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# Government of the District of Columbia



## Department of Fire and EMS

Testimony of

**Dennis L. Rubin**

Chief of Fire and EMS

### **“FY 2009 Performance Oversight”**

Council of the District of Columbia  
Committee on Public Safety and the Judiciary  
Phil Mendelson, Chair

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John A. Wilson Building  
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Good afternoon Chairperson Mendelson and other members of the Committee on Public Safety and the Judiciary. I'm Dennis Rubin, Fire and EMS Chief for the District of Columbia. I am here to provide testimony in response to the Committee's "Public Oversight Hearing" request.

To begin, I would like to thank both Mayor Adrian M. Fenty and the District of Columbia Council for their continued dedication to improving the Fire and Emergency Medical Services Department. Over the last three years, many government officials from other Departments and agencies have significantly contributed to the improvement of services delivered by the Fire and EMS Department. Although I would like to thank each of them individually, the Directors of these organizations know that I appreciate their efforts and cooperation and I look forward to working closely with them in the future. Mayor Fenty emphasizes a team approach to the management of District Government services and our Department always benefited from their help and support.

At this point during previous performance oversight hearings, I discussed an agenda of what I planned to cover, followed by a detailed explanation of each item. However, given the unfortunate and tragic events of the past two weeks, I feel that such an approach today would be disrespectful. Instead, during this hearing, I will only speak about recent events that threaten to overshadow and even destroy much of the good work the excellent members of this Department have accomplished during the previous three years.

Before I begin, I must offer my most sincere and heartfelt apology to the parents and family of Stephanie Stephens for her death. I am the father of three children and grandfather of one and I cannot begin to imagine how I would feel if placed in the same position. I can only say that I was profoundly

shocked and deeply saddened to learn of the circumstances of this case and since learning of them I have devoted almost all of my time to investigating and reviewing this Department's actions. My heart goes out to the parents and family of this little child and if there was anything I could do to change what occurred, I would act immediately to make it happen. That said, and as the Fire and EMS Chief for the District of Columbia, I must accept responsibility for the actions of our employees. Public responsibility for failure in this case will be mine and mine alone and I do not intend to share this responsibility with others. Good leadership begins and ends at the top and I can only hope that my testimony today will reassure this community that the emergency medical services system in the District of Columbia is not broken and does not suffer from a lack of sound judgment and responsible actions by the vast majority of our employees.

Unfortunately, unlike others who may have testified or commented previously, I am restricted by law and regulation about what I can say. The Federal Health Insurance Portability and Accountability Act (HIPAA), District privacy laws, and respect for the parents and family of Stephanie Stephens prevent me from speaking publicly about anything directly related to her medical condition or care. District Government regulations prevent me from saying anything concerning the actions of individual Department employees in this case, because the incident is under investigation by the Metropolitan Police Department and not all the facts are known. My only comment about the investigation is to sincerely and respectfully ask all those involved to please speak with investigators concerning what happened because without such cooperation we cannot move forward effectively. We owe it to the memory of this little girl to discover and document everything we can.

In preparing for today, I have given careful consideration to what I'm about to discuss and in no way intend to minimize my own responsibility in this matter. Mr. Mendelson and other members of this Committee, all of us know that the emergency medical services system in the District of Columbia was broken for a long time and fixing it has not been an easy journey. This Department has taken exhaustive action to plan, introduce, implement and sometimes enforce new strategies and practices in the delivery of out-of-hospital medicine. With the Mayor's Task Force on Emergency Medical Services, we created a roadmap to the future. This roadmap included six recommendations regarding where the Department needed to go, how we should get there and what we needed to report concerning our success or failure. The workforce of this Department accepted that challenge and has accomplished a large number of the more than 50 requirements of Task Force recommendations. My management team has consistently reported our successes – or, in some cases, failures – during EMS CapStat sessions attended by members of this Committee, stakeholders from the medical community and members of the Rosenbaum family. We have been open, honest and have accepted responsibility for what occurred. Much of this information has been shared with the public and discussed in hearings at the request of this Committee. During the past three years, this Department has revised its ambulance and fire truck deployment and staffing strategy to improve both the speed and effectiveness of services, implemented new medical treatment protocols to match national standards and improve patient outcomes, implemented the National Registry certification standard for EMTs and Paramedics to improve professionalism and individual accountability, implemented a quality assessment and improvement program to review and improve patient outcomes, implemented a patient satisfaction survey mailed to all patients transported by Department ambulances to evaluate crew behavior and actions, implemented a comprehensive hospital transport management plan to better identify appropriate treatment facilities and decrease ambulance out-

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of-service time, implemented an electronic patient care reporting system to improve accountability and tracking of patient contacts and treatment, implemented a combined fire and EMS management and supervision plan to better guide employee decision making and management, implemented, re-implemented and revised employee EMS training programs in a continued effort to improve the base level of medical knowledge for the entire workforce, and implemented one of the finest EMS programs in the nation – “Street Calls” – in an effort to provide alternatives to ambulance transport for “at risk” patients who often call 9-1-1 because they have few other options.

I have reviewed these successes not to shift attention away from the Stephanie Stephens case, but instead because I want the members of this Committee and the public to realize that our Department does not suffer from a failure in leadership. Without good leadership, none of these things could have been accomplished. But leadership is almost never judged by how well you succeed. Instead, it’s often judged by what happens when you fail and I can assure everyone listening today that the leadership of this Department is up to that challenge. In listening to statements made by stakeholders over the past week, it seems there has been considerable focus on the departure of Dr. James Augustine and the suggestion that a combined Fire and EMS system is not working in the District of Columbia. Some have tried to suggest these topics are related. Because they each involve the performance of this Department, I will address them now.

Dr. James Augustine was a terrific asset to this Department and accomplished much while he was in the District. I met him while I was Chief in Atlanta and was very impressed by his work ethic, EMS advocacy and “get stuff done” attitude. When I became Chief in the District, I asked Dr. Augustine to become our Assistant Medical Director because I knew that Dr. Augustine’s style would complement

our efforts at the time and – most importantly – improve the quality of out-of-hospital medicine delivered by the Department. Dr. Augustine is an editorial board member for the Journal of Emergency Medical Services (JEMS), an expert on quality management, quality improvement and EMS training, and, above all, a relationship builder. The lack of a good relationship between the Department, the local medical community and local hospitals, more than anything else, was one of the major detriments to improving EMS when he came to work here. Accordingly, a primary goal I tasked Dr. Augustine with was to rebuild the Department’s relationship with the local medical community and our hospitals and to bridge it through our workforce. Without a close and trustful relationship between hospitals and EMS, little can be done to effectively improve the quality of services. Dr. Augustine accomplished this superbly, while simultaneously being thrust into the role of lead Medical Director, something both he and I never intended. Unfortunately, as time passed, it became apparent to all who worked with him that his health was a concern. At some point he needed to make a choice and I supported that choice completely. But please allow me to be clear: Dr. Augustine and I never disagreed or were at odds with the delivery and management of EMS by this Department. It was through an eventual introduction and recommendation by Dr. Augustine that Dr. Mountvarner was asked and accepted the position of interim Medical Director. I trusted Dr. Augustine’s recommendation and I am very thankful to Dr. Mountvarner for accepting the interim position. His guidance, bearing and advice during the past few weeks have all been outstanding and I cannot thank him enough. I share all this to make clear that D. Augustine’s departure was not a sign of a set-back in our EMS reform efforts.

As far as a combined fire and EMS system not working in the District, supposedly as demonstrated by the current and unfortunate case, nothing could be further from the truth. First, as I’m sure I

don't need to remind the Committee, competing missions within the Fire and EMS Department was what the District had before I became Chief and this clash of cultures, people and leadership ultimately contributed to the failures in the Rosenbaum case. But the Rosenbaum case was not an individual failure. Instead, it was a systemic failure. I would encourage both the Committee and anyone listening today to read the OIG's report on the "Emergency Response to the Assault on David E. Rosenbaum." In the June 15, 2006, letter to then Mayor Anthony Williams, the Inspector General noted:

*The OIG team concluded that, with the exception of OUC and OCME, there was an unacceptable chain of failure in the provision of emergency medical and other services to Mr. Rosenbaum as required by FEMS, MPD, and Howard University Hospital protocols. Individuals who played critical roles in providing these services failed to adhere to applicable policies, procedures, and other guidance from their respective employers.*

*These multiple individual failures during the Rosenbaum emergency suggest alarming levels of complacency and indifference which, if systemic, could undermine the effective, efficient, and high quality delivery of emergency services to District residents and visitors. Our review indicates a need for increased oversight and enhanced internal controls by FEMS, MPD, and Howard University Hospital managers in the areas of training and certifications, performance management, and oral and written communications, as well as employee knowledge of protocols, General Orders, and patient care standards.*

In response to this recognition of "multiple individual failures" and a potential systemic problem, the EMS Task Force authored the following recommendations:

- **Recommendation 1:** *The Department of Fire and Emergency Medical Services shall transition to a fully integrated, all hazards agency.*
  - **Part 1:** *All entry-level candidates for operational positions shall be required to have the same minimum qualifications.*
  - **Part 2:** *All operational employees shall be cross-trained at basic levels of EMS, fire*

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*prevention, fire suppression, hazardous materials and technical rescue.*

- **Recommendation 2:** *Reform Department structure to elevate and strengthen the EMS mission.*
  - **Part D:** *Department leadership, at all levels, shall work to facilitate the integration of the full EMS mission and of single-role providers into multi-role operations.*

These recommendations are exactly what the management team of this Department has followed during the past three years. Although some may disagree, the record of success in making this transition is obvious. Never at a time in the previous history of the Department has the EMS mission been as strong as it is now and never in a previous administration have we been as focused. To the naysayers and doubters of the Unified, All-Hazards model, I must simply ask one question: why would a single role EMS system work any better? The point to the OIG Report and Task Force recommendations is that TEAMWORK can and will make a difference for improving the quality of EMS within the District. Firefighters, EMTs and Paramedics must learn to work cooperatively together as a single unit for the benefit of the public. If we can't work effectively as a team in the SAME Department, we certainly could not function as a team in SEPARATE Departments. The fully integrated All-Hazards model is the recommendation that the EMS Task Force made, it's the model the management team of the Department and the Mayor support and it's clearly the best service delivery plan for the residents and visitors to the District. Change is often feared and painful, but it must be the continued priority of this Department to overcome divisiveness and integrate our workforce successfully.

Unfortunately, none of this helped little Stephanie Stephens on February 10<sup>th</sup>. The fact is that the leadership of this Department has worked long and hard to educate and demonstrate expectations

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of service delivery requirements. We research, create and publish medical protocols that provide detail concerning how to treat patients. We review, distribute and enforce General and Special Orders concerning operational requirements and response. We provide supervision at multiple levels to make certain correct decisions are made. We operate a top-notch quality assurance and review program that provides an understanding and fair approach to improving individual employee performance. We hold employees and supervisors accountable if they make poorly informed decisions. We use an employee assistance program to extend a helping hand, if needed. And, when things go wrong, we – the leadership and management of the Department – take responsibility for the outcomes. This approach has increased oversight and enhanced internal controls in our Department, along with improving the areas of training and certifications, performance management, oral and written communications, as well as employee knowledge of protocols, General Orders, and patient care standards.

But even with all this, it continues to be difficult to control decisions by individual employees that may result in tragic outcomes. Although I can assure the members of the Committee and the public listening today that the Fire and EMS Department is making every effort to investigate this case and other cases that have now come to light concerning non-transport issues, I can make no guarantees about preventing possible mistakes from occurring again in the future. The fact is that medicine will always remain a subjective and interpretative science. This Department has approximately 120,000 patient contacts and more than 80,000 patient transports each year. Even if we made mistakes in only 1/100 of 1% of all the patients we see, that still accounts for at least 10 patients per year with potentially undesirable outcomes. The only thing we can do in the future is to again re-evaluate what needs to be done, take immediate corrective action, monitor outcomes and, if indicated, act

on making longer term substantive changes to ultimately prevent similar mistakes. I can only say, in conclusion, that this Department will never offer excuses for potentially bad decisions but we will do everything we can to make certain the same mistakes do not happen again. As I speak today, the Department is revising our non-transport policy to include the addition of a mandatory Supervisory verification that assures all patient protocols were followed prior to the unit leaving the scene. We improved after the tragedy of Rosenbaum and we now need to improve again following the tragedy of Stephanie Stephens.

Chairperson Mendelson, out of respect to the Stephens family and in the interest of time, I will not provide written testimony concerning the other performance oversight topics that I originally prepared for today. Much of this information is provided in answer to the Committee's oversight questions and I would ask the Committee to review this information carefully. I plan to present a number of these topics during the Budget Oversight Hearing scheduled for May 23. This concludes my remarks and I would be happy to answer any questions that you or the Committee may have.