



Senate

General Assembly

File No. 202

February Session, 2000

Substitute Senate Bill No. 164

Senate, March 23, 2000

The Committee on Program Review and Investigations reported through SEN. FONFARA of the 1st Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

An Act Implementing The Recommendations Of The Legislative Program Review And Investigations Committee Concerning The Regulation Of Emergency Medical Services.

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 Section 19a-175 of the general statutes is repealed and the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 and sections 9 to 11, inclusive, of this act,
4 unless the context otherwise requires:

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

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

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

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

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

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

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

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

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

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

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

39 (12) "Rescue service" means any organization, whether profit or
40 nonprofit, whose primary purpose is to search for persons who have
41 become lost or to render emergency service to persons who are in
42 dangerous or perilous circumstances;

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

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

48 (15) "Paramedic" means a person licensed pursuant to section 20-
49 206ll;

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

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

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

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

61 (20) "Automatic external defibrillator" means a device that: (A) Is
62 used to administer an electric shock through the chest wall to the heart;
63 (B) contains internal decision-making electronics, microcomputers or
64 special software that allows it to interpret physiologic signals, make
65 medical diagnosis and, if necessary, apply therapy; (C) guides the user
66 through the process of using the device by audible or visual prompts;

67 and (D) does not require the user to employ any discretion or
68 judgment in its use;

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

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

80 (23) "Municipality" means the legislative body of a municipality or
81 the board of selectmen in the case of a municipality in which the
82 legislative body is a town meeting;

83 (24) "Primary service area" means a specific municipality or part of a
84 municipality to which one designated emergency medical services
85 provider is assigned for each category of emergency medical response
86 services; and

87 (25) "Primary service area responder" means an emergency medical
88 services provider who is designated to respond to a victim of sudden
89 illness or injury in a primary service area.

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

92 The commissioner shall:

93 (1) With the advice of the Office of Emergency Medical Services
94 established pursuant to section 19a-178, as amended by this act, and of

95 an advisory committee on emergency medical services and with the
96 benefit of meetings held pursuant to subsection (b) of section 19a-184,
97 adopt every five years a state-wide plan for the coordinated delivery of
98 emergency medical services;

99 (2) License or certify the following: (A) Ambulance operations,
100 ambulance drivers, emergency medical technicians and
101 communications personnel; (B) emergency room facilities and
102 communications facilities; and (C) transportation equipment, including
103 land, sea and air vehicles used for transportation of patients to
104 emergency facilities and periodically inspect life saving equipment,
105 emergency facilities and emergency transportation vehicles to insure
106 that state standards are maintained;

107 (3) Annually inventory emergency medical services resources
108 within the state, including facilities, equipment, and personnel, for the
109 purposes of determining the need for additional services and the
110 effectiveness of existing services;

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

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

119 (6) Establish such minimum standards and adopt such regulations,
120 in accordance with the provisions of chapter 54, as may be necessary to
121 develop the following components of an emergency medical service
122 system: (A) Communications, which shall include, but not be limited
123 to, equipment, radio frequencies and operational procedures; (B)
124 transportation services, which shall include, but not be limited to,

125 vehicle type, design, condition and maintenance, life saving equipment
126 and operational procedure; (C) training, which shall include, but not
127 be limited to, emergency medical technicians, communications
128 personnel, paraprofessionals associated with emergency medical
129 services, firefighters and state and local police; and (D) emergency
130 medical service facilities, which shall include, but not be limited to,
131 categorization of emergency departments as to their treatment
132 capabilities and ancillary services;

133 (7) Coordinate training of all personnel related to emergency
134 medical services;

135 (8) [Develop] (A) Not later than October 1, 2001, develop or cause to
136 be developed a data collection system [which shall include a method of
137 uniform patient record keeping which] that will follow a patient from
138 initial entry into the emergency medical service system through
139 [discharge from] arrival at the emergency room. The commissioner
140 shall, on a monthly basis, collect the following information from each
141 person or emergency medical service organization licensed or certified
142 under section 19a-180, as amended by this act, that provides
143 emergency medical services: (i) The total number of calls for
144 emergency medical services received by such person or emergency
145 medical service organization through the 9-1-1 system for the
146 reporting month; (ii) each level of emergency medical services, as
147 defined in regulations adopted pursuant to section 19a-179, as
148 amended by this act, required for each such call; (iii) the response time
149 for each level of emergency medical services furnished during the
150 reporting month; (iv) the number of passed calls, cancelled calls and
151 mutual aid calls during the reporting month; and (v) for the reporting
152 month, the prehospital data for the nonscheduled transport of trauma
153 patients required by regulations adopted pursuant to subdivision (6)
154 of this section. The information required under this subdivision may
155 be submitted in any written or electronic form selected by such person
156 or emergency medical service organization and approved by the

157 commissioner, provided the commissioner shall take into
158 consideration the needs of such person or emergency medical service
159 organization in approving such written or electronic form. The
160 commissioner may conduct an audit of any such person or emergency
161 medical service organization as the commissioner deems necessary in
162 order to verify the accuracy of such reported information.

163 (B) The commissioner shall prepare a report that shall include, but
164 not be limited to, the following information: (i) The total number of
165 calls for emergency medical services received during the reporting
166 year by each person or emergency medical service organization
167 licensed or certified under section 19a-180, as amended by this act; (ii)
168 the level of emergency medical services required for each such call; (iii)
169 the name of the provider of each such level of emergency medical
170 services furnished during the reporting year; (iv) the response time, by
171 time ranges or fractile response times, for each such level of emergency
172 medical service, using a common definition of response time, as
173 provided in regulations adopted pursuant to section 19a-179, as
174 amended by this act; and (v) the number of passed calls, cancelled calls
175 and mutual aid calls during the reporting year. The commissioner shall
176 prepare such report in a format that categorizes such information for
177 each municipality in which the emergency medical services were
178 provided, with each such municipality grouped according to urban,
179 suburban and rural classifications. Not later than March 31, 2002, and
180 annually thereafter, the commissioner shall submit such report to the
181 joint standing committee of the General Assembly having cognizance
182 of matters relating to public health, shall make such report available to
183 the public and shall post such report on the Department of Public
184 Health web site on the Internet.

185 (C) If any person or emergency medical service organization
186 licensed or certified under section 19a-180, as amended by this act,
187 does not submit the information required under subparagraph (A) of
188 this subdivision for a period of six consecutive months, or if the

189 commissioner believes that such person or emergency medical service
190 organization knowingly or intentionally submitted incomplete or false
191 information, the commissioner shall issue a written order directing
192 such person or emergency medical service organization to comply
193 with the provisions of subparagraph (A) of this subdivision and
194 submit all missing information or such corrected information as the
195 commissioner may require. If such person or emergency medical
196 service organization fails to fully comply with such order not later than
197 three months from the date such order is issued, the commissioner
198 shall conduct a hearing, in accordance with chapter 54, at which such
199 person or emergency medical service organization shall be required to
200 show cause why the primary service area assignment of such person or
201 emergency medical service organization should not be revoked; [and]

202 (9) (A) Establish rates for the conveyance of patients by licensed
203 ambulance services and invalid coaches and establish an emergency
204 service rate for certified ambulance services, provided the present rates
205 established [by the Public Utilities Commission] for such services and
206 vehicles shall remain in effect until such time as the commissioner
207 establishes a new rate schedule as provided [herein,] in this
208 subdivision; and (B) adopt regulations, in accordance with the
209 provisions of chapter 54, establishing methods for setting rates and
210 conditions for charging such rates. Such regulations shall include, but
211 not be limited to, provisions requiring that on and after July 1, 2000: (i)
212 Requests for rate increases may be filed no more frequently than once
213 a year; (ii) only licensed ambulance services and certified ambulance
214 services that apply for a rate increase shall be required to file detailed
215 financial information with the commissioner; (iii) licensed ambulance
216 services and certified ambulance services that do not apply for a rate
217 increase in any year shall, not later than July fifteenth of such year, file
218 with the commissioner an audited summary financial statement
219 including total revenue and total expenses, a statement of emergency
220 and nonemergency call volume, and a written declaration that no
221 change in the currently effective maximum rates has occurred; and (iv)

222 detailed financial and operational information filed by licensed
223 ambulance services and certified ambulance services to support a
224 request for a rate increase shall cover the time period from the date of
225 the last increase in rates approved by the commissioner to the date of
226 such request;

227 (10) Research, develop and implement appropriate quantifiable
228 outcome measures for the state's emergency medical services system
229 and submit to the joint standing committee of the General Assembly
230 having cognizance of matters relating to public health, in accordance
231 with the provisions of section 11-4a, on or before July 1, 2002, and
232 annually thereafter, a report on the progress toward the development
233 of such outcome measures and, after such outcome measures are
234 implemented, an analysis of emergency medical services system
235 outcomes;

236 (11) Establish primary service areas and assign in writing a primary
237 service area responder for each primary service area; and

238 (12) Revoke primary services area assignments upon determination
239 by the commissioner that it is in the best interests of patient care to do
240 so.

241 Sec. 3. Section 19a-178 of the general statutes is amended by adding
242 subsection (c) as follows:

243 (NEW) (c) The Office of Emergency Medical Services shall, with the
244 advice of the Emergency Medical Services Advisory Board established
245 pursuant to section 19a-178a and the regional emergency medical
246 services councils established pursuant to section 19a-183, develop
247 model local emergency medical services plans and performance
248 agreements to guide municipalities in the development of such plans
249 and agreements. In developing the model plans and agreements, the
250 office shall take into account (1) the differences in the delivery of
251 emergency medical services in urban, suburban and rural settings, (2)

252 the state-wide plan for the coordinated delivery of emergency medical
253 services adopted pursuant to subdivision (1) of section 19a-177, as
254 amended by this act, and (3) guidelines or standards and contracts or
255 written agreements in use by municipalities of similar population and
256 characteristics.

257 Sec. 4. Section 19a-179 of the general statutes is repealed and the
258 following is substituted in lieu thereof:

259 The [Commissioner of Public Health] commissioner shall adopt
260 regulations, in accordance with chapter 54, concerning the methods
261 and conditions for licensure and certification of the operations,
262 facilities and equipment enumerated in section 19a-177, as amended by
263 this act, and regulations regarding complaint procedures for the public
264 and any emergency medical service organization. Such regulations
265 shall be [adopted in accordance with the provisions of chapter 54 and
266 shall be] in conformity with the policies and standards established by
267 the commissioner. Such regulations shall require that, as an express
268 condition of the purchase of any business holding a primary service
269 area, the purchaser shall agree to abide by any performance standards
270 to which the purchased business was obligated pursuant to its
271 agreement with the municipality.

272 Sec. 5. Section 19a-180 of the general statutes is repealed and the
273 following is substituted in lieu thereof:

274 (a) No person shall operate any ambulance service, rescue service or
275 management service without either a license or a certificate issued by
276 the [Commissioner of Public Health] commissioner. No person shall
277 operate a commercial ambulance service or commercial rescue service
278 or a management service without a license issued by the
279 commissioner. A certificate shall be issued to any volunteer or
280 municipal ambulance service which shows proof satisfactory to the
281 commissioner that it meets the minimum standards of the
282 commissioner in the areas of training, equipment and personnel.

283 Applicants for a license shall use the forms prescribed by the
284 commissioner and shall submit such application to the commissioner
285 accompanied by an annual fee of one hundred dollars. In considering
286 requests for approval of permits for new or expanded emergency
287 medical services in any region, the commissioner shall consult with the
288 Office of Emergency Medical Services and the emergency medical
289 services council of such region and shall hold a public hearing to
290 determine the necessity for such services. Written notice of such
291 hearing shall be given to current providers in the geographic region
292 where such new or expanded services would be implemented,
293 provided, [that] any volunteer ambulance service which elects not to
294 levy charges for services rendered under this chapter shall be exempt
295 from the provisions concerning requests for approval of permits for
296 new or expanded emergency medical services [,] set forth [above] in
297 this subsection. Each applicant for licensure shall furnish proof of
298 financial responsibility which the commissioner deems sufficient to
299 satisfy any claim. The commissioner may adopt regulations, in
300 accordance with the provisions of chapter 54, to establish satisfactory
301 kinds of coverage and limits of insurance for each applicant for either
302 licensure or certification. Until such regulations are adopted, the
303 following shall be the required limits for licensure: (1) For damages by
304 reason of personal injury to, or the death of, one person on account of
305 any accident, at least five hundred thousand dollars, and more than
306 one person on account of any accident, at least one million dollars, (2)
307 for damage to property at least fifty thousand dollars, and (3) for
308 malpractice in the care of one passenger at least two hundred fifty
309 thousand dollars, and for more than one passenger at least five
310 hundred thousand dollars. In lieu of the [foregoing] limits set forth in
311 subdivisions (1) to (3), inclusive, of this subsection, a single limit of
312 liability shall be allowed as follows: (A) For damages by reason of
313 personal injury to, or death of, one or more persons and damage to
314 property, at least one million dollars; and (B) for malpractice in the
315 care of one or more passengers, at least five hundred thousand dollars.

316 A certificate of such proof shall be filed with the commissioner. Upon
317 determination by the commissioner that an applicant is financially
318 responsible, properly certified and otherwise qualified to operate a
319 commercial ambulance service, the commissioner shall issue a license
320 effective for one year to such applicant. If the commissioner
321 determines that an applicant for either a certificate or license is not so
322 qualified, the commissioner shall notify such applicant of the denial of
323 [his] the application with a statement of the reasons for such denial.
324 Such applicant shall have thirty days to request a hearing on the denial
325 of [said] the application.

326 (b) Any person or emergency medical [services] service
327 organization which does not maintain standards or violates
328 regulations adopted under any section of this chapter applicable to
329 such person or organization may have [his or its] such person's or
330 organization's license or certification suspended or revoked or may be
331 subject to any other disciplinary action specified in section 19a-17 after
332 notice by certified mail to such person or organization of the facts or
333 conduct which warrant the intended action. Such person or emergency
334 medical [services] service organization shall have an opportunity to
335 show compliance with all requirements for the retention of such
336 certificate or license. In the conduct of any investigation by the
337 commissioner of alleged violations of the standards or regulations
338 adopted under the provisions of this chapter, the commissioner may
339 issue subpoenas requiring the attendance of witnesses and the
340 production by any medical [services] service organization or person of
341 reports, records, tapes or other documents which concern the
342 allegations under investigation. All records obtained by the
343 commissioner in connection with any such investigation shall not be
344 subject to the provisions of section 1-210, as amended, for a period of
345 six months from the date of the petition or other event initiating such
346 investigation, or until such time as the investigation is terminated
347 pursuant to a withdrawal or other informal disposition or until a
348 hearing is convened pursuant to chapter 54, whichever is earlier. A

349 complaint, as defined in subdivision (6) of section 19a-13, shall be
350 subject to the provisions of section 1-210, as amended, from the time
351 that it is served or mailed to the respondent. Records which are
352 otherwise public records shall not be deemed confidential merely
353 because they have been obtained in connection with an investigation
354 under this chapter.

355 (c) Any person or emergency medical service organization
356 aggrieved by an act or decision of the commissioner regarding
357 certification or licensure may appeal in the manner provided by
358 chapter 54.

359 (d) Any person guilty of any of the following acts shall be fined not
360 more than two hundred fifty dollars, or imprisoned not more than
361 three months, or be both fined and imprisoned: (1) In any application
362 to the commissioner or in any proceeding before or investigation made
363 by the commissioner, knowingly making any false statement or
364 representation, or, with knowledge of its falsity, filing or causing to be
365 filed any false statement or representation in a required application or
366 statement; (2) issuing, circulating or publishing or causing to be issued,
367 circulated or published any form of advertisement or circular for the
368 purpose of soliciting business which contains any statement that is
369 false or misleading, or otherwise likely to deceive a reader thereof,
370 with knowledge that it contains such false, misleading or deceptive
371 statement; (3) giving or offering to give anything of value to any
372 person for the purpose of promoting or securing ambulance or rescue
373 service business or obtaining favors relating thereto; (4) administering
374 or causing to be administered, while serving in the capacity of an
375 employee of any licensed ambulance or rescue service, any alcoholic
376 liquor to any patient in [his] such employee's care, except under the
377 supervision and direction of a licensed physician; (5) in any respect
378 wilfully violating or failing to comply with any provision of this
379 chapter or wilfully violating, failing, omitting or neglecting to obey or
380 comply with any regulation, order, decision or license, or any part or

381 provisions thereof; (6) with one or more other persons, conspiring to
382 violate any license or order issued by the commissioner or any
383 provision of this chapter.

384 (e) No person shall place any advertisement or produce any printed
385 matter that holds that person out to be an ambulance service unless
386 [he] such person is licensed or certified pursuant to this section. Any
387 such advertisement or printed matter shall include the license or
388 certificate number issued by the commissioner.

389 (f) A person or emergency medical service organization licensed or
390 certified under this section may operate any number of ambulances,
391 invalid coaches and nontransport emergency vehicles and any number
392 of branch locations as such person or emergency medical service
393 organization deems necessary to provide adequate service, provided
394 such operation is not a new service offered by such person or
395 emergency medical service organization and does not result in any
396 change in rates. A permit for new or expanded emergency medical
397 services under subsection (a) of this section shall not be required for
398 increasing or decreasing the number of ambulances, invalid coaches,
399 nontransport emergency vehicles or branch locations permitted under
400 this subsection. Each person or emergency medical service
401 organization shall, on an annual basis, provide written notice to the
402 commissioner of the number of ambulances, invalid coaches,
403 nontransport emergency vehicles and branch locations operated by
404 such person or emergency medical service organization. If, during any
405 proceeding to establish rates for such person or emergency medical
406 service organization under section 19a-177, as amended by this act, the
407 commissioner finds that the number of such ambulances, invalid
408 coaches, nontransport emergency vehicles or branch locations is
409 excessive, the commissioner may disallow the expenses related to such
410 ambulances, invalid coaches, nontransport emergency vehicles or
411 branch locations for purposes of establishing such rates.

412 Sec. 6. Subsection (c) of section 28-24 of the general statutes is
413 repealed and the following is substituted in lieu thereof:

414 (c) Within a time period determined by the commissioner to ensure
415 the availability of funds for the fiscal year beginning July 1, 1997, to the
416 regional public safety emergency telecommunications centers within
417 the state, and not later than April first of each year thereafter, the
418 commissioner shall determine the amount of funding needed for the
419 development and administration of the enhanced emergency 9-1-1
420 program. The commissioner shall specify the expenses associated with
421 (1) the purchase, installation and maintenance of new public safety
422 answering point terminal equipment, (2) the implementation of the
423 subsidy program, as described in subdivision (2) of subsection (a) of
424 this section, (3) the implementation of the transition grant program,
425 described in subdivision (2) of subsection (a) of this section, (4) the
426 implementation of the regional emergency telecommunications service
427 credit, as described in subdivision (2) of subsection (a) of this section,
428 (5) the training of personnel, as necessary, (6) recurring expenses and
429 future capital costs associated with the telecommunications network
430 used to provide emergency 9-1-1 service, [and] (7) for the fiscal year
431 beginning July 1, 2000, and each fiscal year thereafter, the collection,
432 maintenance and reporting of emergency medical services data, as
433 required under subparagraphs (A) and (B) of subdivision (8) of section
434 19a-177, as amended by this act, provided the amount of expenses
435 specified under this subdivision shall not exceed two hundred fifty
436 thousand dollars in any fiscal year, (8) for the fiscal year beginning
437 July 1, 2000, and each fiscal year thereafter, the reimbursement of
438 emergency medical dispatch start-up costs pursuant to subdivision (4)
439 of subsection (g) of section 28-25b, as amended by this act, and (9) the
440 administration of the enhanced emergency 9-1-1 program by the Office
441 of State-Wide Emergency Telecommunications, as the commissioner
442 determines to be reasonably necessary. The commissioner shall
443 communicate [his] the commissioner's findings to the [chairman]
444 chairperson of the Public Utilities Control Authority not later than

445 April first of each year.

446 Sec. 7. Section 28-25 of the general statutes is amended by adding
447 subdivision (15) as follows:

448 (NEW) (15) "Emergency medical dispatch" means the management
449 of requests for emergency medical assistance by utilizing a system of
450 (A) tiered response or priority dispatching of emergency medical
451 resources based on the level of medical assistance needed by the
452 victim, and (B) prearrival first aid or other medical instructions given
453 by trained personnel who are responsible for receiving 9-1-1 calls and
454 directly dispatching emergency response services.

455 Sec. 8. Section 28-25b of the general statutes is repealed and the
456 following is substituted in lieu thereof:

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

461 (b) Each public safety answering point shall be equipped with a
462 system approved by the office for the processing of requests for
463 emergency services from the physically disabled.

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

470 (d) Except as provided in subsection (e) of this section, no person,
471 firm or corporation shall program any telephone or associated
472 equipment with outgoing access to the public switched network of a
473 telephone company so as to prevent a 9-1-1 call from being transmitted

474 from such telephone to a public safety answering point.

475 (e) A private company, corporation or institution which has full-
476 time law enforcement, fire fighting and emergency medical service
477 personnel, with the approval of the office and the municipality in
478 which it is located, may establish 9-1-1 service to enable users of
479 telephones within their private branch exchange to reach a private
480 safety answering point by dialing the digits "9-1-1". Such 9-1-1 service
481 shall provide the capability to deliver and display automatic number
482 identification and automatic location identification by electronic or
483 manual methods approved by the office to the private safety
484 answering point. Prior to the installation and utilization of such 9-1-1
485 service, each municipality in which it will function, shall submit a
486 private branch exchange 9-1-1 utilization plan to the office in a format
487 approved by the office. Such plan shall be approved by the chief
488 executive officer of such municipality who shall attest that the dispatch
489 of emergency response services from a private safety answering point
490 is equal to, or better than, the emergency response services dispatched
491 from a public safety answering point.

492 (f) On and after January 1, 2001, each public safety answering point
493 shall submit to the office, on a quarterly basis, a report of the calls for
494 emergency medical services received by the public safety answering
495 point. Such report shall include, but not be limited to, the following
496 information: (1) The number of 9-1-1 calls during the reporting quarter
497 that involved a medical emergency; and (2) for each such call, the
498 elapsed time period from the time the call was received to the time the
499 call was answered, and the elapsed time period from the time the call
500 was answered to the time emergency response services were
501 dispatched or the call was transferred or relayed to another public
502 safety agency or private safety agency, expressed in time ranges or
503 fractile response times. The information required under this subsection
504 may be submitted in any written or electronic form selected by such
505 public safety answering point and approved by the Commissioner of

506 Public Safety, provided the commissioner shall take into consideration
507 the needs of such public safety answering point in approving such
508 written or electronic form. On an annual basis, the office shall furnish
509 such information to the Commissioner of Public Health, shall make
510 such information available to the public and shall post such
511 information on its web site on the Internet.

512 (g) (1) Not later than July 1, 2004, each public safety answering point
513 shall provide emergency medical dispatch, or shall arrange for
514 emergency medical dispatch to be provided by a public safety agency,
515 private safety agency or regional emergency telecommunications
516 center, in connection with all 9-1-1 calls received by such public safety
517 answering point for which emergency medical services are required.
518 Any public safety answering point that arranges for emergency
519 medical dispatch to be provided by a public safety agency, private
520 safety agency or regional emergency telecommunications center shall
521 file with the office such documentation as the office may require to
522 demonstrate that such public safety agency, private safety agency or
523 regional emergency telecommunications center satisfies the
524 requirements of subdivisions (2) and (3) of this subsection.

525 (2) Each public safety answering point, public safety agency, private
526 safety agency or regional emergency telecommunications center
527 performing emergency medical dispatch in accordance with
528 subdivision (1) of this subsection shall establish and maintain an
529 emergency medical dispatch program. Such program shall include, but
530 not be limited to, the following elements: (A) Medical interrogation,
531 dispatch prioritization and prearrival instructions in connection with
532 9-1-1 calls requiring emergency medical services shall be provided
533 only by personnel who have been trained in emergency medical
534 dispatch through satisfactory completion of a training course provided
535 or approved by the office under subdivision (3) of this subsection; (B) a
536 medically approved emergency medical dispatch priority reference
537 system shall be utilized by such personnel; (C) emergency medical

538 dispatch continuing education shall be provided for such personnel;
539 (D) a mechanism shall be employed to detect and correct discrepancies
540 between established emergency medical dispatch protocols and actual
541 emergency medical dispatch practice; and (E) a quality assurance
542 component shall be implemented to monitor, at a minimum, (i)
543 emergency medical dispatch time intervals, (ii) the utilization of
544 emergency medical dispatch program components, and (iii) the
545 appropriateness of emergency medical dispatch instructions and
546 dispatch protocols. The quality assurance component shall provide for
547 an ongoing review of the effectiveness of the emergency medical
548 dispatch program by a physician trained in emergency medicine.

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

555 (4) The office shall reimburse each public safety answering point or
556 regional emergency telecommunications center performing emergency
557 medical dispatch in accordance with subdivision (1) of this subsection
558 for start-up costs related to the initial training of emergency medical
559 dispatch personnel and the purchase of an emergency medical
560 dispatch priority reference card set. Before any such reimbursement is
561 approved, the office shall require proof satisfactory to the office that
562 the public safety answering point or regional emergency
563 telecommunications center has established an emergency medical
564 dispatch program in compliance with subdivision (2) of this
565 subsection.

566 Sec. 9. (NEW) (a) Each municipality shall establish a local
567 emergency medical services plan. Such plan shall include the written
568 agreements or contracts developed between the municipality, its

569 emergency medical services providers and the public safety answering
570 point, as defined in section 28-25 of the general statutes, as amended
571 by this act, that covers the municipality. The plan shall also include,
572 but need not be limited to, the following:

573 (1) The identification of levels of emergency medical services,
574 including, but not limited to: (A) The public safety answering point
575 responsible for receiving emergency calls and notifying and assigning
576 the appropriate provider to a call for emergency medical services; (B)
577 the emergency medical services provider that is notified for initial
578 response; (C) basic ambulance service; (D) advanced life support level;
579 and (E) mutual aid call arrangements;

580 (2) The name of the person or entity responsible for carrying out
581 each level of emergency medical services that the plan identifies;

582 (3) The establishment of performance standards for each segment of
583 the municipality's emergency medical services system; and

584 (4) Any subcontracts, written agreements or mutual aid call
585 agreements that emergency medical services providers may have with
586 other entities to provide services identified in the plan.

587 (b) In developing the plan required by subsection (a) of this section,
588 each municipality: (1) May consult with and obtain the assistance of its
589 regional emergency medical services council established pursuant to
590 section 19a-183 of the general statutes, its regional emergency medical
591 services coordinator appointed pursuant to section 19a-185 of the
592 general statutes, its regional emergency medical services medical
593 advisory committees and any sponsor hospital, as defined in
594 regulations adopted pursuant to section 19a-179 of the general statutes,
595 as amended by this act, located in the area identified in the plan; and
596 (2) shall submit the plan to its regional emergency medical services
597 council for the council's review and comment.

598 Sec. 10. (NEW) (a) As used in this section, "responder" means any
599 primary service area responder that (1) is notified for initial response,
600 (2) is responsible for the provision of basic life support service, or (3) is
601 responsible for the provision of service above basic life support that is
602 intensive and complex prehospital care consistent with acceptable
603 emergency medical practices under the control of physician and
604 hospital protocols.

605 (b) Any municipality may petition the commissioner for the
606 removal of a responder. A petition may be made (1) at any time if
607 based on an allegation that an emergency exists and that the safety,
608 health and welfare of the citizens of the affected primary service area
609 are jeopardized by the responder's performance, or (2) not more often
610 than once every three years, if based on the unsatisfactory performance
611 of the responder as determined based on the local emergency medical
612 services plan established by the municipality pursuant to section 9 of
613 this act and associated agreements or contracts. A hearing on a petition
614 under this section shall be deemed to be a contested case and held in
615 accordance with the provisions of chapter 54 of the general statutes.

616 (c) If, after a hearing authorized by this section, the commissioner
617 determines that (1) an emergency exists and the safety, health and
618 welfare of the citizens of the affected primary service area are
619 jeopardized by the responder's performance, (2) the performance of the
620 responder is unsatisfactory based on the local emergency medical
621 services plan established by the municipality pursuant to section 9 of
622 this act and associated agreements or contracts, or (3) it is in the best
623 interests of patient care, the commissioner may revoke the primary
624 service area responder's primary service area assignment and require
625 the chief administrative official of the municipality in which the
626 primary service area is located to submit a plan acceptable to the
627 commissioner for the alternative provision of primary service area
628 responder responsibilities, or may issue an order for the alternative
629 provision of emergency medical services, or both.

630 Sec. 11. (NEW) (a) Any municipality may petition the commissioner
631 to hold a hearing if the municipality cannot reach a written agreement
632 with its primary service area responder concerning performance
633 standards. The commissioner shall conduct such hearing not later than
634 ninety days from the date the commissioner receives the municipality's
635 petition. A hearing on a petition under this section shall not be deemed
636 to be a contested case for purposes of chapter 54 of the general statutes.

637 (b) In conducting a hearing authorized by this section, the
638 commissioner shall determine if the performance standards adopted in
639 the municipality's local emergency medical services plan are
640 reasonable based on the state-wide plan for the coordinated delivery of
641 emergency medical services adopted pursuant to subdivision (1) of
642 section 19a-177 of the general statutes, as amended by this act, model
643 local emergency medical services plans and the standards, contracts
644 and written agreements in use by municipalities of similar population
645 and characteristics.

646 (c) If, after a hearing authorized by this section, the commissioner
647 determines that the performance standards adopted in the
648 municipality's local emergency medical services plan are reasonable,
649 the primary service area responder shall have thirty calendar days in
650 which to agree to such performance standards. If the primary service
651 area responder fails or refuses to agree to such performance standards,
652 the commissioner may revoke the primary service area responder's
653 primary service area assignment and require the chief administrative
654 official of the municipality in which the primary service area is located
655 to submit a plan acceptable to the commissioner for the alternative
656 provision of primary service area responder responsibilities, or may
657 issue an order for the alternative provision of emergency medical
658 services, or both.

659 (d) If, after a hearing authorized by this section, the commissioner
660 determines that the performance standards adopted in the

661 municipality's local emergency medical services plan are unreasonable,
662 the commissioner shall provide performance standards considered
663 reasonable based on the state-wide plan for the coordinated delivery of
664 emergency medical services adopted pursuant to subdivision (1) of
665 section 19a-177 of the general statutes, as amended by this act, model
666 emergency medical services plans and the standards, contracts and
667 written agreements in use by municipalities of similar population and
668 characteristics. If the municipality refuses to agree to such performance
669 standards, the primary service area responder shall meet the minimum
670 performance standards provided in regulations adopted pursuant to
671 section 19a-179 of the general statutes, as amended by this act.

672 Sec. 12. (NEW) Notwithstanding any provision of the general
673 statutes or any Regulation of Connecticut State Agencies, for the fiscal
674 year ending June 30, 2001, and each fiscal year thereafter, the
675 Commissioner of Social Services shall establish the Medicaid rate for
676 basic life support ambulance transportation in the amount of two
677 hundred dollars.

678 Sec. 13. (NEW) (a) As used in this section, "primary service area"
679 means a specific municipality, or part thereof, to which one designated
680 provider of emergency medical services is assigned for each category
681 of emergency medical response services.

682 (b) Not later than February 1, 2001, the Commissioner of Public
683 Health shall submit to the Legislative Program Review and
684 Investigations Committee a plan of action for the implementation of a
685 pilot program to assess the effect of assigning primary service areas to
686 selected providers of emergency medical services based on the
687 periodic issuance of requests for proposals with a right of first refusal
688 granted to the provider that holds the primary service area at the time
689 of such issuance. The plan of action shall identify the elements of and
690 the means of implementing the pilot program, including, but not
691 limited to: (1) The selection of municipalities in which the pilot

692 program shall be implemented; (2) the design of and measurement
693 standards for the pilot program; (3) the identification of factors to be
694 assessed, including the impact on the delivery of emergency medical
695 services and on the market for such services; (4) the identification of
696 the evaluating entity; and (5) the time period for completion of the
697 pilot program and the reporting of the results of such program. The
698 plan of action shall become effective if the Legislative Program Review
699 and Investigations Committee takes no action with respect to such
700 plan by the sixtieth day after the date of submission. The pilot program
701 shall begin on or after July 1, 2001, unless the plan of action is rejected
702 by the Legislative Program Review and Investigations Committee.

703 Sec. 14. This act shall take effect July 1, 2000.

PRI Committee Vote: Yea 12 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, Social Services, Office of Health Care Access

Municipal Impact: Minimal Cost, Indeterminate Cost, 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 costs will not recur.

DPH costs would be offset by up to \$250,000 annually, commencing in FY 01, from the Emergency 9-1-1 (E 9-1-1) Telecommunications Fund. The Office of State-wide Emergency Telecommunications (OSET) in the Department of Public Safety administers the E 9-1-1 Fund. It 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. The 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.

Beginning January 1, 2001, the bill requires each public safety answering point (PSAP) to submit quarterly reports to OSET on the calls it received for emergency medical services (EMS). The bill requires OSET to 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 for these data collection and reporting responsibilities at an annual cost of about \$30,000, financed by the E 9-111 Fund.

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 monthly basis, commencing October 1, 2001.

EMS Rate Setting Process

Streamlining the EMS rate setting process will result in a workload reduction for the DPH and the Office of Health Care Access. Any resources that would otherwise have been dedicated to this function will be redeployed to other EMS-related regulatory duties.

EMS Outcome Measures

The DPH will be required to develop outcome measures for the EMS system and submit a report by July 1, 2002 and annually thereafter on progress toward the development of these outcome measures. This can be accommodated within the agency's anticipated budgetary resources.

Primary Service Area Assignment

The bill requires, by February 1, 2001, the DPH to report to the Program Review and Investigations Committee a plan for a pilot program to assess the effect of assigning primary service areas (PSAs) to EMS providers. It is anticipated that the DPH will be able to accomplish this duty within its anticipated budgetary resources.

Since the DPH currently assigns primary service area (PSA) responders for each PSA no fiscal impact will result from mandating this responsibility.

Holding hearings at the request of a municipality requesting a review of performance standards when disagreements exist between the town and its primary service area responder can be accommodated within the DPH's anticipated budgetary resources.

Municipalities electing to petition the DPH for the removal of a PSA responder may incur a minimal cost to the extent that town representatives devote time to participate in the subsequent hearing process.

Local Emergency Medical Services Plans

The Office of Emergency Medical Services will be required to develop model local EMS plans and performance agreements. It is anticipated that this can be accommodated within the DPH's anticipated budgetary resources. Communities currently without local EMS plans may incur indeterminate legal costs associated with negotiating contracts with EMS providers and PSAPs.

Determination of Need

To the extent that eliminating a requirement that EMS services receive a determination of need (DON) before adding vehicles or branch offices, a workload decrease will occur for the OEMS. Any DPH resources that would otherwise have been devoted to this function will be redeployed to other EMS-related regulatory duties.

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, the implementation of EMD requires dispatchers to have an initial training program, the provision of medical protocol reference sets, and re-certification every two or three years. It requires OSET to provide or approve an EMD training course and to reimburse each PSAP or center doing EMD for initial 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 that the implementation of EMD 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 training costs of existing personnel could be spread over three years. It is estimated that 500 people would require this training each year over the first three years at a cost of about \$300 each. OSET estimates that it would require about one-half staff position for the EMD training responsibilities at an annual cost of about \$30,000. The total costs are estimated at about \$200,000 per year for FY 01 through FY 03, and this would also be funded through the E 9-1-1 Fund. The bill does not require OSET to cover PSAP dispatcher re-certification costs, which range from \$50 to \$130 every two to three years.

Medicaid Ambulance Rates

The Department of Social Services will incur a cost of approximately \$2.1 million per year, commencing in FY 01, from increasing the Medicaid rate for basic life support (BLS) transportation from \$99.25 to \$200.00. The department paid 20,876 BLS claims in FFY 99. This cost would be partially offset by federal financial participation of \$1.05 million.

It should be noted that raising the BLS rate may lead to pressure to increase the advanced life support (ALS) rate from its current \$153.95 level. If this occurs, an additional cost will result. For comparison purposes, raising the ALS rate to \$200 would result in an estimated additional cost of \$245,000 (offset by federal financial participation of \$122,500), based on 5,334 ALS transports in FFY 99.

OLR Bill Analysis

sSB 164

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE REGULATION OF EMERGENCY MEDICAL SERVICES.**SUMMARY:**

This bill makes a number of changes to 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 monthly basis and to prepare an annual report based on the data;
2. allowing DPH to penalize 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 or arrange for emergency medical dispatch (EMD) to be provided by a public or private safety agency or regional telecommunications center for 9-1-1 calls received by the PSAP requiring emergency medical services;
5. requiring the office to provide or approve an EMD training course and to reimburse each PSAP or center doing EMD for certain training costs;
6. providing funding, through the enhanced emergency 9-1-1 program funding mechanism, for the DPH data collection activities

- and certain EMD costs;
- 7. requiring DPH to develop outcome measures for the EMS system;
- 8. requiring each municipality to establish a local EMS plan and requiring the Office of Emergency Medical Services to develop model local EMS plans;
- 9. allowing any municipality to petition the DPH commissioner to remove a primary service responder not meeting certain performance standards;
- 10. requiring DPH to develop a plan for a pilot program for assigning primary service;
- 11. allowing EMS organizations to increase their number of vehicles and branch locations under certain conditions;
- 12. directing the social services commissioner to establish the Medicaid rate for basic life support ambulance transportation at \$200 for fiscal year 2000-2001; and
- 13. requiring DPH to adopt regulations addressing procedures and conditions for filing rate increase requests.

The bill also makes technical changes.

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 emergency medical service (EMS) 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. It requires DPH to collect the following on a monthly basis from each licensed or certified person or EMS organization providing EMS:

1. the total number of calls for EMS received during the month;
2. each level of EMS required for the calls;
3. the response time for each level of EMS given during that month;
4. the number of passed, cancelled, and mutual aid calls during that month (“mutual aid call” means a call for EMS that, according to a written agreement is responded to by a secondary or alternate EMS provider if the primary or designated provider is unable to respond 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 month.

The required information can be submitted in any written or electronic form the service chooses and DPH approves. DPH must consider the services’ needs in approving the form of submittal. The bill allows DPH to audit the service as it determines necessary to verify the reported information’s accuracy.

DPH Report

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

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

The bill allows the commissioner to impose certain penalties on a person or EMS organization for failing to submit the required information. DPH must issue a written order directing the person or organization to comply with the reporting requirement if (1) it does not submit information for six consecutive months or (2) if DPH believes it knowingly or intentionally submitted incomplete or false information.

If the person or EMS organization does not fully comply with the order within three months from its issuance, DPH must hold a hearing where the service must show cause why its primary service area assignment should not be revoked.

PSAP REPORTING

Beginning January 1, 2001, the bill requires each PSAP to submit quarterly to the Office of State-wide Emergency Telecommunications a report 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 from the time the call was received to the time answered, and the elapsed time from when the call was answered to 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). The information can be submitted in any written or electronic form chosen by the PSAP and approved by the commissioner. He must consider the PSAP's needs in approving the submittal method. Annually, the office must give this information to DPH and also make it available to

the public, including Internet posting.

EMERGENCY MEDICAL DISPATCH

Under the bill, by July 1, 2004, each PSAP must provide or arrange for EMD to be provided by a public or private safety agency or a regional emergency telecommunications center for all 9-1-1 calls received by the PSAP that require emergency medical services. "Emergency Medical Dispatch" means the management of requests for emergency medical assistance by 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 required 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 provided only by personnel who have satisfactorily completed an EMD training course offered or approved by the office;
2. a medically approved EMD priority reference 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 start-up costs for the initial training of EMD personnel and purchase of an EMD priority reference card set. Before approving any reimbursement, the office must get satisfactory proof that the PSAP or center has established an EMD program complying with the bill.

FUNDING FOR ENHANCED EMERGENCY 9-1-1

Existing law requires the public safety commissioner to determine and specify the amount of funding needed for developing and administering 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, and (4) establishing a regional emergency telecommunications service credit to support regional dispatch services. It also includes (1) necessary personnel training, (2) recurring expenses and future capital costs of the telecommunications network used to provide E 9-1-1 services, and (3) 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, beginning FY 2000-2001, the expenses of collecting, maintaining, and reporting EMS data to DPH to the items that determine the amount of funding the E 9-1-1 system needs. It specifies

that the expenses for these activities cannot exceed \$250,000.

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

OUTCOME MEASURES

The bill requires the DPH commissioner to research, develop, and implement appropriate, quantifiable outcome measures for the state's EMS system. By July 1, 2002 and annually afterwards, he must report to the Public Health Committee on his progress and after the measures are implemented, on the outcomes.

LOCAL EMERGENCY SERVICES PLANS

The bill requires each municipality to establish a local EMS plan. It must include written agreements or contracts between the EMS providers and the PSAP covering the municipality. The plan must also include (1) identification of levels of EMS, including (a) the responsible PSAP, (b) the EMS provider notified initially, (c) basic ambulance service, (d) advance life support level, and (e) mutual aid call agreements; (2) the person or entity responsible for each EMS level identified in the plan; (3) performance standards for each part of the town's EMS system; and (4) any subcontracts, written agreements, or mutual aid call agreements that EMS providers have with other entities.

In developing the plans, municipalities can get help from their regional EMS council and coordinator, regional EMS medical advisory committees, and any sponsor hospital located in the plan area. The plan must be given to the regional EMS council for review and comment.

Model Local EMS Plans

The bill requires the Office of Emergency Medical Services (OEMS), with the advice of the EMS Advisory Board and the regional EMS councils, to develop model local EMS plans and performance agreements to aid municipalities in developing such plans. OEMS must consider (1) the difference in delivering EMS in urban, suburban

and rural settings; (2) the statewide plan for coordinated delivery of EMS; and (3) guidelines, standards, and contracts or written agreements used by towns with similar populations and characteristics.

PRIMARY SERVICE AREA RESPONDERS

The bill allows any town to petition the DPH commissioner for removal of a responder. A “responder” is any primary service area responder (1) notified for initial response, (2) responsible for basic life support, or (3) responsible for intensive and complex prehospital care above basic life support that is consistent with acceptable emergency medical practices under the control of physician and hospital protocols. A “primary service area” is a specific municipality or part of one to which one designated EMS provider is assigned for each category of emergency medical response services. A “primary service area responder” is the EMS provider designated to respond in a primary service area.

The bill requires the DPH commissioner to establish primary service areas and assign in writing a primary service area responder for each primary service area. He can revoke primary service area assignment in the best interests of patient care.

Responder Removal

A municipality can petition the commissioner for a responder’s removal (1) at any time based on an allegation that an emergency exists and the safety, health, and welfare of the primary service area’s citizens are jeopardized by the responder’s performance or (2) not more than every three years on the basis of unsatisfactory responder performance under the local EMS plan established by the town and associated agreements or contracts. A hearing on a petition is a contested case according to the Uniform Administrative Procedures Act (UAPA).

After a hearing, the commissioner can (1) revoke the responder’s primary service area assignment and require the affected town’s chief administrative official to submit a plan acceptable to the commissioner for alternative primary service responder responsibilities, (2) issue an

order for alternative EMS provision, or (3) do both. In order to take any of these actions, he must find that (1) an emergency exists and the responder's performance jeopardizes the health and safety of those in the affected area, (2) the responder's performance is unsatisfactory based on the local EMS plan, or (3) it is in the best interests of patient care.

Performance Standards

A municipality can petition the commissioner to hold a hearing if it cannot reach a written agreement with its responder on performance standards. The hearing must be held within 90 days after receiving the petition. This hearing is not a contested case under the UAPA.

In the hearing, the commissioner must determine if the performance standards in the town's local EMS plan are reasonable, based on the statewide plan for the coordinated delivery of EMS, model local EMS plans, and the standards and agreements used by similar municipalities.

If the commissioner determines, after the hearing, that the performance standards in the local EMS plan are reasonable, the responder has 30 days to agree to them. If the responder fails or refuses to agree to the standards, the commissioner can (1) revoke the responder's primary service area assignment and require the town's chief administrative official to submit an acceptable plan for alternative primary area responder responsibilities, (2) issue an order for alternative EMS provision, or (3) both.

If the commissioner determines, after the hearing, that the adopted standards are unreasonable, he must provide reasonable performance standards based on the statewide plan for coordinated EMS delivery, model EMS plans, and the standards and agreements used by similar towns.

The responder must meet minimum performance standards in state regulations if the town refuses to agree to such performance standards.

Currently, DPH must adopt regulations on licensure and certification of the operations, facilities, and equipment of EMS organizations. The

bill requires that, as an express condition of purchasing any business that holds a primary service area, the purchaser must agree to abide by any performance standards to which the business was obligated according to an agreement with the municipality.

PRIMARY SERVICE AREA ASSIGNMENT PILOT PROGRAM

By February 1, 2001, the DPH commissioner must provide the Legislative Program Review and Investigations Committee with a plan for implementing a pilot program that examines the effect of assigning primary service areas to select EMS providers based on periodic request for proposals (RFP) with a right of first refusal to the provider holding the primary service area when the RFP is issued.

DPH's plan must address (1) selection of towns for the pilot; (2) design and measurement standards; (3) assessment factors, such as the effect on EMS delivery and the market for such services; (4) an evaluation entity; and (5) the period for program completion and reporting.

The plan takes effect if the Program Review Committee takes no action on it by the 60th day after submission. The pilot begins by July 1, 2001 unless the committee rejects the plan.

OPERATION OF VEHICLES

The bill allows any licensed or certified person or EMS organization to operate any number of ambulances, invalid coaches and nontransport emergency vehicles, and branch locations it deems necessary to provide adequate service. (The bill defines "nontransport emergency vehicle" as a vehicle emergency medical technicians or paramedics use in responding to emergency calls. It does not carry patients.)

The operation must not be a new service offered by the organization and cannot change rates, and the organization does not need a permit for new or expanded EMS to increase or decrease the number of vehicles or branch locations.

Each person or EMS organization must annually provide written notice to the commissioner of the number of such vehicles and branch locations it operates. If, during any proceeding to establish rates, the

commissioner finds the number in any category to be excessive, he can disallow expenses related to these vehicles and locations when establishing rates.

RATE INCREASES

By law, DPH must establish EMS rates and regulations that establish rate-setting methods. The bill requires the regulations to specify that, beginning July 1, 2000, (1) rate increase requests can be filed only once a year; (2) only licensed and certified ambulance services that file for a rate increase must file detailed financial information; (3) licensed and certified ambulance services that do not apply for an increase in a given year must file, by July 15, (a) an audited financial statement including total revenue and total expenses, (b) a statement of call volume, and (c) a written declaration that no change in the current maximum rates has occurred; and (4) detailed financial and operational information filed by licensed and certified ambulance services seeking a rate increase must cover the time period from the date of the last request to this request (see COMMENT).

BACKGROUND

Related Bill

sHB 5287, favorably reported by the Public Health Committee, makes a number of similar changes to the EMS system concerning DPH data collection PSAPs, EMD, and funding related to these functions.

COMMENT

Regulations and Effective Date

Under the bill, DPH must establish EMS rate regulations that specify certain criteria and requirements take effect July 1, 2000. But the bill itself takes effect July 1, 2000, so it is unclear how these regulations could be in place at the same time.

COMMITTEE ACTION

Program Review and Investigations Committee

Joint Favorable Substitute

Yea 12 Nay 0