February | 14

Connecticut Emergency Medical Services Primary Service Area Task Force

Final Report

A Task Force within the Department of Public Health
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Executive Summary

The regulation of Emergency Medical Services (EMS) at the state level is the responsibility of the Department of Public Health. Services are delivered by way of a variety of organizational structures at the local level: commercial, nonprofit, volunteer, and sometimes combination organizations that are a hybrid of these structures.

Given the short 6-month duration of the Task Force, as well as the complexities of the EMS System, the Connecticut Emergency Medical Services Task Force offers the following recommendations in response to the given charge:

Task Force Charge	Task Force Recommendation
1. The process for designating and changing a primary service area;	1. Recommendation #5. Strike a balance between empowering municipalities and protecting statewide system stability.
2. Improvements to local primary service area contract and applicable subcontract language and emergency medical services plans, including provisions of such contracts and plans relating to performance measures and oversight by municipalities of primary service area responders;	2. Recommendations # 1 and #2 DPH shall conduct a review of all Local EMS Plans at least every 5 years. Appendix E: Local EMS Plan Template
3. A. process for expanding or enhancing emergency medical services offered in local primary service areas;	3. Recommendation #5
4. A mechanism for reporting adverse events to the Department of Public Health and for said department to issue a response; and	4. Recommendation # 4 The criteria and process for removal of a PSAR is more specifically defined
5. An outreach plan to educate municipalities on their rights and duties as holders of contracts and subcontracts for primary service area responders	5. Appendix C: Roles and Responsibilities Related to the EMS PSA System Appendix D: Explanation of the Local EMS Plan Template

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Background

The PSA Concept

The concept of Primary Service Areas (PSA) was introduced in Connecticut in 1974. A PSA is a specific geographic area that is served exclusively by an emergency medical services (EMS) provider. The State of Connecticut Department of Public Health (DPH) designates this provider. Only the Primary Service Area Responder (PSAR) designated by the State may answer emergency calls in the specified geographic area. These geographic areas may include or be within the boundaries of a municipality, tax district, tribal entity or other specifically identified areas. For the purposes of this report, they shall be referred to as municipalities.

The statement of intent prefacing the 1974 regulations cited the stacking of emergency calls, rotation lists, and a lack of accountability as some of the more serious problems that were to be eliminated by the PSA System. It was the State's intent to provide a statewide system of emergency medical services and a coordinated response to emergency calls.

The designation of PSARs assigned statutory and regulatory responsibilities to individual providers. It also defined levels of accountability for the coordinated emergency medical response and patient care in specific geographic areas, thus promoting statewide stability.

Levels of Service

There are four PSAR levels of EMS recognized and regulated by the State. They are First Responder, Basic Ambulance, Intermediate, and Paramedic. The levels differ in the level of training and skills performed by personnel, as well as equipment required. Each geographic area should have at least one PSAR designated for each level of service.

The DPH is required to assign a PSAR for each level of service for every municipality in the state. Public Health regulations establish the factors that are to be considered when designating an EMS provider as a PSAR. A single PSAR may be certified or licensed to provide one or more of these levels of service.

The DPH reports that it has designated the following PSAs:

PSAR Level	Quantity of PSAs Assigned by DPH
First Responder	218
Intermediate	4
Basic Ambulance	186
Paramedic	125

* Supplemental First Responder is not a recognized PSA Level, however there are 83 services in the state that presently operate in this capacity.

The DPH's records reflect that at the time of this report, there are specific levels of service that have not been assigned to a PSAR in a number of communities. The lack of a designated PSAR for a specific level of service could ether indicate that the State has not designated a provider or that the service is not being provided.

The PSAR System has remained relatively unchanged for the last quarter century. The DPH reports that the majority of PSA designations, approximately 155, were assigned in 1989. In the past two years, DPH reported that only three PSAs were issued. All three of these PSAs were issued in 2013.

Relevant Features of the Current PSA System
A provider only needs to go through the application process once. The PSAR is an indefinite assignment.
A PSA must be open in order for a provider to apply. The PSA generally would be considered open if the PSA was currently unassigned, the current PSA holder surrendered its assignment, or that assignment was revoked by DPH.
DPH records revealed that the department has not revoked any PSARs within the last decade.
DPH reported that no petitions to remove a PSAR were filed, however a number of concerns were brought to the attention of the department for technical assistance.
If a PSAR holding a PSA Designation is merged or sold, DPH and the municipality served exercises limited oversight over transaction.

Only five broad standards related to PSAs exist in the current Statutes and Regulations.

Current Statutes and Regulations Related to PSAs
1. PSARs are required to respond to all emergency calls 24 hours a day, 7 days a week. There is no defined response time standard in the Regulations of Connecticut State Agencies Sec. 19a-179-11. “Availability of response services”
2. PSARs may lose their assignments if OEMS determines “it is in the best interests of patient care to do so;” as prescribed in the Regulations of Connecticut State Agencies Sec. 19a-179-4(d) as well as CGS Sec. 19a-177(12) and CGS Sec. 19a-181c (c).
3. Municipalities may petition the commissioner to suspend a PSA holder if the chief administrative officer can demonstrate that “an emergency exists and that the safety, health, and welfare of the citizens of the affected area are jeopardized by the performance of the PSA responder.” In accordance with CGS Sec. 19a-181c (b) and the Regulations of Connecticut State Agencies Sec. 19a-179-4(e). The performance of the responder is unsatisfactory based on the Local EMS Plan established by the municipality pursuant to CGS Sec. 19a-181c (b) and associated agreements or contracts.
4. If any licensed or certified ambulance service fails to submit required EMS information for a specified period of time, the Commissioner may take action in accordance with CGS Sec. 19a-177-8(a)(c).
5. A municipality may petition the Commissioner, not more than once every three years, for the removal of a PSAR on the grounds of unsatisfactory performance in accordance with CGS Sec. 19a-181c (b).

Events Leading Up to the Creation of the Task Force

The current PSA process in Connecticut has recently received a significant amount of attention and critical review.

Municipal leaders renewed their efforts for PSA system reform in 2012. Legislation was proposed that would "Enhance the delivery of local public safety by allowing local municipalities the discretion to determine how local ambulance services are delivered within their communities." The committee took no action on the bill.

In the 2013 Legislative Session, two bills were raised: House Bill 5999 and House Bill 6518. The Public Health Committee convened a Public Hearing on HB 6518. A variety of stakeholders including, but not limited to, municipal officials, commercial and volunteer ambulance service providers, career and volunteer fire departments, and others provided testimony. Substitute for Raised H.B. No. 6518

The legislature determined that further study of the PSA system was warranted. This created the Task Force that was established in Public Act No.13-306 (Appendix A).

Task Force Composition

The Connecticut EMS PSA Task Force was comprised of 15 members who represented all geographic areas of EMS delivery at the State, County, City, and Town levels. Task Force Members represented commercial and municipal EMS agencies, including career, volunteer, and combination fire, police, and EMS services; as well as municipal, state, and hospital representatives. The Task Force Members also represented centuries of combined experience in EMS delivery in basic and advanced life support as well as the supervisory, managerial, and executive levels.

PSA System Analysis

Task Force Members completed an evaluation of the Strengths, Weaknesses, Opportunities, and Threats (SWOT) of the current PSA System.

Strengths
EMS system stability
Cost control
Lack of political interference
Regionalization

Weaknesses
Municipalities have limited or no input in choosing or changing their PSAR
Municipalities and PSARs are not proficient with current State Statutes and Regulations that pertain to the PSA System
Historically inconsistent application of current Statutes and Regulations
There have not been recent updates to State Statutes and Regulations

Opportunities
Establish a foundation for statewide performance standards that are measurable, achievable and objective, which include review and enforcement components
Streamline the process for municipalities to change providers based on non-performance
Evaluate the status of Local EMS Plans
Use data to identify opportunities for additional education of all system stakeholders
Establish periodic reviews for all Local EMS Plans

Threats
Increasing demand for services
Decrease in reimbursements
Erosion of trust between municipalities and PSAR holders due to a lack of transparency and inclusion
Challenges created by oversight of 169 municipalities
Potential for deregionalization
EMS system fragmentation and isolation

The Task Force Members used the results of their collective SWOT Analysis as the basis for the recommendations being offered in this report.

Recommendation #1: Changes to the Local EMS Plan

It shall be the responsibility of each municipality or authority having jurisdiction to update its Local Emergency Medical Services Plan (Local EMS Plan) which is required by CGS 19a-181b, to respond to the dynamic needs of their community, as well as specify EMS objectives and performance measures necessary to meet the local community needs. The municipality shall consult with the current PSAR when updating their Local EMS Plan. Municipalities and PSARs shall avail themselves of technical services available through DPH to resolve disagreements arising from the creation or implementation of the Local EMS Plan.

In the event that the existing PSAR refuses to deliver the requisite level of care identified in the updated Local EMS Plan, the municipality may petition DPH for removal of the PSAR in accordance with CGS 19a-181d.

Recommendation #2: DPH Shall Review Local EMS Plans Every 5 Years

DPH shall conduct a review of the EMS delivery system in every municipality in Connecticut a minimum of every five years.

Such review shall include, and independently evaluate, the following elements for compliance with CGS 19a-181b and relevant OEMS Regulations:

1. The applicable Local EMS Plan
2. Performance of all levels of assigned PSARs

DPH shall assign a rating of Meeting Performance Standards, Exceeding Performance Standards, or Failure to Comply with Performance Standards for each PSA reviewed.

Failure to comply may result in a DPH approved improvement plan with periodic follow-up reviews with a 6-month time frame, subject to the approval of both the municipality and the PSAR. Further failure to comply may result in DPH removal of PSA assignment.

It is the position of the Task Force that Appendix E, The Local EMS Plan Template shall be the basis for all Local EMS Plans.

Recommendation #3: Sale or Transfer of a PSAR

Any PSAR that sells or transfers all of its assets to another entity, or has more than fifty percent of its ownership interest sold or transferred to another entity, shall notify the DPH of such sale or transfer no later than sixty (60) days prior to the sale or transfer. The purchasing entity shall file an application with the DPH for approval of the sale or transfer of such PSA Assignment on a form prescribed by the DPH. DPH shall review such application based on the following criteria:

1. Background of purchasing entity
2. Purchasing entity's compliance history in other jurisdictions
3. Financial ability to perform the responsibilities of a PSAR in Connecticut in compliance with the local EMS Plan

DPH shall solicit input from impacted municipalities and sponsor hospitals prior to making a determination on the disposition of the PSA Assignments. The DPH shall complete its review within 45 days of receipt of the purchasing entity's application.

Recommendation #4: Removal of a PSAR

Section 19a-181c should seek to define the terms that enable municipalities to remove a responder:

An ***emergency*** should be defined to include, but not be limited to:

1. Designated PSAR fails to respond to at least 50% of all first call responses in any rolling 3 month review period and fails to implement a mutually agreed upon corrective action plan.
2. Sponsor Hospital of the designated PSAR will not endorse or provide recommendation of PSAR as the designated provider based on defined and unresolved issues with the quality of care rendered to patients.

Unsatisfactory performance should be defined to include, but not limited to:

1. Designated PSAR fails to respond to at least 80% of all first call responses (excluding approved exceptions) in any rolling 12 month review period and fails to implement a mutually agreed upon corrective action plan.
2. Designated PSAR fails to meet defined response time standards (excluding approved exceptions) negotiated by a community and the designated PSAR and fails to implement a mutually agreed upon corrective action plan.
3. Designated PSAR repeatedly fails to investigate and respond to complaints related to quality of emergency care and response.
4. Designated PSAR repeatedly fails to report adverse events as mandated by DPH, or as mutually agreed upon by provider and municipality in the Local EMS plan.
5. Designated PSAR communicates (or municipality becomes aware of) the intent of the PSAR to change the level of service to a level that is inconsistent with the Local EMS Plan or could potentially affect patient outcome negatively.
6. Designated PSAR fails to communicate changes in the level of service or coverage patterns that materially affect the delivery of service as outlined in the Local EMS Plan.
7. Designated PSAR fails to communicate changes in organizational structure of the PSAR that materially affect the delivery of service as outlined in the Local EMS Plan

If an emergency is alleged, DPH shall take action within 5 business days and conclude an investigation within 30 days. In an alleged emergency, the

Department may develop a system of providing emergency medical services to the community served by the PSAR.

If they allege unsatisfactory performance, DPH shall take action within 15 business days and come to a determination within 90 days. Extensions shall be permissible when necessary.

DPH shall have the latitude to reclassify any petition within the Emergency and Unsatisfactory Performance categories based on the findings of its investigation.

Task Force Position Statements on Recommendation #5

This is the only recommendation in this report that does not carry the unanimous endorsement of all of the Task Force Members. This recommendation was approved by a simple majority of the Task Force Members who participated in the meeting.

Position Statement Submitted by Opponents of Recommendation #5:

The Task Force has reached consensus on all items except for certain language relating to the replacement of Primary Service Area Responders ("PSARs") designated as Item 5 (issue in dispute). Proponents of this language believe that DPH should allow municipalities to remove PSARs at any time subject to a showing to DPH that the municipalities or their contractors are capable of operating the PSAs. In other words, there would be no requirement to show "cause" to replace the existing PSARs. Opponents of Item 5 believe such a proposal is an unjustifiable and fundamental change to an EMS system that has worked so well for thirty years. Allowing municipalities to remove PSARs without cause would have a number of serious negative consequences, including but not limited to the following:

1. PSARs will be unwilling to invest the capital necessary to most effectively operate the PSA if they can be removed at anytime.

2. Coordination of regional medical control will suffer with frequent changes in PSARs and their personnel.

3. There will be disparate levels of EMS services throughout the State, where more affluent communities can demand and afford to pay for better levels of EMS care.

4. Conversely, those economically disadvantaged communities that were able to take advantage of regional coverage by EMS providers will be either forced to pay more for the current level of coverage or allow the level of EMS services to decline.

5. Frequent changes to PSARs will result in a greater chance for miscommunication and coordination problems among municipalities in the region when mutual aid is required or in the event of mass casualties.

6. The elimination of regional coverage, which is currently provided by commercial providers who hold a number of PSAs in the same region, will make the EMS system more fractured and less cost effective.

Because of the need for a statewide system approach, primary service area responders should not be removed unless they have not met accepted performance standards and there is a risk to the health & safety of residents in a community. In 2000, the State legislature conducted a comprehensive review of the PSA system in Connecticut and passed legislation that made PSARs more accountable to municipalities, allowed municipalities to create performance standards and goals for their communities through local EMS Plans and provided a mechanism for municipalities to remove those PSARs, who did not meet those performance standards. Unfortunately, few municipalities have developed local

EMS Plans and no community has attempted to remove a PSAR under the statutory mechanism provided. Supporters of a "for cause" removal process respectfully suggest that municipalities utilize the existing tools provided by the legislature before seeking a fundamental legislative change which will have major negative consequences on a very good EMS system. Allowing municipalities to seek removal of an EMS PSAR without cause and without consideration of the impact on the entire statewide system is not in the best interest of the residents of the Connecticut. Indiscriminate removal of any PSAR's would likely compromise Connecticut's delicate statewide system and existing mutual aid agreements by focusing solely on the individual municipality.

Position Statement Submitted by Proponents of Recommendation #5

1. The PSA System is almost 40 years old. It needs to be updated to incorporate the elements of best practice, transparency and home rule; all of which are rudimentary elements of good public policy.
2. The current PSA system is essentially a monopoly. There is no notion of competitiveness factored into the market for emergency medical calls. Municipalities may contract with only the provider assigned to them to obtain better performance or higher level of service. Due to the methods of PSA assignment, this service cannot be bid on the open market. Monopolies are not good government.
3. PSA Holders are able to surrender a PSA at will if they no longer chose to provide the service. Municipalities are not granted that same right; presently a municipality is not able to have a PSA removed if the municipality no longer wishes to have the service provided by the PSA Holder.
4. It should be the role of the municipality to select their provider. It should be the role of DPH to ensure that Local EMS Plans comply with the law and those EMS providers meets the required criterion. Home rule is a fundamental aspect of the laws and traditions of every New England state.
5. No provider should continue to enjoy an entitlement to a PSA. A PSA should never be viewed as a commodity that may be bought and sold. The ability of a municipality to review and change EMS providers will provide EMS companies cause to ensure that their quality of service remain at the highest level and are provided at reasonable costs. Competition for services keeps providers alert and attuned to their own costs and quality.
6. Municipalities routinely go out to bid for proposals to determine the best way to provide a variety of services as a matter of best practice. EMS should be no exception.

This recommendation has evolved throughout the duration of the Task Force and includes significant input from those who represent both sides of the debate.

In response to concerns about stability for the State's EMS system, carefully crafted language was incorporated into the proposal to create a process for the DPH to evaluate and impose oversight secondary to a request to change PSARs. This process creates an appropriate venue for entities with a desire for change to constructively address those concerns with the guidance of the DPH.

PSARs have enjoyed almost 40 years of having the right to be the exclusive provider of EMS in their designated geographic areas within the State of Connecticut. The current PSA System allows these providers to continue to profit from this privilege indefinitely, provided they meet only the minimum requirements. It is not unexpected that these PSARs would support the status quo so that they can indefinitely reap the benefits of this designation without concern for having to improve their service delivery or otherwise react to the dynamic needs of the community that they are designated to serve.

Recommendation #5: Alternative Provision of PSA Responsibilities

Municipalities shall have the right to submit a Local EMS Plan for consideration to DPH for the alternative provision of primary service area responder responsibilities.

In the event that the updated Local EMS Plan demonstrates that said municipality is positioned to deliver EMS Service, or contract to have EMS Service delivered through a responder other than that which is currently designated by the state, DPH shall develop a process to assure the matter is heard and make a determination regarding the aforementioned plan.

A municipality may submit a Local EMS Plan to DPH for consideration of the alternative provision of primary service area responsibilities for the following reasons - this is not an all-inclusive list:

- Improved patient care
- More efficient EMS delivery
- More efficient allocation of resources
- Opportunity to align with a new EMS provider better suited to meet the community's current needs
- Regionalization possibilities
- Response times

When making a determination on the disposition of a plan for the alternative provision of primary service area responder responsibilities, DPH shall consider the following factors. This is not an all-inclusive list:

- Impact on patient care
- Local EMS Plan and all related factors
- EMS System Design including system sustainability
- Impact on the local, regional and statewide EMS System
- Recommendation from Medical Control / Sponsor Hospital

DPH shall reassign the PSA in accordance with the Local EMS Plan if the hearing results in a favorable review of the alternative provision for the primary service area responsibilities. The provider named in the Local EMS Plan must then apply and be approved by DPH for the PSA Assignment in accordance with OEMS Regulations 19a-179-4 in advance of the reassigned PSA Assignment becoming effective.

Conclusion

The Connecticut EMS PSA Task Force was made up of professionals who are dedicated to the quality delivery of EMS to all people in the State of Connecticut. The Task Force applied their cumulative years of experience and training to complete its legislated charges.

Each member of the Task Force appreciates the dedication and time of their counterparts. Task Force members also appreciate and thank the members of the Connecticut Legislature, Connecticut Department of Public Health Staff, and the public who attended meetings and offered insightful comments. Input from all of these interested parties was seriously considered by the Task Force.

In conclusion, the Task Force recommends that the Connecticut Legislature continue the effort to reform and adjust the EMS PSA system using this report as an exceptional and enabling resource which supports needed changes to an EMS system that is so critically vital to the citizens of the State of Connecticut.

Appendix A: Enabling Legislation

Substitute House Bill No. 6518

Public Act No. 13-306

AN ACT CONCERNING THE STANDARDS OF PROFESSIONAL CONDUCT FOR EMERGENCY MEDICAL SERVICE PERSONNEL AND ESTABLISHING AN EMERGENCY MEDICAL SERVICES PRIMARY AREA TASK FORCE.

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

Section 1. Section 20-206nn of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

The Commissioner of Public Health may take any disciplinary action set forth in section 19a-17 against a paramedic, emergency medical technician, emergency medical responder, advanced emergency medical technician or emergency medical services instructor for any of the following reasons: (1) Failure to conform to the accepted standards of the profession; (2) conviction of a felony, in accordance with the provisions of section 46a-80; (3) fraud or deceit in obtaining or seeking reinstatement of a license to practice paramedicine or a certificate to practice as an emergency medical technician, emergency medical responder, advanced emergency medical technician or emergency medical services instructor; (4) fraud or deceit in the practice of paramedicine, the provision of emergency medical services or the provision of emergency medical services education; (5) negligent, incompetent or wrongful conduct in professional activities; (6) physical, mental or emotional illness or disorder resulting in an inability to conform to the accepted standards of the profession; (7) alcohol or substance abuse; or (8) wilful falsification of entries in any hospital, patient or other health record. **[**; or (9)**]** The commissioner may take any such disciplinary action against a paramedic for violation of any provision of section 20-206jj or any regulations adopted pursuant to section 20-206oo. The commissioner may order a license or certificate holder to submit to a reasonable physical or mental examination if his or her physical or mental capacity to practice safely is the

subject of an investigation. The commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to section 19a-17. The commissioner shall give notice and an opportunity to be heard on any contemplated action under said section 19a-17.

Sec. 2. Section 19a-195a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) The Commissioner of Public Health shall adopt regulations in accordance with the provisions of chapter 54 to provide that emergency medical technicians shall be recertified every three years. For the purpose of maintaining an acceptable level of proficiency, each emergency medical technician who is recertified for a three-year period shall complete thirty hours of refresher training approved by the commissioner, or meet such other requirements as may be prescribed by the commissioner.

(b) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to (1) provide for state-wide standardization of certification for each class of (A) emergency medical technicians, including, but not limited to, paramedics, (B) emergency medical services instructors, and (C) **[**medical response technicians**]** emergency medical responders, (2) allow course work for such certification to be taken state-wide, and (3) allow persons so certified to perform within their scope of certification state-wide.

Sec. 3. (*Effective from passage*) (a) There is established, within the Department of Public Health and within available appropriations, the Connecticut emergency medical services primary service area task force. The task force shall review topics, including, but not limited to, the following: (1) The current process for designating and changing primary service areas; (2) local primary service area contract and applicable subcontract language and emergency medical services plans as such language and plans vary among municipalities and as such contracts and plans pertain to performance and oversight measures; (3) methods to designate emergency medical service providers that are used by other states that have populations, geography and emergency medical services systems that are similar to those of this state; and (4) the process by which municipalities may petition for a change or removal of a primary service area responder.

(b) The task force shall consist of the following members:

(1) Five members appointed by the Commissioner of Public Health, one each of whom shall be: (A) A representative of a municipal emergency medical services provider; (B) a representative of a for-profit ambulance service; (C) a representative of the Connecticut Hospital Association; (D) a representative of a

nonprofit emergency medical services provider; and (E) a representative of the emergency medical services advisory board, established pursuant to section 19a-178a of the general statutes;

(2) Two appointed by the speaker of the House of Representatives, one each of whom shall be the chief elected official or an administrator of a municipality, and a representative of a municipal public safety board, public safety agency, or municipal legislative body;

(3) Two appointed by the president pro tempore of the Senate, one each of whom shall be the chief elected official or an administrator of a municipality, and a representative of an emergency medical services provider that primarily provides fire services;

(4) One appointed by the majority leader of the House of Representatives, who shall be a fire chief or representative of a fire department that provides emergency medical services;

(5) One appointed by the majority leader of the Senate, who shall be a fire chief or representative of a fire department that provides emergency medical services;

(6) One appointed by the minority leader of the House of Representatives, who shall be a representative of a not-for-profit emergency medical services provider;

(7) One appointed by the minority leader of the Senate, who shall be a chief elected official or an administrator of a municipality;

(8) One appointed, jointly by the minority leader of the House of Representatives and the minority leader of the Senate, who shall be a representative of the Association of Connecticut Ambulance Providers; and

(9) The Commissioner of Public Health, or the commissioner's designee.

(c) Each person making an appointment pursuant to subsection (b) of this section shall ensure that each member who is associated with a municipality or municipal entity represents a different municipality.

(d) The Commissioner of Public Health, or the commissioner's designee, shall serve as a cochairperson of the task force. The members shall elect another person to serve as a cochairperson from among the members of the task force.

(e) Members shall receive no compensation except for reimbursement for necessary expenses incurred in performing their duties.

(f) All appointments to the task force shall be made not later than thirty days after the effective date of this section. The Commissioner of Public Health or the commissioner's designee shall schedule the first meeting of the task force. A majority of the task force members shall constitute a quorum. A majority vote of a quorum shall be required for any official action of the task force.

(g) The administrative staff of the Department of Public Health shall serve as administrative staff of the task force.

(h) Not later than February 15, 2014, the task force shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health concerning its activities, as described in subsection (a) of this section. Such report shall include, but need not be limited to, recommendations concerning: (1) The process for designating and changing a primary service area; (2) improvements to local primary service area contract and applicable subcontract language and emergency medical services plans, including provisions of such contracts and plans relating to performance measures and oversight by municipalities of primary service area responders; (3) a process for expanding or enhancing emergency medical services offered in local primary service areas; (4) a mechanism for reporting adverse events to the Department of Public Health and for said department to issue a response; and (5) an outreach plan to educate municipalities on their rights and duties as holders of contracts and subcontracts for primary service area responders.

(i) The task force shall submit its report on February 15, 2014. The task force shall terminate on the date it submits its report.

Approved July 12, 2013

Appendix B: Task Force Members

Task Force Member	Appointing Authority	Appointee
1. A representative of a municipal emergency medical services provider	Commissioner of Public Health, Jewel Mullen	Gary Wiemokly Director of EMS Town of Enfield
2. A representative of a for-profit ambulance service	Commissioner of Public Health, Jewel Mullen	Fred Della Valle / Charles Babson American Medical Response
3. A representative of the Connecticut Hospital Association	Commissioner of Public Health, Jewel Mullen	Carl Schiessl Director of Regulatory Advocacy Connecticut Hospital Association
4. A representative of a nonprofit emergency medical services provider	Commissioner of Public Health, Jewel Mullen	Joseph Danao Deputy Chief Gardner Lake Volunteer Fire Company Salem
5. A representative of the emergency medical services advisory board, established pursuant to section 19a-178a of the general statute	Commissioner of Public Health, Jewel Mullen	Charlee Tufts Executive Director Greenwich EMS
6. The chief elected official or an administrator of a municipality	Speaker of the House of Representatives Brendan Sharkey	Mary-Ellen Harper Director of Fire & Rescue Services Town of Farmington Task Force Co-Chair
7. A representative of a municipal public safety board, public safety agency, or municipal legislative body	Speaker of the House of Representatives Brendan Sharkey	Paul Fitzgerald Police Chief Town of Berlin
8. The chief elected official or an administrator of a municipality	President Pro Tempore of the Senate Donald Williams	Matthew Galligan Town Manager South Windsor
9. A representative of an emergency medical services provider that primarily provides fire services	President Pro Tempore of the Senate Donald Williams Brooklyn, Canterbury, Killingly, Mansfield, Putnam, Scotland, Thompson & Windham	Thomas G. Ronalter Fire Chief New Britain Fire Department

Task Force Member	Appointing Authority	Appointee
10. A fire chief or representative of a fire department that provides emergency medical services;	Majority Leader of the House of Representatives, Joe Aresimowicz, Berlin and Southington	Seth Roberts West Haven Fire Dept.
11. A fire chief or representative of a fire department that provides emergency medical services	Majority Leader of the Senate Martin M. Looney New Haven, Hamden & North Haven	Vincent Landisio Fire Chief North Haven Fire Department
12. A representative of a not-for-profit emergency medical services provider	Minority Leader of the House of Representatives Lawrence Cafero	Bruce Baxter Chief New Britain EMS
13. A chief elected official or an administrator of a municipality;	Minority Leader of the Senate John McKinney Easton, Fairfield, Newtown, Weston & Westport	Caroline Calderone Baisley Director Greenwich Department of Health
14. A representative of the Association of Connecticut Ambulance Providers;	Appointed jointly by the Minority Leader of the House of Representatives and the Minority Leader of the Senate, Lawrence Cafero and John McKinney Norwalk and New Canaan Easton, Fairfield, Newtown, Weston & Westport	David Lowell Executive Vice President/Chief Operating Officer Hunters Ambulance Meriden, CT
15. The Commissioner of Public Health, or the commissioner's designee	Commissioner of Public Health Jewel Mullen	Raphael M. Barishansky Director Office of Emergency Medical Services Task Force Co-Chair

Appendix C: Roles and Responsibilities Related to the EMS PSA System

Please find this memo to describe to municipalities their rights, roles and responsibilities under the existing Connecticut emergency medical services (EMS) primary service area (PSA) system.

Presently, the Connecticut Department of Public Health (CT-DPH) assigns exclusive emergency (911) geographic coverage areas or “PSAs” to individual EMS organizations. These assignments are of indefinite duration and rely heavily on local municipal oversight and engagement to assure continued EMS care delivery that meets local community standards. Variations in population density and geography, as well as other factors, make response-time standards and the level of EMS care delivery a very local decision based on community priorities and resources. Municipalities must take an active role in planning their EMS system and all of the requisite components in order to assure optimal outcomes for their constituents.

In order to improve municipal engagement and oversight of their local EMS systems, Connecticut Public Act 00-151 required all municipalities to develop local EMS plans. The legislation defined minimum criteria for these plans and identified groups and officials ideally suited to assist in their development. One of the most important required elements of these plans was supposed to be performance measures for each component of the system (i.e. dispatch, first responders, ambulance, and paramedics.) Each municipality has the right to negotiate performance contracts with their EMS primary service area responder (PSAR) as an element of the Local EMS planning process. These performance measures then serve as the basis for on-going evaluation of local EMS providers. When a municipality and its EMS providers are unable to reach an agreement on establishing “reasonable” performance standards, CT-DPH is authorized to mediate through a hearing process to establish a set of reasonable performance standards.

Providing safe and appropriate patient care services while adhering to established performance standards is requisite to an EMS PSAR’s continued operation within their assigned geographic area. When either of these requirements are not met, municipalities are empowered by C.G.S. Sec. 19a-181c to petition CT-DPH to remove the PSAR. These matters would be handled through a formal hearing process. The CT-DPH commissioner may then determine to remove the PSAR for either of these reasons or if such removal is determined to be in the best interests of patient care.

The Department has assigned EMS coordinators to each of the state’s five regions. Upon request, these coordinators are qualified and available to assist municipalities with local EMS planning, establishment of performance measures or addressing issues related to system improvement.

It is incumbent upon both municipalities and the EMS agencies that service them to avail themselves of all opportunities for communication on issues of mutual concern.

The Office of Emergency Medical Services looks forward to working with both EMS agencies and municipalities to strengthen the statewide EMS system.

Appendix D: Explanation of the Local EMS Plan Template

The effectiveness of Connecticut's EMS system is dependent on the identification and coordination of EMS resources. Local EMS Plans should relate to sub-region, regional and statewide integration of EMS assets.

The Local EMS Plan is an instrument to identify a community's EMS resources, performance expectations and state of readiness for emergency medical response within and between communities. EMS system planning is a dynamic process and the Local EMS Plan should be used to establish standards and set goals and should be amended as necessary.

Connecticut General Statutes, Sec. 19a-181b. Local EMS Plan.
(a) Not later than July 1, 2002. Each municipality shall establish a Local EMS Plan. Such plan shall include the written agreements or contracts developed between the municipality, its EMS providers and the public safety answering point, as defined in section 28-25 that covers the municipality. The plan shall also include, but not be limited to, the following:(1) The identification of levels of EMS, including, but not limited to: (A) The public safety answering point responsible for receiving emergency calls and notifying and assigning the appropriate provider to a call for EMS; (B) the EMS provider that is notified for initial response; (C) basic ambulance service; (D) advanced life support level; and (E) mutual aid call arrangements; (2) The name of the person or entity responsible for carrying out each level of EMS that the plan identifies;(3) The establishment of performance standards for each segment of the municipality's EMS system; and (4) Any subcontracts, written agreements or mutual aid call agreements that EMS providers may have with other entities to provide services identified in the plan.

(b)In developing the plan required by subsection (a) of this section, each municipality: (1) May consult with and obtain the assistance of its regional EMS council established pursuant to section 19a-183, its regional EMS coordinator appointed pursuant to section 19a-185, its regional EMS medical advisory committees and any sponsor hospital, as defined in regulations adopted pursuant to section 19a-179, located in the area identified in the plan; and (2) shall, submit the plan to its regional EMS council for the council's review and comment.

The intent of the law is for each of the 169 municipalities in Connecticut to develop a Local EMS Plan and develop written agreements or performance based contracts. Your Regional EMS Council is available to provide you assistance and consultation. It is recommended that the chief executive officer and/or chief elected official of the municipality convene a meeting of people to include the EMS chief, police chief, fire chief, local health director, hospital representatives, when developing the Local EMS Plan.

Appendix E: The Local EMS Plan Template

LOCAL EMS PLAN

Revision Date: ___/___/_____

Municipality/ Authority of Jurisdiction____________________ Tax Code #_____________

Description of area if other than full geographic boundary:
____

____

Address ____Zip Code__________

Name of municipal CEO____

Name and title of person completing this form______________________________________

Contact Tel. #________________________________ Fax # ______________________________

E-mail Address ____

I. 9-1-1 PUBLIC SAFETY ANSWERING POINT (PSAP)

1. Name of the PSAP that receives 9-1-1 calls from the public for your municipality
____

2. Is your 9-1-1 PSAP also the entity that dispatches your EMS provider services?
___ Yes ___No

If no, identify who provides EMS dispatch of your EMS providers.
____

3. What Emergency Medical Dispatch (EMD) product is utilized in the municipality? ____

4. Name of sponsor hospital for EMD Program providing medical direction and quality assurance oversight:
____

5. Name of Medical Director:

____

6. What EMD performance standards have you set for your PSAP?

____

____

II. LIST OF EMS REPONDERS SERVING YOUR MUNICIPALITY

(If necessary, add additional lines to list additional EMS provider services)

A. FIRST RESPONDER SERVICE

____

1. Chief of Service ____

2. Address of Service

____

3. Is this service the assigned primary service area responder? ____Yes _____No

If yes, list the geographical boundaries of the primary service area.

____

4. Does the service provide AED as first responder? __________Yes ____________No

5. Who provides mutual-aid coverage to the First Responder service?

____

6. Do you have a <u>written</u> mutual-aid agreement for First Responder service?

____

7. Does this service respond to other municipalities for mutual aid? ____Yes ____No

If yes, list municipalities: ____

____

____

8. Identify the desired response time* performance standards for the First Responder response in fractile format:

Under ___ Minutes ___ % of responses for light and siren emergency responses.

Under ___ Minutes ___ % of responses for non-light and siren emergency responses.

9. Identify the target percent of the total EMS first call requests to be answered by the PSAR in a 12 month period:

____

10. Name of sponsor hospital providing medical direction and quality assurance oversight:

____

11. Name of Medical Director:

____

B. SUPPLEMENTAL FIRST RESPONDER (if applicable)

____

1. Chief of Service ____

2. Address of Service

____

3. Is this service the assigned primary service area responder? ______Yes ______No

If yes, list the geographical boundaries of the primary service area.

____

4. Does the service provide AED as first responder? _____________Yes ___________No

5. Who provides mutual-aid coverage to the First Responder service?

____

6. Do you have a written mutual-aid agreement for First Responder service?

____

7. Does this service respond to other municipalities for mutual aid? ___Yes ______No

If yes, list municipalities: ____

____

____

8. Identify the desired response time* performance standards for the Supplemental First Responder response in fractile format:

Under ___ Minutes ___ % of responses for light and siren emergency responses.

Under ___ Minutes ___ % of responses for non-light and siren emergency responses.

9. Identify the target percent of the total EMS first call requests to be answered by the PSAR in a 12-month period:

____

10. Name of sponsor hospital providing medical direction and quality assurance oversight:

____

5. 11. Name of Medical Director:

____

C. BASIC AMBULANCE SERVICE

____

1. Chief of Service ____

2. Address of Service

____

3. Is this service the assigned primary service area responder? ______Yes ______No

   If yes, list the geographical boundaries of the primary service area.

____

4. Who provides mutual-aid coverage to the basic ambulance service?

____

5. Do you have a <u>written</u> mutual-aid agreement for basic ambulance service?

____

6. Does this service respond to other municipalities for mutual aid? ____Yes ____No

If yes, list municipalities: ____
____
____

7. Identify the desired response time* performance standards for the Basic Ambulance response in fractile format:

   Under ___ Minutes ___ % of responses for light and siren emergency responses.

   Under ___ Minutes ___ % of responses for non-light and siren emergency responses.

8. Identify the target percent of the total EMS first call requests to be answered by the PSAR in a 12 month period:

____

9. Name of sponsor hospital providing medical direction and quality assurance oversight:

____

10. Name of Medical Director:

____

D. PARAMEDIC SERVICE

____

1. Chief of Service ____

2. Address of Service

____

3. Is this service the assigned primary service area responder? _______Yes _____No

If yes, list the geographical boundaries of the primary service area.

____

4. Who provides mutual-aid coverage to the paramedic service?

____

5. Do you have a <u>written</u> mutual-aid agreement for paramedic service?

____

6. Does this service respond to other municipalities for mutual aid? _____Yes ___No

If yes, list municipalities: ____

____

____

7. Identify the desired response time* performance standards for the Paramedic Service response in fractile format:

Under ___ Minutes ___ % of responses for light and siren emergency responses.

Under ___ Minutes ___ % of responses for non-light and siren emergency responses.

8. Identify the target percent of the total EMS first call requests to be answered by the PSAR in a 12 month period:

____

9. Name of sponsor hospital providing medical direction and quality assurance oversight:

____

10. Name of Medical Director:

____

III. OTHER TRAINED/ORGANIZED COMMUNITY RESPONSE ASSETS:

(I.e. CERT, Medical Response Teams, etc.)

____

____

IV. Quality Assurance

1. Describe the process used in the municipality to review EMS System performance:

____

____

____

____

Is the Sponsor Hospital involved in this process? ___________Yes ________No

2. Describe the process used for review, maintenance and improvement of the quality of the delivery of medical care:

____

____

____

____

Is the Sponsor Hospital involved in this process? _________Yes ___________No

3. Describe the methodology used to make EMS system improvements within the municipality:

____

____

____

____

4. Describe the process used to document and report adverse events:

____

____

____

____

Is the Sponsor Hospital informed of adverse events affecting patient care?
_____Yes _____No

V. Community Integration and Public Education of EMS System

1. Are community CPR classes conducted annually in the municipality?
   ___ Yes ___No

   If yes, Describe:

____

____

Estimate the % of the population trained in CPR _____%

Does the municipality have a "Heart Safe" Designation? __________Yes ____________No
Info: heartsafe-community.org/
http://www.ct.gov/dph/lib/dph/communications/hs_brochure.pdf

If Yes, Identify the Heart Safe Data Points? ____________________________________

____

2. Does the municipality maintain a record of the locations of Automated External Defibrillators within the community? ______________ _ Yes ________________No

If yes, Describe:____

____

____

____

3. .Does the municipality offer other forms of public education and information related to its EMS system on a regular and structured basis? ________ Yes ________No

Describe:____

____

____

____

VI. Regional and Statewide Integration

1. Is the municipality and/or provider involved in Regional ESF 8 (Health & Medical Services) activities and planning?

   Municipality Representative? ___ Yes ___No
   First Responder Representative? ___ Yes ___No
   Basic Ambulance Service Representative? ___ Yes ___No
   Paramedic Service Provider Representative? ___ Yes ___No

   Describe: ____

   ____

   ____

   ____

2. Is the municipality and/or provider involved with their Regional EMS Council?

   Municipality Representative? ___ Yes ___No
   First Responder Representative? ___ Yes ___No
   Basic Ambulance Service Representative? ___ Yes ___No
   Paramedic Service Provider Representative? ___ Yes ___No

   Describe: ____

   ____

   ____

   ____

3. Is the municipality and/or provider involved in statewide EMS committees, organizations, activities, etc.?

   Municipality Representative? ___ Yes ___No
   First Responder Representative? ___ Yes ___No
   Basic Ambulance Service Representative? ___ Yes ___No
   Paramedic Service Provider Representative? ___ Yes ___No

   Describe: ____

   ____

*For the standardized purpose of this plan, fractile response time at each level should be based on time of dispatch of the responder to the arrival at scene of the responder. Communities may measure other elements of response times as a part of their systems review and planning.

VII. Attachments

All subcontracts, written agreements or mutual aid call agreements that emergency medical services providers have with other entities to provide services identified in the plan.

List the document type and date submitted

Document Type	Date Submitted/Received by DPH Office

DPH USE ONLY

Date Plan Received: ____________________

Date(s) Plan Reviewed	Reviewer Name	Comments