SOUTH METRO FIRE RESCUE
EMS DIVISION

JP Piche – EMS Battalion Chief

WHY SOUTH METRO'S EMS MODEL

- **Exceptional Clinical Outcomes**
  - SMFR has built a reputation for top-tier emergency medical care, consistently outperforming regional averages in cardiac arrest survival, stroke recognition, trauma outcomes, and RSI success.
  - Our integrated deployment ensures ALS-level care arrives on scene, not several minutes later.
- **Unified Response Structure**
  - Our model promotes operational efficiency by ensuring fire and EMS are trained, deployed, and commanded as one unit.
  - This results in faster interventions, fewer handoffs, and improved continuity of care—especially during complex, high-acuity incidents.

WHY SOUTH METRO'S EMS MODEL

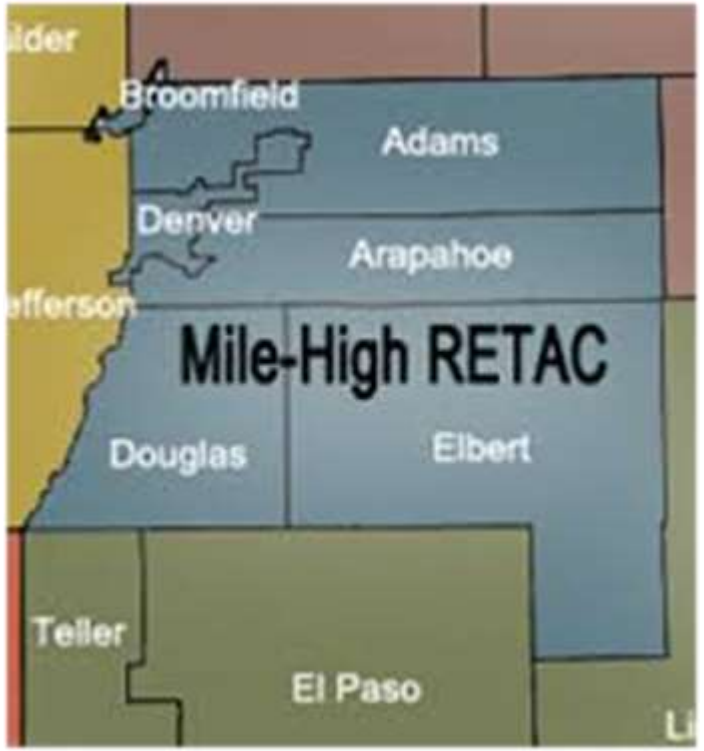
- **Highly Trained Dual-Role Providers**
  - SMFR ambulances staffed primarily by firefighter-paramedics, not EMT-Bs with delayed ALS intercepts. These providers undergo ongoing advanced training, including RSI, cardiac care, trauma, ultrasound, and critical care transport principles.
  - Many of our personnel hold certifications such as CCP-C and FP-C, a clinical edge unmatched in most neighboring departments.
- **Community Impact and Innovation**
  - Our Public Health initiatives reduce 911 overuse, cut hospital readmissions, and address underserved populations—services that contract models simply don't offer.

WHY SOUTH METRO'S EMS MODEL

- **Accountability and Fiscal Stewardship:**
  - Unlike for-profit EMS providers, we operate under public accountability, not a revenue-driven model. Our priority is patient care and community service, not financial gain.
- **Community Trust & Continuity of Care**
  - Residents expect excellence with every 911 call—and SMFR delivers.
    - Outsourcing EMS risks:
      - Slower response times
      - Loss of advanced care capability
      - Decline in public trust and satisfaction

SMFR VS OTHER MODELS

Feature	SMFR Model	Other Models
Response Time	Fast, due to integrated stations	Often delayed if EMS and fire are separate
Provider Skill Level	High (cross-trained firefighter-paramedics)	Varies; often BLS-only on first response
Continuity of Care	Seamless from first contact to hospital	Fragmented in third-party models
Community Programs	Mobile Integrated Healthcare, CPR training, fall prevention	Limited or nonexistent in contract models
Clinical Oversight	Strong, proactive medical direction	Reactive or outsourced direction in many others



WHY NOT REPLICATE OTHER MODELS?

- **Agency 1**
  - Contracted EMS: This agency often face delays in ALS care, reduced clinical scope, and high turnover due to private sector pay and burnout.
- **Agency 2**
  - Third-Service EMS: While technically skilled, these systems face coordination delays, response delays, siloed operations, and dual command confusion.

WHY NOT REPLICATE OTHER MODELS?

❑ Agency 3

- ❑ Hybrid Model (e.g., Agency Fire/Private Ambulance): These split systems often deliver inconsistent care, with ALS arriving separately, risking critical delays.

❑ Agency 4

- ❑ While similar to SMFR, they are full paramedic model, it encountered a major operational truth: more paramedics on every unit doesn't always mean better patient care. In fact, it may lead to skill dilution, increased cost, and inefficiencies in clinical delivery.

WHY NOT REPLICATE OTHER MODELS? A QUICK LOOK

Category	SMFR	Agency 1	Agency 2	Agency 3	Agency 4
Fire/EMS Integration	✓ Full integration	✗ Not integrated Private EMS	✗ Separated	⚠ Partially integrated Private EMS	✓ Integrated
EMS Field Leadership	✓ EMS BC, Captain, Lt. on every shift	⚠ Varies	⚠ Limited EMS officers	⚠ Limited EMS officers	⚠ Varies
Advanced Interventions	✓ RSI, TXA, push-dose pressors, blood (June)	✓ RSI, TXA,	✓ TXA, ketamine	✓ TXA	⚠ TXA
Training & Cadaver Labs	✓ Quarterly scenarios, cadaver lab, AARs	✗ No cadaver access	✓ Strong training, some cadaver	⚠ Soon to be taught by SMFR	⚠ Taught by SMFR
After-Action Reviews (AARs)	✓ Structured after all RSIs, major calls	✗ Minimal	⚠ Informal AARs	✗ Limited	✗ Minimal
Prehospital Blood Program	✓ Launching June 2025	✓ Current Program	✗ None	✗ None	✗ None
Community Paramedicine / MIH	✓ Established, expanding	✓ Large MIH team	✓ Large MIH team	✓ Small program	⚠ Developing
Public Visibility & Recruitment Reach	✓ Strong National and Known Internationally	✗ Limited	⚠ Known locally	⚠ Local	⚠ Local

CARDIAC ARREST (2024)

- **Cardiac Arrest:**
  - 345 Cardiac Arrest:
    - 104 ROSC
      - (30%/NA 25%)
      - Neighboring Agency 17.9% ROSC
    - 44 Neurological intact
      - (12.7%/NA 7.5%) (increase by 6 to 2023)

PUBLIC HEALTH

❑ Public Health Engagement:

- ❑ Our public health program, which served over 1,200 patients in 2024, improved community health outcomes through proactive care, early intervention, and reduced strain on emergency services

WHERE DO REFERRALS COME FROM

- **Referrals are generated in multiple ways**
  - Provider Recognition of Need
  - ESO Auto Generated
  - Follow up
    - Adult Protective Services
    - Child Protective Services

- **Reasons for Referrals**
  - High Utilizers 33.9%
  - Resource Navigation 9.9%
  - Frequent Use of 911 for Non-Emergencies 5.6%
  - Concerns for At-Risk Adults 6.6%

TOTAL REFERRALS

- **Total Referrals**
  - 1,291
- **Total Patients**
  - 837
    - 193 Referred Multiple Times
    - 643 Referred Once

2024 EMERGENCY AND 911 CALL HISTORY

- **911 Calls**
  - 7,156 which represents 15% of SMFR volume
    - 35.4% had 3-5 calls
    - 19.3% had 6-9 calls
    - 15.3% 10 or more calls

- **Emergency Room Transports**
  - 6,079 from 837 Patients
    - 32.4% had 3-5 visits
    - 16.3% had 6-9 visits
    - 11.9 had 10+ visits

PUBLIC HEALTH PATIENT REFERRAL INTERVENTIONS

- **911 Call Data 7,156**
  - Average 911 Call 3 Months prior to intervention: 2.2
  - Average 911 calls during intervention: 0.38
  - Average 911 Calls 3 months after intervention: 0.5
- **Total Decrease in 911 calls: 77.63%**

PUBLIC HEALTH REFERRAL INTERVENTIONS

- **Emergency Department Visits 6,079**
  - Average Emergency Department visits 3 months prior to intervention: 1.78
  - Average Emergency Department visits during intervention: 0.3
  - Average Emergency Department visits 3 months after intervention: 0.42
- **Total Decrease in Emergency Department visits: 76.34%**

HOW PUBLIC HEALTH INTERVENES

- **Assistance in Resource Navigation**
  - Phone calls and in home visits
- **Chronic Disease Management**
  - Education
  - Follow up Appointments
  - Medical evaluations and checks ups
- **Collaboration with External Partners**
  - DC Mental Health Initiative
  - STRIDE – Unhoused navigation and medical evaluation
  - Law Enforcement Co-responders