Keith Anderson, Director
Department of the Environment

Denise Rivera-Portis, Labor Liaison
Department of the Environment

Michael Kelly, Director
Department of Housing and
Community Development

Angela Nottingham, Labor Liaison
Department of Housing and
Community Development

Dr. James E. Lyons, Sr., Interim President
University of the District of Columbia

_____, Labor Liaison
University of the Distri t of Columbia

Neil Stanley. Director
Department of Youth Re ilitation
Services

Tania Mortensen, Labor Liaison
Department of Youth Rehabilitation

iChoriaison
Department of General Services

Ron M. Linton, Commissioner
DC Taxicab Commission

Patty Mason. Labor Liaison
DC Taxicab Commission

Harriet Tregoning, Director
Office of Planning

Sandra Harp, Labor Liaison
Office of Planning

Eric E. Richardson, Executive Director
Office of Cable Television

Angela Harper, Labor Liaison
Office of Cable Television

Robert Mancini, Chief Technology Officer
Office of the Chief Technology Officer

Christina Fleps, Labor Liaison
Office of the Chief Technology Officer

Laura L. Nuss, Director
Department of Disability Services

Kehinde Asuelimen, Labor Liaison
Department of Disability Services

James Staton, Jr., Chief Procurement Officer
Office of Contracting and Procurement

Shirley Lanier, Labor Liaison
Office of Contracting and Procurement

Stephen Baron, Director
Department of Mental Health

Frankie T. Wheeler, Director,
Human Resources
Department of Mental Health

Brendolyn McCarty-Jones, Labor Liaison
Department of Mental Health

APPROVAL

Section 1-617.15 of the Compensation Units 1 and 2, dated April 12, 2012, has been reviewed in accordance with This collective bargaining agreement between the District of Columbia and the District of Columbia Official Code (2011 Ed.), and hereby approved on this 1st day of May 2013.

Vincent Gray
Mayor

APtl!:NnlXA.

•f11Mc :a tall6lg

0>c<4• 1it.2

C..<e•Jrigc.1 e-Ctep ... Rmew

•&hl1icalsaC, ..-n.ll-'er&i> lauib]cdiw- efll'lftjlllo«•tiidl
1..duwP tl--pllOlllllfctlf c.lllEl&ac--.Ssllnll'
t. "r•}odllbaw. qw•--'tb. 'DIB°*W.....11111
of Ii-..dPllftmf ı 'bfW.-'df.14iijiPiii*Abr nrr..-tar,.-'
...,<Wm!Wors 'tWamllf.Crot "•u..1a1. 11B....JRJ08l
lblll:dllanac•Dd. olWifCsw..ctml&W.lm .meqi1ma
'lbeippIOP..a 6f'1lltllpi mmdt '"\lie hiteri«1

r 6t?adU:sluaebf .-a.&eIN&.ic:t.m1't l ebll.....,.....
-labor d ioll...,.....-mlllbonim.laoMwiU
,iclbl. nillpqccrdill. uanmt ad ii'
to em&nWjcilt cln!Qln!ioiD lliidf rrpnattdal Wlilc pufeM:dbJ'Dilftkt
-#dlD1¥1Mi'"P' tttt4dMIDl Jr.tm:flf ..tDcl

la. tr,, R!IPaitll¥\ d •ww.. •q'°'91W-:•w&<OW
-lll Cld-\tmC>ilrlb ... atnes.i
eampmr111 ·orae b&tcoiunJ 'Vilh .-v.itdl.•

For Labor

For Management

January 30, 2001

APPENDIXB

MEMORANDUM OF AGREEMENT
BETWEEN THE
DISTIUCT OF COLUMBIA
AND
COMPENSATION UNITS I AND l
CLASSlnCATION AND COMPENSATION REFORM TASK FORCE INI11ATIVES

Pursuant to the tams of the "Memorandum of Understanding Between Compensation - Units l and 2 and the District of C.Olumbia c.ooceming Classification and C.Ompensation C.ollaborative Review," which was incorporated as part of the Compensation Agreement between the District of Columbia Govermnent and Compensation Units I and 2, FY 2001-FY 2003 {"Compensation AgR'.ClUcnt"), the District of Columbia Government and the Unions in Compeosation Units I and 2, established the Joint Labor-Management Oassification and Compensation Reform Task Poree (Joint Task Force). In addition, under the terms of the C.ompeosation Agreement, the District Government agreed *to* set aside c.ertain funding in fiscal year.; 2002 and 2003, whicli would be used by the Joint Task Force to implement initiatives designed to reform the District's compensation and classification systems.

The Compensation Agreernm.t provides that in FY 2003 the District shall invest the equivalent of a minimum of one peKent (l %) incr in the aggregate salaries of Compensation Units l and 2 {"I % Set-aside") toward classification and compensation refonn. The District expended a portion of the l % Set-aside to implement the first significant change tot compensation system in the District by changing the pay progression of Olmpeosation Units I and 2 employees, or how employees move between steps within a grade. The Joint Task Force has also agreed to begin the first classification refi:>rm project by reviewing the position classifications in each of the 9 occupational pay groups and where appropriate reclassify positions and adjust the grades and rates of pay fi:>r the reclassified positions.

The Joint Task Force classification review will begin in August 2003, with a review of J>!>Sitionli in the clerical/administrative occupational group and specific classification series and/or positions, which the Joint T• Force bas dctenninc̲d, requires immediate review. The Joint Task Force has achat the District shall expeod the unencumbered FY 2003 I% Set-aside fond balance under the term,, of the C.ompensation Agreaneot. to fund ioctcascs in salaries or make other pay adjustments fi:>r employees in Compcmation Units I and 2 who occupy positions the grade and/or the rate of pay of wbicll is changed because of reclassification, grading, rate adjustmeot or c.baoges in the District's classification and/or compensation policy as part of the classification retOrm project initiated by the Joint Task Force in FY 2003.

The Joint Task Force bas agreed to apply any rate adjustmeot rdroactively to a date in FY 2003. The retroactive date of implementation will be detamined based on the llUDlbea- of employccs affected and the unexpended balance of the l%set-aside. That is pay adjUstments will be made in af6lded employees• pay retroactive to the date ptzmitted by the fund balance. Payment to employees should be made by March 31, 2004.

1

Further, the contracting parties agree that amounts hereafter desipated through collective bargaining fur classification and compaisation collabotUivc review under the terms of the FY 2004-to FY2006 Compensation Units 1and 2 Agreement. shalt be accorded similar treatment for purposes of implementation. Specifically, any funds set aside in the F"iscal Years 2004, 2005 or 2006 shalt be available for expenditure incbal 6scal year or any ot.ber fiscal year covcml by the Compe:n.ution Unit I and 2 agreemc:nt. Providt.d however. that all fimds set aside for compensation and classification reform shall be expended or obligated prior to the expiration of the Compensation Units l and 2 Agreement for FY2004 -fY2006.

AGREED, this 26°" day of August. 2003.

FOR THE DISTRICT OF COLUMBIA GOVERNMENT

Mary E. Leary, Director
Office of Labor Relations
and Collective Bargaining

FOR COMPENSATION UNITS

Geq T. Johnson, Chief Negotiator
Compensation Units 1 and 2

I&.2

Memonwwlnm ofUadcr5'elinc

Bcl-.ca

CompensatioD Units I md 2 md&be Distrid ofColarnbia

1k"Manoandom ofUadcatanding bc:tweeD <Ampmwrion Uoib l -12__,a.

···Dislrietaf CobImbia C6DCCaliD ca.mc.tioll andCCImpamlioa CoUaborabve was inkially illcorporated as JJll(of the Cosnpemadon AgRiemca dlB Dislria of CobmllJia OWcnuneot dCoUnits J llDd 2 covcrimt fiscal years 2001 dmDaP 2003.

P...– '°tho tams of this MOU, thejoim Ubor Mamgc:mcnt CbsNicatinn and Collipeosatioo llebmTask FCl'CC (LMCCltTF) shall:

1. Effi:diye March I, 2006, Ibisjoint bbor m.....,. ,OfDlllittee established pmsuam'°the lams of lbe ComptmmoD Units 1and 2 collective: b&pining (the LMCCRTP) sballtie achninistncd uadcr lhe District's Office of Labor Rdatioos adColJcdive B•gaining (OLRCB);

2. The LMCCllTF shall have eight (S')voting es from labcw inicludiq: es6om ea:b natioaal lab« union comprising C.O.n1lft!wt\oo Units I md 211111 the Distrid'sOLRCB sha1I appoint an equal maberof

3. Outside consul.tmts and olhcc subject maucr experts are not members oflhe LMCCRlF and shall not have votillg rigbU in the LMCCRlF. However, such penoas may be inviled to attcad said ""Crings only wheo they are pclC$llllldidg informadon relev&at to the taslc:;

4. The funds &om the LMCCRTF for &cal,.,.-s PY 2004 dlJoo"1 FY 2006 shall be med CO iaiplemmt the new p«y scbrd.J!es the last pay period of Septeo.ba-2006. which are auKbed uAppeadkes A(l)tbrough A(I) managancat's proposals for besc ""iC increases for lbe cootoct begirming Octobcs' I, 2006.

ATTACHMENT

QUESTION 28

(I.H.C. MEETING ATTENDEES)

Name	Title	Organization
Abele, Jennifer	Medical Director and Chair	ER-Sibley Memorial Hospital
Amy, Brian	Chief Medical Officer - HEPRA	DOH
Belton, Carleta		DHCF
Betz, James	Paramedic/LGBT Liasion	EMSAC
Bishop, Carvela	DCHCF	DHCF
Bishop, Darla	Manager - Marketing, Communications and Health Promotion	Medstar
Bittle,Theresa	Sen. Dir., Case Management	Medstar
Bowen, Jacquelyn	CEO	DCPCA
Brannon, Donald		The Lab @ DC
Buchanan, Douglass	Chief Communication Officer	DCFEMS
Bucksell, Ingrid	Emergency Operations Manager	OUC
Campbell, Cyd P	Medicaid Director	Medstar
Chaudhari, Summita	Deputy Director Medicaaid	DHCF
Chung, Hyesook	Deputy Mayor	Health and Human Services
Dale, Karen	Market President	Amerihealth
Dalton, Marc E.	Medical Director	DBH
Dean, Gregory	Fire/EMS Chief	DCFEMS
Donahue, Kevin	Deputy Mayor	Public Safety and Justice
Dugan, Ellen	Emergency Medicine Specialist	Georgetown Hospital
Duncan, Tommy	CEO	Trusted
Fitzpatrick, Lisa	Medical Director	DHCF
Foster-Moor, Eric	The Lab@DC	The Lab @ DC
Gil, Helder		DMPSJ
Hafiz, Stephanie	Dir. Member Engagement	Medstar
Harris, Kimberly	Supervisory Public Health Advisor	DOH
Henry-Phillip, Sharon	Director, Case Management	Medstar
Holman, Robert	I/Medical Director	DCFEMS
Holmes, Karima	Director	OUC
Jackson, Margaretia	Chief Medical Officer	Trusted
Johnson, Ernestine	Dir. of Utilization Mgmt.	Trusted Health Plan
Kimlin, Edward	Assistant Medical Director	MedStar Family Choice
Kornfield, Daniel	Senior Budget Analyst	DMPSJ
Lacey, Antonio	Program Analyst	DHCF
Lester, Carla	Director Integrated Healthcare Management	Medstar
Lyles Smith, Leslie	Exe. Dir., DC Operations	Medstar
Mauro, Amy	Chief of Staff	DCFEMS
Mills, Edward	Asst. Fire Chief of EMS	DCFEMS
Mitchell, Candice	Manager Compliance and Local Government Relations	Medstar
Nesbitt, LaQuandra	Director	DOH
Nwaete, Clothida	Special Assistant	DCFEMS
Orr, Lavdena	Market Chief Med. Ofc	AmeriHealth Caritas
Papariello, Joseph	EMS Chairman	Local 36
Puppala, Neha	Asst. Medical Director	DCFEMS
Raczynski, Christopher	Ass. Chief Medical Officer	DBH
Reynolds, Lauren	Communications Consultant	Medstar

Name	Title	Organization
Roque, Sarah (FEMS)	Sup. Public Health Analyst	DCFEMS
Schlosberg, Claudia	Senior Deputy Director/Medicaid	DHCF
Sears, Felicia	Director of Operations	Trusted Health Plan
Stephens, Rosalyn Carr	Integrated Healthcare Management Consultant	Medstar
Tamasco, Christian		DCOA
Timmons, Michael	Fire/EMS Captain	DCFEMS
Toye, Patryce	Senior Medical Director	Medstar
Tribe Clark, Sara	Associate Director	DCOA
Vicks, Eric	Ass. Dir. Advocacy and Public Policy	DCPCA
Washington, Edward	Operations Manager	OUC
Watson, Jacqueline	Chief of Staff	DOH
Weissfield, Joe	Project Manager	DHCF
Wobbleton, Jeffrey	Chief operations	OUC
Young, Gwendolyn O.	Dir. of QI and Operations	DCPCA

ATTACHMENT

QUESTION 1 (OPS)

(Chief Dean’s Message on EMS)

February 16, 2017

A Message to the Department on EMS

Introduction

As we start 2017, I want to share with you some information about where we are headed with our efforts to improve our delivery of Emergency Medical Services (EMS). We discussed some of these issues during our town hall meetings in December and I want the whole Department to have the benefit of this information.

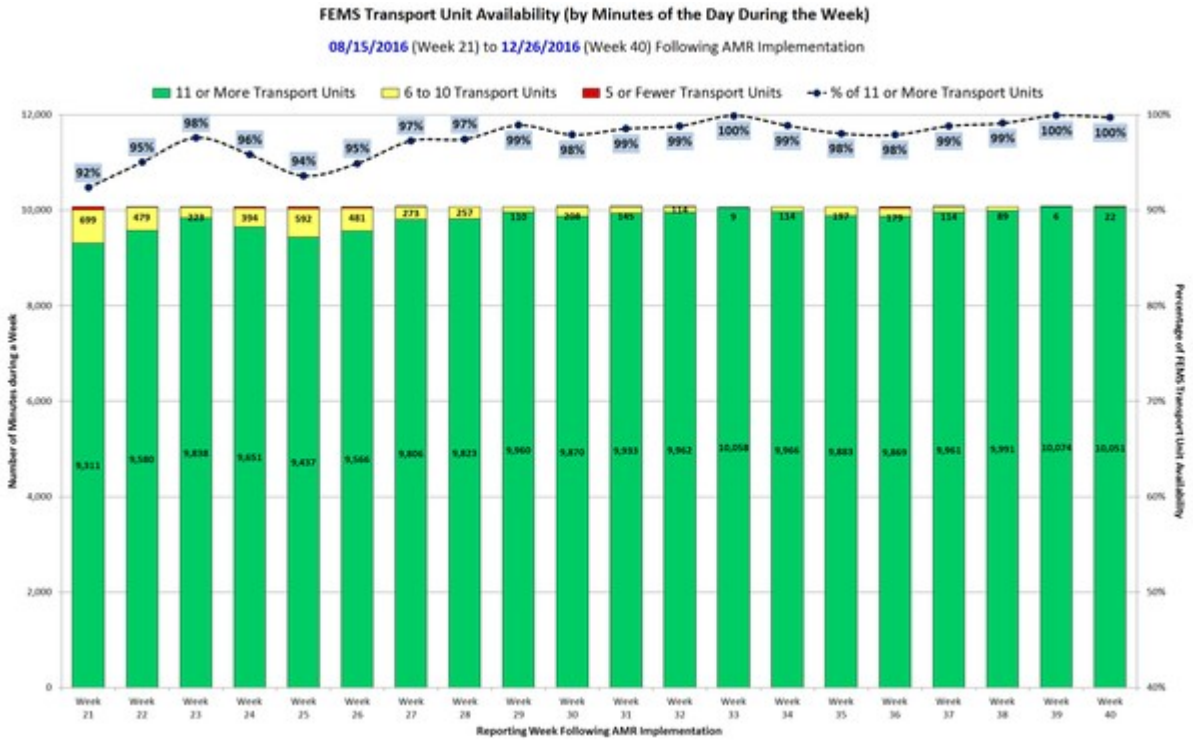
Looking Back: a Stabilized System

While we always have more work to do, looking back over the course of the last 21 months, we have accomplished a lot together and in partnership with our two labor unions, Mayor Bowser, the Council, and the community. Two years ago, we were in a different place as an organization, and we had a number of fundamental and complicated challenges. During the summer of 2015, we did not have sufficient transport resources to respond to our EMS call volume. We routinely ran out of Department transport units, which put our most critical patients at risk. I knew that we could not expect to overcome our larger challenges without first fixing the basics that underpin everything we do. We asked the Mayor and Council for help and they responded with a great show of support: the largest dollar investment in EMS reform in recent history.

As you know, we launched the AMR contract on March 28, 2016. We hoped that the contract would enable us to better meet our response time goals, more frequently train our providers, preserve resources for our highest acuity patients, provide better field supervision and performance evaluation, do preventive maintenance on our fleet, and improve agency culture surrounding EMS. Nine months into the contract, I think we have delivered on some

of these goals, and in other areas the contract has helped crystallize our remaining challenges.

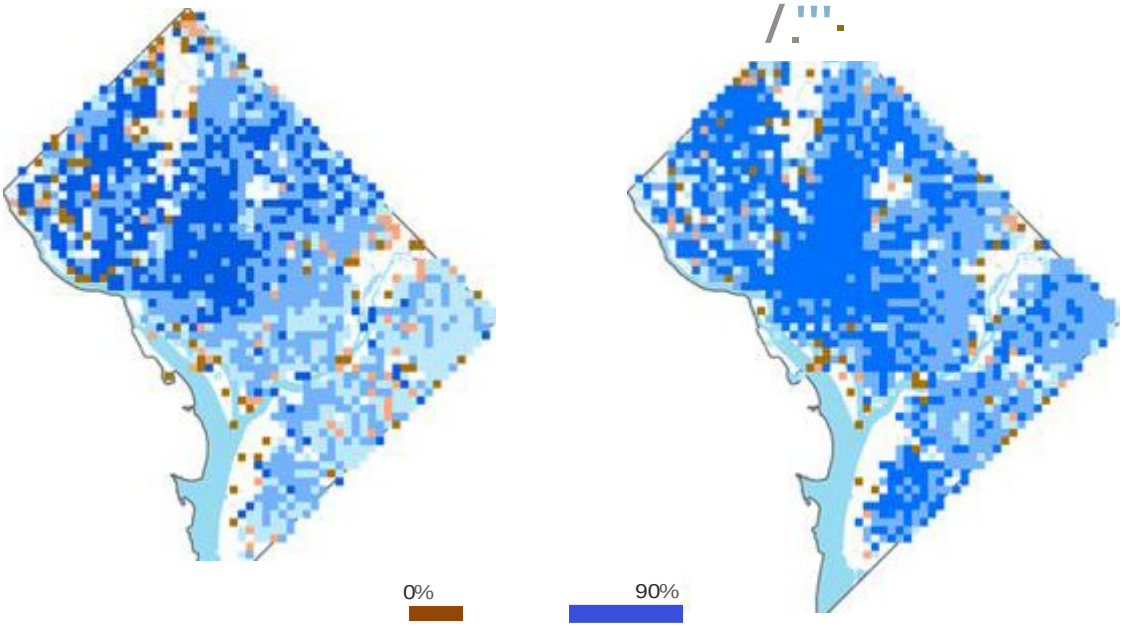
As the following graphics show, our FEMS unit availability has improved significantly for BLS transport units. Our first response and transport unit response times have also improved. We have increased our training hours, although we are continuing to work on improving the frequency and quality of our training. And our fleet is in better condition. While building a reserve for fire apparatus is a work in progress, our "up time" for ambulances is on a positive trend.

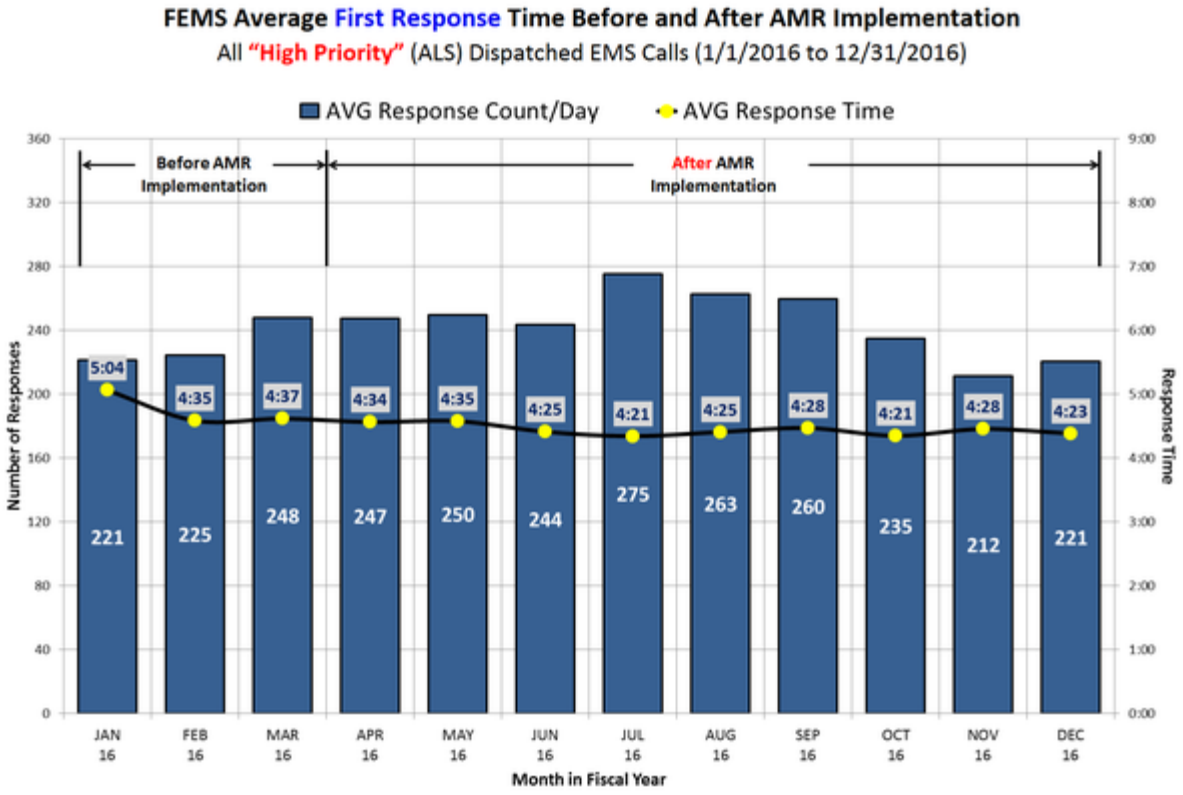


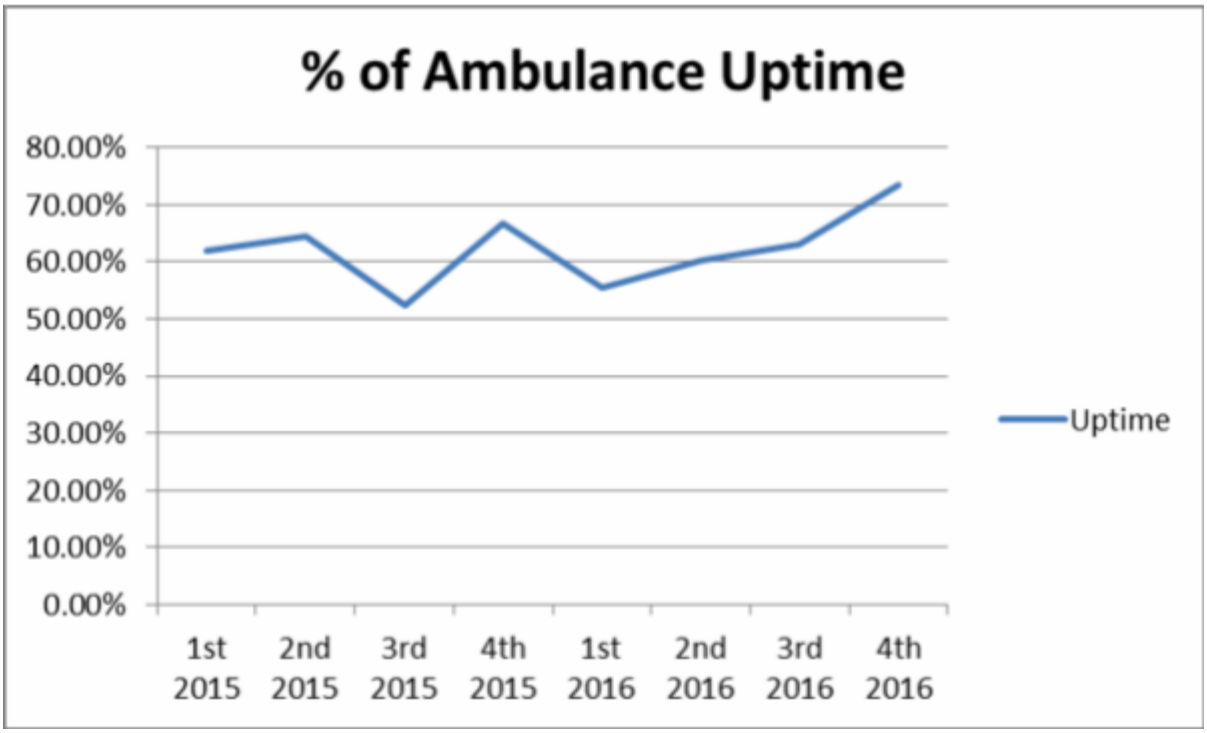
Percentage of FEMS Transport Unit Response Times in 9 Minutes or Less
All Dispatched EMS Calls (FY 2015 and FY 2016)

Before AMR
4/1/2015 to 10/24/2015

After AMR
4/1/2016 to 10/24/2016







Remaining Challenges: ALS Resources

Despite this progress, we have not seen all of the improvements that we want, in particular in

our delivery of ALS. We still struggle with the availability of medic units, and our response times for first arriving paramedic on critical medical calls have not improved. Our senior leadership team has spent the last few months looking at this challenge. And we have concluded that we need more ALS resources. We already decided in early 2015 that we needed to hire more Firefighter Paramedics and over the last 18 months we hired 45. We have identified the need and will push to hire additional Firefighter Paramedics, with another two classes planned for this fiscal year. This is in addition to the 48 Firefighter EMTs and 36 cadets we have hired during the last two years and the additional classes (one each) of Firefighter EMTs and cadets planned for FY 2017.

Ultimately, with today's call volume and a climbing District population, we think we need 20 medic units and 21 PECs to begin to address our ALS needs into the future. Getting to this level of staffing will take time and budget dollars. But we think that with the additional Firefighter Paramedics who are either on board now or in the mentoring pipeline, soon we will convert three of our BLS units into medic units. We plan to do this as early as March 5, 2017. We will convert the basic ambulances at Engines 3, 10 and 25 into medic units. Working closely with our unions, we are also planning to pilot a different staffing model for these units, where the station houses will be responsible for staffing both the medic unit and the paramedic engine company using their own rosters, rather than the resources of detailed members. We are interested in seeing whether such a staffing model will yield efficiencies in staffing, managing supplies and medication, mentoring, training, teamwork and other areas. We look forward to your feedback on this as a concept and as a work in practice.

But we know that we cannot hire our way out of our ALS resource challenges. We also need to make some significant changes in the way we operate, in order to make the best use of our existing ALS resources. First, our ALS providers should only be doing ALS work. Our ALS providers are a highly skilled and limited resource and we need to preserve their availability for our most critical patients. We have been monitoring this issue and talking to you about it for several months. After the launch of the AMR contract, we began to see a gradual decrease in the percentage of BLS transports by ALS providers, which we attributed to the greater availability of BLS ambulances. This percentage decreased from an overall rate of 23 percent in June 2016 to 19 percent in August 2016.

We recently reviewed the data from September through December and are encouraged by further incremental improvement. While the overall percentage of BLS transports by ALS transport units has decreased by only one additional percentage point, the data shows that for some units there has been a decrease of up to fifty percent (while for other units, unfortunately, there has been an increase).

June through August (Q3-AMR)

TOTAL	M01	M02	M05	M07	M08	M14	M17	M19	M21	M24	M27	M30	M31	M33	ALL
BLS	57	150	44	141	84	38	107	82	94	120	98	102	38	81	**1,236**
ALS1	389	412	331	389	462	357	349	485	376	393	381	362	174	414	**5,274**
ALS2	6	7	3	7	8	1	4	7	4	7	4	9	3	1	**71**
BLS	57	150	44	141	84	38	107	82	94	120	98	102	38	81	**1,236**
ALS	395	419	334	396	470	358	353	492	380	400	385	371	177	415	**5,345**
TOTAL	**452**	**569**	**378**	**537**	**554**	**396**	**460**	**574**	**474**	**520**	**483**	**473**	**215**	**496**	**6,581**
% BLS	**13%**	**26%**	**12%**	**26%**	**15%**	**10%**	**23%**	**14%**	**20%**	**23%**	**20%**	**22%**	**18%**	**16%**	**19%**
% ALS	**87%**	**74%**	**88%**	**74%**	**85%**	**90%**	**77%**	**86%**	**80%**	**77%**	**80%**	**78%**	**82%**	**84%**	**81%**

September through November (Q4-AMR)

TOTAL	M01	M02	M05	M07	M08	M14	M17	M19	M21	M24	M27	M30	M31	M33	ALL
BLS	55	119	39	99	39	18	93	41	104	92	46	81	21	86	**933**
ALS1	292	318	225	265	383	302	301	414	290	293	341	276	191	323	**4,214**
ALS2	9	2	6	6	26	10	6	11	7	10	4	9	4	5	**115**
BLS	55	119	39	99	39	18	93	41	104	92	46	81	21	86	**933**
ALS	301	320	231	271	409	312	307	425	297	303	345	285	195	328	**4,329**
TOTAL	**356**	**439**	**270**	**370**	**448**	**330**	**400**	**466**	**401**	**395**	**391**	**366**	**216**	**414**	**5,262**
% BLS	**15%**	**27%**	**14%**	**27%**	**9%**	**5%**	**23%**	**9%**	**26%**	**23%**	**12%**	**22%**	**10%**	**21%**	**18%**
% ALS	**85%**	**73%**	**86%**	**73%**	**91%**	**95%**	**77%**	**91%**	**74%**	**77%**	**88%**	**78%**	**90%**	**79%**	**82%**

We will continue to monitor the decisions you are making in the field that impact this percentage and want to encourage you to continue working together to use the right resource for each patient. Ultimately we would like to see this percentage go down to ten percent for every unit. At the same time, we understand and support your ability to make the best decision in the interest of patients, which may result in the occasional (and justifiable) transport of a BLS patient by an ALS resource.

Second, we know that our dispatch system needs to preserve our critical resources for critical patients. Under the leadership of Interim Medical Director Robert Holman and Assistant Medical Director Neha Puppala, the Department submitted revised Charlie protocols to the Office of Unified Communications (OUC) this fall that re-coded 194 types of calls from ALS to BLS. The revisions were implemented by OUC on November 30, 2016. We are still analyzing the impact of these changes and it is not possible to draw any conclusions from

only one month of data. But preliminarily, it appears that the changes resulted in 200-300 fewer ALS dispatches to Charlie calls in December. Of course this constitutes a minor impact on the Department's overall ALS call volume in December, which reached 6,635 calls. We are continuing to review dispatch procedures and resource assignments to identify additional improvements and to work with OUC on other strategies.

Third, we are attempting to improve our transfer of patient care times at hospitals. As we announced this fall with Special Order 239R, Series 2016, we want units to be in and out of the hospital in 30 minutes, which we think is a reasonable period of time and which other organizations are able to do, including AMR. While there are some aspects of hospital transfer of care time that are out of our control, there is also clearly room for improvement. In all cases where we have the opportunity, we not only want to have our ambulances and medic units available, we also want to increase the time that they are available in their local alarm district. If we are going to be able to do that, efficient transfer of patient care times must be important at all times, not just during periods of high call volume.

We are encouraged to see that our hospital drop times, especially for BLS units, have improved since September and we want you to continue to work to improve in this area. In October, we met our 30 minute goal only 18.4 percent of the time. In December, that percentage increased to 23.7 percent. The average drop time has decreased by approximately three minutes, from an average of 47 minutes and 27 seconds in October to an average of 44 minutes and 15 seconds in December. Let's keep working together to push these numbers down to 30 minutes, close to 100 percent of the time.

Other Initiatives

We have worked to improve our delivery of EMS through other initiatives. We worked with Local 3721 to move their members to a 24 hour shift schedule on a pilot basis this summer. This change became permanent for all Local 3721 members in January. We are excited about how the pilot project improved our work together as teams in the battalions, and expect this change to continue to reap benefits throughout the agency.

We have also strengthened our medical direction by increasing resources in the Office of the Medical Director (with Dr. Holman starting full-time in January 2017 and the hiring of Dr.

Puppala and additional CQI nurses in 2016), by bringing back the EMS Battalion Fire Chief positions (EMS 8) and by clarifying the responsibilities of EMS Captains. Our EMS supervisors in recent months have been focusing on launching monthly clinical evaluations of our paramedics. This effort is to identify our providers' strengths, as well as areas that need additional training focus, which in turn is informing our training agenda for the future.

And speaking of training, Dr. Holman is looking forward to rolling out several new initiatives this spring. Enhanced pediatric training will include eight-hour clinical rotations at Children's National Medical Center (CNMC) that will focus on asthma treatment and pediatric triage. This training is planned to run from March 1, 2017 through December 15, 2017, pending curriculum and course approval from the DC Department of Health (DOH). Once approved, participation will be mandatory for all ALS providers. In addition, our new Paramedic Grand Rounds will include rotating four-hour symposiums to be conducted by the local medical schools/teaching hospitals. The first session is on March 28 and March 30, 2017 at Providence Hospital and the topic is sepsis. Participation in these sessions will be mandatory for all ALS providers and optional for BLS providers.

For our BLS providers, our focus will be on company-based, case-based education. Beginning in March 2017, two-hour modules to be presented by supervisors at the station level, using a case-based discussion approach, written by the Medical Director and informed by trends and key issues identified through the CQI process. These sessions will focus on the BLS providers and use team-based, interactive learning methods. An emphasis on critical thinking skills will be sought by exploring differential diagnosis and the gentle use of the Socratic method. The Medical Director will train the trainers in creating an optimal and trusting learning environment necessary to allow open provider participation.

We will also continue our revised approach to the delivery of required continuing medical education (CME) as part of the National Registry and DC DOH recertification process. Instead of the traditional 36-hour biannual block of CME, the Medical Director has created 4-hour blocks of rotating topical content that is structured to meet recertification requirements while simultaneously providing the flexibility to address urgent operational and CQI-driven topics. We launched this new modular training last spring and summer with Module 1: Patient Assessment and High Performance CPR and Module 2: Hemorrhage Control and Excited Delirium. We are currently scheduling members who missed these

sessions for mandatory make-up sessions.

Patient Outcomes

Of course, all of this hard work is worth it only if it results in better outcomes for patients. In an effort to improve the District's rate of survival from sudden cardiac arrest, we launched the Hands on Hearts program to train residents in hands-only CPR. In FY 16, FEMS trained over 10,000 people, doubling its 5000 resident goal. As of today, FEMS has trained over 17,000 people.

We recently reviewed our calendar year 2015 and 2016 CARES (Cardiac Arrest Registry to Enhance Survival) data. It shows that our overall cardiac survival rate increased from 7.3% during 2015 to 8.3% in 2016, while the national survival rate for the same measure decreased from 10.6% to 8.8%. Our Utstein (1) cardiac survival rate (or patients surviving non-traumatic cardiac arrests, witnessed by bystander and found in a shockable rhythm) decreased from 31.6% during 2015 to 28.1% in 2016, but the national survival rate for the same measure also decreased from 33.1% to 27.5%. Most encouragingly, our Utstein Bystander (2) cardiac survival measure (or patients surviving non-traumatic cardiac arrests, witnessed by bystander, found in a shockable rhythm and receving bystander CPR and/or AED use) increased from 25.9% during 2015 to 33.3% in 2016, while the national survival rate for the same measure decreased from 36.8% to 31.6%. Overall, bystander CPR participation for witnessed cardiac arrests in the District increased by more than 80% during 2016 compared to 2015 (38 cases in 2015, 69 cases in 2015), clearly showing improved public participation.

These percentages are based on small data sets and, therefore, it is too early to tell if we are seeing a positive long-term trend. Nonetheless, we are hopeful that these rates will continue to improve as we continue our Hands-on-Hearts campaign, our improved training and use of high volume CPR and the continued wider availability of AED devices.

Looking Ahead

Looking ahead to the rest of 2017, we have an ambitious agenda. While continuing to work on all of the efforts I have described above, we will soon turn to measuring and decreasing our EMS turn-out times. Dr. Holman will also continue to work with the administration to release and implement the recommendations of the Integrated Healthcare Collaborative,

which was convened with the goal of reducing misuse of 911 and connecting non-emergency patients with the most appropriate healthcare resources. As we move forward, we will need to continue to work together to address our remaining challenges so that we can become even stronger as an agency. I look forward to us reaching new goals together.

Very truly yours,

Gregory M. Dean
DC Fire and EMS Chief