



House of Representatives

General Assembly

File No. 236

February Session, 2000

Substitute House Bill No. 5287

House of Representatives, March 27, 2000

The Committee on Public Health reported through REP. EBERLE of the 15th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

An Act Concerning Emergency Medical Services Data Collection And Emergency Medical Dispatch.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 19a-175 of the general statutes is repealed and the
2 following is substituted in lieu thereof:

3 As used in this chapter, unless the context otherwise requires:

4 (1) "Emergency medical service system" means a system which
5 provides for the arrangement of personnel, facilities and equipment for
6 the efficient, effective and coordinated delivery of health care services
7 under emergency conditions;

8 (2) "Patient" means an injured, ill, crippled or physically
9 handicapped person requiring assistance and transportation;

10 (3) "Ambulance" means a motor vehicle specifically designed to
11 carry patients;

12 (4) "Ambulance service" means an organization which transports
13 patients;

14 (5) "Emergency medical technician" means an individual who has
15 successfully completed the training requirements established by the
16 [Commissioner of Public Health] commissioner and has been certified
17 by the Department of Public Health;

18 (6) "Ambulance driver" means a person whose primary function is
19 driving an ambulance;

20 (7) "Emergency medical technician instructor" means a person who
21 is certified by the Department of Public Health to teach courses, the
22 completion of which is required in order to become an emergency
23 medical technician;

24 (8) "Communications facility" means any facility housing the
25 personnel and equipment for handling the emergency communications
26 needs of a particular geographic area;

27 (9) "Life saving equipment" means equipment used by emergency
28 medical personnel for the stabilization and treatment of patients;

29 (10) "Emergency medical service organization" means any
30 organization whether public, private or voluntary which offers
31 transportation or treatment services to patients under emergency
32 conditions;

33 (11) "Invalid coach" means a vehicle used exclusively for the
34 transportation of nonambulatory patients, who are not confined to
35 stretchers, to or from either a medical facility or the patient's home in
36 nonemergency situations or utilized in emergency situations as a
37 backup vehicle when insufficient emergency vehicles exist;

38 (12) "Rescue service" means any organization, whether profit or
39 nonprofit, whose primary purpose is to search for persons who have

40 become lost or to render emergency service to persons who are in
41 dangerous or perilous circumstances;

42 (13) "Provider" means any person, corporation or organization,
43 whether profit or nonprofit, whose primary purpose is to deliver
44 medical care or services, including such related medical care services
45 as ambulance transportation;

46 (14) "Commissioner" means the Commissioner of Public Health;

47 (15) "Paramedic" means a person licensed pursuant to section 20-
48 206ll;

49 (16) "Commercial ambulance service" means an ambulance service
50 which primarily operates for profit;

51 (17) "Licensed ambulance service" means a commercial ambulance
52 service or a volunteer or municipal ambulance service issued a license
53 by the commissioner;

54 (18) "Certified ambulance [services] service" means a municipal or
55 volunteer ambulance service issued a certificate by the commissioner;

56 (19) "Management service" means an organization which provides
57 emergency medical technicians or paramedics to any entity including
58 an ambulance service but does not include a commercial ambulance
59 service or a volunteer or municipal ambulance service; [and]

60 (20) "Automatic external defibrillator" means a device that: (A) Is
61 used to administer an electric shock through the chest wall to the heart;
62 (B) contains internal decision-making electronics, microcomputers or
63 special software that allows it to interpret physiologic signals, make
64 medical diagnosis and, if necessary, apply therapy; (C) guides the user
65 through the process of using the device by audible or visual prompts;
66 and (D) does not require the user to employ any discretion or
67 judgment in its use;

68 (21) "Nontransport emergency vehicle" means a vehicle used by
69 emergency medical technicians or paramedics in responding to
70 emergency calls that is not used to carry patients; and

71 (22) "Mutual aid call" means a call for emergency medical services
72 that, pursuant to the terms of a written agreement, is responded to by a
73 secondary or alternate emergency medical services provider if the
74 primary or designated emergency medical services provider is unable
75 to respond because such primary or designated provider is responding
76 to another call for emergency medical services or the ambulance or
77 nontransport emergency vehicle operated by such primary or
78 designated provider is out of service.

79 Sec. 2. Section 19a-177 of the general statutes is repealed and the
80 following is substituted in lieu thereof:

81 The commissioner shall:

82 (1) With the advice of the Office of Emergency Medical Services
83 established pursuant to section 19a-178 and of an advisory committee
84 on emergency medical services and with the benefit of meetings held
85 pursuant to subsection (b) of section 19a-184, adopt every five years a
86 state-wide plan for the coordinated delivery of emergency medical
87 services;

88 (2) License or certify the following: (A) Ambulance operations,
89 ambulance drivers, emergency medical technicians and
90 communications personnel; (B) emergency room facilities and
91 communications facilities; and (C) transportation equipment, including
92 land, sea and air vehicles used for transportation of patients to
93 emergency facilities and periodically inspect life saving equipment,
94 emergency facilities and emergency transportation vehicles to insure
95 that state standards are maintained;

96 (3) Annually inventory emergency medical services resources

97 within the state, including facilities, equipment, and personnel, for the
98 purposes of determining the need for additional services and the
99 effectiveness of existing services;

100 (4) Review and evaluate all area-wide plans developed by the
101 emergency medical services councils pursuant to section 19a-182 in
102 order to insure conformity with standards issued by [said] the
103 commissioner;

104 (5) Within thirty days of their receipt, review all grant and contract
105 applications for federal or state funds concerning emergency medical
106 services or related activities for conformity to policy guidelines and
107 forward such application to the appropriate agency, when required;

108 (6) Establish such minimum standards and adopt such regulations
109 in accordance with the provisions of chapter 54, as may be necessary to
110 develop the following components of an emergency medical service
111 system: (A) Communications, which shall include, but not be limited
112 to, equipment, radio frequencies and operational procedures; (B)
113 transportation services, which shall include, but not be limited to,
114 vehicle type, design, condition and maintenance, life saving equipment
115 and operational procedure; (C) training, which shall include, but not
116 be limited to, emergency medical technicians, communications
117 personnel, paraprofessionals associated with emergency medical
118 services, firefighters and state and local police; and (D) emergency
119 medical service facilities, which shall include, but not be limited to,
120 categorization of emergency departments as to their treatment
121 capabilities and ancillary services;

122 (7) Coordinate training of all personnel related to emergency
123 medical services;

124 (8) [Develop] (A) Not later than October 1, 2001, develop or cause to
125 be developed a data collection system [which shall include a method of
126 uniform patient record keeping which] that will follow a patient from

127 initial entry into the emergency medical service system through
128 [discharge from] arrival at the emergency room. The commissioner
129 shall, on a quarterly basis, collect the following information from each
130 licensed ambulance service or certified ambulance service that
131 provides emergency medical services: (i) The total number of calls for
132 emergency medical services received by such licensed ambulance
133 service or certified ambulance service during the reporting period; (ii)
134 each level of emergency medical services, as defined in regulations
135 adopted pursuant to section 19a-179, required for each such call; (iii)
136 the response time for each level of emergency medical services
137 furnished during the reporting period; (iv) the number of passed calls,
138 cancelled calls and mutual aid calls during the reporting period; and
139 (v) for the reporting period, the prehospital data for the nonscheduled
140 transport of trauma patients required by regulations adopted pursuant
141 to subdivision (6) of this section. The information required under this
142 subdivision may be submitted in any written or electronic form
143 selected by such licensed ambulance service or certified ambulance
144 service and approved by the commissioner, provided the
145 commissioner shall take into consideration the needs of such licensed
146 ambulance service or certified ambulance service in approving such
147 written or electronic form. The commissioner may conduct an audit of
148 any such licensed ambulance service or certified ambulance service as
149 the commissioner deems necessary in order to verify the accuracy of
150 such reported information.

151 (B) The commissioner shall prepare a report that shall include, but
152 not be limited to, the following information: (i) The total number of
153 calls for emergency medical services received during the reporting
154 year by each licensed ambulance service or certified ambulance
155 service; (ii) the level of emergency medical services required for each
156 such call; (iii) the name of the provider of each such level of emergency
157 medical services furnished during the reporting year; (iv) the response
158 time, by time ranges or fractile response times, for each such level of
159 emergency medical service, using a common definition of response

160 time, as provided in regulations adopted pursuant to section 19a-179;
161 and (v) the number of passed calls, cancelled calls and mutual aid calls
162 during the reporting year. The commissioner shall prepare such report
163 in a format that categorizes such information for each municipality in
164 which the emergency medical services were provided, with each such
165 municipality grouped according to urban, suburban and rural
166 classifications. Not later than March 31, 2002, and annually thereafter,
167 the commissioner shall submit such report to the joint standing
168 committee of the General Assembly having cognizance of matters
169 relating to public health, shall make such report available to the public
170 and shall post such report on the Department of Public Health web site
171 on the Internet.

172 (C) If any licensed ambulance service or certified ambulance service
173 does not submit the information required under subparagraph (A) of
174 this subdivision for a period of six consecutive months, or if the
175 commissioner believes that such licensed ambulance service or
176 certified ambulance service knowingly or intentionally submitted
177 incomplete or false information, the commissioner shall issue a written
178 order directing such licensed ambulance service or certified ambulance
179 service to comply with the provisions of subparagraph (A) of this
180 subdivision and submit all missing information or such corrected
181 information as the commissioner may require. If such licensed
182 ambulance service or certified ambulance service fails to fully comply
183 with such order not later than three months from the date such order is
184 issued, the commissioner (1) shall conduct a hearing, in accordance
185 with chapter 54, at which such licensed ambulance service or certified
186 ambulance service shall be required to show cause why the primary
187 service area assignment of such licensed ambulance service or certified
188 ambulance service should not be revoked, and (2) may take such
189 disciplinary action under section 19a-17 as the commissioner deems
190 appropriate; and

191 (9) (A) Establish rates for the conveyance of patients by licensed

192 ambulance services and invalid coaches and establish an emergency
193 service rate for certified ambulance services provided the present rates
194 established by the Public Utilities Commission for such services and
195 vehicles shall remain in effect until such time as the commissioner
196 establishes a new rate schedule as provided [herein,] in this
197 subdivision; and (B) adopt regulations, in accordance with the
198 provisions of chapter 54, establishing methods for setting rates and
199 conditions for charging such rates.

200 Sec. 3. Subsection (c) of section 28-24 of the general statutes is
201 repealed and the following is substituted in lieu thereof:

202 (c) Within a time period determined by the commissioner to ensure
203 the availability of funds for the fiscal year beginning July 1, 1997, to the
204 regional public safety emergency telecommunications centers within
205 the state, and not later than April first of each year thereafter, the
206 commissioner shall determine the amount of funding needed for the
207 development and administration of the enhanced emergency 9-1-1
208 program. The commissioner shall specify the expenses associated with
209 (1) the purchase, installation and maintenance of new public safety
210 answering point terminal equipment, (2) the implementation of the
211 subsidy program, as described in subdivision (2) of subsection (a) of
212 this section, (3) the implementation of the transition grant program,
213 described in subdivision (2) of subsection (a) of this section, (4) the
214 implementation of the regional emergency telecommunications service
215 credit, as described in subdivision (2) of subsection (a) of this section,
216 provided, for the fiscal year beginning July 1, 2000, and each fiscal year
217 thereafter, such credit for coordinated medical emergency direction
218 services as provided in regulations adopted under this section shall be
219 based upon the factor of thirty cents per capita and shall not be
220 reduced each year, (5) the training of personnel, as necessary, (6)
221 recurring expenses and future capital costs associated with the
222 telecommunications network used to provide emergency 9-1-1 service,
223 [and] (7) for the fiscal year ending June 30, 2001, the development of

224 the data collection system and the collection and reporting of
225 information by the Commissioner of Public Health pursuant to
226 subparagraphs (A) and (B) of subdivision (8) of section 19a-177, as
227 amended by this act, provided the amount of expenses specified under
228 this subdivision shall not exceed two hundred fifty thousand dollars,
229 (8) for the fiscal year beginning July 1, 2000, and each fiscal year
230 thereafter, the reimbursement of emergency medical dispatch costs
231 pursuant to subdivision (4) of subsection (g) of section 28-25b, as
232 amended by this act, and (9) the administration of the enhanced
233 emergency 9-1-1 program by the Office of State-Wide Emergency
234 Telecommunications, as the commissioner determines to be reasonably
235 necessary. The commissioner shall communicate [his] the
236 commissioner's findings to the [chairman] chairperson of the Public
237 Utilities Control Authority not later than April first of each year.

238 Sec. 4. Section 28-25 of the general statutes is amended by adding
239 subdivision (15) as follows:

240 (NEW) (15) "Emergency medical dispatch" means the management
241 of requests for emergency medical assistance by utilizing a system of
242 (A) tiered response or priority dispatching of emergency medical
243 resources based on the level of medical assistance needed by the
244 victim, and (B) prearrival first aid or other medical instructions given
245 by trained personnel who are responsible for receiving 9-1-1 calls and
246 directly dispatching emergency response services.

247 Sec. 5. Section 28-25b of the general statutes is repealed and the
248 following is substituted in lieu thereof:

249 (a) Each public safety answering point shall be capable of
250 transmitting requests for law enforcement, fire fighting, medical,
251 ambulance or other emergency services to a public or private safety
252 agency that provides the requested services.

253 (b) Each public safety answering point shall be equipped with a

254 system approved by the office for the processing of requests for
255 emergency services from the physically disabled.

256 (c) No person shall connect to a telephone company's network any
257 automatic alarm or other automatic alerting device which causes the
258 number "9-1-1" to be automatically dialed and provides a prerecorded
259 message in order to directly access emergency services, except for a
260 device approved by the office and required by a physically disabled
261 person to access a public safety answering point.

262 (d) Except as provided in subsection (e) of this section, no person,
263 firm or corporation shall program any telephone or associated
264 equipment with outgoing access to the public switched network of a
265 telephone company so as to prevent a 9-1-1 call from being transmitted
266 from such telephone to a public safety answering point.

267 (e) A private company, corporation or institution which has full-
268 time law enforcement, fire fighting and emergency medical service
269 personnel, with the approval of the office and the municipality in
270 which it is located, may establish 9-1-1 service to enable users of
271 telephones within their private branch exchange to reach a private
272 safety answering point by dialing the digits "9-1-1". Such 9-1-1 service
273 shall provide the capability to deliver and display automatic number
274 identification and automatic location identification by electronic or
275 manual methods approved by the office to the private safety
276 answering point. Prior to the installation and utilization of such 9-1-1
277 service, each municipality in which it will function, shall submit a
278 private branch exchange 9-1-1 utilization plan to the office in a format
279 approved by the office. Such plan shall be approved by the chief
280 executive officer of such municipality who shall attest that the dispatch
281 of emergency response services from a private safety answering point
282 is equal to, or better than, the emergency response services dispatched
283 from a public safety answering point.

284 (f) On and after January 1, 2001, each public safety answering point
285 shall submit to the office, on a quarterly basis, a report of the calls for
286 emergency medical services received by the public safety answering
287 point. Such report shall include, but not be limited to, the following
288 information: (1) The number of 9-1-1 calls during the reporting quarter
289 that involved a medical emergency; and (2) for each such call, the
290 elapsed time period from the time the call was received to the time the
291 call was answered, and the elapsed time period from the time the call
292 was answered to the time emergency response services were
293 dispatched or the call was transferred or relayed to another public
294 safety agency or private safety agency, expressed in time ranges or
295 fractile response times. On an annual basis, the office shall furnish
296 such information to the Commissioner of Public Health, shall make
297 such information available to the public and shall post such
298 information on its web site on the Internet.

299 (g) (1) Not later than July 1, 2004, each public safety answering point
300 shall provide emergency medical dispatch, or shall arrange for
301 emergency medical dispatch to be provided by a public safety agency,
302 private safety agency or regional emergency telecommunications
303 center, in connection with all 9-1-1 calls received by such public safety
304 answering point for which emergency medical services are required.
305 Any public safety answering point that arranges for emergency
306 medical dispatch to be provided by a public safety agency, private
307 safety agency or regional emergency telecommunications center shall
308 file with the office such documentation as the office may require to
309 demonstrate that such public safety agency, private safety agency or
310 regional emergency telecommunications center satisfies the
311 requirements of subdivisions (2) and (3) of this subsection.

312 (2) Each public safety answering point, public safety agency, private
313 safety agency or regional emergency telecommunications center
314 performing emergency medical dispatch in accordance with
315 subdivision (1) of this subsection shall establish and maintain an

316 emergency medical dispatch program. Such program shall include, but
317 not be limited to, the following elements: (A) Medical interrogation,
318 dispatch prioritization and prearrival instructions in connection with
319 9-1-1 calls requiring emergency medical services shall be provided
320 only by personnel who have been trained in emergency medical
321 dispatch through satisfactory completion of a training course provided
322 or approved by the office under subdivision (3) of this subsection; (B) a
323 medically approved emergency medical dispatch priority reference
324 system shall be utilized by such personnel; (C) emergency medical
325 dispatch continuing education shall be provided for such personnel;
326 (D) a mechanism shall be employed to detect and correct discrepancies
327 between established emergency medical dispatch protocols and actual
328 emergency medical dispatch practice; and (E) a quality assurance
329 component shall be implemented to monitor, at a minimum, (i)
330 emergency medical dispatch time intervals, (ii) the utilization of
331 emergency medical dispatch program components, and (iii) the
332 appropriateness of emergency medical dispatch instructions and
333 dispatch protocols. The quality assurance component shall provide for
334 an ongoing review of the effectiveness of the emergency medical
335 dispatch program by a physician trained in emergency medicine.

336 (3) Not later than July 1, 2001, the office shall provide an emergency
337 medical dispatch training course, or approve any emergency medical
338 dispatch training course offered by other providers, that meets the
339 requirements of the U.S. Department of Transportation, National
340 Highway Traffic Safety Administration, Emergency Medical Dispatch
341 (EMD): National Standard Curriculum, as from time to time amended.

342 (4) The office shall reimburse each public safety answering point or
343 regional emergency telecommunications center performing emergency
344 medical dispatch in accordance with subdivision (1) of this subsection
345 for (A) start-up costs related to the initial training of emergency
346 medical dispatch personnel and the purchase of an emergency medical
347 dispatch priority reference card set, and (B) costs related to the

348 ongoing training of emergency medical dispatch personnel. Before any
349 such reimbursement is approved, the office shall require proof
350 satisfactory to the office that the public safety answering point or
351 regional emergency telecommunications center has established an
352 emergency medical dispatch program in compliance with subdivision
353 (2) of this subsection.

354 Sec. 6. This act shall take effect July 1, 2000.

PH Committee Vote: Yea 22 Nay 0 JFS

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact: Significant Cost (Enhanced 9-1-1 Telecommunications Fund and General Fund), Minimal Cost

Affected Agencies: Departments of Public Health, Public Safety

Municipal Impact: Minimal Cost, Indeterminate Cost, Potential Savings, STATE MANDATE

Explanation

State and Municipal Impact:

Collection of EMS Data

The Department of Public Health (DPH) will incur an estimated cost of \$249,645 in FY 01 to institute an emergency medical services (EMS) data collection system by October 1, 2001. Included in this sum is \$5,600 in equipment funding for a computer and printer, \$240,000 to purchase 800,000 trip record forms (at \$0.30 each), and \$4,045 in associated other expenses. The agency anticipates hiring staff required to oversee the data collection system within its current services budget before the end of FY 00. In FY 01 and subsequent fiscal years, a cost of approximately \$244,000 will be incurred as one time equipment expenses will not recur.

DPH costs would be offset in FY 01 by up to \$250,000 from the

Emergency 9-1-1 (E 9-1-1) Telecommunications Fund. As the bill does not provide for ongoing subsidization of the EMS data collection system from the E 9-1-1 Fund, an appropriation adjustment will be required in FY 02 and subsequent fiscal years.

It is anticipated that the DPH will be able to conduct audits to verify the accuracy of the reported information, conduct hearings involving EMS organizations failing to submit adequate information, compile a report summarizing the EMS data by March 31, 2002 and annually thereafter, and post this information upon its internet web site within its anticipated budgetary resources.

Municipally affiliated EMS companies will incur minimal costs to complete and forward tracking documents to the Department of Public Health on a quarterly basis, commencing October 1, 2001.

Beginning January 1, 2001, each public safety answering point (PSAP) would be required to submit quarterly reports to the Office of State-wide Emergency Telecommunications (OSET) in the Department of Public Safety on calls received for emergency medical services. OSET shall submit an annual report to the Department of Public Health. The costs to PSAPs would depend on the level of computerization and the number of EMS calls. It is anticipated that most would incur minimal additional costs. OSET estimates that it would require about one-half staff position to meet these data collection and reporting responsibilities, at an annual cost of about \$30,000, financed by the E 9-111 Fund.

C-MED Credit

The bill also requires that the credit for regional coordinated medical emergency direction (C-MED) services be increased to \$0.30 per capita and maintained at that level. This results in costs to the E 9-1-1 Fund estimated at \$600,000 in FY 01, \$750,000 in FY 02, and \$900,000 annually beginning in FY 03. The C-MED credit was

established in FY 97 at \$0.25 per capita and has been reduced by \$0.05 per year. It was established to provide partial relief to the local municipalities from the cost burden imposed by these operations, and then phased out in order to encourage the consolidation of dispatch centers. While this subsidy of C-MED services could potentially reduce costs to municipalities, the actual experience of municipalities in FY 97 indicated that few had any reduction in their costs for C-MED service. It should be noted that funding increases from the E 9-1-1 Fund has already offset the impact of the declining C-MED credit on the regional emergency communications centers.

Emergency Medical Dispatch System

By July 1, 2004, the bill requires that each PSAP must provide itself or arrange for emergency medical dispatch (EMD) to be provided by a public or private safety agency or a regional emergency dispatch center. Based on national standards, implementation of EMD requires dispatchers to attend an initial training program, the provision of medical protocol reference sets, and re-certification every two or three years. The bill requires OSET to provide or approve an EMD training course and to reimburse each PSAP or center doing EMD for initial and ongoing training costs.

Information contained in the Program Review and Investigations Committee report, and verified by OSET, indicates that while EMD adds to the length of some medical emergency calls, it does not usually require an increase in the number of dispatchers. Most increases were very minor and could be handled with minor overtime costs. In addition, an analysis of the current volume of emergency calls handled by each PSAP in Connecticut indicates that most could handle an increase in the time per call with current staff. Therefore, minimal additional costs are anticipated from a minimal workload increase. The PSAPs and the municipalities that provide funding for them would incur these potential minimal costs.

Since the EMD system does not have to be in place until FY 04, the costs for training existing personnel could be spread over three years. Total costs of about \$195,000 would be incurred in FY 01. This estimate is based upon an assumption that 500 people would require training each year at a cost of about \$300 each (for a total of \$150,000). Additionally, OSET estimates that it would require one-half staff position to oversee EMD training responsibilities at an annual cost of about \$30,000. In FY 01, a cost of approximately \$15,000 would be incurred to purchase approximately 300 priority reference card sets, at a cost of \$50 each. Ongoing costs of \$180,000 would be experienced in FY 02 and 03, as personnel training and OSET oversight duties would recur. These costs would also be funded through the E 9-1-1 Fund.

Finally, the bill allows OSET to cover PSAP dispatcher re-certification costs, which range from \$50 to \$130 every two to three years. This, in addition to the training of new dispatchers would result in ongoing costs of about \$150,000 per year.

E 9-1-1 Fund

The E 9-1-1 Fund is primarily financed through fees assessed against subscribers of local telephone service. It is a non-lapsing, non-appropriated fund. The resources of the fund must be used solely for expenses associated with the enhanced emergency 9-1-1 program. Estimated FY 00 collections are \$9.14 million resulting from a \$0.31 per telephone line surcharge. The surcharge is capped by statute at \$0.50 per line. Each cent in the surcharge generates \$250,000 to \$300,000 per year.

OLR Bill Analysis

sHB 5287

AN ACT CONCERNING EMERGENCY MEDICAL SERVICES DATA COLLECTION AND EMERGENCY MEDICAL DISPATCH.

SUMMARY:

This bill makes a number of changes IN the state's emergency medical services (EMS) system including: (1) requiring the Department of Public Health (DPH) to collect specific EMS data from licensed and certified ambulance services on a quarterly basis and prepare an annual report based on this data; (2) allowing DPH to impose penalties on ambulance services not submitting the required data; (3) requiring each public safety answering point (PSAP) to submit information quarterly to the Office of State-Wide Emergency Telecommunications on EMS calls received and requiring the office to provide DPH with this information annually; (4) requiring each PSAP, by July 1, 2004, to provide emergency medical dispatch (EMD) or arrange for it to be provided by a public or private safety agency or regional telecommunications center, for 9-1-1 calls the PSAP receives that require emergency medical services; (5) requiring the office to provide or approve an EMD training course and to reimburse PSAPs or centers for certain EMD training costs; and (6) providing funding, through the enhanced emergency 9-1-1 program funding mechanism, for the DPH data collection activities and certain EMD costs.

EFFECTIVE DATE: July 1, 2000

DATA COLLECTION SYSTEM

By law, the DPH commissioner must develop a data collection system that follows a patient from initial entry into the system through discharge from the emergency room. The bill, instead, directs DPH to develop the EMS data collection system by October 1, 2001 and follow the patient from initial EMS entry through emergency room arrival. The bill requires DPH to collect the following on a quarterly basis from each licensed or certified ambulance service providing EMS:

1. the total number of calls for EMS service received during the reporting period;
2. the level of EMS required for each call;
3. the response time for each level of EMS given during that period;
4. the number of passed, cancelled, and mutual aid calls during that period (“a mutual aid call” is a call for EMS that, according to a written agreement, a secondary or alternate EMS provider responds to because the primary or designated provider cannot because it is responding to another call or the vehicle is out of service); and
5. the prehospital data for the unscheduled transport of patients for that period.

This information can be submitted in any DPH-approved written or electronic form the service chooses. DPH must consider the services’ needs in approving the form. DPH can audit the service as necessary to verify the reported information’s accuracy.

DPH Report

The bill directs DPH to prepare a report for the year that includes:

1. the total number of calls for EMS received during the reporting year by each licensed or certified ambulance service;
2. the level of EMS required for each call;
3. the name of the provider of each level of EMS given during the reporting year;
4. the response time (in time ranges or fractile response times) for each level of EMS using a common definition of response time; and
5. the number of passed, cancelled, and mutual aid calls.

This report must be in a format that categorizes the information for each town in which the EMS was provided, grouped according to urban, suburban, and rural categories. By March 31, 2002 and annually thereafter, DPH must submit this report to the Public Health Committee, make it publicly available, and post it on the Internet.

Penalties

Under the bill, the commissioner can impose certain penalties on a licensed or certified ambulance service that fails to submit the required information. DPH must issue a written order directing the service to comply with the reporting requirement if (1) the service does not submit information for six consecutive months or (2) if DPH believes the service knowingly or intentionally submitted incomplete or false information.

If the service does not fully comply with the order within three months from its issuance, DPH (1) must hold a hearing at which the service must show cause why its primary service area assignment should not be revoked and (2) can take a variety of disciplinary actions against the service (e.g. license revocation or suspension, censure, letter of reprimand, probation, civil penalties) as it deems appropriate.

PSAP REPORTING

Beginning January 1, 2001, the bill requires each PSAP to submit quarterly reports to the Office of State-wide Emergency Telecommunications of the calls it received for EMS. A "PSAP" is a facility operated 24 hours a day to receive 9-1-1 calls and, as appropriate, directly dispatch emergency response services or transfer or relay emergency 9-1-1 calls to other public safety agencies.

The report must include (1) the number of 9-1-1 calls during the quarter involving a medical emergency and (2) for each call, the elapsed time between the time the call was received and the time it was answered, and the elapsed time between when the call was answered and the time emergency response services were dispatched or the call was transferred or relayed to another public or private safety agency (this must be reported in time ranges or fractile response times). Annually, the office must give this information to DPH and make it available to the public, including Internet posting.

EMERGENCY MEDICAL DISPATCH

Under the bill, by July 1, 2004, each PSAP must itself provide or arrange for emergency medical dispatch (EMD) to be provided by a public or private safety agency or a regional emergency telecommunications center, concerning all 9-1-1 calls received by the

PSAP that require EMS. "Emergency Medical Dispatch" means the management of requests for emergency medical assistance using a system of (1) tiered response or priority dispatching of emergency medical resources based on the level of assistance needed and (2) prearrival first aid or other medical instructions given by trained personnel who are responsible for receiving 9-1-1 calls and directly dispatching emergency response services. Any PSAP arranging for EMD from a public or private agency or regional center must file with the office documentation demonstrating that the agency or center satisfies the bill's requirements.

An EMD program must include:

1. medical interrogation, dispatch prioritization, and prearrival instructions for 9-1-1 calls requiring EMS that are provided only by personnel who have satisfactorily completed an EMD training course offered or approved by the office;
2. a medically approved EMD priority system used by the personnel;
3. EMD continuing education;
4. a mechanism to detect and correct discrepancies between established EMD protocols and actual practice; and
5. a quality assurance component to monitor EMD time intervals, use of EMD program components, and appropriateness of EMD instructions and protocols. (There must be an ongoing review of the EMD program's effectiveness by an emergency medicine physician.)

EMD Training Course

By July 1, 2001, the bill requires the office to provide an EMD training course or approve one offered by others, if the course meets requirements of the U.S. Department of Transportation, National Highway Traffic Safety Administration, EMD: National Standard Curriculum.

Reimbursement

The bill requires the office to reimburse each PSAP or regional center doing EMD for (1) start-up costs for the initial training of EMD personnel and purchase of an EMD priority reference card set and (2)

costs related to ongoing training of personnel. Before approving any reimbursement, the office must get satisfactory proof that the PSAP or center has established an EMD program complying with the law.

FUNDING FOR ENHANCED EMERGENCY 9-1-1

Existing law requires the public safety commissioner to determine and specify the funding needed for development and administration of the enhanced Emergency 9-1-1 (E 9-1-1) program. This includes (1) purchasing and maintaining new PSAP terminal equipment, (2) subsidizing regional public safety emergency centers, (3) establishing a transition grant program to encourage regionalization of public safety communication, (4) establishing a regional emergency telecommunications service credit to support regional dispatch services, (5) necessary personnel training, (6) recurring expenses and future capital costs of the telecommunications network used to provide E 9-1-1 services, and (7) administrative expenses of the office.

To pay for the expenses of the E 9-1-1 program, the Department of Public Utility Control (DPUC) establishes a monthly assessment on each subscriber of local telephone and commercial mobile radio service as defined by federal law.

This bill adds, for FY 2000-01, the expenses of developing the data collection system and reporting by DPH to the items that determine the amount of funding the E 9-1-1 system needs. The bill specifies that the expenses for the data collection and reporting activities cannot exceed \$250,000. It specifies that, for FY 2000-01 and afterwards, the regional emergency telecommunication service credit for coordinated EMS must be based on a factor of 30 cents per capita and cannot be reduced each year.

The bill also adds, beginning FY 2000-2001 and afterwards, the reimbursement of EMD costs for start-up and training.

BACKGROUND

Related Bill

sSB 164, favorably reported by the Program Review and Investigations

Committee, makes a number of changes to the EMS system, some similar to those in this bill.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute

Yea 22 Nay 0