TESTIMONY OF GARY B. O'CONNOR
BEFORE THE PUBLIC HEALTH COMMITTEE
OF THE GENERAL ASSEMBLY

MARCH 6, 2009

IN SUPPORT OF H.B. NO. 6599

AN ACT CONCERNING PATIENT SAFETY

Good Morning, my name is Gary O'Connor. I am a partner at the law firm of Pepe & Hazard LLP. I have had more than 15 years of experience representing ambulance providers in the State of Connecticut. I am here on behalf of the Association of Connecticut Ambulance Providers (ACAP). I would like to thank the Public Health Committee for the opportunity to speak today in support of H.B. No. 6599, An Act Concerning Patient Safety. The Bill, in its present form, addresses a very important patient safety issue in the State of Connecticut, namely, the transportation of patients who are confined to stretchers.

H.B. No. 6599 would amend Section 19a-180 of the Connecticut General Statutes to prohibit anyone from transporting in a motor vehicle a person on a stretcher without a license issued by the Commissioner of Public Health. This provision will insure that the transportation of patients on stretchers will be properly regulated by the Commissioner of Public Health.

In the past few years, the use of stretcher vans to transport patients who are confined to stretchers has increased in other parts of the country, including our neighboring states. This dangerous trend has now crept closer to home. Recently, a livery service provider in Connecticut advertised "stretcher car" services in the

yellow pages. ACAP believes that it is not in the best interest of patient safety to transport patients confined to stretchers in so-called stretcher vans. The safety of patients is put at risk when they are not transported in vehicles that are staffed and equipped to meet their medical needs. Generally, stretcher vans are staffed by only one person, who is not trained to the level of ambulance personnel. Ambulances are staffed by two medically trained individuals so that the stretcher bound patient can be properly attended to while the ambulance is being driven.

ACAP acknowledges that transportation providers, licensed by the Department of Transportation, serve an important role in the transportation of individuals requiring a lesser level of care, such as those individuals being transported to and from methadone clinics or rehab clinics. However, these providers do not possess the skills necessary to safely transport stretcher patients. A stretcher-bound patient by definition has advanced medical needs. This type of patient requires medical observation and handling by at least an EMT in a vehicle which is equipped with patient monitoring and management equipment.

Currently, the medical transportation of stretcher-bound patients is being operated safely and efficiently under the oversight of the Department of Public Health in vehicles that are inspected by the Department on a regular basis and staffed with emergency medical technicians who are required to complete rigorous training and recertification programs. It would be a folly, indeed, to permit an inferior form of transportation which is not regulated by the Department of Public Health.

In sum, ACAP believes that the emergence of stretcher vans as a substitute for regulated medical transportation creates a huge patient safety issue. In our opinion, stretcher vans are an unsafe mode of transportation for stretcher bound patients. Without the adoption of H.B. No. 6599, Connecticut will see more stretcher bound patients inappropriately placed with lower level transportation providers at great potential risk to patient health and safety. The passage of H.B. No. 6599 will prevent this serious problem from happening.

ACAP also recommends an additional amendment to Section 19a-180, which we have included in a proposed amended H.B. No. 6599 attached as an exhibit to my written testimony. The amendment permits a primary service area responder (PSAR) within the EMS Council Region in which a Certificate of Need (CON) applicant operates or proposes to operate, to request and receive intervenor status with the opportunity for cross-examination. In addition, the amendment requires the Commissioner of Public Health to consider the impact, including the financial impact, on any such PSAR in rendering a decision to grant or deny any CON Application.

A brief history of the EMS system in Connecticut is in order. Prior to the enactment of legislation creating the comprehensive EMS system in 1974 (P.A. 74-305, now §§ 19a-175 et. seq.), there was no single number to call for emergencies; emergency calls were made directly to providers using 7-digit phone numbers; towns called providers on a rotation basis; providers often had insufficient equipment and supplies; the system lacked supervision and accountability; staff were not always adequately trained; and there was very little communication between providers and

destination hospitals. Moreover, prior to 1974, there were allegations of widespread abuse among competitors within the emergency medical system including the use of radio scanners to intercept calls, races to emergencies by multiple providers, fraud, bribery, stacked calls, harassment, fights at the scene of emergency calls and the practice of calling in false emergencies to keep a provider busy so another provider could respond to a legitimate call.

In 1974 the Emergency Medical Services Assistance Act was passed to (i) create a statewide coordinated emergency response system to insure that emergency calls were answered by assigning accountability to one provider within a designated geographic area; (ii) insure that rural areas were afforded the same quality of care as urban areas; (iii) control costs by minimizing the number of providers that respond to an emergency; (iv) eliminate unsafe practices; (v) encourage investment and marketed efficiency by insuring stability; and (vi) develop and enforce standards.

The Act created the basic structure of today's emergency medical system including the designation of primary service areas (PSAs) throughout the State with each PSA having one responder at the First Responder Level, the Basic Life Support Level and the Advanced Life Support Level. The Regulations were also promulgated regarding the training of emergency personnel, the equipment and design of ambulances, advertising, the use of scanners and rates.

Designated PSARs are responsible for providing emergency services 24 hours each day, 7 days each week and are required, among other things, to: (i) maintain a trained and licensed staff; (ii) maintain vehicles and equipment that meet mandated

standards; (iii) maintain a comprehensive set of records regarding requests for service; (iv) coordinate medical control issues with sponsor hospitals; (v) coordinate efforts with local authorities and other PSARs within their service area; and (vi) be prepared to respond to mass casualty situations.

Since 1974, the EMS system in Connecticut has worked extraordinarily well, but make no mistake about it, the system relies heavily on the strength and financial well-being of its licensed PSARs. The licensed PSARs handle most of the emergency trips in Connecticut's major cities. The licensed PSARs transport a majority of the State's Medicaid patients as well as the indigent and uninsured. When the 911 system is activated, the licensed PSAR must respond regardless of a patient's ability to pay. The licensed PSARs have served as the safety net for EMS response to mass casualty situations. Historically, licensed providers have been able to offset the operating losses sustained with respect to Medicaid emergency trips and uncollectible emergency trips by operating on a more regional basis and by generating revenues from non-emergency transports. Only licensed ambulance providers may charge for non-emergency transportation.

It is crucial, therefore, that the licensed PSAR, an essential stakeholder in the statewide EMS system, be allowed to participate as an intervenor, with cross-examination rights, in any CON hearing within its region. It is also critical that the Commissioner of Public Health, in rendering his or her decision, consider the impact, including financial impact, of the CON decision on any intervening licensed PSAR. Indeed, this type of due consideration is essential in any effective public utility model,

especially with Connecticut's EMS public utility model, where there are over 160 PSAs in the State. The approval of a new company or additional ambulance authorizations in a PSA will have an impact on the delicate balance which exists among PSARs in Connecticut.

Presently, as a result of a Supreme Court case in 1997, Med-Trans of Connecticut, Inc. vs. Department of Public Health and Addiction Services, the Department of Public Health believes that it cannot take into consideration the financial condition of existing EMS providers when new or existing companies apply for ambulance licenses. It makes no sense to restrict the Commissioner in this manner. The Commissioner must be allowed to look at the entire EMS system and consider the impact of a new company or the expanded service of an existing company on the efficient operation of the system. In today's current environment, with increased demands on the EMS system, increased provider costs, and stagnant or decreasing reimbursement to providers by both government and private health insurers, it is in the public's best interest for the EMS system to operate in the most efficient, cost-effective manner possible. Unfortunately, if impacted licensed PSARs are not able to participate as intervenors with cross-examination rights, and the Commissioner is not allowed to consider all impacts on existing PSARs, we will see more CON approvals, more licensed ambulances companies, excess capacity in the system, increased costs without the benefit of economies of scale, and little financial self-sufficiency among ambulance providers. We risk having literally hundreds of licensed services, none of whom will be financially solvent and all of whom will be dependent on taxpayer subsidies.

In sum, the EMS system in Connecticut works. ACAP believes that the system works in large part due to the important role played by the licensed PSARs. H.B. No. 6599, as amended, will go a long way towards preserving our wonderful EMS system.

PROPOSED AMENDED LANGUAGE
TO HB6599 "An Act Concerning Patient Safety"

Proposed by The Association of Connecticut Ambulance Providers

Sec. 19a-180. (Formerly Sec. 19-73bb). Licensure and certification of emergency medical service organizations. Suspension or revocation. Records. Penalties. Advertisement. Medical control by sponsor hospital. New or expanded emergency medical services. (a) No person shall operate any ambulance service, rescue service or management service without either a license or a certificate issued by the commissioner. No person shall operate a commercial ambulance service or commercial rescue service or a management service, **or otherwise transport in a motor vehicle a person on a stretcher,** without a license issued by the commissioner. A certificate shall be issued to any volunteer or municipal ambulance service which shows proof satisfactory to the commissioner that it meets the minimum standards of the commissioner in the areas of training, equipment and personnel. No license or certificate shall be issued to any volunteer, municipal or commercial ambulance service, rescue service or management service, as defined in subdivision (19) of section 19a-175, unless it meets the requirements of subsection (e) of section 14-100a. Applicants for a license shall use the forms prescribed by the commissioner and shall submit such application to the commissioner accompanied by an annual fee of one hundred dollars. In considering requests for approval of permits for new or expanded emergency medical services in any region, the commissioner shall consult with the Office of Emergency Medical Services and the emergency medical services council of such region and shall hold a public hearing to determine the necessity for such services. Written notice of such hearing shall be given to current providers in the geographic region where such new or expanded services would be implemented, provided, any volunteer ambulance service which elects not to levy charges for services rendered under this chapter shall be exempt from the provisions concerning requests for approval of permits for new or expanded emergency medical services set forth in this subsection. A primary service area responder in a municipality in which the applicant operates or proposes to operate**, or a licensed primary service area responder within the region defined pursuant to section 19a-183 in which applicant operates or proposes to operate,** shall, upon request, be granted intervenor status with opportunity for cross-examination. **The Commissioner shall consider the impact, including financial impact, on any such primary service area responder in rendering a decision to grant or deny any license application.** Each applicant for licensure shall furnish proof of financial responsibility which the commissioner deems sufficient to satisfy any claim. The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to establish satisfactory kinds of coverage and limits of insurance for each applicant for either licensure or certification. Until such regulations are adopted, the following shall be the required limits for licensure: (1) For damages by reason of personal injury to, or the death of, one person on account of any accident, at least five hundred thousand dollars, and more than one person on account of any accident, at least one million dollars, (2) for damage to property at least fifty thousand dollars, and (3) for malpractice in the care of one passenger at least two hundred fifty thousand dollars, and for more than one passenger at least five hundred thousand dollars. In lieu of the limits set forth in subdivisions (1) to (3), inclusive, of this

subsection, a single limit of liability shall be allowed as follows: (A) For damages by reason of personal injury to, or death of, one or more persons and damage to property, at least one million dollars; and (B) for malpractice in the care of one or more passengers, at least five hundred thousand dollars. A certificate of such proof shall be filed with the commissioner. Upon determination by the commissioner that an applicant is financially responsible, properly certified and otherwise qualified to operate a commercial ambulance service, rescue service or management service, the commissioner shall issue the appropriate license effective for one year to such applicant. If the commissioner determines that an applicant for either a certificate or license is not so qualified, the commissioner shall notify such applicant of the denial of the application with a statement of the reasons for such denial. Such applicant shall have thirty days to request a hearing on the denial of the application.

(b) Any person, management service organization or emergency medical service organization which does not maintain standards or violates regulations adopted under any section of this chapter applicable to such person or organization may have such person's or organization's license or certification suspended or revoked or may be subject to any other disciplinary action specified in section 19a-17 after notice by certified mail to such person or organization of the facts or conduct which warrant the intended action. Such person or emergency medical service organization shall have an opportunity to show compliance with all requirements for the retention of such certificate or license. In the conduct of any investigation by the commissioner of alleged violations of the standards or regulations adopted under the provisions of this chapter, the commissioner may issue subpoenas requiring the attendance of witnesses and the production by any medical service organization or person of reports, records, tapes or other documents which concern the allegations under investigation. All records obtained by the commissioner in connection with any such investigation shall not be subject to the provisions of section 1-210 for a period of six months from the date of the petition or other event initiating such investigation, or until such time as the investigation is terminated pursuant to a withdrawal or other informal disposition or until a hearing is convened pursuant to chapter 54, whichever is earlier. A complaint, as defined in subdivision (6) of section 19a-13, shall be subject to the provisions of section 1-210 from the time that it is served or mailed to the respondent. Records which are otherwise public records shall not be deemed confidential merely because they have been obtained in connection with an investigation under this chapter.

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

(d) Any person guilty of any of the following acts shall be fined not more than two hundred fifty dollars, or imprisoned not more than three months, or be both fined and imprisoned: (1) In any application to the commissioner or in any proceeding before or investigation made by the commissioner, knowingly making any false statement or representation, or, with knowledge of its falsity, filing or causing to be filed any false statement or representation in a required application or statement; (2) issuing, circulating

or publishing or causing to be issued, circulated or published any form of advertisement or circular for the purpose of soliciting business which contains any statement that is false or misleading, or otherwise likely to deceive a reader thereof, with knowledge that it contains such false, misleading or deceptive statement; (3) giving or offering to give anything of value to any person for the purpose of promoting or securing ambulance or rescue service business or obtaining favors relating thereto; (4) administering or causing to be administered, while serving in the capacity of an employee of any licensed ambulance or rescue service, any alcoholic liquor to any patient in such employee's care, except under the supervision and direction of a licensed physician; (5) in any respect wilfully violating or failing to comply with any provision of this chapter or wilfully violating, failing, omitting or neglecting to obey or comply with any regulation, order, decision or license, or any part or provisions thereof; (6) with one or more other persons, conspiring to violate any license or order issued by the commissioner or any provision of this chapter.

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

(f) Each licensed or certified ambulance service shall secure and maintain medical control, as defined in section 19a-179, by a sponsor hospital, as defined in section 19a-179, for all its emergency medical personnel, whether such personnel are employed by the ambulance service or a management service.

(g) Each applicant whose request for new or expanded emergency medical services is approved shall, not later than six months after the date of such approval, acquire the necessary resources, equipment and other material necessary to comply with the terms of the approval and operate in the service area identified in the application. If the applicant fails to do so, the approval for new or expanded medical services shall be void and the commissioner shall rescind the approval.

(h) Notwithstanding the provisions of subsection (a) of this section, any volunteer or municipal ambulance service that is licensed or certified and is a primary service area responder may apply to the commissioner to add one emergency vehicle to its existing fleet every three years, on a short form application prescribed by the commissioner. No such volunteer or municipal ambulance service may add more than one emergency vehicle to its existing fleet pursuant to this subsection regardless of the number of municipalities served by such volunteer or municipal ambulance service. Upon making such application, the applicant shall notify in writing all other primary service area responders in any municipality or abutting municipality in which the applicant proposes to add the additional emergency vehicle. Except in the case where a primary service area responder entitled to receive notification of such application objects, in writing, to the commissioner not later than fifteen calendar days after receiving such notice, the application shall be deemed approved thirty calendar days after filing. If any such primary service area responder files an objection with the commissioner within the

fifteen-calendar-day time period and requests a hearing, the applicant shall be required to demonstrate need at a public hearing as required under subsection (a) of this section.

(i) The commissioner shall develop a short form application for primary service area responders seeking to add an emergency vehicle to their existing fleets pursuant to subsection (h) of this section. The application shall require an applicant to provide such information as the commissioner deems necessary, including, but not limited to, (1) the applicant's name and address, (2) the primary service area where the additional vehicle is proposed to be used, (3) an explanation as to why the additional vehicle is necessary and its proposed use, (4) proof of insurance, (5) a list of the providers to whom notice was sent pursuant to subsection (h) of this section and proof of such notification, and (6) total call volume, response time and calls passed within the primary service area for the one-year period preceding the date of the application.

(P.A. 74-305, S. 9, 19; P.A. 75-112, S. 7, 18; 75-140; P.A. 77-614, S. 323, 610; P.A. 80-480, S. 2, 3; P.A. 81-259, S. 2, 3; 81-472, S. 47, 159; P.A. 85-585, S. 2; P.A. 86-59, S. 1, 2; P.A. 88-172, S. 1; P.A. 90-172, S. 2; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; 95-271, S. 37; P.A. 98-195, S. 8; P.A. 00-151, S. 5, 14; P.A. 06-195, S. 35; P.A. 07-134, S. 6; 07-252, S. 10.)