	0:00	0:00	497:52
FY 21-22	1653:23	3000:11	4074:15	4978:42	4978:42	4978:42	4978:42	4978:42	4978:42	4978:42	4978:42	4978:42	
FY 20-21	2182:31	4192:21	6681:37	9019:50	11030:56	12886:12	14447:23	15488:25	16935:54	18658:17	20829:39	22555:35	71602:36:00

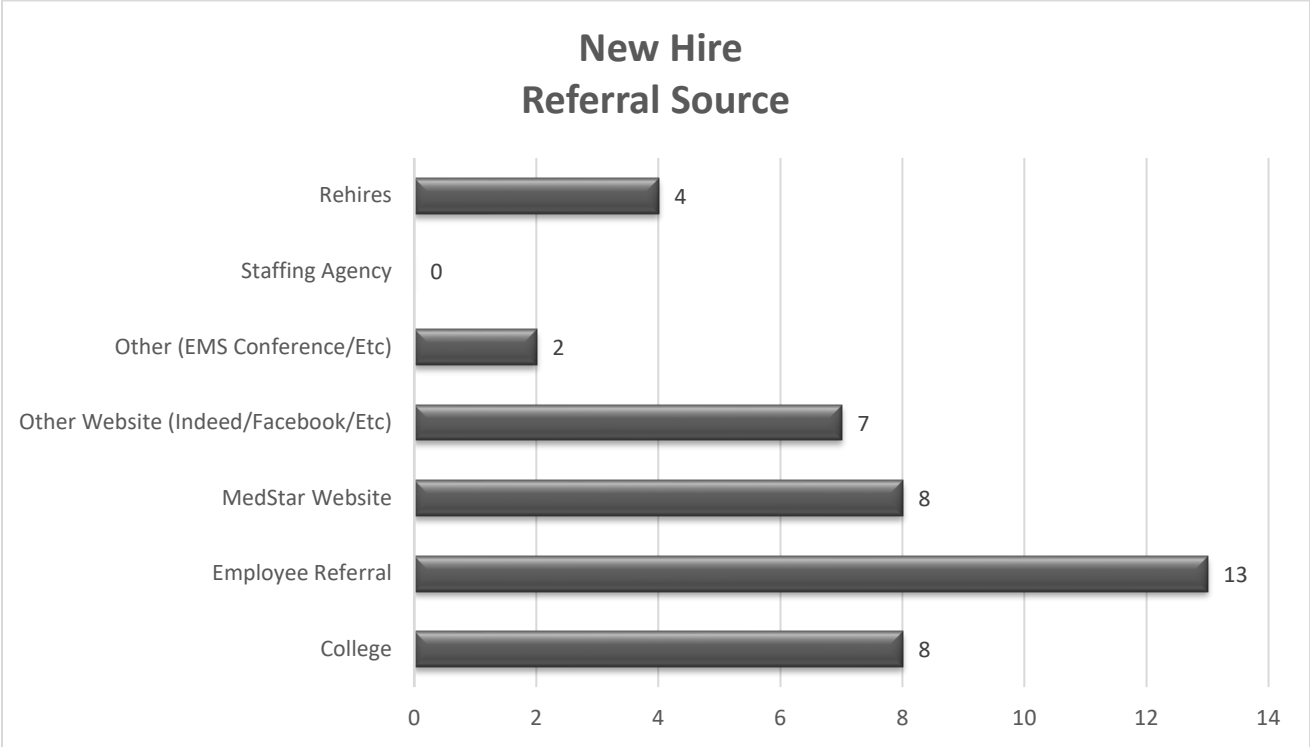
Summary of Fiscal Year 2020-2021							
	Light Duty WC	Light Duty HR	Worker's Comp	FMLA	All Other Leave	Military	Total
YTD	1967:40	2272:36	24:00	2557:02	31952:48	430:00	4978:42
Goal-Compare	3254:00	2162:30	0:00	17497:06	69441:53	1096:00	93451:29

Revision #2 9/24/2014

Recruiting & Staffing Report

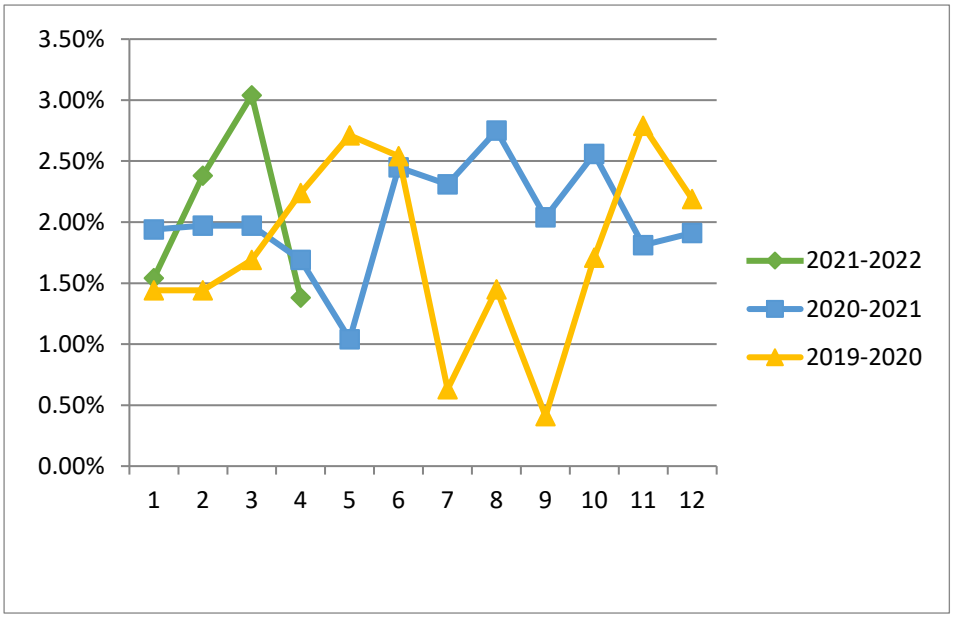
Fiscal Year 2021-2022





MedStar Mobile Healthcare Turnover
Fiscal Year 2021 - 2022

	Full & Part Time Turnover			Full Time Only
	2021-2022	2020-2021	2019-2020	2020-2021
October	1.54%	1.94%	1.44%	1.05%
November	2.38%	1.97%	1.44%	2.40%
December	3.04%	1.97%	1.69%	2.90%
January	1.38%	1.69%	2.24%	1.53%
February		1.04%	2.71%	
March		2.45%	2.54%	
April		2.31%	0.63%	
May		2.75%	1.45%	
June		2.04%	0.41%	
July		2.56%	1.71%	
August		1.81%	2.79%	
September		1.91%	2.19%	
Actual Turnover	6.28%	16.17%	19.91%	5.80%



Tab E – Compliance and Legal

Compliance Officer's Report
January 20, 2022-February 15, 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 criminal investigations, records, and crew member interviews as needed.
- Assisted Tarrant County Medical Examiner's office with multiple death investigations.
- Four Narcotic Anomalies occurred during this reporting period:
    - Paramedic inadvertently took their narcotic pouch home at the end of shift.
    - Paramedic accidently dropped a vial of Ketamine while checking the vials at the start of her shift.
    - Paramedic inadvertently failed to turn a vial of Ketamine from their personal pouch to the issued narcotic pouch at the end of shift.
    - Paramedic inadvertently left a half administered vial of Fentanyl on scene.

  In all occurrences, the Medstar narcotics anomaly process was followed, drug screens performed as warranted, and no foul play was discovered.
- Begin collecting data on crew member assaults at the boards request. Should have some data to report by next month.

Paralegal Duties

- 16 DFPS reports were made for suspected abuse, neglect, or exploitation.
- Conducted multiple employee investigations regarding various employment matters.
- Drafted, reviewed, and executed agreements with outside parties as needed.

Chad Carr
Compliance Officer
General Counsel Paralegal
CACO, CAPO, CRC, EMT-P

Tab F – Operations

Metropolitan Area EMS Authority dba MedStar Mobile Healthcare

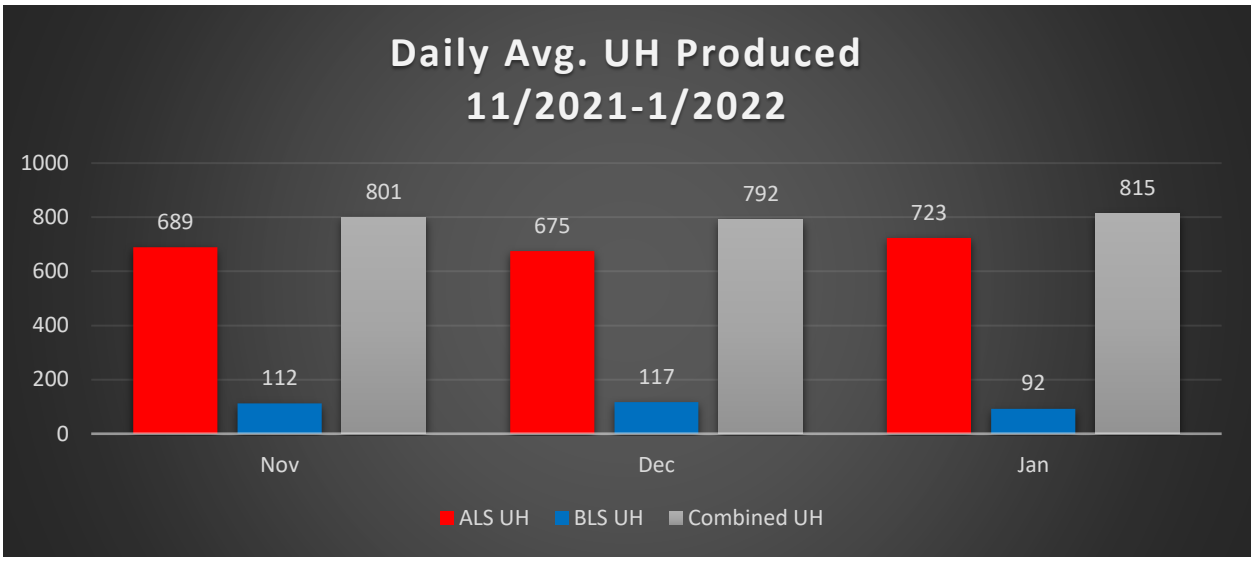
Operations Report- January 31st, 2022

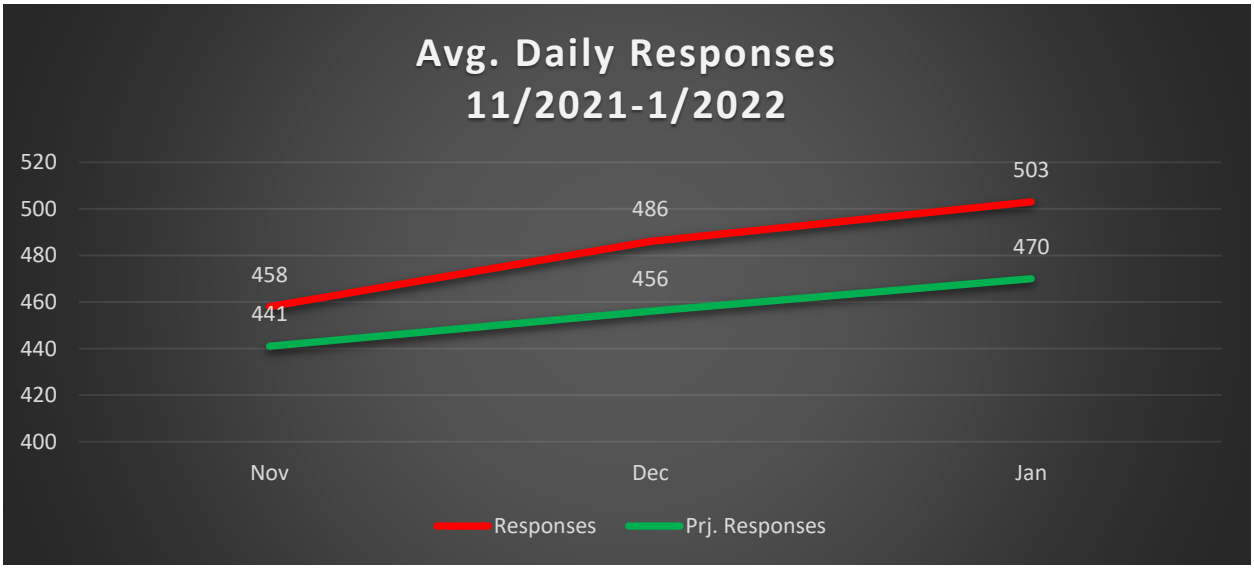
The following summarizes significant operational items through January 31st, 2022:

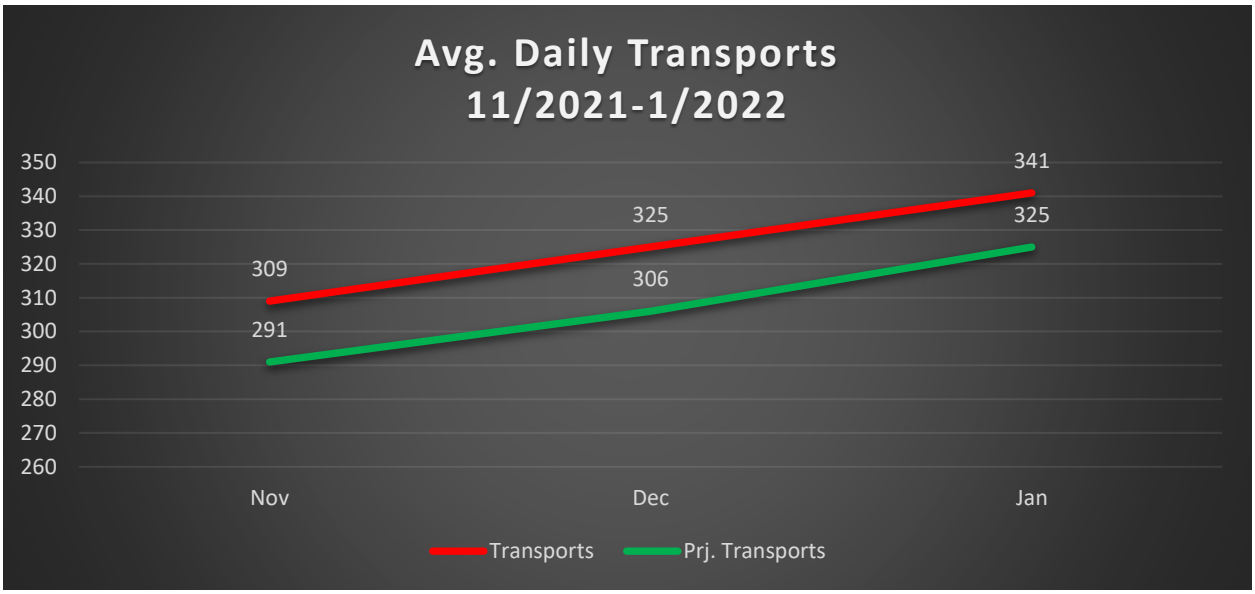
Field Operations:

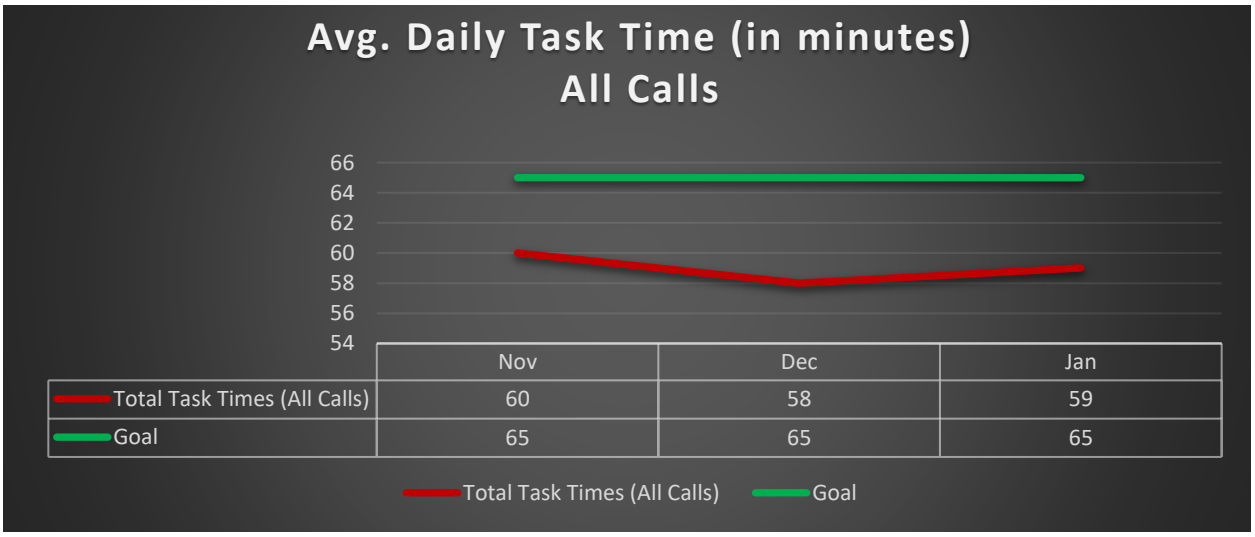
- January's transport volume exceeded budget expectations by approximately 4.92%.
- Call volume continued to increase through January, we believe primarily due to spike in COVID cases from the omicron variant, responses volume for January exceeded projections by 7%.
- Continuing to utilizing incentive shifts to buffer schedule for MedStar staff off for COVID leave
- Next NEOP starting on 2/21/2022

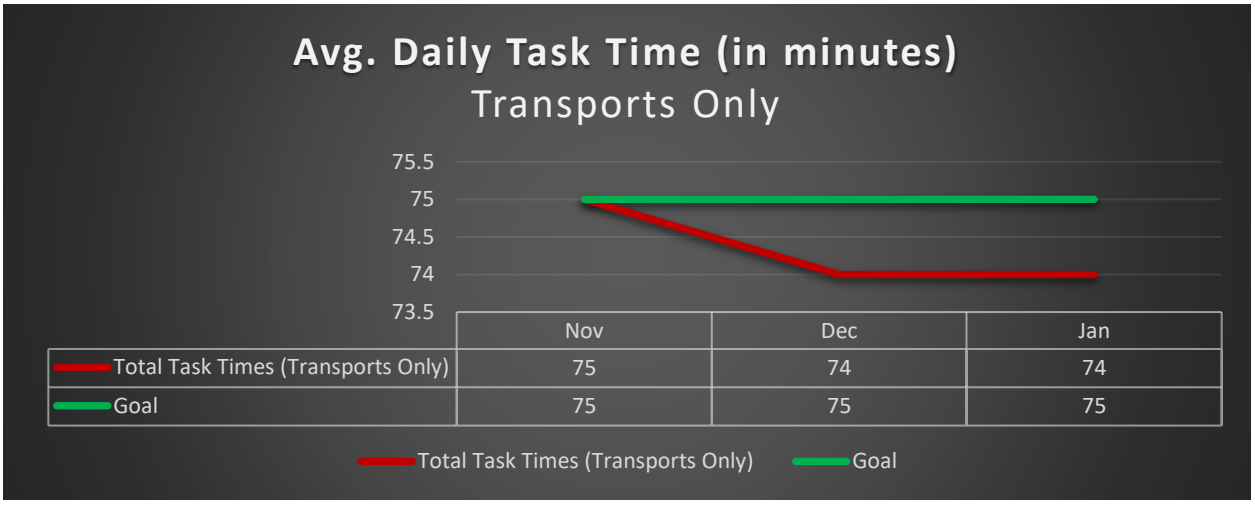
Field Ops Metrics






Avg. Daily Transports
11/2021-1/2022
350
340
330
320
310
300
290
280
270
260
309
325
341
291
306
325
Nov
Dec
Jan
Transports
Prj. Transports


Avg. Daily Task Time (in minutes)
All Calls
66
64
62
60
58
56
54
Nov
Dec
Jan
Total Task Times (All Calls)
60
58
59
Goal
65
65
65
Total Task Times (All Calls)
Goal

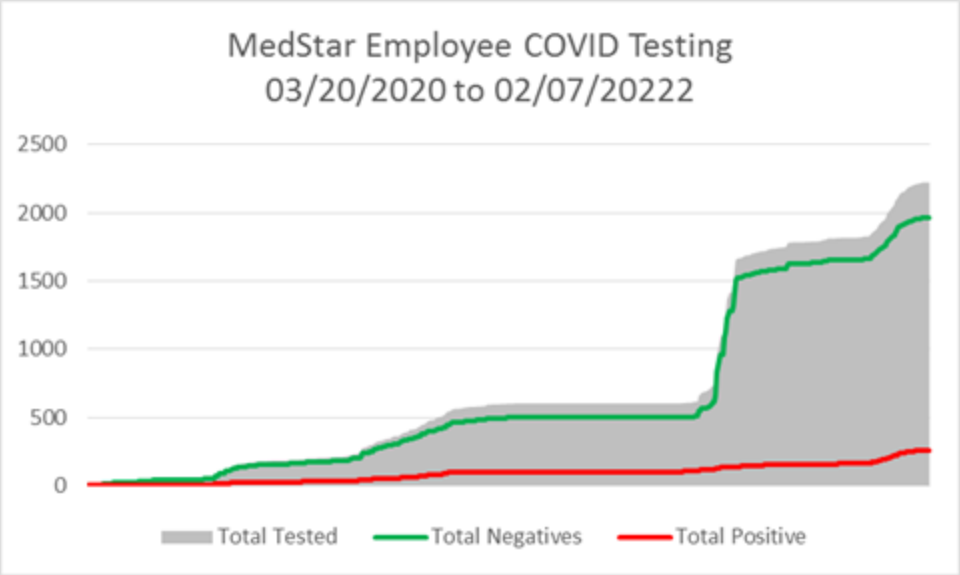

Avg. Daily Task Time (in minutes)
Transports Only
75.5
75
74.5
74
73.5
Nov
Dec
Jan
Total Task Times (Transports Only)
75
74
74
Goal
75
75
75
Total Task Times (Transports Only)
Goal

Fleet/Logistics:

- Working to stay ahead of supply chain challenges through active management
- New support vehicles were very useful in keeping units in service during recent snow/ice event
- Fleet team continues to keep units up and available for deployment

Emergency Management:

Testing 12/11/21 to 02/07/22	
Total Unvaccinated Negatives	88
Total Unvaccinated Positives	29
Positivity Rate	24.79%
% of Positives Unvaccinated	30.21%
Total Vaccinated Negatives	180
Total Vaccinated Positives	55
Positivity Rate	23.40%
% of Positives Vaccinated	57.29%
Total Boosted Negatives	42
Total Boosted Positives	12
Positivity Rate	22.22%
% of Positives Boosted	12.50%
Total Negatives	310
Total Positives	96
Positivity Rate	23.65%
Positive Retest- Includes Confirmatory PCR Test	39
Total Recovered	96
Active Cases	0
Active Field Cases	0
% of Active Employees w/ Positive COVID Test	15.88%
Average Time off Duty	7 Days
Total Testing 03/20/2020 to 02/07/2022	
Total Negatives	1965
Total Positives	255
Positivity Rate	11.47%
% of Active Employees w/ Positive COVID Test	37.65%
Average Time off Duty	11 Days
Vaccinations	
% of Organization w/ 1 Shot	72.94%
% of Organization Vaccinated	70.00%
% of Organization Boosted	20.00%



Vaccine Administration

Vaccine Administrations	
Total Vaccines Administered	9,031
Total Sites	113
Vaccines Administered at MedStar	862
Total MedStar Sites	47
Home Bound Vaccines Administered	118
Total Home Bound Sites (days administered)	17
Community Vaccines Administered	8,051
Community Sites	49

Infusions

Monoclonal Antibody Infusions have been suspended since December 2021 due to lack of availability of product for Omicron variant

Disposition	Total
Completed	217
Declined	27
Did not qualify	19
Scheduled w/ other	17
No Contact	15
Paused	14
No Call/No Show	8
Unable to Process	4
Duplicate	3
Unable to schedule	1
Grand Total	**325**

Special Operations:

- AMBUS 2.0 was delivered 2/11/2022
- Provided support for the 2022 Fort Worth Stock Show and Rodeo (FWSSR)
- Completed a record 71 events for the month of January

Mobile Integrated Health

- Continuing to operationalize new agreements while maintaining current demand from other programs
- Working to utilize Critical Care Paramedics (CCP's) on higher acuity calls to assist with scene management and delivery of high quality care in the most critical cases
- Collaborated with communications to adjust response plans for MHP/CCP's to better match supply/demand for episodic client responses

Information Technology:

- Migrating Gateways and mobile devices to FirstNet, First Response cellular network.
- Providing IT support to facilitate drillable dashboards through vendors and in-house BI team.
- Replacing network equipment that has reached the end of its vendor-supported life-cycle.
- Began the project for the consolidation and modernization of MedStar's access control and video surveillance systems.
- Began implementation of software to assist in change management process, document repository and version control moving forward. Implementation expected in coming months.

Business Intelligence:

- Onboarded Business and Data Analytics Manager.
- Implemented an improved workflow for FTO candidate reporting.
- Developed several reports for Operations and Communications.
- Deployment Manager and Business and Data Analytics Manager are collaborating to assure smooth transition.

Communications:

- In process of re-accreditation with the International Academy of Emergency Medical Dispatchers, on track to be submitted March 15th
- RQIT Project is going well. All Dispatchers are current with quarterly assignments and remain RQIT T-CPR Certified
    - Working closely with AHA to lower average T-CPR Hands-on-Chest time by the end of 2nd Quarter
- Medical Transport Priority System (MTPS) for non-emergency transportation implementation in progress, go-live postponed pending upgrade to LOGIS 4
- Actively training four new hire System Status Controllers to help meet answer time standards for inbound call demand. They are tentatively scheduled to be released from training mid-March.
- Have had significant improvement in call answer times since refocusing on meeting organizational standards
    - 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
    - December 2021: 83.52% answered in 15 seconds or less; 86.49% answered in 20 seconds or less
    - January 2022: 87.06% answered in 15 seconds or less; 90.04% answered in 20 seconds or less

PSAP Answer Times	Total 911 Calls	Avg. Duration	% Answered	
			≤ 15 Secs	≤ 20 Secs
'December 2021	10,039	277.6	83.52%	86.49%
'January 2022	10,832	282.5	87.06%	90.04%

MedStar Mutual Aid Response Task Time Report

Criteria: **Period: 01/01/2022 thru 01/31/2022**

Aid Given	Mutual Aid Received	Total % of Mutual Aid
70	46	0.29%

Aid Type		Total
Given		70
	Aid TO	Total
	Aledo	1

Aid TO	Unit	Inc Date	Incident Number	Priority	Area	Problem	Task Time (Assign to Clear)	Cancel Reason	Resulted In TX
Aledo	M35	01/22/2022 04:42:50	2068069	1	Aledo	27D04 - G - Gunshot wound - Gunshot - P1	00:18:05	Unit On Scene Cancelled	0

Alvarado	1

Aid TO	Unit	Inc Date	Incident Number	Priority	Area	Problem	Task Time (Assign to Clear)	Cancel Reason	Resulted In TX
Alvarado	M72	01/08/2022 22:13:04	2050409	2	Alvarado	06C01 - Breathing Problems - P2	00:02:16	Calling Party Cancelled	0

Arlington	20

Aid TO	Unit	Inc Date	Incident Number	Priority	Area	Problem	Task Time (Assign to Clear)	Cancel Reason	Resulted In TX
Arlington	M70	01/12/2022 09:10:11	2054566	2	Arlington	28C12 - U - Stroke (CVA) / Transient Ischemic Attack (TIA) - Unknown when the symptoms started - P2	01:10:51		1
Arlington	M54	01/08/2022 23:29:37	2594936	2	Arlington	17B01 - Falls - P2	00:09:41		0
Arlington	M39	01/27/2022 18:11:12	2075217	3	Arlington	01A01 - Abdominal Pain / Problems - P3	01:02:39		1
Arlington	M27	01/17/2022 09:38:25	2061718	1	Arlington	26B01 - Sick Person (Specific Diagnosis) - P2	00:10:15	FD/PD Cancelled MedStar	0
Arlington	M54	01/08/2022 23:29:37	2050503	2	Arlington	17B01 - Falls - P2	01:22:27		1
Arlington	M59	01/17/2022 09:36:28	2061719	3	Arlington	17B04 - Falls - P2	01:23:39		1
Arlington	M40	01/17/2022 10:15:06	2061762	3	Arlington	01A01 - Abdominal Pain / Problems - P3	00:03:25	Calling Party Cancelled	0
Arlington	M47	01/09/2022 17:57:33	2051378	3	Arlington	26A10 - Sick Person (Specific Diagnosis) - P3	00:02:15	Calling Party Cancelled	0
Arlington	M75	01/27/2022 13:07:14	2074769	1	Arlington	31D04 - Unconscious / Fainting (Near) - P1	00:53:19	AMA - Assessed and/or Treated & Released	0
Arlington	M41	01/01/2022 18:46:09	2040909	1	Arlington	06C01 - Breathing Problems - P2	01:21:09		1
Arlington	M61	01/15/2022 23:04:52	2060039	2	Arlington	17B04 - Falls - P2	01:06:28		1
Arlington	M43	01/17/2022 10:24:56	2061790	3	Arlington	26A05 - Sick Person (Specific Diagnosis) - P3	00:44:03	AMA - Assessed and/or Treated & Released	0
Arlington	M28	01/09/2022 10:42:13	2050902	3	Arlington	26A05 - Sick Person (Specific Diagnosis) - P3	01:14:06		1
Arlington	M64	01/26/2022 09:59:09	2073343	2	Arlington	29B05 - V - Vehicle vs. vehicle - Multiple patients - P2	00:05:13	FD/PD Cancelled MedStar	0

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MedStar Mutual Aid Response Task Time Report

Criteria: **Period: 01/01/2022 thru 01/31/2022**

			Arlington	M76	01/11/2022 17:07:50	2053920	1	Arlington	29D05 - U - Vehicle vs. vehicle - Unknown number of patients - P1	00:06:13	Calling Party Cancelled	0
			Arlington	M37	01/27/2022 15:11:17	2074881	3	Arlington	33A02 - T - Transfer / Interfacility / Palliative Care - Transfer/Interfacility - P3	01:40:57		1
			Arlington	M62	01/10/2022 10:22:15	2052120	3	Arlington	26A10 - Sick Person (Specific Diagnosis) - P3	01:05:50		1
			Arlington	M59	01/02/2022 10:04:33	2041535	2	Arlington	06C01 - E - Breathing Problems - COPD (Emphysema/Chronic bronchitis) - P2	00:03:36	FD/PD Cancelled MedStar	0
			Arlington	M33	01/26/2022 22:40:17	2074185	2	Arlington	10C01 - Chest Pain / Chest Discomfort (Non-Traumatic) - P2	00:59:15		1
			Arlington	M79	01/20/2022 08:35:25	2065615	2	Arlington	13C01 - Diabetic Problems - P2	00:04:18	Calling Party Cancelled	0
	Azle	1										
			Aid TO	**Unit**	**Inc Date**	**Incident Number**	**Priority**	**Area**	**Problem**	**Task Time (Assign to Clear)**	**Cancel Reason**	**Resulted In TX**
			Azle	M70	01/20/2022 19:53:03	2066409	1	Azle	21D03 - M - Hemorrhage (Bleeding) / Lacerations - MEDICAL - P1	01:30:09		1
	Benbrook	21										
			Aid TO	**Unit**	**Inc Date**	**Incident Number**	**Priority**	**Area**	**Problem**	**Task Time (Assign to Clear)**	**Cancel Reason**	**Resulted In TX**
			Benbrook	M40	01/23/2022 21:20:45	2070161	3	Benbrook	33C06 - T - Transfer / Interfacility / Palliative Care - Transfer/Interfacility - P2	00:53:38		1
			Benbrook	M42	01/04/2022 02:50:11	2043652	2	Benbrook	06C01 - Breathing Problems - P2	00:03:23	FD/PD Cancelled MedStar	0
			Benbrook	M36	01/10/2022 01:52:05	2051693	3	Benbrook		00:12:32	FD/PD Cancelled MedStar	0
			Benbrook	M400	01/07/2022 16:54:40	2048635	1	Benbrook	11D01 - U - Choking - Unknown - P1	00:14:18	Unit On Scene Cancelled	0
			Benbrook	M48	01/12/2022 01:58:01	2054338	3	Benbrook	26A05 - Sick Person (Specific Diagnosis) - P3	01:11:52		1
			Benbrook	M45	01/21/2022 21:00:46	2067685	2	Benbrook	33C05 - T - Transfer / Interfacility / Palliative Care - Transfer/Interfacility - P2	00:47:34		1
			Benbrook	M30	01/02/2022 10:11:29	2041544	2	Benbrook	06C01 - Breathing Problems - P2	01:05:07		1
			Benbrook	M48	01/07/2022 16:54:40	2048620	1	Benbrook	11D01 - U - Choking - Unknown - P1	01:20:30		1
			Benbrook	M68	01/19/2022 05:39:45	2064206	2	Benbrook	17B01 - G - Falls - On the ground or floor - P2	01:07:00		1
			Benbrook	M26	01/25/2022 11:23:11	2072161	2	Benbrook	33C04 - T - Transfer / Interfacility / Palliative Care - Transfer/Interfacility - P2	01:20:16		1
			Benbrook	M41	01/09/2022 19:57:40	2051498	1	Benbrook	06D02 - Breathing Problems - P1	00:36:08	AMA - Assessed and/or Treated & Released	0
			Benbrook	M30	01/09/2022 23:27:50	2051610	2	Benbrook	17B01 - G - Falls - On the ground or floor - P2	01:02:20		1

MedStar Mutual Aid Response Task Time Report

Criteria: **Period: 01/01/2022 thru 01/31/2022**

		Benbrook	M75	01/24/2022 20:01:41	2071516	3	Benbrook	26A11 - Sick Person (Specific Diagnosis) - P3	01:12:16		1
		Benbrook	M62	01/15/2022 20:13:26	2059941	2	Benbrook	17B01 - Falls - P2	01:04:40		1
		Benbrook	M23	01/16/2022 05:35:52	2060337	2	Benbrook	17B04 - G - Falls - On the ground or floor - P2	01:01:45		1
		Benbrook	M54	01/16/2022 17:51:10	2061013	2	Benbrook	13C01 - Diabetic Problems - P2	01:05:21		1
		Benbrook	M21	01/28/2022 10:32:58	2075881	2	Benbrook	17B01 - G - Falls - On the ground or floor - P2	01:07:30		1
		Benbrook	M62	01/28/2022 02:31:12	2075597	3	Benbrook	26A06 - Sick Person (Specific Diagnosis) - P3	00:51:57		1
		Benbrook	M73	01/06/2022 20:18:30	2047458	2	Benbrook	33C01 - T - Transfer / Interfacility / Palliative Care - Transfer/Interfacility - P2	01:32:38		1
		Benbrook	M57	01/14/2022 18:51:47	2058630	2	Benbrook	17B04 - Falls - P2	01:18:22		1
		Benbrook	M63	01/05/2022 13:04:19	2045657	3	Benbrook	26A08 - Sick Person (Specific Diagnosis) - P3	01:35:08		1
Cleburne	2										
		Aid TO	**Unit**	**Inc Date**	**Incident Number**	**Priority**	**Area**	**Problem**	**Task Time (Assign to Clear)**	**Cancel Reason**	**Resulted In TX**
		Cleburne	M73	01/27/2022 13:06:25	2074768	3	Cleburne	01A01 - Abdominal Pain / Problems - P3	00:05:12	FD/PD Cancelled MedStar	0
		Cleburne	M72	01/08/2022 22:04:37	2050400	1	Cleburne	29D02 - p - Rollover - Rollovers - P1	00:06:38	FD/PD Cancelled MedStar	0
Colleyville	1										
		Aid TO	**Unit**	**Inc Date**	**Incident Number**	**Priority**	**Area**	**Problem**	**Task Time (Assign to Clear)**	**Cancel Reason**	**Resulted In TX**
		Colleyville	MPV 2-04	01/15/2022 15:35:24	2059672	3	Colleyville		06:50:21		0
Crowley	11										
		Aid TO	**Unit**	**Inc Date**	**Incident Number**	**Priority**	**Area**	**Problem**	**Task Time (Assign to Clear)**	**Cancel Reason**	**Resulted In TX**
		Crowley	M54	01/23/2022 18:50:03	2069998	1	Crowley	29D05 - V - Solitary vehicle - Multiple patients - P1	00:14:01	Calling Party Cancelled	0
		Crowley	M46	01/04/2022 13:15:23	2044202	1	Crowley	12D04 - Convulsions / Seizures - P1	01:27:19		1
		Crowley	M32	01/29/2022 19:45:10	2077657	1	Crowley	12D04 - Convulsions / Seizures - P1	01:05:38		1
		Crowley	M81	01/31/2022 15:06:46	2079779	2	Crowley	26C01 - Sick Person (Specific Diagnosis) - P2	00:58:38	AMA - Assessed and/or Treated & Released	0
		Crowley	M47	01/31/2022 13:46:26	2079689	1	Crowley	29D02 - I - Auto vs. motorcycle - Auto vs. bicycle/Auto vs. motorcycle - P1	00:04:54	FD/PD Cancelled MedStar	0
		Crowley	M22	01/21/2022 17:08:52	2613040	2	Crowley	25B06 - Psychiatric / Abnormal Behavior / Suicide Attempt - P2	00:01:03		0
		Crowley	M70	01/11/2022 11:56:54	2053503	2	Crowley	06C01 - Breathing Problems - P2	00:28:02	FD/PD Cancelled MedStar	0
		Crowley	M57	01/16/2022 12:22:15	2060643	2	Crowley	06C01 - Breathing Problems - P2	00:55:32		1

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MedStar Mutual Aid Response Task Time Report

Criteria: **Period: 01/01/2022 thru 01/31/2022**

			Crowley	M60	01/21/2022 17:08:52	2613041	2	Crowley	25B06 - Psychiatric / Abnormal Behavior / Suicide Attempt - P2	00:16:46		0
			Crowley	M24	01/24/2022 08:20:34	2070567	2	Crowley	26A10 - Sick Person (Specific Diagnosis) - P3	01:00:15	Telemedicine Consult - Treated in Place	0
			Crowley	M22	01/04/2022 14:33:20	2044285	2	Crowley	26B01 - Sick Person (Specific Diagnosis) - P2	01:29:29		1
	Joshua	1										
			Aid TO	**Unit**	**Inc Date**	**Incident Number**	**Priority**	**Area**	**Problem**	**Task Time (Assign to Clear)**	**Cancel Reason**	**Resulted In TX**
			Joshua	M38	01/27/2022 13:44:24	2074803	2	Joshua	10C01 - Chest Pain / Chest Discomfort (Non-Traumatic) - P2	01:27:09		1
	Keene	1										
			Aid TO	**Unit**	**Inc Date**	**Incident Number**	**Priority**	**Area**	**Problem**	**Task Time (Assign to Clear)**	**Cancel Reason**	**Resulted In TX**
			Keene	M76	01/08/2022 16:15:35	2049991	2	Keene	17B04 - Falls - P2	01:06:27		1
	Keller	1										
			Aid TO	**Unit**	**Inc Date**	**Incident Number**	**Priority**	**Area**	**Problem**	**Task Time (Assign to Clear)**	**Cancel Reason**	**Resulted In TX**
			Keller	M51	01/28/2022 16:50:56	2076287	3	Keller	26A10 - Sick Person (Specific Diagnosis) - P3	00:29:04	Transferred Care	0
	Richland Hills	1										
			Aid TO	**Unit**	**Inc Date**	**Incident Number**	**Priority**	**Area**	**Problem**	**Task Time (Assign to Clear)**	**Cancel Reason**	**Resulted In TX**
			Richland Hills	M81	01/07/2022 07:59:52	2047873	3	Richland Hills		00:03:44	FD/PD Cancelled MedStar	0
	Roanoke	1										
			Aid TO	**Unit**	**Inc Date**	**Incident Number**	**Priority**	**Area**	**Problem**	**Task Time (Assign to Clear)**	**Cancel Reason**	**Resulted In TX**
			Roanoke	M56	01/19/2022 17:42:27	2065002	2	Roanoke	29D03 - V - Vehicle vs. vehicle - Multiple patients - P1	00:32:43	AMA - Assessed and/or Treated & Released	0
	Tarrant County	4										
			Aid TO	**Unit**	**Inc Date**	**Incident Number**	**Priority**	**Area**	**Problem**	**Task Time (Assign to Clear)**	**Cancel Reason**	**Resulted In TX**
			Tarrant County	M28	01/11/2022 05:22:22	2053159	1	Tarrant County	31D04 - Unconscious / Fainting (Near) - P1	00:33:56	AMA - Assessed and/or Treated & Released	0
			Tarrant County	M53	01/18/2022 13:08:38	2063267	3	Tarrant County		00:12:30	FD/PD Cancelled MedStar	0
			Tarrant County	M70	01/18/2022 05:00:26	2062814	1	Tarrant County	17D04 - Falls - P1	00:55:19		1
			Tarrant County	M73	01/25/2022 12:29:24	2072244	2	Tarrant County	26A05 - Sick Person (Specific Diagnosis) - P3	00:01:54	Calling Party Cancelled	0
	Watauga	1										
			Aid TO	**Unit**	**Inc Date**	**Incident Number**	**Priority**	**Area**	**Problem**	**Task Time (Assign to Clear)**	**Cancel Reason**	**Resulted In TX**
			Watauga	M68	01/15/2022 02:32:35	2059123	3	Watauga	26A04 - Sick Person (Specific Diagnosis) - P3	01:09:06		1
Received		46										
	Aid FROM	**Total**										
	Arlington EMS	3										

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MedStar Mutual Aid Response Task Time Report

Criteria: **Period: 01/01/2022 thru 01/31/2022**

		Aid FROM	Unit	Inc Date	Incident Number	Priority	Area	Problem	Task Time (Assign to Clear)	Cancel Reason	Resulted In TX
		Arlington EMS	AMR Arlington 1	01/22/2022 00:32:12	2067840	2	Fort Worth	24C03 - Pregnancy / Childbirth / Miscarriage - P2	00:57:28		1
		Arlington EMS	AMR Arlington 1	01/26/2022 17:23:05	2073869	2	Fort Worth	12C03 - E - Convulsions / Seizures - Epileptic or Previous seizure diagnosis - P2	01:16:17		1
		Arlington EMS	AMR Arlington 1	01/01/2022 17:40:48	2040852	2	Fort Worth	06C01 - Breathing Problems - P2	00:15:02	FD/PD Cancelled MedStar	0
Crowley	9										
		Aid FROM	**Unit**	**Inc Date**	**Incident Number**	**Priority**	**Area**	**Problem**	**Task Time (Assign to Clear)**	**Cancel Reason**	**Resulted In TX**
		Crowley	Crowley 254	01/21/2022 12:24:03	2067138	2	Burleson	17B04 - G - Falls - On the ground or floor - P2	00:11:53	FD/PD Cancelled MedStar	0
		Crowley	Crowley 254	01/31/2022 10:30:31	2079452	2	Burleson	25B03 - Psychiatric / Abnormal Behavior / Suicide Attempt - P2	00:08:48		0
		Crowley	Crowley 254	01/14/2022 10:44:42	2057763	2	Burleson	06C01 - Breathing Problems - P2	00:49:56		1
		Crowley	Crowley 254	01/24/2022 19:45:23	2071511	3	Burleson	26A03 - C - Sick Person (Specific Diagnosis) - Suspected coronavirus illness - P3	01:06:45		1
		Crowley	Crowley 54	01/12/2022 17:16:04	2055301	2	Burleson	29A02 - V - Vehicle vs. vehicle - Multiple patients - P3	00:15:54		0
		Crowley	Crowley 254	01/25/2022 11:32:23	2072175	2	Burleson	33C05 - T - Transfer / Interfacility / Palliative Care - Transfer/Interfacility - P2	01:35:58		1
		Crowley	Crowley 254	01/25/2022 09:56:29	2072053	2	Burleson	13C02 - Diabetic Problems - P2	01:10:31		1
		Crowley	Crowley 254	01/12/2022 15:31:51	2055046	2	Burleson	33C03 - T - Transfer/Interfacility - Transfer/Interfacility - P2	01:09:15		1
		Crowley	Crowley 254	01/14/2022 18:09:24	2058589	2	Burleson	17B04 - Falls - P2	01:00:27		1
Eagle Mountain	27										
		Aid FROM	**Unit**	**Inc Date**	**Incident Number**	**Priority**	**Area**	**Problem**	**Task Time (Assign to Clear)**	**Cancel Reason**	**Resulted In TX**
		Eagle Mountain	Eagle Mountain	01/22/2022 13:57:47	2068504	2	Fort Worth	29B05 - Y - Vehicle vs. vehicle - Multiple patients and Additional response required - P2	00:19:19		0
		Eagle Mountain	Eagle Mountain	01/17/2022 11:48:55	2061895	2	Fort Worth	26C01 - C - Sick Person (Specific Diagnosis) - Suspected coronavirus illness - P2	01:00:37		1
		Eagle Mountain	Eagle Mountain	01/06/2022 16:14:19	2047187	2	Fort Worth	28C07 - X - Stroke (CVA) / Transient Ischemic Attack (TIA) - No test evidence of stroke (< T hours) - P2	01:23:32		1

MedStar Mutual Aid Response Task Time Report

Criteria: **Period: 01/01/2022 thru 01/31/2022**

	Eagle Mountain	Eagle Mountain	01/05/2022 12:45:54	2045635	2	Saginaw	29B05 - U - Solitary vehicle - Unknown number of patients - P2	01:03:16	RAS - Release At Scene	0
	Eagle Mountain	Eagle Mountain	01/13/2022 17:19:28	2056751	1	Fort Worth	06E01 - A - Breathing Problems - Asthma - P1	01:05:08		1
	Eagle Mountain	Eagle Mountain	01/06/2022 11:04:51	2046745	3	Fort Worth	17A03 - G - Falls - On the ground or floor - P3	01:20:11		1
	Eagle Mountain	Eagle Mountain	01/26/2022 01:47:56	2073076	1	Fort Worth	23D02 - A - Overdose / Poisoning (Ingestion) - Accidental - P1	00:15:03		0
	Eagle Mountain	Eagle Mountain	01/09/2022 12:04:22	2051028	2	Saginaw	05C04 - Back Pain (Non-Traumatic or Non-Recent Trauma) - P2	00:07:49	FD/PD Cancelled MedStar	0
	Eagle Mountain	Eagle Mountain	01/27/2022 15:36:51	2074925	2	Fort Worth	26C01 - C - Sick Person (Specific Diagnosis) - Suspected coronavirus illness - P2	01:50:33		1
	Eagle Mountain	Eagle Mountain	01/10/2022 09:11:12	2052055	2	Fort Worth	28C01 - J - Stroke (CVA) / Transient Ischemic Attack (TIA) - CLEAR evidence of stroke (< T hours) - P2	01:20:56		1
	Eagle Mountain	Eagle Mountain	01/05/2022 09:50:39	2045404	1	Fort Worth	05D02 - Back Pain (Non-Traumatic or Non-Recent Trauma) - P1	01:17:17		1
	Eagle Mountain	Eagle Mountain	01/20/2022 11:52:21	2065810	1	Fort Worth	06D02 - O - Breathing Problems - Other lung problems - P1	01:07:09		1
	Eagle Mountain	Eagle Mountain	01/10/2022 17:58:28	2052753	3	Fort Worth	11O01 - F - Choking - Food - P3	00:40:16	AMA - Assessed and/or Treated & Released	0
	Eagle Mountain	Eagle Mountain	01/23/2022 20:06:04	2070098	3	Fort Worth	01A01 - Abdominal Pain / Problems - P3	00:21:30		0
	Eagle Mountain	Eagle Mountain	01/26/2022 10:58:43	2073422	1	Fort Worth	26D01 - Sick Person (Specific Diagnosis) - P1	01:43:49		0
	Eagle Mountain	Eagle Mountain	01/07/2022 20:00:13	2048865	3	Lake Worth	33C06 - T - Transfer / Interfacility / Palliative Care - Transfer/Interfacility - P2	01:12:39		1
	Eagle Mountain	Eagle Mountain	01/21/2022 15:13:01	2067320	3	Fort Worth	26A03 - C - Sick Person (Specific Diagnosis) - Suspected coronavirus illness - P3	01:38:42		1
	Eagle Mountain	Eagle Mountain	01/14/2022 16:11:47	2058367	2	Fort Worth	26C01 - Sick Person (Specific Diagnosis) - P2	01:17:05		1
	Eagle Mountain	Eagle Mountain	01/21/2022 05:52:30	2066827	2	Fort Worth	29B01 - Vehicle vs. vehicle - P2	00:09:30	FD/PD Cancelled MedStar	0

MedStar Mutual Aid Response Task Time Report

Criteria: **Period: 01/01/2022 thru 01/31/2022**

			Eagle Mountain	Eagle Mountain	01/08/2022 23:22:02	2050494	1	Fort Worth	04D04 - A - Assault / Sexual Assault / Stun Gun - Assault - P1	00:56:17		0
			Eagle Mountain	Eagle Mountain	01/01/2022 15:25:19	2040634	2	Fort Worth	06C01 - Breathing Problems - P2	00:01:29	FD/PD Cancelled MedStar	0
			Eagle Mountain	Eagle Mountain	01/03/2022 14:52:07	2042904	1	Fort Worth	06D01 - Breathing Problems - P1	01:35:22		1
			Eagle Mountain	Eagle Mountain	01/12/2022 15:48:23	2055077	3	Saginaw	03O03 - Animal bite - P3	00:06:19	FD/PD Cancelled MedStar	0
			Eagle Mountain	Eagle Mountain	01/15/2022 11:41:24	2059443	1	Fort Worth	12D02 - GENERALIZED seizure (not FOCAL or Impending) - P1	00:42:11	AMA - Assessed and/or Treated & Released	0
			Eagle Mountain	Eagle Mountain	01/27/2022 20:19:22	2075346	2	Lakeside	29B01 - Y - Motorcycle (solitary) - Multiple patients and Additional response required - P2	01:57:42		1
			Eagle Mountain	Eagle Mountain	01/06/2022 09:37:26	2046633	2	Fort Worth	31C02 - Unconscious / Fainting (Near) - P2	00:18:03		0
			Eagle Mountain	Eagle Mountain	01/25/2022 12:15:55	2072228	3	Fort Worth	12A01 - E - Convulsions / Seizures - Epileptic or Previous seizure diagnosis - P3	00:24:32		0
Johnson County	1											
		Aid FROM	**Unit**	**Inc Date**	**Incident Number**	**Priority**	**Area**	**Problem**	**Task Time (Assign to Clear)**	**Cancel Reason**	**Resulted In TX**	
		Johnson County	AMR JC 1	01/28/2022 18:46:15	2076476	2	Burleson	31C01 - Unconscious / Fainting (Near) - P2	01:27:19		1	
Justin EMS	1											
		Aid FROM	**Unit**	**Inc Date**	**Incident Number**	**Priority**	**Area**	**Problem**	**Task Time (Assign to Clear)**	**Cancel Reason**	**Resulted In TX**	
		Justin EMS	Justin EMS	01/24/2022 11:45:50	2070791	1	Fort Worth	06D02 - Breathing Problems - P1	01:22:13	AMA - Assessed and/or Treated & Released	0	
Watauga	5											
		Aid FROM	**Unit**	**Inc Date**	**Incident Number**	**Priority**	**Area**	**Problem**	**Task Time (Assign to Clear)**	**Cancel Reason**	**Resulted In TX**	
		Watauga	Watauga	01/12/2022 17:08:12	2055289	1	Haltom City	17B04 - Falls - P2	00:54:45		1	
		Watauga	Watauga	01/07/2022 16:34:59	2048592	2	Fort Worth	28C09 - X - Stroke (CVA) / Transient Ischemic Attack (TIA) - No test evidence of stroke (< T hours) - P2	00:56:03		1	
		Watauga	Watauga	01/14/2022 00:00:39	2057288	1	Fort Worth	21D04 - M - Hemorrhage (Bleeding) / Lacerations - MEDICAL - P1	00:59:58		1	
		Watauga	Watauga	01/09/2022 12:10:50	2051098	2	Fort Worth	26A10 - Sick Person (Specific Diagnosis) - P3	00:55:04		1	

MedStar Mutual Aid Response Task Time Report

Criteria: **Period: 01/01/2022 thru 01/31/2022**

			Watauga	Wataug a	01/08/2022 15:48:13	2049948	2	Fort Worth	26C01 - Sick Person (Specific Diagnosis) - P2	00:57:25		1

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MedStar Response Time Reliability and AVG Response Time Performance

Period: Jan 2022

		Current Month							100 Response Compliance Period		
Member City	Pri	Calls	On Scene	Avg RT	Late Responses	On Time %	Extended Responses Count	%	Compliance Calculated Responses	Late Responses	On Time %
Blue Mound	1	7	7	00:11:48	3	57.1%	2	28.6%	31	5	83.9%
	2	15	14	00:09:44	3	80.0%	0	0.0%	52	5	90.4%
	3	5	2	00:09:29	1	80.0%	0	0.0%	23	5	78.3%
Total Blue Mound		**27**	**23**								
Burleson	1	131	123	00:07:17	20	84.7%	3	2.3%	131	20	84.7%
	2	223	214	00:09:02	40	82.1%	13	5.8%	223	40	82.1%
	3	128	119	00:10:44	18	85.9%	8	6.3%	128	18	85.9%
	4	103	102	00:31:37	7	93.2%	2	1.9%	103	7	93.2%
Total Burleson		**585**	**558**								
Edgecliff Village	1	12	12	00:09:05	3	75.0%	1	8.3%	32	7	78.1%
	2	6	6	00:09:10	1	83.3%	0	0.0%	6	1	83.3%
	3	9	9	00:10:40	1	88.9%	1	11.1%	30	2	93.3%
Total Edgecliff Village		**27**	**27**								
Forest Hill	1	60	58	00:09:51	20	66.7%	2	3.3%	145	38	73.8%
	2	87	83	00:09:29	10	88.5%	1	1.1%	180	20	88.9%
	3	42	36	00:10:41	2	95.2%	2	4.8%	97	7	92.8%
Total Forest Hill		**189**	**177**								
Fort Worth	1	3331	3213	00:08:38	639	80.8%	83	2.5%	3331	639	80.8%
	2	5377	5088	00:09:17	744	86.2%	142	2.6%	5377	744	86.2%
	3	3362	3018	00:10:28	355	89.4%	86	2.6%	3362	355	89.4%
	4	1398	1388	00:26:18	63	95.5%	27	1.9%	1398	63	95.5%
Total Fort Worth		**13468**	**12707**								
Haltom City	1	114	110	00:08:51	25	78.1%	5	4.4%	114	25	78.1%
	2	162	155	00:09:55	28	82.7%	3	1.9%	162	28	82.7%
	3	114	97	00:11:36	17	85.1%	2	1.8%	208	41	80.3%
	4	3	3	00:28:09	0	100.0%	0	0.0%	26	2	92.3%
Total Haltom City		**393**	**365**								
Haslet	1	2	2	00:05:23	0	100.0%	0	0.0%	57	18	68.4%
	2	14	13	00:08:18	1	92.9%	0	0.0%	108	37	65.7%

MedStar Response Time Reliability and AVG Response Time Performance

Period: Jan 2022

		Current Month							100 Response Compliance Period		
Member City	Pri	Calls	On Scene	Avg RT	Late Responses	On Time %	Extended Responses Count	%	Compliance Calculated Responses	Late Responses	On Time %
	3	6	5	00:15:08	1	83.3%	1	16.7%	31	3	90.3%
Total Haslet		**22**	**20**								
Lake Worth	1	26	24	00:08:05	7	73.1%	0	0.0%	26	7	73.1%
	2	60	55	00:09:01	11	81.7%	2	3.3%	60	11	81.7%
	3	31	26	00:11:07	4	87.1%	1	3.2%	98	14	85.7%
	4	5	5	00:13:22	0	100.0%	0	0.0%	7	0	100.0%
Total Lake Worth		**122**	**110**								
Lakeside	1	6	6	00:12:04	3	50.0%	0	0.0%	18	5	72.2%
	2	11	9	00:12:19	5	54.5%	0	0.0%	26	9	65.4%
	3	2	1	00:13:43	0	100.0%	0	0.0%	9	5	44.4%
Total Lakeside		**19**	**16**								
River Oaks	1	25	25	00:08:38	5	80.0%	0	0.0%	124	23	81.5%
	2	24	23	00:08:55	3	87.5%	0	0.0%	24	3	87.5%
	3	19	17	00:12:31	7	63.2%	1	5.3%	100	26	74.0%
Total River Oaks		**68**	**65**								
Saginaw	1	69	67	00:10:59	26	62.3%	7	10.1%	69	26	62.3%
	2	96	87	00:10:46	22	77.1%	4	4.2%	153	33	78.4%
	3	55	46	00:12:37	8	85.5%	2	3.6%	55	8	85.5%
	4	25	25	00:30:55	2	92.0%	0	0.0%	27	2	92.6%
Total Saginaw		**245**	**225**								
Sansom Park	1	26	25	00:08:49	4	84.6%	2	7.7%	111	30	73.0%
	2	38	38	00:09:56	8	78.9%	4	10.5%	131	19	85.5%
	3	31	28	00:11:52	7	77.4%	0	0.0%	120	25	79.2%
	4	2	2	00:16:06	0	100.0%	0	0.0%	10	1	90.0%
Total Sansom Park		**97**	**93**								
Westover Hills	1	3	3	00:10:22	1	66.7%	0	0.0%	3	1	66.7%
	2	5	4	00:10:44	2	60.0%	0	0.0%	7	2	71.4%
Total Westover Hills		**8**	**7**								
	1	13	13	00:08:59	3	76.9%	0	0.0%	59	14	76.3%

MedStar Response Time Reliability and AVG Response Time Performance

Period: Jan 2022

		Current Month							100 Response Compliance Period		
Member City	Pri	Calls	On Scene	Avg RT	Late Responses	On Time %	Extended Responses Count	%	Compliance Calculated Responses	Late Responses	On Time %
Westworth Village	2	27	27	00:12:39	6	77.8%	4	14.8%	75	13	82.7%
	3	21	18	00:12:21	3	85.7%	0	0.0%	74	13	82.4%
	4	2	2	00:24:42	0	100.0%	0	0.0%	5	0	100.0%
Total Westworth Village		63	60								
White Settlement	1	60	59	00:07:46	10	83.3%	0	0.0%	60	10	83.3%
	2	125	122	00:08:57	16	87.2%	2	1.6%	125	16	87.2%
	3	57	53	00:09:26	4	93.0%	0	0.0%	131	11	91.6%
	4	7	7	00:20:21	0	100.0%	0	0.0%	7	0	100.0%
Total White Settlement		249	241								
System Wide	1	3885	3747	00:08:39	769	80.2%	105	2.7%	4311	868	79.9%
	2	6270	5938	00:09:20	900	85.6%	175	2.8%	6709	981	85.4%
	3	3882	3475	00:10:34	428	89.0%	104	2.7%	4466	533	88.1%
	4	1545	1534	00:26:44	72	95.3%	29	1.9%	1584	75	95.3%
Total System Wide		15582	14694								

Tab G – FRAB

Tab H – EPAB

Tab I – Chief Transformation Officer

Transformation Report

February 2022

Alternate Payment Models & Expanded Services

- ET3 Model
  - Updated outcomes attached.
- Molina Healthcare agreement signed for FFS model for MIH visits of high-risk patients MIH services.
  - Operationalizing likely in late March
- **Cigna** agreement executed for ET3 payment model for their ***commercial*** population
  - Operationalizing March 1, 2022
- Landmark Health agreement launched January 1st.
  - 57 EMS activations, 35 with MHP on-scene.
  - 6 MIH episodic requests
- Working with **Medically Home** and **THR** in a project to provide services to patients admitted to Hospital in the Home patients.
  - Potential operationalization April 1st.

Ambulance Balanced Billing

- CBS 11 did 'investigative' report on ground ambulance balanced billing
  - MedStar interviewed and the report was actually not bad
- MedStar representative nominated by NAEMT to service on the Congressional Committee established by the 'No Surprises Act'.
  - Pending appointment decisions

Medicaid Payment for Treatment in Place

- HHSC reached out, asking for help drafting the rules
- Needs to be in place by 9/1/22 (including all hearings, etc.)

Ambulance Supplemental Payment Program (ASPP)

- Still awaiting response from CMS

Upcoming Presentations:

Event (location)	Date	Attendees
AAMS Leadership Institute (Wheeling, WV)	April 2022	~150
North Carolina EMS Expo (Charlotte)	May 2022	~750
Michigan EMS Expo	May 2022	~350

Media Summary

Local –

- Winter Weather Safety and Response Volume
  - NBC 5, CBS 11, KRLD, WBAP, Star-Telegram
- 2-11 Event remembrance
  - CBS 11, FOX 4
- Winter Storm Uri Impact on First Responders
  - NBC 5
- Balanced Billing
  - CBS 11

ET3 Model Outcome Summary:

ET3 Program Summary		
April 5, 2021 through:	1/30/2022	
Overall Emergency Response Volume		
Documented Medicare Patient Contacts	28,580	
≥ 65	21,040	73.6%
< 65	7,540	26.4%
Transported	24,783	86.7%
AMA (incl. Refused All Care & Refusal w/o Capacity)	2,382	8.3%
ET3 Telehealth Intervention	415	
IES	411	
MHMR	4	
Outcomes		
Transported	47	11.4%
Hospital ED	44	
Other	3	
TIP	349	84.9%
Dispatch Health Referral	138	
MCOT Referral	3	

ET3 Use Post-CE Analysis			
As of 1/30/2022			
	Pre-October 15, 2021	**Since October 15, 2021**	**% Change**
Days	191	108	
ET3 Telehealth Offers	2,699	1,174	
Number per day	14.1	10.9	-23.1%
ET3 Telehealth Offers Accepted	247	213	
% Accepted	9.2%	18.1%	98.3%
Patient Declined Telehealth	2,452	961	
Number per day	12.8	8.9	-30.7%
% Declined	90.8%	81.9%	-9.9%

Times on Task Analysis	Through:	**1/30/2022**
Medicare Patients		
Scene Time AMA w/Telehealth Completed	1:00:55	N = 497
Scene Time AMA w/o Telehealth Attempted	0:37:16	N = 1,169
AMA Scene Time Difference with and w/o Telehealth	0:23:39	
AMA w/Telehealth Completed	1:00:55	N = 497
AMA w/Telehealth Started, but Not Completed	0:51:53	N = 57
Difference	0:09:02	
Total Task Times		
Average Task Time - All Calls	1:01:32	
Average Task Times - Transport	1:15:35	
Pulse Report April 5 - January 28, 2022		
Summary		
Task Time Difference Telehealth Completed vs. Transport	0:14:40	Less Time

Enrollments by Team Member		Through:	1/30/2022
Crew Member	Records that qualify for ET3 and offered & Accepted by Patien	Records that qualify for ET3 and offered	Patient Consent %
Zane Felkins	37	37	100.0%
Thomas Dorosky	27	30	90.0%
Matthew Hansen	26	26	100.0%
Shawn Nicholson	23	23	100.0%
Elena Dikovitskaya	17	17	100.0%
Mary Haight	13	13	100.0%
Sadie Gamez	13	13	100.0%
Daniel Richmond	12	12	100.0%
Desiree King	11	11	100.0%
Philip Akin	11	12	91.7%
John Massey	10	16	62.5%

Here are some great examples of ET3 at work from these MedStars:

Matthew Hansen, Caleb Postoak, Kathryn Thetford
Dr Larussa Telehealth. Pt states that she has been to the doctor for the back pain previously for the back pain. Pt stated that on her last visit she had a CT and X-, and they had scheduled her for an appointment on Monday. When offered a Telehealth consult the pt agreed, and a consult was initiated. After consulting with the Dr., it was suggested that the pt use a lidocaine patch to help with the pain, and the pt accepted. Pt's daughter stated that she would go and pick up the patches from the pharmacy. PT signatures were obtained, and Medstar XXX returned to service.

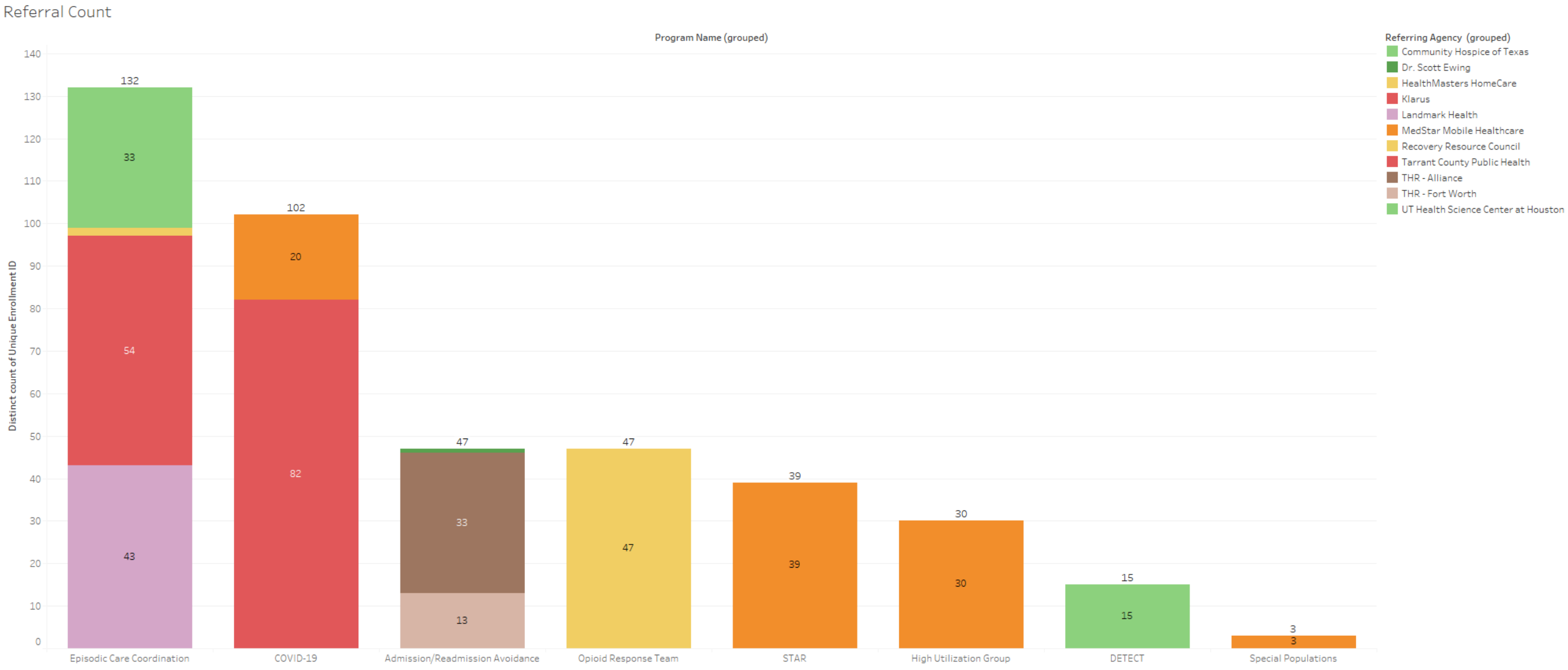
Philip Akin, Justin Taylor
Dispatched to report of a sick person. Upon arrival crew found pt sitting on toilet, complaining of nausea, vomiting, diarrhea, and stomach cramps which began at appx 1900 tonight, immediately after eating dinner. Pt states she does not want to go to the hospital unless she absolutely has to. Pt assisted into living room for assessment. Vitals obtained and found to be stable. Crew advised pt of ET3 service, and pt accepted. Telehealth session started with Dr. Larussa, who agreed with crew's assessment and impression of food poisoning. Dr. Larussa instructed crew to give pt a 500cc NS IV bolus and 4mg Zofran IV, and to arrange for a follow up visit with Dispatch Health. IV established, 20g in L hand attached to saline lock, and fluid bolus started. Pt given 4mg Zofran IV. Pt received 500cc NS bolus, and reports that her stomach cramps have subsided as well as her nausea. Dispatch Health contacted an appointment set up for tomorrow morning. Once IV bolus administered, IV was removed and site bandaged. Pt was advised by EMS to call 911 if her symptoms became worse or if new symptoms appeared. MXX cleared scene.

Elena Dikovitskaya, Brandon Elliott
Height 180cm. Weight 150kgs. Dispatched to UGM , men's shelter to XX y.o. Male pt who had Episodes of dizziness: poss. dehydration, poss. orthostatic hypotension. Pt was found sitting on the bench in the lobby. Pt was AAOx4. Pt's initial BP and HR were elevated, which improved as pt's assessment was progressing. Pt's 12 Lead EKG indicated Sinus Tachycardia. Pt relayed that he felt dizzy earlier when he was trying to stand up from sitting position. Pt was taking LASIX and had dry mucus membranes. Pt possibly was dehydrated. On the time of the assessment pt denied having sob, chest pain or dizziness. Pt accepted offered by EMS telehealth. Pt's telehealth Dr was Dr Reyner. The Dr assessed pt by asking medical questions. Pt's stroke screen was performed and was negative. The Dr Reyner advised pt to schedule an appt with the dr as soon as possible and withhold taking lasix until he consults with his dr. Also, Dr Reyner relayed that pt did not need to go to the ER today. Pt was left on scene as dr advised. Pt was offered 911 call back if needed.

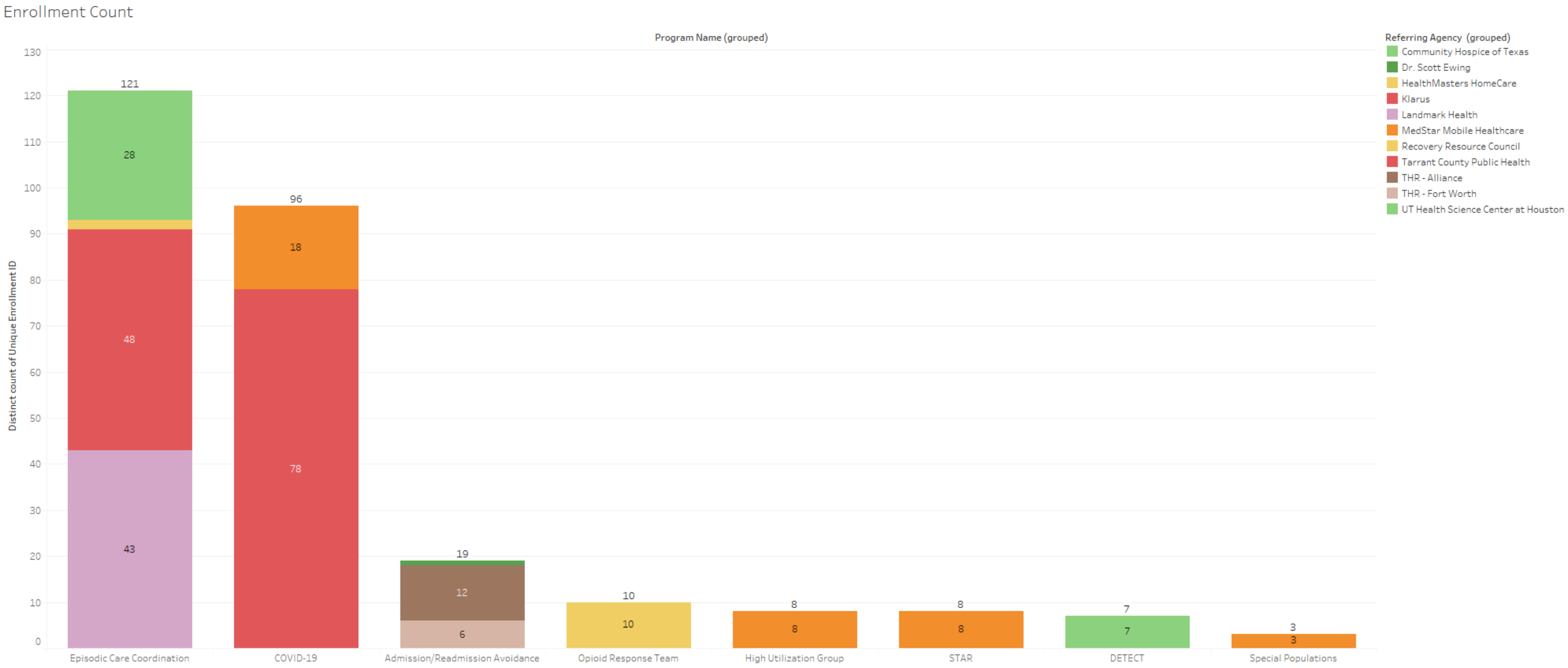
Renee Conley, Matthew Hansen

Medstar XX called to a XX-year-old female c/o not feeling well. Pt was found sitting upright on couch and did not appear in distress. Pt was A&Ox4 and GCS 15. Pt reported that she tested positive for COVID-19 approximately 10 days ago. Pt has symptoms including nausea, vomiting, diarrhea, weakness, headache and dizziness. Pt reported that she called her PCP on Tuesday and they prescribed her a Z-pak. Pt stated that she started taking the Z-Pak yesterday afternoon. Pt met criteria for Telehealth consultation. Pt agreed to speak with a Telehealth physician. Dr. Faraz Saifi was the Teledoc for this consultation. Dr. Saifi stated that he would recommend that the Pt stay at home with stable vitals. Dr. Saifi recommended that the Pt go to the drug store to buy a pulse oximeter and monitor her SpO2. Dr. Saifi stated that if her oxygen level goes below 90% to call 911 immediately. Dr. Saifi stated that Dispatch health will be notified. Pt agreed with care plan and having Dispatch Health come to her home. Pt was informed of and signed all documentation.

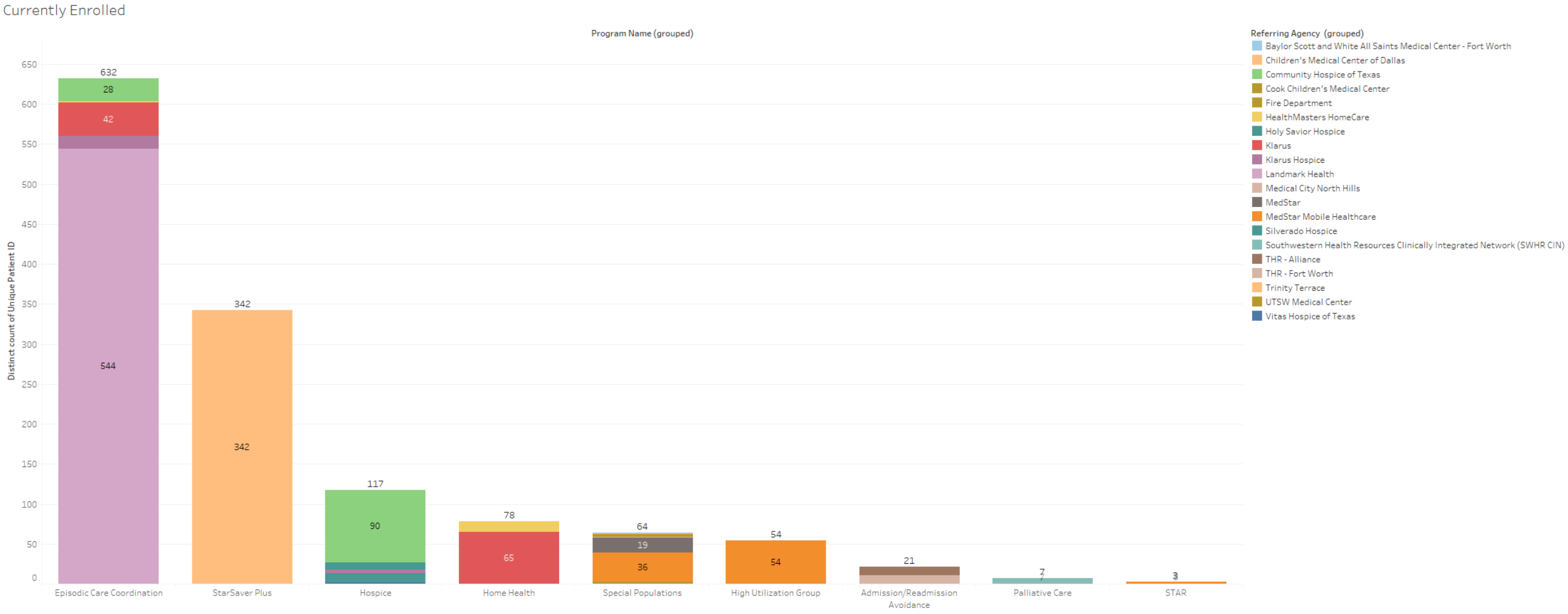
Mobile Integrated Healthcare Referrals – January 2022



Mobile Integrated Healthcare Enrollments – January 2022



Mobile Integrated Healthcare Current Enrollments



Mobile Integrated Healthcare Outcomes for THR Partnerships

Hospital Utilization	THFW & THAL	Admission/Readmission Avoidance		
As of:	12/31/2021			
	Before Enrollment (1)	After Graduation (2)	Change	30-Day Readmission (3)
Sample Size (4)	137			371
ED Utilization	141	83	-41.13%	16.71%
Unplanned Admission	329	140	-57.45%	

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

Mobile Integrated Healthcare Clients' Self Assessment of Health Status

Patient Self-Assessment of Health Status (1)									
As of:	1/31/2022								
	High Utilizer Group			Admission/Readmission Avoidance			Obs Admit Avoidance		
	Enrollment	Graduation	Change	Enrollment	Graduation	Change	Enrollment	Graduation	Change
Sample Size	**330**			**844**			**81**		
Mobility (2)	2.29	2.51	9.6%	2.32	2.52	8.7%	2.41	2.57	6.5%
Self-Care (2)	2.55	2.72	6.7%	2.58	2.73	5.7%	2.67	2.78	4.1%
Perform Usual Activities (2)	2.25	2.59	**15.2%**	2.33	2.60	**11.2%**	2.47	2.57	3.9%
Pain and Discomfort (2)	2.00	2.35	**17.7%**	2.39	2.60	8.7%	2.17	2.34	7.8%
Axiety/Depression (2)	2.21	2.53	**14.2%**	2.50	2.72	8.7%	2.46	2.72	**10.8%**
Overall Health Status (3)	5.23	6.92	**32.4%**	5.53	7.09	**28.2%**	4.98	6.98	**40.2%**

Notes:

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

2. Score 1 - 3 with 3 most favorable

3. Score 1 - 10 with 10 most favorable

NOTES ON AMENDED BYLAWS OF

METROPOLITAN AREA EMS AUTHORITY

ARTICLE ONE

NAME, PURPOSES AND OFFICES

Section 1.1. Name. The name of the organization is the Metropolitan Area EMS Authority (formerly known as the Area Metropolitan Ambulance Authority) (the "Authority"). The standard abbreviation is “MAEMSA.”

Section. 1.2. Purposes. The Authority was established on August 1, 1988 as a governmental administrative agency under Chapter 791 of the Tex. Government Code (the Interlocal Cooperation Act) to administer and operate a prehospital emergency medical services and medical transportation system in a service area comprised of the Authority’s member jurisdictions. As more fully set out in Restated Interlocal Cooperative Agreement (“Interlocal Agreement”) between the member jurisdictions and the Uniform EMS Ordinance adopted by the member jurisdictions, as they may be amended and restated from time to time, the Authority’s purposes are to provide a regulated prehospital emergency medical services and medical transportation system and to provide a mobile integrated healthcare program and other programs to benefit the public health and welfare.

@@need to update name of Interlocal Agreement

Section 1.3. Offices. The principal office of the Authority shall be located at 2900 Alta Mere Drive, Fort Worth, Texas 76116, or at any other place designated by the Board of Directors. The Authority may also have offices at such other places as the Board of Directors may from time to time determine.

ARTICLE TWO

BOARD OF DIRECTORS

Section 2. 1. General Powers. Subject to the provisions of these Bylaws and the lnterlocal Agreement, the Authority shall be administered by the Board of Directors (“Board”) who shall provide overall direction with respect to all matters within the scope of these Bylaws and the Interlocal Agreement and Uniform EMS Ordinance.

Section 2.2 Composition of Board. The number and qualifications of directors and the method of selecting and appointing directors are set forth in Article II of the Interlocal Agreement.

Section 2.3 Holdover. Directors shall hold office until their successors are elected or appointed and qualified, or until their earlier death, resignation, retirement, disqualification or removal.

Section 2.4 Removal of Directors. Any voting member of the Board who fails to attend any three consecutive, regularly scheduled Board meetings or who fails to attend at least six regularly scheduled meetings in any twelve-month period without good cause may be removed from the Board at the request of a majority of their appointing jurisdiction(s) and their position will be filled for the remainder of their term as provided in the Interlocal Agreement.

Section 2.5. Regular Meetings. Regular meetings of the Board shall be held on dates and times determined by the Board, but no less often than quarterly, at the principal offices of theAuthority; provided, however, that the Chairperson may postpone, cancel or reschedule a regular meeting if the Chairperson determines that a quorum will not be present at such meeting.[1]

Section 2.6. Special Meetings. A special meeting of the Board may be called at any time by the Chairperson or the Chief Executive Officer, or by the written request of three or more voting directors.

Section 2.7. Quorum and Minutes. At all meetings of the Board, the presence of a majority of the number of current voting directors shall be necessary and sufficient to constitute a quorum for the transaction of business. The act of a majority of the voting members present in person at a meeting which a quorum is present shall be the act of' the Board unless the act of a greater number is required by these Bylaws or the Interlocal, in which case the act of such greater number shall be requisite to constitute the act of the Board. All acts and proceedings of the Board shall be recorded by the Secretary in a minute book and shall be submitted to the Board for its approval at the next regular meeting.

Section 2.8. The Open Meetings Act. All regular and special meetings of the Board shall be conducted in accordance with the Open Meetings Act, Chapter 551 of the Texas Government Code.

@@add that Board shall adopt policies as required by Interlocal or as it otherwise deems necessary.

ARTICLE THREE
COMMITTEES

The Board may, by resolution adopted by the Board, from time to time designate from among the members of the Board one or more committees, each committee to consist of one or more members, but less than a majority of the members of the Board. Except as limited by the Interlocal Cooperative Agreement, these Bylaws or the resolution establishing such committee, each committee shall have and may exercise all of the authority of the Board as the Board may determine and specify in the respective resolutions appointing each such committee. A majority of all the members of any such committee may fix the time and place of its meetings, unless the Board shall otherwise provide, and meetings of any committee may be held upon such notice, or without notice, as shall from time to time be determined by the members of any such committee. At all meetings of any committee, a majority of its members shall constitute a quorum for the transaction of business, and the act of a majority of the members present shall be the act of any such committee, unless otherwise specifically provided by law, the lnterlocal Cooperative Agreement, these Bylaws, or the resolution establishing such committee. The Board shall have power at any time to change the number, subject to the foregoing, and members of any such committee, to fill vacancies and to discharge any such committee.

@@ Historically the Chair has nominated committee for Board Approval

[1] Section 2.5 was amended on 4/24/19

ARTICLE FOUR
BOARD OFFICERS

Section 4.1. Officers. The officers of the Board shall be elected by the Board and shall consist of a Chairperson, Vice Chairperson and Secretary, and may consist of such other officers and agents as the Board may deem necessary thereof.

Section 4.2. Term: Removal; Resignation; Vacancies. Officers shall hold office until their successors are elected or appointed and qualified, or until their earlier death, resignation, retirement, disqualification or removal. Any officer or agent elected or appointed by the Board may be removed at any time with or without cause by the affirmative vote of a majority of all other voting directors whenever, in their judgment, the best interests of the Authority shall be served thereby. Any officer may resign at any time by giving written notice to the Board. Any such resignation shall take effect at the date of the receipt of such notice or at such other time specified therein, and unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

@@set terms and regular elections for officers?

Section 4.3 Chairperson. The Chairperson shall conduct and preside at all meetings of the Board and shall perform such other duties as the Board may direct.

@@do officers duties/authority need more specificity?

Section 4.4. Vice Chairperson. The Vice Chairperson shall have such authority and perform such duties as may be delegated, permitted or assigned from time to time by the Chairperson or the Board and, in the event of the absence, unavailability or disability of the Chairperson, or in the event of the Chairperson's inability or refusal to act, shall perform the duties and have the authority and exercise the powers of the Chairperson, unless otherwise determined by the Board.

Section 4.5. Secretary. The Secretary, or his/her designee, shall have the duty of recording the proceedings of the meetings of the Board in a minute book to be kept for that purpose and shall perform all like duties for any committees. The Secretary shall perform such other duties as may be prescribed by the Board or the Chair, under whose supervision the Secretary shall be. In the absence of the Secretary, the minutes of all meetings of the Board shall be recorded by such person as shall be designated by the Board. The Secretary may serve as acting Chairperson at any regular meeting where the Chairperson and Vice Chairperson are both unable to attend.

@@Executive Committee-composition and duties/authority?

ARTICLE FIVE
CHIEF EXECUTIVE OFFICER AND OTHER OFFICERS

Section 5.1. Chief Executive Officer. The Board shall appoint a Chief Executive Officer who shall have and exercise direct charge and supervision of the business affairs of the Authority in performing its duties under these Bylaws and the Interlocal Cooperative Agreement. The Chief Executive Officer shall have such other powers and duties as the Board may determine.

Section 5.2. Other Officers Reporting to Board. The Board shall appoint a Compliance Officer, Privacy Officer, Security Officer, General Counsel, and other similar officers as may be required by law or determined by the Board to be necessary. These officers may be regular employees of the Authority with other duties but shall report to the Board in their capacity as officers.

Section 5.3. Medical Director. In accordance with the Interlocal Cooperative Agreement between the member cities, the Board shall contract with a Medical Director appointed by EPAB who shall report to EPAB and the Board.

@@needs to be changed to similar language as 5.1 for Medical Director and General Counsel

ARTICLE SIX
AMENDMENTS

These Bylaws may be altered, amended or repealed or new Bylaws may be adopted at any regular or special meeting of the Board by the affirmative vote of two-thirds of the number of the members of the Board fixed by these Bylaws, provided notice of the proposed alteration, amendment or repeal or adoption be contained in the notice of such meeting.

ARTICLE SEVEN
PREVIOUS BYLAWS REPEALED

Any and all previous Bylaws are hereby repealed and are replaced and superseded in their entirety by these Bylaws.

ARTICLE EIGHT
CONTROLLING DOCUMENTS

To the extent any of the provisions in these Bylaws conflict with any of the provisions in the Restated Interlocal Cooperative Agreement or the Uniform EMS Ordinance, the provisions of the Interlocal Cooperative Agreement and Uniform EMS Ordinance shall control. The terms used in these Bylaws shall have the meanings defined in those documents.

ARTICLE NINE
GENERAL PROVISIONS

Section 9.1 Restrictions on Distribution of Net Earnings. No part of the net earnings of the Authority shall inure to the benefit of, or be distributed to, its directors, officers, or other private persons, except that the Authority shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of its purposes.

Section 9.2 Distribution of Assets Upon Dissolution. In the event of dissolution of the Authority, after payment of or provision for all liabilities of the Authority, all of the assets of the Authority shall be distributed to, the Member Jurisdictions on a pro-rata basis. Each Member Jurisdiction's pro-rata share of such distributed assets or proceeds shall be based upon the population of the Member Jurisdiction (as reported by the U.S. Census Bureau) as compared to the

total population of all Member Jurisdictions (as reported by the U.S. Census Bureau).

CERTIFICATE OF SECRETARY

I certify that I am the duly elected and acting Secretary of the Metropolitan Area EMS Authority and that the above Bylaws were approved by the affirmative vote of at least two-thirds of the members of the Board of Directors on _____.

_____

Secretary of Board of Directors

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