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***TESTIMONY OF PATRICA SQUIRES ON SB 85: AN ACT APPROPRIATING FUNDS
FOR A STUDY ON COMMUNITY-BASED HEALTH CARE SERVICES***

Honorable members of the Public Health Committee, my name is Patricia Squires. I serve, and have served for the last thirteen years, as the Chief Executive Officer of Emergency Medical Services, Inc. (“SEMS”), the primary service area provider of emergency medical services (“EMS”) for the City of Stamford. I was a formerly practicing lawyer and registered nurse who worked in a hospital and other related health care environments for 30 years. As the Chief Executive Officer of SEMS, I am responsible for managing a staff of more than 75 career and volunteer Paramedics and Emergency Medical Technicians. I appreciate this opportunity to address ***SB 85: AN ACT APPROPRIATING FUNDS FOR A STUDY ON COMMUNITY-BASED HEALTH CARE SERVICES.***”

Last session I, along with many other members of the Emergency Medical Services Community, testified in support of No. SB 800: AN ACT CONCERNING A MUNICIPAL PILOT PROGRAM ALLOWING EMERGENCY MEDICAL SERVICES PERSONNEL TO PROVIDE COMMUNITY BASED PARAMEDICINE. We hoped that the enactment of SB 800 would allow EMS providers such as SEMS to initiate community paramedicine programs, also known as mobile integrated health care (“MIHC”) programs in their communities under direction and supervision of their Sponsor Hospitals. A copy of my written testimony describing the acute need for community paramedicine is attached.

Unfortunately, SB 800 was not enacted. Instead the legislature enacted PA 15-5 which authorized the Commissioner of Social Services and Commissioner of Public Health (collectively the “Commissioners”) to study the effectiveness of providing community-based health care services in the state, including services that would be included in a mobile integrated health care program (“Study”). Pa 15-5 provided for issuance of the Commissioners’ preliminary report by February 1, 2016. That never occurred due to a lack of funding for the Study.

It is imperative that funding be provided for this Study. As described in my testimony in support of SB 800, MIHC programs are an essential component of a cost effective health care delivery system, particularly in reducing hospital readmissions and as evidenced by the proliferation of



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such programs in other states. The first step in this direction is performance of the Study. I would therefore urge you to report favorably on SB 85 and support its passage.

Thank you for your consideration.

/s/ Patricia Squires



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TESTIMONY PRESENTED TO THE PUBLIC HEALTH COMMITTEE OF THE
CONNECTICUT GENERAL ASSEMBLY REGARDING PROPOSED SENATE BILL No.
800

AN ACT CONCERNING A MUNICIPAL PILOT PROGRAM ALLOWING EMERGENCY
MEDICAL SERVICES PERSONNEL TO PROVIDE COMMUNITY BASED
PARAMEDICINE

PATRICIA SQUIRES – EXECUTIVE DIRECTOR OF STAMFORD EMERGENCY
MEDICAL SERVICES, INC.

Good morning. My name is Patricia Squires. I serve, and have served for the last 12 years, as the Executive Director of Stamford Emergency Medical Services, Inc. (“SEMS”). I have both legal and medical training; am a member of the Connecticut Bar Association since 1994 and a registered nurse since 1986. As the full-time Executive Director of SEMS I am responsible for managing a staff of more than 75 career and volunteer paramedics and emergency medical technicians. I appreciate this opportunity to discuss with you Proposed Bill No. 800: AN ACT CONCERNING A MUNICIPAL PILOT PROGRAM ALLOWING EMERGENCY MEDICAL SERVICES PERSONNEL TO PROVIDE COMMUNITY BASED PARAMEDICINE.

Let me begin by telling you about SEMS. SEMS is a Connecticut non-profit corporation that serves as the primary emergency medical service (“EMS”) provider for the City of Stamford. SEMS’ core mission is to provide the residents of the City of Stamford with high quality professional emergency medical services, including advanced life support. In furtherance of that mission SEMS operates a fleet of ambulances and “fly-cars” operating out of five stations, including our headquarters on Long Ridge Road. SEMS also provides Advanced Life Support to the Town of Darien Post 53 Emergency Medical Services. During calendar year 2013 we responded to 13,242 emergency calls, transporting 10,067 patients to the appropriate emergency department. During calendar year 2014 we responded to 13,488 emergency calls, transporting 10,169 patients. This call volume, combined with our involvement in dozens of public events each year, provides us with a unique perspective on the health care needs of the community.



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We are particularly proud of the high quality of EMS service we provide to the Stamford and Darien communities, which is evidenced by our third consecutive CAAS accreditation. CAAS (Commission on Accreditation of Ambulance Services) is an independent commission that establishes standards of care and management for EMS providers. Additionally, there are many other commercial and non-profit emergency service providers in this state that share our passion and deliver a very high level of care. A number of those providers have joined us in supporting the program that I am about to discuss with you.

What we and others in our industry have observed and experienced with increasing frequency is the transport of patients with chronic medical conditions who repeatedly cycle through the EMS system and the hospital emergency department, sometimes multiple times per month. These people are discharged from the hospital with medication and monitoring requirements for chronic conditions such as diabetes, chronic obstructive pulmonary disease, and cardiovascular disease. The management of these chronic diseases by the patient is frequently misunderstood and poorly executed, resulting in a readmission to the emergency department of the hospital from which he or she was just recently discharged. Readmissions frequently occur via a 911 call and transport by EMS. In short, a chronic medical issue becomes (or is perceived by the patient to become) a more acute medical issue leading to a 911 call, an emergency response by EMS and an ambulance transport to the hospital. It is certainly not surprising to us that a recent analysis conducted by Stamford Hospital found that **52%** of all hospital emergency visits were either non-emergent, emergent but primary care treatable, or emergent but preventable. These types of calls divert EMS resources from true emergencies and adds to the cost of health care. Consequently, the Stamford Hospital and the City of Stamford Department of Health & Social Services have identified as community health priorities reducing preventable hospitalizations and unnecessary emergency department visits by those suffering from chronic diseases.

This is a national issue which resulted in various states authorizing community paramedicine programs – also known as mobile integrated health care (“MIHC”). At its core, MIHC programs permit paramedics to do what they are trained to do – assess and treat patients within the scope of their licensure – but without necessarily transporting the patient to the hospital. For example, a MIHC program might permit a paramedic to meet, at a pre-arranged time, a recently discharged hospital patient at his/her home, assess the patient’s medical condition, assist the patient with managing their condition and review with the patient his/her discharge instructions *without* necessarily transporting the patient to the hospital. A MIHC program might also permit the paramedic to transport the patient to the primary care physician’s office or a facility other than the hospital emergency department if circumstances so require. These types of programs – which are aimed at an underserved patient population for whom home healthcare services are typically not available – are designed to avoid repetitive, unnecessary and costly visits to the hospital emergency department. In fact, national models suggest an estimated savings of \$550 million in annual Medicare/Medicaid savings if stable patients are redirected from crowded emergency departments.

There are at least 232 various combinations of MIHC programs across numerous states, including but not limited to Massachusetts, New York, North Carolina, Colorado, Minnesota, Maine, Oregon, California, Nevada, Pennsylvania, Idaho, Arizona, Tennessee, Indiana and Texas. Funding for these programs has varied widely including grants, both at the local and federal level, Medicaid reimbursement and internal funding

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from the EMS services. We do not suggest that this Committee design a suitable MIHC program for Connecticut. That is more appropriately left in the hands of the state agency having jurisdiction over the EMS providers, the Department of Public Health, and the EMS providers' respective sponsor hospitals. Nor do we suggest any permanent legislation in this area without a thorough review of Connecticut-specific data. What is required here is a **pilot** program which would generate such data and allow stakeholders to evaluate the efficacy of MIHC in reducing unnecessary hospitalizations and enhancing the efficiency of the health care systems in the state.

What we asking the legislature to address is the current legal impediment to creating a MIHC pilot program. As will be more fully explained by Attorney Marc Kurzman, who serves on SEMS' its executive committee of the board of directors, the Department of Public Health regards the existing statutory and regulatory scheme in Connecticut as authorizing licensed paramedics to provide *only* prehospital medical care in an emergency situation. We were told that MIHC is not statutorily permitted. Therefore we urge you to allow the implementation of a MIHC pilot program. We believe this is an important step toward the delivery of more cost efficient health care in this state.

A handwritten signature in cursive script, appearing to read "Patricia Gurus". The signature is written in black ink on a white background.