

Legislative History for Connecticut Act

**Public Act:** 00-151

**Bill Number:** 5287

**Senate Pages:** 2034, 2071-2073

**House Pages:** 3500-3519

**Committee:** Public Health: 1407-1413, 1416-1433, 1436-1446,  
1462, 1464, 1525, 1528-1555, 1563-1567, 1571-1573  
Program Review: 306-308, 350, 358-360, 376-378

**Page Total:**

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Transcripts from the Joint Standing Committee Public Hearing(s) and/or Senate  
and House of Representatives Proceedings

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CONNECTICUT  
GEN. ASSEMBLY  
SENATE

PROCEEDINGS  
2000

VOL. 43  
PART 6  
1733-2082

002034

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pat

Senate

Monday, May 1, 2000

Page 6, 503 is PR.

504, HB5204 I move to the Consent Calendar.

THE CHAIR:

Without objection, so ordered.

SEN. JEPSEN:

505, HB5287 I move to the Consent Calendar.

THE CHAIR:

Without objection, so ordered.

SEN. JEPSEN:

506 is Go.

507 is to be passed temporarily.

508 is PR.

Page 7, 510, HB5792 I move to the Consent Calendar.

THE CHAIR:

Without objection, so ordered.

SEN. JEPSEN:

511 is Go.

512 is Go.

513 is to be passed temporarily.

514 is Go.

515 is Go.

Page 8, 516 is Go.

517 is to be passed temporarily.

518 is to be passed temporarily.

519 is to be passed temporarily.

002071

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pat

Senate

Monday, May 1, 2000

Madam President, if the Clerk would call the  
Consent Calendar.

THE CHAIR:

Mr. Clerk, would you first announce a roll call  
vote on the Consent Calendar before we call it.

THE CLERK:

An immediate roll call has been ordered in the  
Senate on the Consent Calendar. Will all Senators  
please return to the Chamber.

An immediate roll call has been ordered in the  
Senate. Will all Senators please return to the Chamber.

Madam President, the First Consent Calendar begins  
on Calendar Page 2, Calendar 341, Substitute for HB5177.

Calendar Page 4, Calendar 497, HB5610.

Calendar Page 5, Calendar 499, Substitute for  
HB5524.

Calendar 500, Substitute for HB5180.

Calendar 501, Substitute for HB5707.

Calendar Page 6, Calendar 504, Substitute for  
HB5204.

Calendar 505, Substitute for HB5287.

Calendar 506, Substitute for HB5798.

Calendar Page 7, Calendar 510, Substitute for  
HB5792.

pat

Senate

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Monday, May 1, 2000

Calendar 512, HB5689.

Calendar 514, Substitute for HB5679.

Calendar Page 14, Calendar 135, Substitute for  
SB381.

Calendar 169, Substitute for SB60.

Calendar Page 15, Calendar 482, Substitute for  
HB5285.

Madam President, that completes today's First  
Consent Calendar.

THE CHAIR:

Thank you, Sir. Would you once again announce a  
roll call vote. The machine will be opened.

THE CLERK:

The Senate is now voting by roll call on the  
Consent Calendar. Will all Senators please return to  
the Chamber.

The Senate is now voting by roll call on the  
Consent Calendar. Will all Senators please return to  
the Chamber.

THE CHAIR:

Have all members voted? If all members have voted,  
the machine will be locked. The Clerk please announce  
the tally.

THE CLERK:

Motion is on adoption of Consent Calendar No. 1.

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pat

Senate

Monday, May 1, 2000

Total number voting, 36. Those voting "yea", 36;  
those voting "nay", 0. Those absent and not voting, 0.

THE CHAIR:

The Consent Calendar is adopted.

Senator Jepsen.

SEN. JEPSEN:

Madam President, I'm going to ask that the Chamber stand in recess at this time. It is our intention to put together a second Go list and to come back and start running bills as soon as that Go list is ready. I would expect to be back in this Chamber within 45 minutes or so.

Of course what I expect and what will in fact happen can be two very different things.

THE CHAIR:

Without objection, the Chamber will stand in recess subject to the Call of the Chair.

On motion of Senator Jepsen of the 27th, the Senate at 5:47 p.m. recessed.

The Senate reconvened at 11:03 p.m., the President in the Chair.

THE CHAIR:

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CONNECTICUT  
GEN. ASSEMBLY  
HOUSE

PROCEEDINGS  
2000

VOL. 43  
PART 11  
3424-3748

003500

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House of Representatives

Tuesday, April 25, 2000

The machine will be opened.

CLERK:

The House of Representatives is voting by roll call. Members to the Chamber. The House is voting by roll call. Members to the Chamber, please.

DEPUTY SPEAKER HYSLOP:

Have all members voted? If all members have voted, please check the machine to make sure your vote is properly recorded.

The machine will be locked and the Clerk will take a tally.

The Clerk will announce the tally.

CLERK:

Senate Bill Number 89, in concurrence with the Senate

Total Number Voting	149
Necessary for Passage	75
Those voting Yea	149
Those voting Nay	0
Those absent and not Voting	2

DEPUTY SPEAKER HYSLOP:

The bill passes.

Clerk, please call Calendar 220.

CLERK:

On page 20, Calendar 220, Substitute for House Bill

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003501

House of Representatives

Tuesday, April 25, 2000

Number 5287, AN ACT CONCERNING EMERGENCY MEDICAL SERVICE  
DATA COLLECTION AND EMERGENCY MEDICAL DISPATCH.

Favorable Report of the Committee on Legislative  
Management.

DEPUTY SPEAKER HYSLOP:

Representative McGrattan.

REP. MCGRATTAN: (42ND)

Good afternoon, Mr. Speaker.

DEPUTY SPEAKER HYSLOP:

Good afternoon.

REP. MCGRATTAN: (42ND)

I move for acceptance of the Joint Committee's  
Favorable Report and passage of the bill.

DEPUTY SPEAKER HYSLOP:

The question is on acceptance and passage. Will you  
remark?

REP. MCGRATTAN: (42ND)

This bill concerns emergency medical services data  
collection and emergency medical -- the institution of  
emergency medical dispatch.

The Clerk has LCO 4234. Will he please call and I  
be allowed to summarize?

DEPUTY SPEAKER HYSLOP:

Clerk, please call LCO 4234 to be designated House  
"A" and the Representative has asked leave to summarize.

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House of Representatives

Tuesday, April 25, 2000

CLERK:

LCO Number 4234, House "A" offered by  
Representatives McGrattan and Eberle.

DEPUTY SPEAKER HYSLOP:

Representative McGrattan.

REP. MCGRATTAN: (42ND)

This is a strike out everything amendment and the amendment becomes the bill.

This truly has been a work in progress. We have been working on this since January of 1999. The bill is based on a report on emergency medical services done by the Program Review and Investigations staff and I thank them very much for their patience and input.

In addition, there was input from the Program Review Committee, Public Health Department. This bill is very important to the Commissioner, the Public Safety Department, Connecticut Conference of Municipalities, the Governor's office, Emergency EMS Regional Councils, and other emergency EMS providers.

It has been to the committees on Public Health, Appropriations, Public Safety, Planning and Development and Legislative Management.

There is a lot of material to absorb so I will try and break it down into components or sections so it will be easier to understand.

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House of Representatives

Tuesday, April 25, 2000

The biggest part of the bill and the reason that we sort of started on this is the data collection. The Commissioner has been asked for the last twenty-five years to collect some data on EMS and it was never done.

Not later than October the 1st in the year 2001 the Department of Public Health will develop a data collection system that will follow a patient from initial entry into the EMS system through arrival at the emergency room.

On a quarterly basis the Commissioner shall collect from commercial and licensed ambulances the following information.

The total number of calls; each level of EMS required for such a call; the response time for each level; the number of passed calls, cancelled calls, and mutual aid calls and also pre-hospital data, for instance, vital signs.

The information may be submitted in a written or electronic form based on an agreement between the Commissioner and the ambulance provider. The Commissioner will then, on an annual basis, prepare a report in a format that categorizes such information for each municipality and then groups each municipality according to urban, suburban, and rural. Not later than March 31st in the year 2002 the Commissioner shall

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submit a report to the Public Health Committee, the public and the Department of Health's web site.

The cost of this will not exceed \$250,000 annually and funding will come from the E-911 funds.

In five years the Commissioner will be required to collect the same information from the first responders and the paramedics and it would be included in his annual report.

The next section is on rate increases. Requests for rate increases can be filed no more than once a year and must include detailed financial information to support the request. If an ambulance does not apply for a rate increase, not later than July 15th they must file with the Commissioner an order to summary financial statement or accountant's review including total revenue and expenses statement of emergency and non-emergency call volume and a written declaration that no change in the currently effective maximum rates have occurred.

Outcomes. The Department of Health will research, develop, track, and report on quantifiable outcome measures for the State's EMS system and report to the Public Health Committee and annually thereafter on the progress towards the development of such measures.

Office of Emergency Medical Services. On or before July 1, 2001 the Office of OEMS with the advice of the

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EMS Advisory Board and the Regional EMS Councils shall develop model local EMS plans and performance agreements to guide municipalities in the development of such plans and agreements. The Office shall take into account the differences in the delivery of EMS in urban, suburban, and rural settings and look at agreements already in use by municipalities.

Local EMS plans. On or before July 1, 2002 each municipality shall establish a local EMS plan. The plan shall include, but not be limited to: written agreements or contracts developed between the municipality, its EMS providers and the PSAP, that's the Public Safety Answering Point that covers that municipality.

Number two. The name of the person or entity responsible for carrying out each level of emergency services. For instance, the first responder, the basic ambulance and the paramedic.

Number three, performance standards.

Number four, any subcontracts, written agreements or mutual aid call agreements that the EMS providers may have with other entities.

In drafting these plans and agreements, the municipality may consult with and obtain assistance from the Regional EMS Councils, the EMS Advisory Committee, and any sponsor hospital.

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The plan then goes to one of the State's five regional EMS councils for review.

Emergency medical dispatching. Not later than July 1, 2001, the Department of Public Safety shall provide and pay from the E-911 fund, an EMD training course or approve one offered by other providers. After the initial training of all dispatchers, a continuing education program as warranted. An EMD priority reference card set for each station at each PSAP, the public safety answering point, provide a quality assurance component prepared with the assistance of a Connecticut doctor trained in emergency medicine.

This is a four year phase in and not later than July 1, 2004, each PSAP shall provide emergency medical dispatching or arrange for someone else to do it, either a public safety agency or a regional emergency telecommunications center.

CMEDS. There are thirteen CMEDS - those are coordinated medical emergency directions systems - starting July 1, 2000, each fiscal year thereafter, CMEDS shall receive 15 cents per capita from the E-911 fund.

PSAPs, public safety answering points. On or after January 1, 2001, each PSAP, on a quarterly basis, shall submit to the Office of Statewide Emergency

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Telecommunications, a report of the calls for EMS received by that PSAP. The report shall include the number of 911 calls that involved an emergency; the elapsed time between the call and the answer; and the elapsed time between the answered call and when a person was dispatched.

Again, information maybe submitted in a written or electronic form agreed upon between the Commissioner and the PSAP. This information will then be furnished to the Commissioner of Public Health and made available to the public on the web site.

Pilot. A pilot program. Not later than February 1, 2000, the Commissioner shall submit to the Public Health Committee a plan of action for implementation of a pilot program in not more than two towns that consent to participate in the program a plan that would assess the effect of assigning a primary service area to a selected provider of EMS based on the issuance of request for proposal with the right of first refusal granted to the provider that holds the PSA.

The Commissioner will hold a public hearing and the Public Health Committee has sixty days to consider the plan. If it is rejected, the Commissioner has ninety days to come up with a new plan and the pilot plan will begin on October 1, 2005.

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Throughout this bill there are penalties for non-compliance of the different sections.

Determination of need. By December in the year 2000, the Commissioner will study and make recommendations to the Public Health Committee concerning one, the implementation of a expedited approval or the waiver of any required approval for the operation of additional ambulances or other emergency vehicles as long as this is not a new service.

I move adoption of the bill.

DEPUTY SPEAKER HYSLOP:

The question is on adoption of House "A"? Will you remark on House "A"? Will you remark on House "A"? If not -- Representative Wasserman.

REP. WASSERMAN: (106TH)

Thank you, Mr. Speaker. I would like to congratulate Representative Mary Eberle and Mary McGrattan for doing a job that we weren't able to do and a bill that is really a beautiful bill and that has had 3-1/2 years of background work, public hearings and so and as Mary McGrattan has said, everybody has had their finger on it. It's a very fine bill and it ought to pass.

And thank you again, especially from the Program Review and Investigations Committee staff.

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Thank you.

DEPUTY SPEAKER HYSLOP:

Representative Winkler.

REP. WINKLER: (41ST)

Thank you, Mr. Speaker. A question, through you to Representative McGrattan.

DEPUTY SPEAKER HYSLOP:

Please frame your question.

REP. WINKLER: (41ST)

Thank you. Representative McGrattan, on lines 559 through 566, dealing with the medical dispatch training course. Is there any sort of exam that's given at the end of this course?

DEPUTY SPEAKER HYSLOP:

Representative McGrattan.

REP. MCGRATTAN: (42ND)

Through you, Mr. Speaker. I am not familiar with one. There may be, but I don't know.

DEPUTY SPEAKER HYSLOP:

Representative Winkler.

REP. WINKLER: (41ST)

Thank you. Through you, sir. Was this one of the recommendations of the Program Review or where did this come from?

DEPUTY SPEAKER HYSLOP:

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Representative McGrattan.

REP. MCGRATTAN: (42ND)

Through you, Mr. Speaker. It was a recommendation of the Program Review Committee.

DEPUTY SPEAKER HYSLOP:

Representative Winkler.

REP. WINKLER: (41ST)

Thank you. If I might ask Representative Wasserman and I would also like to thank Representative McGrattan for all of the work that she did on this particular bill. I know it was very time consuming and my compliments to her.

DEPUTY SPEAKER HYSLOP:

Proceed.

REP. WINKLER: (41ST)

Thank you. Representative Wasserman, could you tell me if there's any exam that's given after this training course or continuing education course?

DEPUTY SPEAKER HYSLOP:

Representative Wasserman.

REP. WASSERMAN: (106TH)

Through you, Mr. Speaker. To my knowledge, there's no examination given. And I do not believe that we had recommended an examination. It was supposed to be under the guidance from the Department of Public Health,

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obviously, has to have its input also. But if you're talking about a regular test, I do not believe that was to be given.

DEPUTY SPEAKER HYSLOP:

Representative Winkler.

REP. WINKLER: (41ST)

Thank you. I will be supporting the bill. It's a shame that we have to put something so cumbersome on all of the towns when there were just a few towns where there was a problem. Looking at the fiscal note, I guess it is a state mandate and will cost the towns something. I do know that many of the towns do collect this data and will have it readily available. So it shouldn't be too much of a problem.

Thank you, Mr. Speaker.

DEPUTY SPEAKER HYSLOP:

Representative Cleary.

REP. CLEARY: (80TH)

Thank you, Mr. Speaker. I rise in support of this amendment which then becomes the bill and would like to thank Representative McGrattan who has worked tirelessly over the last month to bring everybody on board to support this bill. And certainly also the chairs and ranking members of Program Review and all of their staff that have researched all these things in detail.

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I would also like to thank the staff of the Department of Public Health and, certainly, the Commissioner for his leadership on this issue. I believe that EMS in the State of Connecticut is alive and well and I believe this bill will certainly make the system better and will give us the data to be able to do future planning and to actually be able to make improvements in patient care within the EMS system.

So I would ask for my colleagues' support.

DEPUTY SPEAKER HYSLOP:

Will you remark further on House "A"? Will you remark further on House "A"?

If not, we will try your minds.

All those in favor, signify by saying aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER HYSLOP:

Those opposed. House "A" passes.

Will you remark further on the bill, as amended?

Will you remark further on the bill, as amended?

Representative Prelli.

REP. PRELLI: (63RD)

Thank you, Mr. Speaker. Mr. Speaker, I congratulate Representative McGrattan and all those who worked on the underlying amendment in making this bill better.

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But, through you, I have a couple of questions to the Representative. Through you, Mr. Speaker.

DEPUTY SPEAKER HYSLOP:

Proceed.

REP. PRELLI: (63RD)

Representative McGrattan, did you have a fiscal note on this bill and could you tell us - or on the amendment and could you please tell us what the fiscal impact of the new underlying bill is?

Through you, Mr. Speaker.

DEPUTY SPEAKER HYSLOP:

Representative McGrattan.

REP. MCGRATTAN: (42ND)

Through you, Mr. Speaker. What particular section are you talking about? There are different costs for different parts of it.

DEPUTY SPEAKER HYSLOP:

Representative Prelli.

REP. PRELLI: (63RD)

Thank you, Mr. Speaker. I guess the parts I'm concerned with are the effects on the municipalities and also the effects on the 911 money that's -- the thirty cents in the 911 and how that's being divided up.

Through you, Mr. Speaker.

DEPUTY SPEAKER HYSLOP:

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Representative McGrattan.

REP. MCGRATTAN: (42ND)

The CMEDs are getting fifteen cents, not thirty cents.

Through you, Mr. Speaker.

DEPUTY SPEAKER HYSLOP:

Representative Prelli.

REP. PRELLI: (63RD)

Thank you, Mr. Speaker. Mr. Speaker, I was handed a copy of the fiscal note and I thank the lady for answering and I understand the fifteen cents.

Mr. Speaker, I'd like to support this bill. And I've done a lot of talking and I know there are a lot of people who do support this. And I understand the concerns. But I've got to tell you, I come from an area where we're 100% volunteers. The closest town -- the only one in my area at all that is paid is the City of Torrington. The rest of the area is volunteer and we're putting a collection on them, I agree, not right away, but a couple years out that they're going to have to do.

I know how difficult it was as a volunteer in the fire department and having to fill out the forms after coming back from a major fire. And we have less calls than the ambulances have.

I understand that in certain areas of the State

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it's necessary to get this information because their service might have some problems. And I'm not going to argue against that part and maybe it is. But maybe those areas should clean up their own act.

My problem is that in the fiscal note on this when I read municipal impact, even though we reduced it, there's two major words here in bold print. And that's a "state mandate". And it's an unfunded state mandate because we're not truly giving them the money and we're asking our small towns to take care of that. Many of them are volunteers who are having a hard time getting volunteer service.

I understand all the work that's gone into this and I understand there are people from my area that have worked very hard to make sure this works.

The way I read this, it's still going to be a mandate on my EMTs. It's still going to be a mandate in the future on my areas and for that reason, I can't support it.

I supported the amendment. I think it's much better than the underlying bill, but I still think this goes too far and puts too much of a burden on our volunteers.

Thank you, Mr. Speaker.

DEPUTY SPEAKER HYSLOP:

Will you remark further on the bill, as amended?

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Will you remark further on the bill, as amended?

Representative Eberle.

REP. EBERLE: (15TH)

Thank you, Mr. Speaker. First I would like to thank my vice-chairman, Mary McGrattan for the work that she's done on this. I don't think either she or I realized how involved it was going to get and how hard it was going to be to put a simple data collection and reporting bill together on this issue.

But she's done it with grace and she's done it with concern and compassion and she's put a lot of time into making sure that she talked with virtually every group interested in the provision of these very critical services.

In response to some of Representative Prelli's comments, we have been very concerned about the fact that much of our EMS services are provided by volunteers in this state. And that we want to make it - the burden as little as possible for them. But I think you also have to look at this service from the perspective of the people that it serves and the fact that the towns are already mandated to make sure that emergency medical service is available to their residents and without this data collection, they really don't have a way of understanding and evaluating whether they really have

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their residents covered.

Some places do it very well. Some places may not. Some places may think they do it better than they actually do. And the whole point of a statewide data collection system is to make sure that the towns know what they've got and if there are gaps, they know what they are and whether or not can make conscience decisions on whether or not to move to fill those gaps.

It's not meant to point fingers at anyone. It's simply meant to put information in people's hands on which plans can be made.

I don't know how you evaluate a service when you really don't - you haven't collected data on it and you don't know for a fact what you've got and it is with that in mind, with the obligation to our residents, that we move forward with this bill and I would urge the Chamber to support it.

Thank you.

DEPUTY SPEAKER HYSLOP:

Representative Roraback.

REP. RORABACK: (64TH)

Thank you, Mr. Speaker. Briefly, in support of the bill, as amended. I listened to what Representative Prelli had to say, but my support of the bill is colored by my recognition that last year at this time there was

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an effort to bring out a bill and there was panic and I think the panic was not ill-founded on the part of the volunteer community that we were going to be passing a bill without fully assessing the consequences of that bill on the work that they do.

Representative McGrattan, to her credit, in the interim took the time to come out to Litchfield County. It's a long way from Ledyard to Litchfield. She came in the dark of night. She stayed later than she needed to. She heard out each and every first selectman and volunteer who came out that evening and this bill incorporates the concerns that were articulated and I just want to express, publicly, my gratitude to her for incorporating those changes, for recognizing the importance of consensus building and I think that this bill holds some promise for system improvement which will be to the benefit of not only the volunteers, but the citizens of our state.

Thank you, Mr. Speaker.

DEPUTY SPEAKER HYSLOP:

Will you remark further on the bill, as amended?

Will you remark further on the bill, as amended?

If not, staff and guests to the well of the House.

The machine will be opened.

CLERK:

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House of Representatives

Tuesday, April 25, 2000

The House of Representatives is voting by roll call. Members to the Chamber. The House is voting by roll call. Members to the Chamber, please.

DEPUTY SPEAKER HYSLOP:

Have all members voted? If all members have voted, please check the machine to make sure your vote is properly recorded.

The machine will be locked and the Clerk will take a tally.

The Clerk will announce the tally.

CLERK:

House Bill Number 5287, as amended by House Amendment Schedule "A"

Total Number Voting	148
Necessary for Passage	75
Those voting Yea	142
Those voting Nay	6
Those absent and not Voting	3

DEPUTY SPEAKER HYSLOP:

The bill, as amended passes.

Clerk, please call Calendar 270.

CLERK:

On page 5, Calendar 270, Substitute for Senate Bill Number 60, AN ACT CONCERNING ELECTRONIC MONITORING.  
Favorable Report of the Committee on Judiciary.

JOINT  
STANDING  
COMMITTEE  
HEARINGS

PUBLIC  
HEALTH  
PART 5  
1211-1492

2000

DMHAS. We would continue to have authority and money to have the transportation needs of individuals who are general assistance eligible. DSS would continue to fund services for the Medicaid eligible clients.

The Department's allocation for this program is funded \$300,000. To date, eight months after this budget began, our commitments for this service are approximately \$125,000. Thank you for your time and attention to this matter. I'd be happy to answer any questions you may have at this time.

REP. EBERLE: Thank you. Are there questions from the Committee? All right, thank you both for coming. I think that this is a very difficult issue. We'll think about it. Thank you very much.

COMM. PATRICIA A. WILSON-COKER: Thank you.

COMM. ALBERT SOLNIT: Thank you.

REP. EBERLE: Commissioner Joxel Garcia from the Department of Public Health.

COMM. JOXEL GARCIA: Hi. Good afternoon. Good afternoon, Senator Harp, Representative Eberle and members of the Public Health Committee. My name is Joxel Garcia. I'm the Commissioner of Public Health for the State of Connecticut and I'm here testifying in favor of HB5287 An Act Concerning Emergency Medical Data Collection and Emergency Medical Services.

I already submitted my written testimony and I also would like to have this opportunity before I comment on the bill. First, I would like to express to you what we are doing in our agency that relates to this bill.

Let's start from the beginning. There have been a lot of history about emergency medical services in our state and there have been significant organization in the past three, four years in our agency. I became Commissioner nine months ago. Since I came here to the agency, one of the first things that I decided to do was get involved with

EMS.

When the Governor appointed me here, he was not looking for a politician, definitely, because he chose me. So, but he was looking for someone who has experience in terms of administrator and a scientific person and an educator, which I am. I have been here nine months. I am about science not politics.

So one of the first things I start doing was to learn about EMS. I have some background in EMS in terms of working in the emergency room when I was in training and also in my private practice, I was a gyn surgeon. I am still a gyn surgeon.

One of the first things that I start doing was visiting the communities and I essentially started to know about the difference areas of the state and the culture of the EMS in our state and I have said this, I think already 1,000 times, but this is a very proud Yankee state.

One thing that I found is that we cannot use the same type of template or the same type of blanket program to cover the entire state because the politics of the state, the culture of the state is not applicable that way. So, we start meeting with all the players and that means all the providers, but also with the elected officials in terms of getting some feedback.

One of the first things that we did was, we started working on a new plan of EMS for our state and I think you have copies of my organizational chart and the EMS plan that we have created in our agency.

If you look at the plan, the first thing that it strikes is that we have five new positions coming to the agency. The most significant change is the EMS director, a position that has been absent in our agency for more than two years.

We also are adding HPA. We are also adding epidemiologist. We're bringing back a manager and also we're getting some clerical help. That's what

you see in terms of the organizational chart. When you look in the process, we also created an internal EMS Committee, and the EMS Committee is extremely important. This is not just another layer for bureaucratic intent. This is essentially based on science and logic.

We've got three bureau chiefs. The bureau committee health, the bureau of regulatory service and the bureau of policy planning and evaluation and we put an executive assistant in charge of the Committee. The executive assistant actually is accountable to me every day.

So what happens is, now we open EMS not as a division of the regulatory service where it was a month ago, now essentially it's elevated to answer to the Commissioner's office directly through this EMS Committee. And this EMS Committee is a process. That means that for example, the bureau committee held Dr. Wilson, her background and expertise that that division has, or that bureau has, is that they create programs. They create didactics. They create education.

The bureau of regulatory service, well, regulations are always important and we are in the process right now of evaluating all the regulations that we have in our agency. Some of them have been there even while I was in high school.

And then the bureau of policy and planning evaluation. I think we have one of the biggest and largest group of scientific people in our state in our agency. I don't think there is any place in our state that has more epidemiologists that we have and more scientific people. And we need data, so these people will help us with the data processing part.

But not only that it makes the EMS transcendental in our agency so that means that when we are talking about EMS now we talk about from before the 911 call, all the way after the rehabilitation process at finish.

That creates like, the way I see it, it's like a

continuum. We start talking about prevention and we start talking about regulation and we start talking about actions and we start talking about best practices and best outcomes. And I think that's extremely important. I think it was about time that we did that and I think we were trying to find the best way to create a product like that and that's what we are doing right now.

We, as an example of these in terms of thinking outside the square lines, we asked NHTSA to come to our agency and visit our agency. The last time they were here was in 1991. And we want them to evaluate EMS in our state, in our agency. Instead of us going for some funds from our own agency, we have been working with the federal DOT the Department of Transportation to give us a grant of \$30,000 so we can actually pay for this. So those are things that were are doing.

And we are using (inaudible) and the injury prevention to try to also bring some funds to EMS so we do not have to depend for interest of only the budget that we have. So we also are doing some data collection right now. And at the beginning of March of this year, which means this week, we are looking in terms of basic level services and we are looking in terms of proportional of goals, outreach response times and this is a plan that was created with our regional councils which are great partners with us, the regional council and advisory council, they have to be partners with us and we have to be partners with them.

This is not a great scientific way of getting data, but at least it's a beginning and brings that into mind the perception that everybody should have that data is extremely important if we are going to have best practices.

We also are working in terms of the trauma collection and with the trauma committee. I think it's extremely important. We have to bring the universities aboard this and we have to bring every possible segment of the system.

And I have some other data collection efforts that

we have in the agency but I'm not going to bore you with those issues. I would provide to all of you that.

Now, just going to the bill HB5287. Essentially, I support and the agency support the bill. But I have two concerns. I have the concern in terms of the funding. I didn't see DPA receiving any funds there, so I thought that, I probably think it's a typo. I don't know if it was a typo, but.  
(Laughter)

But I think that would be very good from the EMS community if the fund goes through, identified to go to our agency. And then the other thing that I'm concerned about is in terms of the date. There's a date for March 1, 2002 for me to present to all of you a report about the data collection that we have done and I think that's fair. But what I think is not reasonable is that January 1, 2001 to have the mechanism in place.

And the reason I say that is, there's a lot of concerns among different segments of the community of EMS, about what that data collection system is going to be all about. So I think I need to educate the people of all our communities, all our providers in terms of importance of data collection and how we're going to standardize that data collection mechanism that is fair for everybody.

So what I'm asking is, an extension of nine months, instead of being January 1, 2001, I think I should have enough resources in turn so, energy and people in my agency to do it for October 1, 2001.

We also support AMB. I think it extremely important that it creates efficiency in our state, but I think that before we do that, we have to educate people, so it takes a little more time than the one that is presented here.

And the last concern I have is that we don't have right now a system that links data in between my sister agency, DPS and DPH. And I think that we have to work on that as well. So, I thank you for this opportunity but before I finish I just want to

say this is a lot of fun being a Commissioner, especially when you're working with a product that is very nice, which is like health. And working the heros of EMS is really nice.

And I have to say because many, many times and this is not for them to have bigger egos, because they have bigger egos, is that many times they saved my patient before I have to bring them to OR so I thank them. And this is an opportunity for me to say all of this. I welcome any questions that you may have.

REP. EBERLE: Thank you very much, Doctor. Are there questions from the Committee? Representative Cleary.

REP. CLEARY: Good afternoon, Doctor.

COMM. JOXEL GARCIA: Good afternoon, Sir.

REP. CLEARY: I'm just looking at the reorganization plans for the EMS office and will the new director position, as I read this, will be reporting to the EMS Committee?

COMM. JOXEL GARCIA: Internal, DPH, DMS Committee. That's the three bureau chiefs and my executive assistant. So it's not that it's reporting, reporting will be a one way street. It will be a two way street in a sense that any issue that he or she brings to the Committee, that it will be studied by the Committee, instead of me creating a task force every time that he or she comes to me.

What we would do is, they would look at all the options and alternatives around the issue that has been brought up. And then what will happen is when it comes to me, I will have the alternatives right away. The Committee, the way I envision this Committee and they are working as I speak right now, probably they are watching me right now. But what they are doing is, they are going to be meeting at least twice a week and I would be meeting with them at least once a week because I meet with my executive assistant every day. So essentially, we'll be having an ongoing process.

Right now the EMS director, we're in the hiring process of the EMS director, in the interview process. That's the part that we are in terms of the hiring process. I was told that no one would be interested on this and we already have more than 20 applicants. So this is not a layer to essentially protect me from EMS. As a matter of fact, this is a layer to bring science to me when I meet with the EMS director.

REP. CLEARY: So then that Committee is really three or four people --

COMM. JOXEL GARCIA: Four people.

REP. CLEARY: -- that are already executives within your Department.

COMM. JOXEL GARCIA: Yes, Sir.

REP. CLEARY: Thank you.

REP. EBERLE: All right, thank you. Are there other questions? Thank you very much, Commissioner.

COMM. JOXEL GARCIA: Thank you.

REP. EBERLE: And I see Commissioner Gorman has now arrived. Would you like to go next?

COMM. RAYMOND GORMAN: Good afternoon, Senator Harp, Representative Eberle and other distinguished members of the Public Health Committee. I'm Raymond J. Gorman, Commissioner of the Office of Health Care Access and I'm here today to testify on two bills, SB129 and Raised SB437.

SB129 An Act Concerning Hospital Uncompensated Care and a Grant and Assistance Program for Nongovernmental Hospitals accomplishes two objectives.

The first is to clean up language in Sections 19a-670 to 19a-672 of the Connecticut General Statutes concerning calculation methodologies for payments to hospitals in the uncompensated care pool.

I would be most happy to share this type of information with the Committee should you find it helpful.

Thank you for the opportunity to present my opinions to you today. I'll be glad to answer any questions that the Committee may have.

REP. EBERLE: Thank you very much, Commissioner. Are there questions from the Committee? All right, thank you, Commissioner.

COMM. RAYMOND GORMAN: Thank you.

REP. EBERLE: That completes the public officials portion of the hearing and we will move now to the public sign up list on HB5287. First is Ernie Herrick then Derrylyn Gorski and Chris Salafia. And I apologize if I mispronounced names.

ERNEST HERRICK: Good afternoon, Chairman Harper and Representative Eberle, Committee members and guests. My name is Ernest Herrick. I have been connected with the Fire Service for 45 years, past president of the Connecticut State Firefighters Association, immediate past president of Tolland County Mutual Aid Fire Service, which is a regional dispatch center that answers emergency calls for Tolland County, retired assistant chief (inaudible) Fire Department. I'm also involved in many committees and commissions of the State of Connecticut.

I would like to take this opportunity to thank you for the opportunity to be heard this afternoon regarding Raised HB5287. I'm before you this afternoon representing the Tolland County Mutual Aid Fire Service, Incorporated and will speak on issues pertaining to this bill on their behalf.

Tolland County Mutual Aid has been, has some grave concerns regarding Raised HB5287 in its present state, citing some concerns over both parts of the bill, data collection and emergency medical dispatch.

Tolland County Mutual Aid Fire Service is an

organization which represents 13 towns in eastern Connecticut, without the boundaries of Tolland County, parts of Windham County and Hartford County. Logistically, this area comprises of 22 separate emergency service organizations.

Tolland County Mutual Aid Fire Service operates a regional dispatch center throughout the area and answers approximately 31,000 calls a year, 911 calls a year and approximately a high percentage, maybe better than two-thirds of those calls are medical calls for emergency medical services, fire service and in addition, to those also answers emergency 911 calls both the cellular emergency's trunk to the center as well as the 911 calls for the Connecticut State Police Troop C.

Tolland County has operated this dispatch center for over 30 years at its present location. With that history know, I would like to address some of the concerns our member departments have in regard to the bill.

The suggestion of requesting the emergency services, most of which are volunteer or at very best have limited part-time staff, to submit in a timely manner, information for services rendered is not only time consuming but extremely cumbersome to an already overburdened service.

In many cases the volunteers, especially during the daytime hours, have just enough time to answer the emergency call and complete the extended run forms provided to them from the Office of Emergency Medical Services before returning back to their regular schedules. Is that bell for me?

REP. EBERLE: (Inaudible-not using mike)

ERNEST HERRICK: I would like to offer some suggestions, that the standard form, that the form, standard form would not become redundant with the form presently being used and should be made user friendly and so much that the submission can be done easily and efficiently, also remembering the limits available by the originator.

And I'll move along. You already have some of this testimony. Moving to the emergency medical dispatch, to implement this practice without funding raises grave concerns for our representative members. This section of the bill, as written, would cause our association to be forced to implement a program that cannot be funded through our present system.

In order for the original PSAPs to implement EMD without funding sources, the PSAPS or in this case, Tolland County Mutual Aid Fire Service, would have to increase dramatically the per capita assessments they charge the individual organizations and town we provide service to.

And I'll just go on to give you three of our suggestions. Tolland County Mutual Aid Fire Service would like to offer the services of our representatives to assist in the development of the form necessary for the proposed data collection that will hopefully benefit the bill and the PSAP users alike.

The second suggestion is a suggestion on a possible funding source for the implementation of emergency medical dispatch, I offer the use of the already established telephone assessment which was developed for the purpose of the 911 upgrade equipment and the continued operation and maintenance of the emergency 911 system statewide.

And three, we believe that a standard medical control protocol must be developed when implementing E911 in an effort to reduce the liability to the PSAPs when answering 911 calls and particular when the PSAP utilizes multiple medical facilities. In our case, we operate with three different hospitals.

I'd like to, in closing, I would like to thank the Committee for hearing our comments and we would be willing to answer any questions at this time or if you wish to contact us through the Connecticut State Firefighters legislative rep Ted Scholl, we'll make ourselves available. Thank you very much.

REP. EBERLE: Thank you. Representative McGrattan.

REP. MCGRATTAN: I think the intent of the bill in the data collection was to require just the ambulances to submit their run forms and they're already doing that. In other words, it would not involve all of the volunteers submitting form, it would be just the ambulance form, for the data collection.

ERNEST HERRICK: Yeah. We understand that.

REP. MCGRATTAN: Oh, okay.

ERNEST HERRICK: But there are a numerous amount of volunteer ambulance services that operate out of Tolland County. We're just concerned that if we're already providing information to OEMS now, the concern that we had, is this additional information, and if so --

REP. MCGRATTAN: No. No.

ERNEST HERRICK: Okay.

REP. EBERLE: All right. Thank you, Sir.

ERNEST HERRICK: Thank you.

REP. EBERLE: Derrylyn Gorski.

DERRYLYNN GORSKI: Good afternoon, Senator Harp, Representative Eberle and members of the Public Health Committee. Thank you for allowing me to testify in support of HB5287 An Act Concerning Emergency Medical Services Data Collection and Emergency Medical Dispatch.

Specifically, emergency medical dispatch. My name is Derrylyn Gorski. I'm the advocacy director for the American Heart Association in Connecticut. The 1992 American Heart Association guidelines for CPR and emergency cardiac care state, all EMS dispatch systems must be able to immediately answer all emergency medical calls and offer telephone assisted CPR instructions.

You have the Heart Association's position in my written testimony. I'd like to share with you my personal experience with the 911 dispatch system that's not trained in emergency medical dispatch.

A year ago in February, my husband and ten year old daughter and I were watching TV in our room. Bill went to check on the clothes in the dryer. We heard a clattering noise and then a moan. I ran out and found Bill lying face down on the floor, breathing erratically and unresponsive. I called 911. I called his cardiologist, I called the neighbor. I called 911 back, where are they? He said, they're on the way, does he have a pulse. I tried to check. My hands were trembling so that I couldn't tell whether he had a pulse or not. I've taken CPR courses. I have a chart on my refrigerator that tells me how to do CPR. It never occurred to me to do CPR.

When people call 911 they expect help. When your life is going along calmly and then a thunderbolt strikes and you can't think clearly. This morning before I left home my 11 year old daughter handed me an essay, a memory essay she had to do for school. I had never seen this until this morning.

As I sat in my parents' bedroom watching TV, I kept hearing a soft moaning sound. What's that noise, I asked my mother? I really didn't expect anything to be wrong, but I was still very curious as to what the noise was. Probably just the cats. Go see if they need food was the reply. So thinking nothing out of the ordinary I left the room and headed down the hall. I was not prepared for the sight that awaited me in the dining room. Papers and old magazines were strewn across the floor and a chair had been knocked over. On the chair lie a hand, Dad's hand. He was unconscious.

Mom, come quick I said. She came out of her room and for a while I just stood out of the way and stared. Bill, wake up, Bill, she screamed, then rushed to the phone. She called 911 and said Dad was having a heart attack. After I heard that, I rushed into my room, sobbing my head off. God,

please don't let him die, I yelled.

Then I made God promises about praying every night and things like that. In my heart I knew this was useless, but I did it anyway. Soon a neighbor came to get me. The ambulance was there. And so I had to wait in the garage for them to leave. I waited and waited for what seemed like years for them to leave.

Finally, Dad was carried out on a stretcher and he looked so horrible I had to turn away. I know that I will never forget the way he looked. Somehow I knew that it would be the last time I ever saw him alive again. The neighbors did a good job keeping me distracted. I had hot chocolate and chatted about little unimportant things. When I went to sleep that night, Dad had already left this world, though I didn't know it.

The next morning I ate and went home. Mom was sitting on the couch and my uncle's girlfriend was working in the kitchen. I rushed over to Mom clutching my great beat up teddy bear. I knew that Dad was dead by the way she looked at me.

So what happened to Dad, I asked you fully as I plopped down on the couch. I was unprepared for the answer, even though I knew what it was. Daddy had another heart attack and this time he didn't make it, she said. I hugged her and sobbed so hard that I soon needed a drink of water. I took it and gulped it down. Then my sister came out and we all cried some more.

I will never forget that night no matter how hard I might try. That night changed my life and me with it. Now, no matter how bad things get, I know that they can always get worse, especially with only one parent.

My point is that, you're not rational when something like that happens, when someone you love is lying there unconscious on the floor and to call 911 and have somebody tell you what to do, to tell me, did you feel in his neck, anything like that would have possibly not saved his life, he had

heart disease, he had had bypass surgery. But at least it would have helped me to know that I did what I could do to save his life. Thank you.

REP. EBERLE: Thank you very much. That's a very powerful story. Are there questions? Thank you. Chris Salafia and then John Gustafson.

CHRIS SALAFIA: Good afternoon and thank you for the opportunity to appear before the Committee. My name is Chris Salafia and I'm the president of Power Phone Incorporated. A Connecticut corporation, Power Phone is the world leader in 911 emergency communications training. Over the last 18 years, we have certified more than 75,000 public safety personnel representing all 50 states in more than a dozen foreign countries.

We are proud to have trained more than 2,500 Connecticut dispatchers representing more than 95% of the state's public safety answering points.

I appear before you today to support the introduction of Raised HB5287, specifically Section 4, Subdivision 15, emergency medical dispatch. Emergency medical dispatch is not a new concept. First introduced by the Department of Transportation in 1969, emergency medical dispatch, or EMD as it is commonly known, is a proven, widely accepted system.

A common misconception regarding the adoption of an EMD system is the fear of liability exposure increasing. This is simply not the case. Emergency medical dispatch is becoming the rule, not the exception. As more and more cities, states and countries adopt EMD, an agency's standard of care and duty to act is intensified. There is little doubt today's citizens anticipate they will receive pre-arrival instructions. Agencies that do not meet these expectations will be held accountable.

As residents of this state, we, like you, are stakeholders in the Connecticut EMS system. Power Phone has closely followed the progression of this legislation and as subject matter experts,

respectfully offers the following points for consideration.

First and foremost, don't wait. Proven EMD systems already exist and many Connecticut agencies have already implemented EMD. Why wait until July 1, 2004 for agency compliance? EMD works and we respectfully suggest you empower the agencies to use it. The sooner the better.

Second, the system adopted must be functional. It is absolutely imperative that agencies view this as a boon to their communities, not the bane of their existence. A properly implemented EMD program not only improves response, but also alleviates stress on the system and those charged with running it.

Third, don't reinvent the wheel. Private training providers exist. It will be much more efficient, cost-effective and better quality than if the state created its own EMD training division. Power Phone spends in excess of \$1 million each year in insuring we offer the highest quality products and services.

Not only would the state lose the luxury of third party accountability, it has now assumed all liability for the validity of the training, instructor credentials and student proficiency. That, coupled with the challenge of remaining current with all that transpires in the field creates a no win situation.

Finally, Section 5g4 alludes to initial training in the purchase of a medical dispatch priority reference card set. We submit EMD is an ongoing process requiring initial training, continuing education and recertification. Also, at a minimum, card sets must be available per work station. A single set per agency is not functional and does not meet the minimum standards.

As important, card sets are quickly becoming backup for software driven protocols. EMD software is quicker and more efficient than its printed predecessors.

That said, we applaud the large number of Connecticut public safety agencies that have recognized the importance of emergency medical dispatch and have for a number of years now, endeavored to provide prearrival instructions to their communities.

It is our strongest opinion that the Committee should endorse this concept and move forward to enact legislation to assist remaining agencies in implementing an EMD system.

Emergency medical dispatch must no longer be a home rule issue. A uniform standard of care, border to border, can only improve the EMS system, enhance the image of the state, and most importantly, save lives. Thank you very much for your attention.

REP. EBERLE: Thank you. Representative McGrattan.

REP. MCGRATTAN: Could you go back to third, don't reinvent the wheel, private training providers exist that would be much more efficient than if the state created its own EMD? Would you kind of explain that a little bit.

CHRIS SALAFIA: Yes, Ma'am. My point --

REP. MCGRATTAN: In other words, that's your business?

CHRIS SALAFIA: Yes, Ma'am. And there are a number of trained providers that do this for a living. Our opinion is not to invest the money and the time required to go out and try to do something that there are private sector companies that have been doing for their business. We've been doing it for 18 years.

REP. MCGRATTAN: Okay, thank you. I understand.

REP. EBERLE: Thank you. Are there other questions? Thank you very much. John Gustafson, followed by Marcia Wellman.

JOHN GUSTAFSON: Good afternoon, Senator Harp, Representative Eberle. My name is John Gustafson. I'm supervisor of South Central Connecticut

HB 5287

Emergency Medical Communications System, CMED in New Haven. We're a special fund agency funded by 20 towns and cities in the greater New Haven area providing emergency communications services.

We support the initiative to require each public safety answering point in Connecticut provide emergency medical dispatch including prearrival instructions. We support the initiative to require development of a statewide EMS data collection system.

However, we have reservations about funding it through the existing 911 surcharge. We encourage you to amend Section 3 subsection c of item 4, section 20 and 24 of the General Statutes to include restoration of full funding from the 911 surcharge for the regional CMED centers to the regional emergency telecommunications service credit.

We also encourage you to amend Section 3, subsection c item 2 to include the restoration of full funding from the 911 surcharge to cities with populations in excess of 70,000 people who have not consolidated their dispatch centers, such as New Haven and Bridgeport.

The provision of emergency medical dispatch service by the state's PSAPs will greatly enhance the chance of patient survival in a medical emergency.

We laud the proposal to fund the cost of training.

However, this being said, there are other costs that you should be aware of that have to do with the standards in the training program.

This does not constitute opposition on our part, but you should be aware of them. Based on our agency's review of the costs, it would cost us an additional \$31,000 a year to do the quality assurance program for our operation, roughly \$2,000 per emergency telecommunicator employed.

I'm also sure you'll hear various reasons for not implementing EMD. Most common is the delay in answering subsequent 911 calls while EMD is in progress and liability. Concerns that 911 call

answering will be delayed by provision of EMD is a valid concern but is a concern that is overcome by common sense and standardized operating procedures.

Our communication center SOP allows for priority of actions, in which case an incoming 911 call is always entertained because logically, this is a person that does not yet have help.

Exposure to liability is commonly stated. I would submit that the municipality which chooses not to provide help to the citizens is just as exposed as one who provides that help in a planned organized manner. Further, implementing a formal program for EMD establishes standards for employee performance and gives the municipality or the employer greater control over any exposure.

It will be of some assistance if our emergency telecommunicators were granted good samaritan status. We have some concerns about the data collection system. Principally, the issue appears that there may be a possibility of funding it from the 911 surcharge. The 911 surcharge is developed to fund the operation of 911 system. We are concerned that if the consistent tapping of that fund, regardless of the minimal amount, I believe it's one cent per phone, raised by one penny.

If this continues to go on when we do need the additional funds in five to ten years to rebuild the 911 system and replace technology, that funding will not be available. Although we endorse the fact that there needs to be an EMS data collection system that's been recognized in General Statutes since 1979. It's a statutory regulation.

Again, I have to say the final part is, we really need restoration of the funding for the CMEDs and regional communication centers and in closing, I'd like to say this. The lady from the Heart Association lives in one of the towns that we provide 911 PSAP service to. Please give us the tools to be able to help her when she calls again. I thank you.

REP. EBERLE: Thank you, Sir. Could you tell us which

tools you don't have.

JOHN GUSTAFSON: Training. The standardized card system and the dollars. Dispatch is not done by volunteers. They are paid, professional personnel.

Our center handled over 80,000 incidents last year which is roughly 200 incidents a shift. We have a staff of three on days, three on evenings and two on midnights. The City of New Haven has the same basic staffing. We need additional staff to entertain these calls.

REP. EBERLE: Representative McGrattan.

REP. MCGRATTAN: Are you saying that the dispatcher that answered that woman's call was not EMD trained?

JOHN GUSTAFSON: All of our personnel are emergency medical technicians. We do a modified emergency medical dispatch. That call was reviewed. It would be my contention that had we had better training, that was very costly training, we may have been able to do a better job.

REP. MCGRATTAN: Okay, thank you.

REP. EBERLE: So this is more than just the EMT training?

JOHN GUSTAFSON: Correct. It's call techniques, controlling the caller. You can be a very fine technician as a paramedic or an EMT and not be able to relate those skills to that caller who has no technical skills, in order to help them out.

So this is all part of formalized EMD training regardless of which vendor you go to and that's very important. And also the state, when you do this at the state telecommunicator training program as well, in trying to train our personnel through various and sundry methodologies for a controlled caller.

REP. EBERLE: All right. So it's more specialized than just the EMT training. It's also in how to handle

the people on the phone.

JOHN GUSTAFSON: That's correct. These people, in fact most people that call 911 for any reason, are at the last gasp of everything. We're the safety net for all the various human service and public safety agencies that failed.

When they call 911 they're in trouble. They may not be as rational as they'd like to be. They may not be thinking clearly and they look to us to be the sentinels and to guide them through that. And that requires specialized training and specialized skills.

REP. EBERLE: All right. Thank you. Representative McGrattan.

REP. MCGRATTAN: Do most dispatch centers or PSAPs require their dispatchers to be EMTs?

JOHN GUSTAFSON: No, Ma'am. No, they do not. We've been requiring that since we began business in 1977. Part of our major role is the coordination of the EMS communication system where we felt it was required that they have that skill to know what was going on, to work between the paramedics, EMTs and the hospitals.

Our insurance carrier likes it, the fact that we have EMT certified personnel. It's not necessary, though, that the personnel be certified as EMTs or MRTs to provide emergency medical dispatch.

REP. MCGRATTAN: Okay. That was my next question.

JOHN GUSTAFSON: Not required at all. It would be helpful for them to be CPR certified. Anything is helpful, but to provide that because of protocol, call guides and out rhythms for treatment. And also, I think there's a lot of contention that you have to stay on the call with the caller on every EMS call until the call is complete. That is not the case.

Because not all the EMS calls require prearrival instructions and that's a misnomer that's out there

that I think a lot of people get nervous about.

REP. EBERLE: Representative Winkler.

REP. WINKLER: Thank you, Madam Chairman. What towns

(GAP FROM SIDE A TO SIDE B)

JOHN GUSTAFSON: -- Branford, North Haven, Orange, Oxford, Seymour, Shelton and Wallingford, West Haven and Woodbridge. Some of which have their own dispatch centers. We act as the dispatch center, 911 PSAP for Bethany with a fire and ambulance dispatcher for Seymour, Ansonia and Derby, as well as the Town of Bethany.

REP. WINKLER: Who pays the salaries of the dispatch?

JOHN GUSTAFSON: Member towns.

REP. WINKLER: The towns.

JOHN GUSTAFSON: Right. We're a special fund agency operated by the City of New Haven on behalf of those towns and by our annual budget, which is based on a population usage formula, each town is assessed a certain amount for the services based on population usage.

The revenue from the 911 fund, which we are now losing is accounted for, it was now down to about 5.5% of our budget. At one point it was 5.15% of our budget. So by losing the state aid, we're now finding that the towns are having to pay additional costs over and above what they would have paid because we're obviously trying to improve service.

REP. WINKLER: And what's the average cost per town for this service? Can you give me a ballpark figure?

JOHN GUSTAFSON: It varies. The City of New Haven is paying us in excess of \$300,000 because of population usage. The Town of Bethany, the Town of Oxford is somewhere in the vicinity of \$5,000 to \$6,000 annually.

REP. WINKLER: Thank you.

REP. EBERLE: Senator Harp.

SEN. HARP: I think you probably mentioned this last year and I probably dropped the ball on that. How do you get the money again for CMED and where has the money gone that you've lost and how do you see this bill impacting that again? So, just to remind us, and who makes the decision about when that money is cut?

JOHN GUSTAFSON: Okay. The state money that we've been receiving is part of the telecommunication surcharge which was introduced in 1996 with the most recent 911 legislation.

The intent was that there was a great feeling that regional dispatch centers were to spring up throughout the state and the single town dispatch centers would disappear. This has not been the case.

And the thought was that the CMEDs that were freestanding such as our own in southwestern Connecticut and north central would be to become regional dispatch centers or be absorbed by newly created regional dispatch centers. This was not the case. That was based on 25 cents per capita with a five year phase out of that money.

So we started out with 25 cents per capita for 600,000 people and we're not down to, I believe it's down to 10 cents per capita for our 600,000 people and will end in fiscal year 2001-2002. So that difference in our operating budget which is set by the mayors and selectmen, just so everyone knows, the major and selectmen lead pencil me every year and they determine the basic operating budget. Then a revenue is applied to that. We determine how much each town pays.

Does that answer your question, Senator?

SEN. HARP: I guess you did. The bill itself, the telecommunications surcharge law was a law that we passed here in the General Assembly that allowed the telephone companies to add a surcharge of 25

cents.

JOHN GUSTAFSON: Up to 50 cents.

SEN. HARP: Up to 50 cents? And is that per month, or -

JOHN GUSTAFSON: Per month, per wire line or cellular telephone, what's out there.

SEN. HARP: Okay. And so now, in that law, it diminished to over five years.

JOHN GUSTAFSON: The CMED credit diminished over five years. The regional public safety answering point such as Tolland County retained funding because they regionalized. That was part of the task force report.

SEN. HARP: And one of the things that you would like to see is to have that funding reinstated.

JOHN GUSTAFSON: Correct. That would benefit not only us but the other 13 CMEDS, including the regional dispatch center such as Tolland, my friend Ernie Herrick sitting next to me and Litchfield County, Willimantic, Valley Shore, Groton Fire Alarm.

SEN. HARP: And I guess the thing is, I know it's not in the bill, but I guess, but it does impact the bill because if they're losing money they're not going to be able to do more things.

JOHN GUSTAFSON: Right.

SEN. HARP: Who do you get the money from? How do you get it?

JOHN GUSTAFSON: It comes from the Department of Public Safety.

SEN. HARP: Public Safety. Okay.

JOHN GUSTAFSON: It comes in a quarterly check. We have to file financial reports annually and place that against our budget. We're not allowed to use it for capital projects, leasing of equipment or vehicles. We essentially apply it to salary in our

agency.

REP. EBERLE: Thank you. Are there other questions?  
Thank you very much, Sir.

JOHN GUSTAFSON: We'd be glad to assist you in any way possible in working on this legislation. We do believe in the concepts and hope to wish you success in the session.

REP. EBERLE: Thank you. We're going to keep trying.  
Marcia Wellman, followed by James Strillacci.

MARCIA WELLMAN: Good morning, Senator Harp, Representative Eberle, members of the Public Health Committee. I'm here today to testify on HB5287 An Act Concerning Emergency Medical Services Data Collection and Emergency Medical Dispatch.

CCM would like to thank the Committee for having worked not only with ourselves but with municipalities throughout the summer and the fall.

This is a far different bill than we saw at the end of session last year and we feel that many of the municipal concerns that were in last year's bill have been addressed by this one. We would very much like to be on the record saying thank you for the efforts made.

In terms of the bill before us today, we have two concerns. One is the issue of liability which I know you've heard about earlier today. And many municipalities are reluctant to deliver EMD because of liability concerns so we urge the Committee to amend the bill to include immunity from liability for the delivery of EMD.

I know there's good samaritan legislation that's been discussed in terms of if this would be applicable to that. Also, that the delivery of emergency medical dispatch will have ongoing costs associated with both the continuous training of personnel and the quality assurance measures, so we ask that the Committee amend HB5287 to require OSET to provide ongoing funding not just the one time funding that's associated with the initial start up cost that's here in the bill. And that's it.

REP. EBERLE: Representative McGrattan.

REP. MCGRATTAN: I'm sure your membership is aware that the liability exists on the other side, too. If you do not provide EMD, they could be accused of dispatcher abandonment.

REP. EBERLE: Representative Orange.

REP. ORANGE: Good afternoon.

MARCIA WELLMAN: Hi.

REP. ORANGE: What is the cost? Do you know the cost to train an EMD?

MARCIA WELLMAN: No, I do not.

REP. ORANGE: I probably should have asked that gentleman before you. I'm sorry.

MARCIA WELLMAN: Sorry.

REP. EBERLE: All right. Are there further questions? I guess I'm curious about the position the towns take as to whether this is something they ought to be providing their residents or not, whether you see it as just a state obligation to the residents of the state or whether the towns feel this is something they ought to be doing.

MARCIA WELLMAN: We actually haven't had that conversation. Our membership has not had that conversation, that I'm aware of.

REP. EBERLE: All right. Do you view provision of ambulance services as something that the towns ought to be, whether it's through volunteers or paid or a combination is something that they ought to be doing?

MARCIA WELLMAN: I think that our membership would view that as a basic public safety endeavor, yes.

REP. EBERLE: Thank you. Other questions? Thank you very much.

JAMES STRILLACCI: I know of at least two confirmed fatalities that went the other way. There have been other minor EMDs that we saved people. I didn't bring our complete history with us, so I can't comment with confidence on it.

SEN. HARP: So in three years you've had maybe three suits?

JAMES STRILLACCI: Oh, suits? I'm sorry. I thought you said saves. No, we have -- oh, gosh! Microphone is a wonderful thing. We have not been sued yet on EMD.

SEN. HARP: So you haven't had any in three years.

JAMES STRILLACCI: No.

SEN. HARP: Okay, thank you.

REP. EBERLE: Could you tell me, do you know whether your town insurance premiums went up when you started providing EMD and have they stayed up, based on your experience?

JAMES STRILLACCI: We are self-insured for liability purpose, so there's no way to tell that.

REP. EBERLE: All right, so to date, though, you haven't had any exposure?

JAMES STRILLACCI: That's correct. All right.

REP. EBERLE: Is it something that you could insure for in the insurance market?

JAMES STRILLACCI: Our finance department could buy additional liability insurance if they were that concerned. So far, they have not done so.

REP. EBERLE: Okay, thank you very much. Other questions? Thank you, Sir. Jonathan Lillpopp and then Jason Meilleur.

JONATHAN LILLPOPP: Good afternoon. I am here to represent the Eastern Connecticut EMS Council.

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However, I have to tell you there's some logistical problems with getting official point of view in such short time and I understand your busy schedules.

So, on behalf of the majority of the board of directors, they did ask me to come up here and support the bill. But, not being able to represent an official approved stance on the bill, let me just offer some support of the bill by comparing it with the regional plan for the delivery of EMS in eastern Connecticut that was filed with the Department of Health this past June.

Some of you were fortunate enough to be at our presentation this past January and let me just state that these are two objectives within the plan that is based upon the state plan that need to be addressed.

First is data collection. The problem with our system now is that we do know that it needs some improvements and tweaking, but we don't have any benchmarks to work off of and I think that the establishment of a data collection system, although it's been in statute since 1974, or thereabouts, needs to be accomplished.

We can't go forward if we don't know where we are.

Most of our changes are based on anecdotes and some small pockets of systems that are able to collect data, so we do support your legislative initiative to make that a reality.

The second issue is emergency medical dispatch. I think you'll find there are quite a few national organizations that support this as part of the chain of survival and in the eastern Connecticut region I can attest to through our assessment of the system this past year, that it's somewhat lacking. We have about five and one-third towns that are covered by this lifesaving program out of 39 communities. So I think that it's very important that that's accomplished.

I did note there was some funding that was addressed in the bill. I wasn't really clear as to

who that was going to, how much, you know as far as the costs that are involved. But we've heard enough of that.

One thing I did not see was, I did not see any funding going toward the data collection. The Department of Health will probably need some financial assistance for this and I can't speak for them but I think that's an important concept to look at. That's all.

REP. EBERLE: Representative McGrattan.

REP. MCGRATTAN: Thank you, Jonathan. The bill does address funding for both data collection and EMD.

REP. EBERLE: Okay? Thank you, Sir. Jason Meilleur and Lisa Searles.

JASON MEILLEUR: Good afternoon. It's actually Jason Meilleur but I commend you for your first pronunciation of the accurate French way that it should be done. I'm Jason Meilleur, administrator of K-B Ambulance in Killingly, Connecticut. I speak to you today in support of Raised HB5287 which addresses the issue of EMS data collection and emergency medical dispatch.

Please allow me to briefly address these two issues in the respective order I just mentioned. The EMS system within the State of Connecticut on the whole is good, strong, and a competent system comprised of paid and volunteer professionals.

However, as with any system, there are always areas that need to be monitored for areas of improvement.

By establishing a comprehensive data collection system, the Legislature and Department of Public Health Office of Emergency Medical Services will be laying the groundwork which will allow for the assessment and evaluation and correction of precise areas of the EMS system that are found to be deficient, rather than an overhaul of the EMS system as a whole.

Regarding EMD, as EMS professionals, we often speak of the chain of survival. Emergency medical

dispatch centers are considered a substantial first link within this chain. Recognizing as certified EMD centers are the first link within the chain, it is crucial to consider that if the chain of survival is weak at its beginning, then the remaining parts of the chain in the EMS system will also be weakened and less efficient.

Having certified EMD center staff by properly trained and certified dispatchers sends a message to the providers within the EMS system that there is a serious approach to maintaining a strong EMS system.

Finally, by establishing certified EMD centers, the citizenry of Connecticut will be better served by having access to a system that they have come to recognize and expect through various avenues of the media.

In closing, I would advocate that the Legislature not only support and pass Raised HB5287 but encourage you to not allow it to become an unfunded mandate. I thank you for your time.

REP. EBERLE: Thank you. Are there questions? Thank you, Sir. Lisa Searles and then Phil Coco. Is Lisa here? Mr. Coco.

PHILIP COCO: Good afternoon. My name is Philip Coco. I'm the regional director for technical operations for American Medical Response. I'm also an active firefighter paramedic with the Town of Branford Fire Department.

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I'm here this afternoon to talk to you a little bit about emergency medical dispatch. I know you've heard a great deal today, as I have, about the patient care implications and how emergency medical dispatch really in an EMS system that doesn't have emergency medical dispatch, there really is an entire layer missing and that needs to be added.

But what I wanted to, the points I wanted to cover today are sort of beyond the patient care benefits, which I think are obvious and you've heard a great deal about today.

An emergency medical dispatch system really is more than just providing patient advocacy over the phone before help arrives. A quality emergency medical dispatch system actually does much more for the EMS system than that. Not to say that that's not an important part of this. It is. It's one of the most important parts.

But overall, the EMS system is a system that has a lot of different kinds of resources. First responders, ambulances, we use police officers and firefighters.

One of the other major aspects of emergency medical dispatch is that, when done correctly, the dispatchers are able to prioritize, or better prioritize the cases that are coming in and provides a mechanism and infrastructure to better allocate the limited resources that we have.

We hear a great deal about emergency response time and the need to arrive quickly. The fact of the matter is that that is very true, but it's only true for cases in which someone's life is in immediate danger. Part of what emergency medical dispatch is designed to do is to help identify those cases first and foremost, so that we can take the maximum number of resources and get them to those patients.

And in reality, that's about 5% of the cases that the EMS system handles. The rest of the cases are, you know, bleeding wounds with the bleeding under control, fractures that are currently stable. And if we can use EMD to identify those cases and we can route vehicles and route resources efficiently using that information, then we can keep the system up and allocate resources more effectively.

As an example in the community that uses police first response with cardiac defibrillators, a case that comes in for a wound with bleeding under control, perhaps we don't send that police officer, we only send the ambulance, leaving that police officer available to respond to the next cardiac emergency or to handle their police

responsibilities. So we can better manage the resources and the participants that are in the system.

In addition to that, we can also reduce risk and liability to communities. How do we do that? Light and siren responses are dangerous and as we stated earlier, one of the benefits of the EMD system is to prioritize and triage which cases are life threatening and which are not. If we can effectively, through the use of proper EMD, identify which cases are not, we can limit not only the numbers of responders that are going, but also the method and mode in which they respond.

And I'd entertain any questions that you may have.

REP. EBERLE: Thank you. Representative McGrattan.

REP. MCGRATTAN: I would like to thank you, Mr. Coco for coming. I heard you last September and I was quite impressed with the way you presented the case for EMD. Thank you very much.

PHIL COCO: Thank you.

REP. EBERLE: Thank you. Are there any other questions? Thank you. Bob Corrigan and then Russ Kimes.

ROBERT CORRIGAN: Good afternoon, Senator Harp, Eberle, members of the Committee. (Bell rang) My goodness, that's it. I didn't get a very good shot there. (Laughter)

SEN. HARP: Sometimes three minutes goes faster. We'll turn it back.

ROBERT CORRIGAN: I think that one's Doc's fault. Thank you for having me here today. I would like to, my name is Bob Corrigan. I'm director of Northwest Regional Council, the advisory body for the 43 towns in northwest Connecticut. I'm also the chairperson of the Statewide Data Committee and I would like to tell you that the Northwest EMS Council approves and supports HB5287.

There are three areas that I would like to touch on

that I think are extremely important. Number one, and I think if we went to line 163, if I can find it, here it is, one of the problems we have is that you're requesting that the providers give all of this information to the state, will go through region to the state. One of the things I don't see is the return trip.

In other words in 163 the commissioner shall prepare such a report in a format that categorizes such information for each municipality. Also, I believe in this bill they have, the commissioner has to report to the Legislature. But there is nothing in here where it says it goes back to the providers in a form that would be acceptable to them and I think this is extremely important because many of these providers are volunteers.

The other area is, as far as the time is concerned, we have, reports are to be filed monthly. Yet on line 278 where we're dealing with public safety, it says on or after January 1, 2001 each public safety answering point shall submit to the office on a quarterly basis. I would request that these reports be made quarterly.

One of the reasons being, the chair of the data committee, this is exactly what we're doing right now before this legislation goes into place is starting a quarterly report, and that's what it is, a quarterly report as far as information on EMS. So I think it should follow that. Being monthly, again, I think just puts a lot of administrative extra efforts as far as the volunteers are concerned and also on my commercial friends and municipalities also.

The last thing I'd like to address is funding and it's a funny thing. We discussed this many years up here in the building across the street, when Jamie McLaughlan and John Rowland were freshmen legislators and I hate to say I remember that. And one of the things is that in this bill, you have funding, I think on line 201 for, within a time period determined by the commission to ensue the availability of funds for the fiscal year etc. to the regional public safety emergency

telecommunication centers within the state. And I certainly agree with that.

But the one thing I don't see in here is funding for the EMS data collection system. And if I missed it, I really don't see it. And you know, I asked this question, what is it, 222? Okay. That's true, yeah, I understand that, but what it is, it doesn't, it's under public safety. And the way it appears to me, and not that public safety shouldn't get it as far as the communication centers are concerned, but it appears to me that, and I may be wrong, that this money would not be going to the regular collection system. There are two systems here. There are two systems.

And it appears to me it's not going there. I may be wrong and I certainly would like to discuss it at a later time if we have the time, but I just don't see the vehicle in there that brings the money, any of the funding to the commissioner of health as far as the data is concerned.

I can tell you at the moment there is no money in the system as far as data, as far as data collection for EMS is concerned. So if we could get it, that would be, I think it would be great. If it were for that \$250,000 which we have here and I think possibly maybe if it could be clarified, I think it would be a lot easier to accept.

Besides that, I have nothing else to give you at this time, but thank you for your time as far as this bill is concerned and I did not mention anything about EMD but we certainly applaud and we support EMD 100%. Thank you very much.

SEN. HARP: Thank you. Are there questions? Are there questions or comments? If not, thank you very much. Our next speaker is Russ Kimes.

RUSSELL KIMES: I'm Russell Kimes. I'm president of the Council of Regional Chairpersons, also president of Southwestern Connecticut EMS Council. I'm a captain in the New Canaan Volunteer Ambulance Corps and I'm on the advisory board, the Governor's Connecticut EMS Advisory Board and a member of the

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advisory board's data committee.

I think all EMS providers would agree there is a need to develop a data system to evaluate EMS. I think the failure of the Department for the last 25 years is deplorable. While most EMS providers would agree that patient data should be reported, since 1995, they've been doing just that. Dutifully recording patient data on all their patients and dutifully dropping it at the hospitals where they drop the patients.

But since 1995 there's only been one report. Yes, that's only one report, reflecting any of this data and it wasn't distributed to anyone but the Department of Health and a few people on the trauma committee. The reason for this is lack of funding.

There was from January, 1994 to October of 1995, \$300,000 in federal trauma system dollars. That money was expended to develop a data system and we can see they came up with one report.

Trauma patients are 14,000 of the estimated 392,000 patients that we see each year. That's only 3-1/2% of the patients and \$300,000 wasn't enough to do the system.

If I could, I'd like to quote Page 32 of the Program Review and Investigation Committee's Report on the Regulation of EMS, Phase II. The Program Review Committee concludes that the collection of trauma data should be consolidated with the data collected on the entire prehospital system so that all EMS cases can be evaluated. Attempts to revive the trauma registry and maintain the data separately will only divert resources and attention away from the establishment of an overall data collection system.

If you do nothing else, you should change Paragraph 8 of Section 2 and take out the word trauma and put in the word all patients.

How much money does this bill provide for EMS? I can't find any and most of the other speakers haven't either, I guess, is the answer to that one.

We need adequate permanent funding to collect, analyze and disseminate this data once it's collected, otherwise the data will just be useless and unreliable. I don't see that this bill will do anything to reverse that 25 year trend that we see.

It will add ten more mandates to the commissioner's already existing list of unperformed duties.

And lastly, there is another bill you're considering, which is the scope of practice for paramedics, HB5650. It seems to deal mostly with automatic defibrillators, mostly technical changes, but we have found that the amendment to the good samaritan law allowing people to use defibrillators who have passed courses, who have been trained in courses in accordance with standards established by the Red Cross and the American Heart.

If you read that technically, it might not apply to an off duty EMT or paramedic who have been trained in the use of the defibrillators through a Department of Health Course. And, if possible, to change to amend this bill HB5650 to sneak something in there to amend that good samaritan law to expand it to pick up the people that also have received training under EMS would be a good idea. Those are my thoughts.

SEN. HARP: Thank you very much. Representative McGrattan.

REP. MCGRATTAN: The only thing that HB5650 does is allow the paramedics working within this system and under written protocols from their medical director, is to administer controlled substances without being in direct communication. That's the only thing that bill does.

RUSSELL KIMES: Yeah, but there were some other sections before that where someone, I guess, figured out that a person with an in dwelling defibrillator should register it with the Department of Health and I guess they figured that that was not their intent, so it's now an external automatic defibrillator that has to be registered.

But there was some other language in there that talked about defibrillation by paramedics and I was thinking maybe you could sneak that in there.

SEN. HARP: Thank you.

RUSSELL KIMES: I think some other committees are working on that, too, though, I don't know. I've heard, rumor has it.

SEN. HARP: Okay.

RUSSELL KIMES: Okay.

SEN. HARP: Are there further questions? If not, thank you very much. We're going to move on to another bill. Our next bill is SB128 An Act Concerning Nonemergency Medical Transportation Services and our first speaker is Kevin Guptill.

KEVIN GUPTILL: Senator Harp, Representative Eberle and members of the Committee. I thank you for the opportunity to speak to you this afternoon. LogistiCare is one of two transportation management organizations that arrange nonemergency transportation for Connecticut's Medicaid population and for SAGA members.

During the two years in which this program has been in place, it has been extremely successful. Members can easily make their transportation reservations, transportation is timely and reliable, overall medical costs has been reduced as this population has gained greater access to preventative care and early treatment for conditions which previously would not have been addressed until they have become more acute and thus more costly to treat.

Dialysis patients have access to the treatment that keeps them alive. Patients being treated with methadone are able to put their lives back together. Patients who receive regular mental health counseling get it, keeping them independent and out of inpatient institutions.

no problem at all with the bill as it is drafted and supported, but it is an integral piece and particularly with Section 2 and 3.

DR. JAY WALSHON: Yes, that's correct.

REP. CLEARY: Thank you.

REP. MCGRATTAN: Thank you very much. Our next speaker is Michael Zacchera. Followed by Maureen Smith, followed by Cody Stober.

MICHAEL ZACCHERA: Good afternoon, Madam Chairman, ladies and gentlemen of the Committee. My name is Mike Zacchera. I'm a national registered paramedic and I'm one of the EMS educators over at Hartford Hospital and I'm here today to actually discuss Raised HB5650 and I also would like to mention Raised HB5287 which is the EMD and the EMS data information bill.

I'll try and be brief. I know my testimony is a little bit longer than it should be but I'll give you a quick synopsis and you can read over the written testimony at your leisure.

Just to take HB5650 apart real quickly, Section 1 I support 100%. It makes perfect sense. It is something the paramedics can already do but there's no harm in reiterating that fact.

Section 2 of HB5650 specifically defines the scope of practice of what paramedics can do and what paramedicine is and it is currently as you've heard, the opinion of the office of the Attorney General that paramedics could operate and practice outside of the defined EMS system.

Restricting medics to only the EMS system actually may be detrimental and you will see, or you may have heard some research that as the trend currently nationwide is to expand the scope of practice of paramedics outside of the traditional EMS system, that's actually started to have been done in Connecticut in some forms already.

Examples off the top of my head, Middlesex Hospital

patients, patients with congestive heart failure.

Lastly, I just want to touch on HB5287 and to tell you that I support it and you can read the rest of my testimony at your leisure. But I support HB5287. I think it's a very good idea and it's a long time in coming. Thank you for your time.

REP. MCGRATTAN: Thank you very much. Are there any questions? Representative Winkler.

REP. WINKLER: Yes thank you, Madam Chairman. Who is your employer?

HB 5650

MICHAEL ZACCHERA: I work for Hartford Hospital.

REP. WINKLER: You work for Hartford Hospital.

MICHAEL ZACCHERA: Yes, Ma'am.

REP. WINKLER: As a paramedic?

MICHAEL ZACCHERA: Yes, Ma'am. I work as an EMS educator there. I teach paramedicine, ACLS, CPR.

REP. WINKLER: Okay, those paramedics that are being utilized at Middlesex Hospital, are they employed by Middlesex Hospital.

MICHAEL ZACCHERA: My understanding is that they are, yes. They're employed as paramedics to go and they respond --

REP. WINKLER: As a paramedic. And so when they're not being, if they're not out on a run at that point, they're being utilized if there is a need within the facility.

MICHAEL ZACCHERA: Correct. Correct. They're not specifically hired just to be a paramedic in the ER I should say.

REP. WINKLER: But their contract that they have with Middlesex, does it state that they would be working in the emergency room.

MICHAEL ZACCHERA: I honestly don't know, Ma'am.

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**Pages:** 1  
**Re:** Bills listed below

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The Board of Directors of the South Central Connecticut Emergency Medical Services Council met Monday evening, 28 February, and voted to take the following positions:

Legislation #	Purpose/Title	Hearing date	Position
<u>SB314</u>	An Act Concerning Reports of Child Abuse	2/29	Support
<u>HB5720</u>	An Act Concerning Failure to Yield to Emergency Vehicles	2/29	Support
<u>SB100</u>	An Act Concerning the Wilful or Negligent Obstruction of an Emergency Vehicle	Ref to Joint Comm on Transportation	Support
<u>SB128</u>	An Act concerning Nonemergency Medical Transportation Services	3/02	Opposed
<u>HB5650</u>	An Act Concerning the Scope of the Practice of Paramedicine	3/02	Support <b>ONLY IF SECTION 2 REMAINS A PART OF THE BILL</b>
<u>HB 5287</u>	An Act Concerning EMS Data Collection and Emergency Medical Dispatch	3/02	Support
<u>HB5261</u>	An Act Concerning Leave for Volunteer Fire or Ambulance Duty and Specialized Disaster Relief Services	2/22	Support
<u>SB428</u>	Re Booster Seats		Support

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001528



## STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

### TESTIMONY PRESENTED BEFORE THE PUBLIC HEALTH COMMITTEE

March 2, 2000

Joxel Garcia, M.D., Commissioner, Department of Public Health 509-7101

### House Bill 5287 - An Act Concerning Emergency Medical Services Data Collection and Emergency Medical Dispatch

Good Morning, Senator Harp, Representative Eberle, and members of the Public Health Committee. I'm Dr. Joxel Garcia, Commissioner of the Connecticut Department of Public Health, and I'm here to testify in support of House Bill 5287, "An Act Concerning Emergency Medical Services Data Collection and Emergency Medical Dispatch.

It is my pleasure to appear before this Committee to provide feedback regarding House Bill 5287 and to discuss my plan for the revitalization of emergency medical services (EMS). In my nine months as Commissioner, I have pursued a variety of avenues in studying the industry. From my meetings with key providers, agency staff, state and local elected officials and sister agencies, it is clear that EMS is a complex health care delivery system, one which requires strong leadership from the state to make it function as efficiently and effectively as possible.

Earlier this year, I unveiled my plan for the revitalization of our Office of Emergency Medical Services (OEMS). A brief overview of the plan is attached to my written testimony. Key to the revitalization plan, which has been endorsed by a number of legislators, local elected officials and members of the EMS community, is the addition of several key positions in OEMS, increasing the current staffing of the office from eight to thirteen positions. One of these positions is the newly reestablished Director position, eliminated more than two years ago. Interviews of some candidates for the Director position have already been scheduled. Organizationally, the OEMS has been elevated to a direct report to the Office of the Commissioner, through an internal EMS Committee comprised of bureau chiefs representing community health, policy and planning, and regulation. This new reporting mechanism elevates the status of OEMS in the agency while more accurately reflecting the scope of influence EMS has on the residents of Connecticut.

Connecticut currently has a strong system in place to regulate its health care providers, including those involved in EMS. However, this legislative proposal provides an opportunity for the state to improve its ability to collect data, and addresses an important link in the chain of survival, statewide emergency medical dispatch.

The question of adequate funding needs to be resolved. Although, Section 3 of this proposal provides a funding stream for a data collection system established by the Office of Statewide Emergency Telecommunications, the bill does not make a similar allocation of funds for the Department of Public Health. As this Legislative Program Review and Investigations

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Committee correctly noted in its December, 1999 report, this enhanced data collection proposal "...will require funding not allocated currently." While it may be that this Committee intends to support the DPH data collection effort via the surcharge on phone lines that cover the 9-1-1 system, this intent is not clear in the proposed language of the bill. As has been the case historically, failure to secure funding will result in the Department's inability to develop and implement this extremely important data collection system.

Assuming the funding issue is able to be resolved, there are several recommendations for technical revisions that I believe are necessary to ensure Connecticut establishes a system that provides data that will establish a solid foundation for regulatory oversight, quality assurance and policy development. For your information, I have attached a listing of these recommendations, and I will be happy to work with the Committee on technical revisions.

I strongly favor the implementation of Emergency Medical Dispatch (EMD) technology and techniques for all dispatching of EMS providers in Connecticut. As is noted in the Connecticut EMS Plan, statewide EMD is a major component of a quality EMS response system. It ensures that an appropriate EMS response is dispatched for each call and that pre-arrival instruction is given to the 9-1-1 caller when needed.

Let me close by reiterating my commitment to providing strong EMS leadership at the state level. Working together, the Department, the legislature and the EMS community will continue to ensure that all residents of the state receive the highest quality pre-hospital care.

Thank you for your consideration of the Department's views on this bill.

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## STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

### HOUSE BILL 5287 RECOMMENDED TECHNICAL REVISIONS

#### SECTIONS 2(8)(A)(B)

- The Department does not feel it is feasible to develop a patient tracking system by January 1, 2001, and suggests an implementation date of October 1, 2001.
- It is not clear if the intent of this legislation is to collect data on each patient served by the system or to collect aggregate data per service provider. The requirement for data collection and report generation, as contained in both proposals, reflects various data collection approaches. Some provisions require the collection of aggregate data, while others require data per individual service provider. It is important to point out that these data elements will not allow the Department to follow a patient from initial entry into the emergency medical service system through arrival at the emergency room, on a patient by patient basis. As we design the requirements for this data collection system, it is critical to remember that there are approximately 400,000 patient transports on a yearly basis.
- This legislation should clearly indicate that DPH is collecting data only on calls which come through the 911 system.
- There is no mechanism or requirement to link OSET and DPH databases.

#### Sections 2(8)(C)

- As drafted, there are no enforcement provisions available if an emergency medical services provider does not hold a Primary Service Area. Legislation should include other enforcement actions as deemed appropriate by the Department.



Phone:

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## EMS PROPOSAL 2000

CONNECTICUT DEPARTMENT OF  
**PUBLIC HEALTH**

Commissioner  
Joxel Garcia, MD, MBA

### Current Efforts

- DPH requests NHTSA EMS Assessment Unit to evaluate current OEMS and benchmark best practices
- DPH initiates process to refill manager's position with the OEMS
- Proposes new EMS Restructuring Efforts
  - Personnel Actions
  - Organizational Actions
  - Programmatic Actions
  - Fiscal Impact
  - Funding Sources

## Personnel Actions

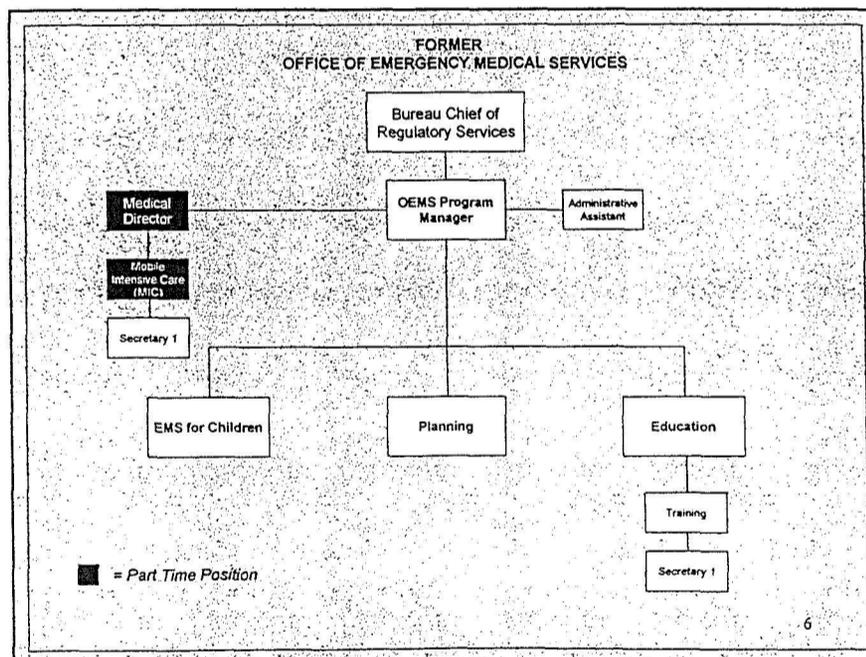
- Reestablish and re-fill the OEMS Director Position to implement EMS State Plan
- Re-fill the Program Manager Position to oversight technical, field-based activities
- Add an Epidemiologist or Program Analyst to address pre-hospital and trauma data collection and analysis
- Add a Health Program Associate or Supervisor to OEMS to head up planning efforts, and to coordinate agency-wide disaster planning efforts
- Add an Office Assistant to support data collection and analysis

## Organizational Actions

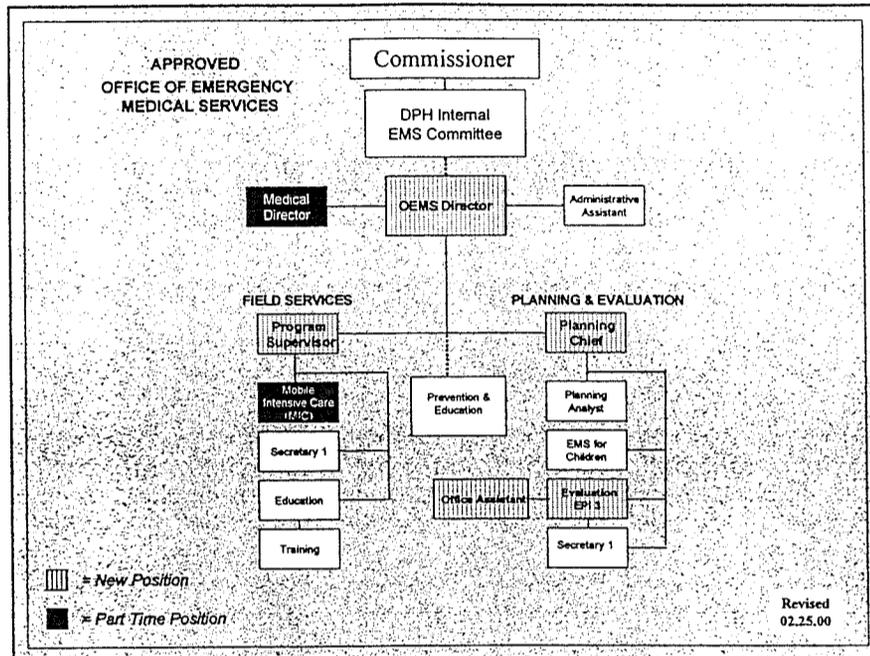
- Re-elevate the Office to a direct report to the EMS committee
- NHTSA re-assessment to benchmark current status and national best practices
- Strengthen internal relationship with Injury Prevention Program

### Programmatic Initiatives

- Contract with Yale to recommend course of action for Trauma
- Support Legislative Program Review and Investigations Committee (LPRIC) recommendations regarding pre-hospital data collection
- Support LPRIC Recommendations regarding EMD
- Pursue additional funding opportunities with state DOT



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*TOLLAND COUNTY MUTUAL AID  
FIRE SERVICE, INC.  
56 TOLLAND GREEN, PO BOX 6  
TOLLAND, CT 06066*

**RAISED HOUSE BILL NO. 5287**

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

Good afternoon Chairperson, representatives, committee members, and guests.

My name is Ernest Herrick and I would like to thank you for the opportunity to be heard this afternoon regarding Raised House Bill No. 5287. I stand before you this afternoon representing the Tolland County Mutual Aid Fire service, Inc. and will speak on issues pertaining to this bill on their behalf.

Tolland County Mutual Aid has some grave concerns regarding Raised House Bill No. 5287 in its present state, sighting some concerns over both parts of the Bill, Data Collection and Emergency Medical Dispatch.

The Tolland County Mutual Aid Fire Services is an organization which represents 13 towns in Eastern Connecticut within the boundaries of Tolland County, parts of Windham County and Hartford County. Logistically this area comprises 22 separate emergency service organizations. Tolland County Mutual Aid Fires Service ,Inc. operates a regional dispatch center throughout this area and answers emergency 911 calls for the emergency medical services, fire services and in addition to those, also answers emergency 911 calls for both the cellular emergencies trunked to the center as well as all 911 calls for the Connecticut State Police, Troop "C". Tolland County has operated this dispatch center for over 30 years at its present location.

With that history known, I would like to address some of the concerns our member

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department have in regards to this Bill.

The suggestion of requesting the emergency services, most of which are volunteer or at the very best have a limited part-time staff, to submit, in a timely manner, information for services rendered, is not only time consuming, but extremely cumbersome to an already over burdened service.

In many cases, the volunteers, especially during the day time hours, have just enough time to answer the emergency call and complete the extended run forms provided to them from the Office of Emergency Medical Services before returning back to their regular schedules.

I would like to offer the suggestion of one standard form that will not become redundant, with the form presently being used and should be made user friendly in so much that the submission can be done easily and efficiently also remembering the limited time available by the originator.

While the thought of Data Collection is an important issue and perhaps an issue that needs to be addressed at some point, one might look at the form (s) already in use and perhaps modify the form to meet this Bills goal.

Moving on to letter (g) (1) of the Bill, Emergency Medical Dispatch.

To implement this practice without funding raises grave concerns for our representative members. This section of the Bill as written would cause our Association to be forced to implement a program that can not be funded through our present system.

In order for the regional PSAPs to implement EMD without a funding source, the PSAPs or in this case TCMAFS, would have to increase, dramatically, the per capita assessments they charge to the individual organizations and towns we provide service to.

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I would however like to offer the following recommendations regarding these portions of this Bill:

- TCMAFS would like to offer the services of our representatives to assist in the development of the form(s) necessary for the purpose of data collection that will hopefully benefit this Bill and the PSAP users alike.
- As a suggestion on the possible funding source for the implementation of Emergency Medical Dispatch, I offer the use of the already established, telephone assessment which was developed for the purpose of the 911 up grade equipment and the continued operation and maintenance of the Emergency 911 system state wide.
- We believe that a standard medical control protocol must be developed when implementing EMD, in an effort to reduce the liability to the PSAPs when answering 911 calls, particularly when the PSAP utilizes mutable medical facilities.

In closing, we urge the committee to hold up on the passage of this bill and to take the time necessary to review the content of the Bill and the impact it will have to the many organizations that it effects.

I would like to once again thank you for the opportunity to testify before your committee on this important issue and it is hoped that you will consider our suggestions when deciding the fate of this Bill.

I will be happy to answer any questions that you may have at this time and it will be my pleasure to make representatives available to assist in drafting legislation that will work for all involved and our state.

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Wallingford, CT 06492-7522  
(203) 294-0088  
(203) 294-3577



March 2, 2000

TO: Senator Harp, Representative Eberle and other members of the Public Health Committee

FROM: Derrylyn Gorski, Advocacy Director, American Heart Association, Connecticut

RE: HOUSE BILL 5287: AN ACT CONCERNING EMERGENCY MEDICAL SERVICES DATA COLLECTIT ON AND EMERGENCY MEDICAL DISPATCH.

Good afternoon, Senator Harp, Representative Eberle and members of the Public Health Committee. Thank you for allowing me to testify in support of House Bill 5287, An Act Concerning Emergency Medical Services Data Collection and Emergency Medical Dispatch.

My name is Derrylyn Gorski, I am the Advocacy Director for the American Heart Association in Connecticut. As an organization whose declared mission is to the reduce disability and death from cardiovascular diseases and stroke, the American Heart Association has long been known for its emphasis on prevention. Recently, the American Heart Association nationally and here in Connecticut has expanded that focus to include added emphasis in all aspects of Emergency Cardiovascular Care.

For many years the American Heart Association has developed and promoted the now widely accepted chain of survival. The links in that chain are:

- Early access to emergency care (call 911)
- Early CPR
- Early defibrillation
- Early advanced care

The Emergency Cardiovascular Care Committee of the American Heart Association has made strengthening every link in the chain of survival one of its top association-wide initiatives. To achieve that goal the American Heart Association has already:

- Published guidelines for CPR
- Developed a wide variety of resuscitation courses for lay and medical rescuers
- Established a Community Training Center Network
- Promoted Public Access Defibrillation
- Increased media awareness of the need to learn CPR and to expand access to defibrillation
- Helped initiate a clinical trial on the use of AEDs

- Continue to promote ongoing scientific research to identify new techniques for Basic Life Support and Advanced Life Support
- Produced mass CPR training guidelines
- Developed materials to promote and explain the chain of survival and the need for early defibrillation
- Developed a program package to support community efforts to strengthen the chain of survival

Prompt access to appropriate quality medical care includes implementation of an effective heart and stroke chain of survival. The Association strongly endorses the enactment of regulatory and legislative remedies in support of the development of a strong chain of survival, including the passage of appropriate public access defibrillation laws. This includes the removal of barriers to providing emergency response through prompt access to the emergency medical system, universal CPR training, expanded use of life-saving strategies of care (including automated external defibrillators), and clinical research relative to treatment of sudden cardiac death.

By requiring all Public Safety Answering Points (PSAPs) to provide emergency medical dispatch services (EMD) or arrange for EMD services to be provided to all callers requiring emergency medical services, H.B. 5287 will strengthen the first link in chain of survival. Early Access is comprised of several components which include the 911 telephone system and the EMS Dispatch system.

Although Connecticut enjoys Enhanced-911, one vital aspect of Early Access is still missing. In accordance with the "1992 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care" as published in *The Journal of the American Medical Association* "All EMS Dispatch Systems must be able to immediately answer all emergency medical calls. . . and offer telephone-assisted CPR instructions."

**HB 5287 – Public Hearing**  
*Testimony in favor of implementing Emergency Medical Dispatch*

*Respectfully Submitted By:*  
*Chris Salafia, President*  
*PowerPhone, Incorporated*  
*1321 Boston Post Road*  
*Madison, CT 06443*  
*203.245.8911 ~ fax: 203.245.3022*  
*www.powerphone.com ~ chris@powerphone.com*

Good Afternoon and thank you for the opportunity to appear before the Committee.

My name is Chris Salafia and I am the President of PowerPhone, Incorporated. A Connecticut corporation, PowerPhone, is the world leader in "9-1-1" emergency communications training. Over the last 18 years, we have certified more than 75,000 public safety personnel, representing all 50 states and more than a dozen foreign countries. We are proud to have trained more than 2500 Connecticut dispatchers representing more than 90% of the State's Public Safety Answering Points.

I appear before you today to support the introduction of Raised Bill Number 5287, specifically Section 4 Subdivision 15 – Emergency Medical Dispatch.

Emergency Medical Dispatch is not a new concept. First introduced by the Department of Transportation in 1969, Emergency Medical Dispatch, or EMD as it is commonly known, is a proven, widely accepted system.

A common misconception regarding the adoption of an EMD system is the fear that liability exposure increases. This is simply not the case. Emergency Medical Dispatch is becoming the rule, not the exception. As more and more cities, states and countries adopt EMD, an agency's standard of care and duty to act is intensified. There is little doubt today's citizens anticipate they will receive pre-arrival instructions. Agencies that do not meet these expectations will be held accountable.

As residents of this state, we, like you, are stakeholders in the Connecticut EMS system. PowerPhone has closely followed the progression of this legislation and as subject matter experts, respectfully offer the following points for consideration:

First and foremost, don't wait. Proven EMD systems already exist and many Connecticut agencies have already implemented EMD. Why wait until July 1 of 2004 for agency compliance? EMD works and we respectfully suggest you empower the agencies to use it, the sooner the better.

Second, the system adopted must be functional. It's absolutely imperative that agencies view this as a boon to their communities, not the bane of their existence. A properly implemented EMD

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program not only improves response but also alleviates stress on the system and those charged with running it.

Third, don't reinvent the wheel. Private training providers exist that would be much more efficient, cost effective and of better quality than if the state created its own EMD training division. PowerPhone spends in excess of \$1 million each year in ensuring we offer the highest quality products and services. Not only would the state lose the luxury of third party accountability, it now has assumed all liability for the validity of the training, instructor credentials and student proficiency. That coupled with the challenge of remaining current with all that transpires in the field creates a no-win situation.

Finally, Section 5 (g) (4) alludes to "initial training" and "the purchase of a medical dispatch priority reference card set." We submit EMD is an ongoing process requiring initial training, continuing education and re-certification. Also, at a minimum card sets must be available per workstation. A single set per agency is not functional and does not meet the minimum standards. As important, card sets are quickly become "back-up" for software driven protocols. EMD software is quicker and more efficient than its printed predecessors.

That said, we applaud the large number of Connecticut public safety agencies that have recognized the importance of Emergency Medical Dispatch, and have for a number of years now, endeavored to provide pre-arrival instructions to their communities. It is our strongest opinion that the Committee should endorse this concept and move forward to enact legislation to assist remaining agencies in implementing an EMD system. Emergency Medical Dispatch must no longer be a "home rule" issue. A uniform standard of care, border to border, can only improve the EMS system, enhance the image of the state, and most importantly save lives.

Thank you.

###

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CMED

DENNIS W. DANIELS  
*Director*  
Tel. (203) 946-6300

SOUTH CENTRAL CONNECTICUT REGIONAL  
EMERGENCY MEDICAL COMMUNICATIONS SYSTEM  
P. O. Box 374 • New Haven, Connecticut, 06502

JOHN G. GUSTAFSON  
*Supervisor*  
Tel. (203) 946 7038

March 2 2000

Honorable Members of the Committee on Public Health  
Connecticut General Assembly  
Legislative Office Building  
Hartford, Connecticut

Honorable Ladies and Gentlemen:

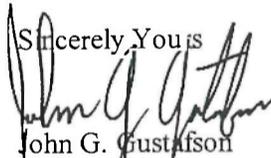
Included in the attached pages is testimony by this agency concerning House Bill 5287, An Act Concerning Emergency Medical Service Data Collection and Emergency Medical Dispatch.

Over the past three years the members of the General Assembly have been dealing with the on going difficulties identified with the States Emergency Medical Service Program. This effort on your part has been long and often difficult.

While solutions to all the real and perceived problems have yet to be found, certainly the actions proposed in House Bill 5287, reflect your desire to make needed improvements, and take a positive step toward the future.

We hope that you accept our comments as the views of an agency which is in the front line of the provision of EMS and often finds itself stuck in the middle of the conflicting goals and opinions of the varied participants in the operating EMS System.

We urge you to act favorably on this legislation and shepherd it through to final passage by the General Assembly. Thank you in advance for your time and effort, and best wishes for a successful session.

Sincerely,  
  
John G. Gustafson  
Supervisor

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North Branford • North Haven • Orange • Oxford • Seymour • Shelton • Wallingford • West Haven • Woodbridge

TESTIMONY BEFORE THE CONNECTICUT GENERAL ASSEMBLY  
COMMITTEE ON PUBLIC HEALTH  
CONCERNING HOUSE BILL 5287  
MARCH 2 2000

My name is John Gustafson, I am Supervisor of CMED New Haven, and I am here today to speak to you concerning House Bill 5287, An Act Concerning Emergency Medical Services Data Collection and Emergency Medical Dispatch.

CMED New Haven is a special fund agency operated by the City of New Haven, on behalf of and funded by twenty towns and cities in the greater New Haven area, providing emergency communications services.

- We support the initiative to require each public safety answering point (PSAP) in Connecticut to provide Emergency Medical Dispatch service including pre-arrival instructions to callers.
- We support the initiative to require the development of statewide data concerning EMS response times, including the role identified for the PSAP's. However we have reservations about funding it through the existing 911 surcharge.
- We encourage you to amend Sec 3, subsection(c) item (4) of section 28-24 of the general statutes to include restoration of full funding from the 911 surcharge for the regional CMED Centers, through the regional emergency telecommunications service credit,
- We encourage you to amend Sec 3, subsection (c) item (2) of the general statutes to include restoration of full funding from the 911 surcharge to cities with populations in excess of 70,000 who have not consolidated their dispatch centers.

#### PROVISION OF EMERGENCY MEDICAL DISPATCH SERVICE

The provision of Emergency Medical Dispatch service by all of the states PSAP's will greatly enhance the chances of patient survival in a medical emergency. We laud the proposal to fund the costs of the training and implementation of this program, limited budgets and availability of funds to pay personnel to attend training programs is always a major obstacle to undertaking new programs at the local government level. Based on our reading of the proposed legislation these costs will be reimbursable both to establish the initial program and fund basic training for new personnel as they are hired to replace attrition.

This being said it is important for you to be aware of other costs which will be have to be borne by PSAP's to maintain the quality assurance/improvement required by current standard, after initial program implementation.

Current national standards require: review of at least 1000 calls for service each year and regular quality assurance sessions with Emergency Telecommunicators.

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TESTIMONY BEFORE THE CONNECTICUT GENERAL ASSEMBLY  
COMMITTEE ON PUBLIC HEALTH  
CONCERNING HOUSE BILL 5287  
MARCH 2 2000

Based on personnel costs for our agency which has a staff of 15 Emergency Telecommunicators, the cost of this breaks out as follows:

Review of audio tapes	\$18,000.00
Quarterly quality review sessions	\$11,268.00
Administrative costs	<u>\$1,821.00</u>
Total	\$31,089.00

While variations will exist in each individual PSAP, implementation of EMD statewide will add additional cost to each PSAP of approximately \$2,072.00 per Emergency Telecommunicator employed. There are 108 PSAP's.

You will I am sure hear various reasons for not implementing EMD, among the most common is the potential delay in answering subsequent 911 calls while EMD, specifically pre-arrival instructions are in progress, another is liability.

In reference to perceived delays in call answering, our PSAP answers the vast majority of incoming 911 calls less than 10 seconds after the phone rings at the dispatcher console. Last year our agency handled over 80,000 EMS and fire incidents and provided limited EMD, making us one of the busier communications centers in the State. When a 911 call is received at any PSAP four pieces of data are immediately recorded and printed on an installed printer, Time call Rings, Time Call Answered, Time Call Transferred, and Time call Terminated. It would be our contention that those who believe that the provision of EMD pre-arrival instructions will delay 911 call answering probably have not looked at their current call answering performance, if they do they will probably discover performance similar to ours.

While our experience reveals that the concern that 911 call answering will be delayed by provision of EMD may not be statistically supportable, it is a valid concern, but it is a concern that is overcome by common sense and standardized operating procedures. Our Communications Center SOP allows for priority of actions by our Emergency Telecommunicators. In effect it calls for giving any ringing 911 call first priority over all other tasks, including pre-arrival instructions. If pre-arrival instructions are being given the caller is placed on hold until the incoming 911 call is answered and evaluated. The logic being that the unanswered 911 call is some one who has not yet received help.

Exposure to liability is a commonly stated reason for not providing EMD, I would submit that the municipality which chooses not to provide help to the citizen is just as exposed as one who provides that help in a planned organized manner. Further implementing a formal program for

TESTIMONY BEFORE THE CONNECTICUT GENERAL ASSEMBLY  
COMMITTEE ON PUBLIC HEALTH  
CONCERNING HOUSE BILL 5287  
MARCH 2 2000

EMD establishes standards for employee performance which gives the municipality or the employer greater control over any exposure.

It would be of some assistance if the General Assembly saw fit to extend Good Samaritan status to trained and certified Emergency Telecommunicators.

#### IMPLEMENTATION OF A STATEWIDE EMS DATA SYSTEM

Our agency has and does support the development of a statewide EMS Data Collection and Evaluation system.

The requirement for an EMS Data collection system has to our knowledge existed in statute as a responsibility of the Department of Public Health since at least 1979. To date no such system exists.

The legislation before you will mandate new data collection responsibilities on the PSAP's through the Office of Statewide Emergency Telecommunications. Logic dictates that the PSAP's the points where calls for EMS are first answered must play a major role in this effort. Further the collection of response times also seems to be a role that can be played by the PSAP's as they are often the agencies which dispatch and coordinate EMS response, however this is only one part of the EMS Data Collection System, data concerning the effectiveness of patient treatment, positive or negative outcomes, etc. must all come from other sources which include EMS services and hospitals.

Our reading of the proposed bill indicate that up to \$250,000.00 annually will be made available for the collection of EMS data from the PSAP's. This expenditure will be of great assistance to the PSAP's in providing the data required of them by the proposed bill, including the collection of response times. Technology will have to be obtained to establish standard time in all 108 PSAP's, not to mention the costs associated with modification or establishment of systems in each PSAP to collect the required data. We have no doubt that the Office of Statewide Emergency Telecommunications will successfully undertake and implement a system to meet this new statutory requirement.

We are concerned about information heard from some quarters that the \$250,000.00 being made available through the 911 surcharge will be used to fund the Department of Public Health's efforts to establish an EMS Data System. The 911 Fund was established to fund the costs of operating the 911 system, including equipment, network costs, direct aid to regional and large city PSAP's, CMED's, and local system development, in short direct support of the provision of 911 telecommunications service. The surcharge rate varies up or down year to year based on the needs of the 911 system, this was a clear intent to keep the cost to the telephone rate payer as low as possible, while meeting the valid operational needs of the 911 system. It is our contention that

TESTIMONY BEFORE THE CONNECTICUT GENERAL ASSEMBLY  
COMMITTEE ON PUBLIC HEALTH  
CONCERNING HOUSE BILL 5287  
MARCH 2 2000

using 911 fund money to fund an effort not directly related the operation of the 911 network and the PSAP's is not appropriate. It could lead to this fund becoming a convenient source for State agencies to fund programs which can not be justified in the General Fund, ultimately this may lead to the degradation of the 911 system when its available funds have been used up for non 911/PSAP related costs.

This begs the question of funding for the other components of the EMS Data Collection System. We can find no reference in the bill or the DPH budget to establish a funding method for the parts of the EMS Data Collection system which will be the responsibility of the Department of Public Health. If DPH is not given sufficient dedicated funds for the completion of their part of the data system, it will surely again fail to materialize.

#### CMED FUNDING

While the proposed bill calls for increased use of funds from the 911 surcharge to address EMS issues, funding for an important aspect of the EMS Communications System is being phased out. The Regional Emergency Telecommunications Service Credit is being phased out. These funds were established under Public Act 96-150 passed by the General assembly in 1996 based on the 911 Task Force Report, and called for a five year phase out of the program based on the premise that the States thirteen CMED's would become part of or be absorbed by regional 911 emergency communications centers which would come into being as a result of the task force report and subsequent legislation.

The annual allocation from the 911 fund was intended to help underwrite the costs to towns and cities for CMED services. The thirteen CMED Centers in Connecticut provide the communications service required to allow our EMT's and Paramedics to communicate directly with physicians and nurses in hospital emergency departments for medical direction and control.

The premise that the CMED's evolve or be absorbed by regional 911 dispatch centers has not come to pass. Further regardless of any progress toward regionalization, the cost of providing CMED service will still remain.

We would request you to revisit the issue of mandated phase out of these funds and establish this allocation as a permanent part of the 911 Fund at a rate of \$.30 per capita, for the following reasons.

- The cost of operating the 13 regional CMED's has not changed, and is in fact rising, due to the need to bring technology up to date and increasing call volume. In Calendar 1998 our center serviced 76,350 Incidents in Calendar 1999 we serviced 80,450 incidents, a 9.5% increase in work load.
- Every Town and City in the State receives CMED services.

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TESTIMONY BEFORE THE CONNECTICUT GENERAL ASSEMBLY  
COMMITTEE ON PUBLIC HEALTH  
CONCERNING HOUSE BILL 5287  
MARCH 2 2000

- As the level of State financial support declines the difference will have to be made up by the Towns and Cities, until once again the municipalities are bearing the total financial burden.

FUNDING OF CITIES WITH OVER 70,000 POPULATION.

Public Act 96-150 also established a funding program by which cities with a population of over 70,000 were provided funding using the same formula as was applied to the regional emergency communications centers which serve the most rural areas of the State. However a penalty was applied which required those municipalities to consolidate their communications services to maintain their funding level. Of the States three largest cities Hartford which was consolidated prior to the passage of this legislation at significant cost, is the only one of the three largest cities to accomplish this. Bridgeport and New Haven have not yet been able to accomplish this primarily due to the significant infrastructure costs required .

The penalty for failure to consolidate its communications functions unfairly penalizes the largest cities, who in fact have high 911 and emergency call volumes due to their unique positions as regional hubs of commerce, education, cultural, social service, and health care. We would request that you also revisit this issue and amend this bill to provide for the 911 communications centers in the States largest cities to be funded in the same manner as the regional 911 communications centers which serve our rural areas.

Thank you for the opportunity to appear before you today and our best wishes in the tasks you have before you.

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**NORTHWEST CONNECTICUT  
EMERGENCY MEDICAL SERVICES COUNCIL, INC.**

March 2, 2000

The Legislative Public Health Committee  
Legislative Office Building  
Room 3000  
Hartford, Ct. 06106

To: All Committee Members

The following comments are from the Northwest Connecticut EMS Regional Council (NWCEMSRC, Inc.). The NWCEMSRC, Inc. is the EMS advisory body for the forty three towns in Northwest Connecticut.

The Northwest Connecticut EMS Regional Council approves House Bill 5287, An act Concerning Emergency Medical services Data Collection And Emergency Medical Dispatch, with this exception:

That the data provided to the Dept. of Health, by the EMS providers, in turn, be provided to all EMS agencies that provide this information in a manner that will be useful to them. If the EMS services must collect this data, then it should be noted in the legislation that they receive this information in return, in order to use this information as a gauge to measure their proficiency in the EMS field.

Also that reporting time be changed to quarterly instead of the monthly requirement that is now currently in the bill.

At this time I wish to report as the chairperson of the State Data Committee that a quarterly report has been designed and approved by the EMS Data Committee, the EMS Advisory Board and the Department of Health containing the elements requested in this bill to be sent to all EMS providers. Very shortly we will begin to collect basic but important data which will begin to address many questions that we have concerning the system. This can only improve a good system into a much better system.

Emergency Medical Dispatch is most important to the EMD providers and the State of Connecticut. By having this much needed system, lives will be saved and ambulances will be dispatched more appropriately to the scene of a medical emergency.



P.O. Box 627 Southbury, Connecticut 06488 Telephone 1(203) 264-0460

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The following EMS Services are located within the Northwest Ct. EMS Region V.

American Medical Response:  
Bantam Vol. Fire Dept. ( Waterbury / Watertown )  
Beacon Falls Vol. Fire Dept.  
Bethlehem Vol. Fire Dept.  
Bethlehem Vol. Amb.  
Bridgewater Vol. Fire Dept.  
Brookfield Vol. Fire Dept.  
Bethel Vol. Fire Dept.  
Campion Ambulance ( Torrington )  
Campion Ambulance ( Waterbury )  
Campion Ambulance ( Cheshire )  
Campion Ambulance ( Prospect )  
Cornwall Vol. Fire Dept.  
Danbury Fire Dept.  
Falls Village Vol. Fire Dept.  
Georgetown Vol. Fire Dept.  
Goshen Fire Dept.  
Harwinton Vol. Amb  
Heritage Village Ambulance  
Kent Vol. Fire Dept.  
Lime Rock Race Track Amb.  
Litchfield Vol. Amb.  
Middlebury Vol. Fire Dept.  
Morris Vol. Fire Dept.  
Naugatuck Amb. Service  
New Fairfield Vol. Fire Dept.  
New Hartford Amb.  
Newtown Vol. Amb.  
New Milford Vol. Amb.  
North Canaan Vol. Amb.  
Norfolk Vol. Amb.  
Northfield Vol. Fire Dept.  
Oxford Vol. Amb.  
Redding Ridge #1 Vol. Fire Dept.  
Ridgefield Fire Dept.  
Roxbury Vol. Amb.  
Salisbury Vol. Amb.

Warren Vol. Fire Dept.  
Watertown Vol. Fire Dept.  
Washington Vol. Fire Dept.  
Winsted Vol. AAA  
Woodbury Vol. Amb.  
West Redding Vol. Fire Dept.  
Sharon Vol. Fire Dept.  
Sherman Vol. Fire Dept.  
Thomaston Vol. Ambulance  
STS Fire Dept  
Stony Hill Vol. Fire Dept.  
Wolcott Vol. Ambulance



CONNECTICUT CONFERENCE OF MUNICIPALITIES

900 Chapel St., 9th Floor, New Haven, CT 06510-2807 • Phone (203) 498-3000 • FAX (203) 562-6314

001550

TESTIMONY OF THE  
CONNECTICUT CONFERENCE OF MUNICIPALITIES  
TO THE  
PUBLIC HEALTH COMMITTEE

March 2, 2000

**HB 5287 "AAC Emergency Medical Services Data Collection and Emergency Medical Dispatch"**

CCM thanks the Committee for the opportunity to testify on HB 5287 - a bill which has widespread implications for the local delivery of Emergency Medical Services.

CCM also thanks the Committee for the efforts it has made to address municipal concerns – allowing local EMS providers to submit their reports to DPH on a form and in a manner best suited to the individual provider.

CCM has *the following concerns* with the Committee's proposals:

- Many municipalities are reluctant to deliver emergency medical dispatch because of liability concerns. For example, a person could bring suit because (a) EMD-delivered advice was deemed incorrect or inadequate, or (b) response to another 911 call lagged because the dispatcher was delivering EMD to another caller. The mandate to deliver emergency medical dispatch (EMD) must be accompanied by amending statutes to include public safety personnel delivering EMD. *CCM urges the Committee to amend HB 5287 to include immunity from liability for the delivery of EMD.*
- The delivery of EMD will have on-going costs associated with both the continuous training of personnel and quality assurance measures. It is also estimated that many PSAPs will have to hire additional staff. *CCM urges the Committee to amend HB 5287 to require the Office of State-Wide Telecommunications provide on-going funding, not just one-time funding associated with initial start-up costs.*
- It is unclear as to how the public safety answering points are to meet the quarterly reporting requirements. *CCM urges the Committee to amend HB 5287 to include language similar to that used for EMS reporting requirements – the PSAP could submit the information in any written or electronic form selected by such PSAP.*

★★★★★

If you have any questions concerning this testimony please call Marcia Wellman, Jim Finley, Jr., or Gian-Carl Casa of CCM at (203) 498-3000.

001551



EASTERN CONNECTICUT EMERGENCY MEDICAL SERVICES COUNCIL, INC.

12 Case Street / Suite 307 / Norwich, Connecticut / 06360  
Phone 860 / 889-0089

Walter T. Weissmuller  
*President*

Ian Cummings, M.D., Ph.D.  
*Medical Director*

Good afternoon. Thank you for the opportunity to address this Committee.

Due to the expeditious nature of this short legislative session, the Eastern Connecticut EMS Council is unable to review Raised Bill 5287 under our normal process. As such, I am unable to represent an official, approved stance on the content of the Bill. Let me, then, offer support by comparing the intent of the Bill with the *Plan for the Delivery of EMS in Eastern Connecticut* as filed with the Department of Health in June of 1999.

Bill 5287, if passed, would address two main components of the EMS System that are either absent or severely lacking in our system today. The first of the Bill's main components, Data Collection, is all but non-existent within our state. The importance of data cannot be emphasized enough. Without adequate data, we cannot accurately evaluate and plan for the improvement of our EMS System. Simple questions, such as the number of ambulance calls done annually, cannot be answered. We cannot benchmark where we are and scientifically project where we will be. We can properly judge the adequacy of our resources. Only through anecdotes are changes for improvement executed. The establishment of a Data Collection System is an objective contained within the Council Plan. We therefore support legislative initiatives to make it a reality.

Emergency Medical Dispatch has been recognized by the State of Connecticut Department of Public Health as being a critical link in the "chain of survival." During the Council's assessment of the current status of the EMS System in Eastern Connecticut, Emergency Medical Dispatch was identified as being available only to a small segment of the population. Although EMD has been available to this limited area for over 10 years, it still has not been adopted by other areas in Eastern Connecticut. This demonstrates the need for legislative intervention on our citizens' behalf.

Of note within the Bill, there is funding identified for EMD, but no funding is provided for Data Collection. I hope the Committee will address this, as some funding will be required.

Please accept our gratitude for the attention your Committee has given to EMS.

Sincerely,

Jonathan S. Lillpopp  
Regional Coordinator/Executive Director



**K-B Ambulance Corps.**  
PO Box 7  
Danielson, CT 06239  
860-774-7625

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I speak to you today in support of Raised Bill 5287, which addresses the issue of **Data Collection and Emergency Medical Dispatch**. Please allow me to briefly address these two issues in the respective order I just mentioned.

The EMS system within the State of Connecticut on the whole is a good, strong, competent system comprised of paid and volunteer professionals. However, as with any system there are always areas that need to be monitored for areas of improvement.

By establishing a comprehensive data collection system, the Legislature and the Department of Public Health, Office of Emergency Medical Services will be laying the groundwork, which will allow for the assessment and evaluation and correction of precise areas of the EMS system that are found to be deficient, rather than an overhaul of the system as a whole.

As EMS professionals, we often speak of the “**chain of survival**”; Emergency Medical Dispatch Centers (EMD) are considered a substantial link within this chain. Recognizing that certified EMD centers are the first link within the chain, it is crucial to consider that if the “**chain of survival**” is weak at its beginning, then the remaining parts of the chain and the EMS system will also be weakened and less efficient.

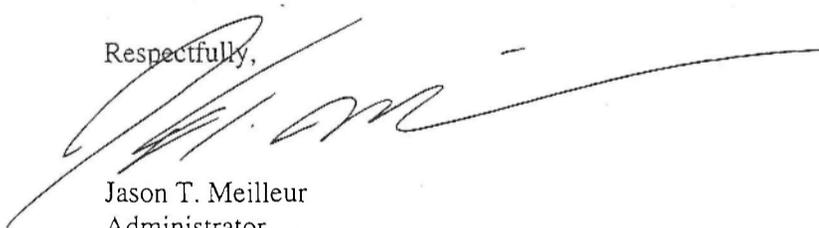
Having certified EMD centers staffed by properly trained and certified dispatchers sends a message to the providers within the EMS system, that there is a serious approach to maintaining a strong EMS system.

Finally, by establishing certified EMD centers, the citizenry of Connecticut will be better served by having access to a system they have come to expect through various avenues of the media.

In closing, I would advocate the Legislature to not only support and pass Raised Bill 5287, but encourage you to not allow it to become an unfunded mandate.

I thank you for your time and attention.

Respectfully,

  
Jason T. Meilleur  
Administrator

001553

Remarks by  
Russell A. Kimes, Jr.  
to the Committee on Public Health  
March 2, 2000

I am Russell Kimes, President of the Council of Regional EMS Chairpersons, President of the Southwest Connecticut EMS Council and Captain of the New Canaan Volunteer Ambulance Corps. I also serve as a Governor's appointee to the Connecticut EMS Advisory Board and a member of the Advisory Board's Data Committee.

HB 5650

**Raised Bill No. 5287**  
**Data Collection**

Addressing the proposed legislation Raised Bill 5287 entitled An Act Concerning Emergency Medical Services Data Collection and Emergency Medical Dispatch: The proposed bill is deficient in that it requires the collection of data on number of times an ambulance responds and the time required to reach patients. While interesting, without data on the patient condition and location this data is really meaningless.

All EMS providers will agree that there is a need to develop a data system to evaluate EMS in Connecticut. The failure of Commissioners of the Department of Public Health to develop a data system for the past 25 years in violation of the statutory direction is deplorable.

While EMS providers would all agree to the requirement that patient data be reported to the State, they will also universally oppose any such requirement if the data submitted is not going to be used in a meaningful way.

Since October 1, 1995 all EMS services in the State have dutifully recorded patient data on all patients they transport and have been dutifully leaving copies of those records in the hospitals which received these patients. Since October 1, 1995 there has been one report, yes I said one report reflecting this information and it was not distributed to anyone but the Department of Health and a few members of the Trauma Committee. The reason, the money ran out.

In 1991 the National Highway and Traffic Safety Administration conducted a study of Connecticut EMS and issued a report recommending a program be established to assure adequate funding for EMS. In 1993 the unofficial Connecticut EMS Advisory Board proposed a "\$1 for Life" program that would have added 50 cents to the cost of motor vehicle registrations and would have provided the needed dedicated funding to ensure money for among other things a statewide data collection system " which is of vital importance to the planning, resource distribution, improvement of medical interventions, training and public information." Health Commissioner Addis presented the program to the Office of Policy and Management as a budget alternative in the Fall of 1993. A bill was introduced in 1994 to establish the program. It died in the Transportation Committee at the hand of Representative Cocco. Perhaps discouraged by the austere attitude in the legislature, the chairman of the funding committee resigned, the DPH became involved with Trauma Grants, and EMS for Children Grants and the initiative died.

It is this record that leads me to believe there has also been no real interest on the part of the Legislature to provide the past or present Commissioner with the permanent funding needed to develop and run a data system. The only money the Department has ever made available for data was \$300,000 in Federal Trauma System dollars spent between January, 1994 and October, 1995 to establish a "Trauma Registry". These funds were clearly inadequate as evidenced by the fact that the "Trauma Registry" never produced more than that one report and yet Trauma patients account for only 14,000 of the estimated 392,000 EMS patients transported each year. That's only 3.5% of the patients. Now the proposed bill seeks to make ambulance services compile this data on trauma patients and submit it MONTHLY to the Commissioner. WHY?

To quote page 32 of the report of the Program Review and Investigations Committee entitled *Report on the Regulation of Emergency Medical Services, Phase 2*, December 1999:

... the program review committee concludes that the collection of trauma data should be consolidated with the data collected on the entire pre-hospital system so that all EMS cases can be evaluated. **Attempts to revive the trauma registry or maintain the data separately will only divert resources and attention away from establishing [an] overall data collection system.** *Report on the Regulation of Emergency Medical Services, Phase 2*, December 1999, p. 32.

Section 2 paragraph 8 of the proposed bill must be changed to create a requirement that **all** patient data be collected, not just on the **Trauma** patients, but on **ALL** patients. You should take out the word "Trauma" and substitute "all".

How much money does this bill provide for EMS? NONE! While the bill provides funding for collection and quarterly reporting of data on ambulance service response times by the Public Safety Answering Points and money for training of Public Safety Answering Points Emergency Medical Dispatch personnel. There is no money for the collection, analysis or dissemination of any data collected by ambulance services or the Department of Public Health. The bill should also provide permanent EMS funding, not just for start up costs, but for all costs. Failure to adequately fund this mandate will result in the collection of more unreliable, insignificant, meaningless data from ambulance providers and 911 centers than will just accumulate in cardboard boxes somewhere in the Department of Public Health. There must be adequate, permanent funding to collect, analyze and disseminate the data submitted. Otherwise the data will be unreliable and useless.

The proposed bill 5287 will do nothing to reverse the 25 year trend. The bill will only add ten (10) more mandates to the Commissioner's already existing list of unperformed duties and put another unnecessary burden on the EMS services:

Just as the data system mandate that has been completely ignored for 25 years, these new additional duties will likewise go unperformed unless you are prepared to provide the necessary permanent EMS funding to run both the State and Regional Offices.

**Raised Bill No. 5287**  
**Emergency Medical Dispatch**

Most will agree that requiring all 911 answering points be capable of providing the prioritizing of requests for medical aid and pre-arrival instructions to the callers, or an Emergency Medical Dispatch Program, will improve the quality of EMS in Connecticut.

Unlike the first half of the proposed bill, the second half of the bill provides money dedicated to the initial training and equipment costs associated with an Emergency Medical Dispatch Program. However there are no provisions made for the continuing costs for recertification or data collection, analysis or dissemination and in that respect it is just as deficient as the first part.

**Raised Bill No. 5650**  
**Paramedic Scope of Practice**

In closing I have some thoughts on An Act Concerning The Scope Of The Practice Of Paramedics (*Raised Bill 5650*): Section 1 is clearly needed. I am embarrassed that it never occurred to me that anyone who has an internal automatic defibrillator in their body who failed to register it with the Department of Public Health would be violating the law passed last year.

However, it has occurred to many people that the recent changes to the Good Samaritan Law (52-557b) should be expanded to include persons who are part of the EMS system and trained in the use of automatic and semiautomatic defibrillators but not in courses that are "in accordance with the standards set forth by the American Red Cross or American Heart Association" but yet are qualified to operate automatic defibrillators. I would recommend adding a 4th section with language to allow persons qualified in the use of automatic and semiautomatic defibrillators who are off duty to use them with immunity from litigation.

Russell A. Kimes, Jr., Attorney at Law, 22 East Avenue, New Canaan, CT 06840  
(203) 966-1137

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**STATE OF CONNECTICUT**

DEPARTMENT OF PUBLIC SAFETY

1111 Country Club Road  
P.O. Box 2794  
Middletown, CT 06457-9294

March 2, 2000

Senator Toni Harp  
Representative Mary Eberle  
Co- Chairmen  
Public Health Committee  
Legislative Office Building  
Hartford, CT 06106

HB 5287 - AAC Emergency Medical Services Data Collection and  
Emergency Medical Dispatch

(note – this testimony also addresses SB 164)

The Department of Public Safety wishes to address provisions of both bills related to the collection of data for EMS response times and the implementation of Emergency Medical Dispatch (EMD) pre-arrival instructions. Provisions of SB 164, related to rate increases for ambulance services, ambulance service licenses and certification do not impact the Department of Public Safety directly and will not be commented on.

Both SB 164 and HB 5287 address the collection of Emergency Medical Service (EMS) data, by directing EMS organizations and Public Safety Answering Points (PSAPs) to collect and submit data related to the delivery of emergency medical services. The data includes, number of EMS calls, level of service provided, response times, number of passed calls, canceled and mutual aid calls. The data will be collected monthly and can be written or electronic in format with the Commissioner (DPH) submitting an annual report to the General Assembly. Requirements for data collection for EMD purposes dictate that quarterly reports will be submitted to Department of Public Safety (DPS) Office of Statewide Emergency Telecommunications (OSET) for aggregation and dissemination. Issues related to the provisions of this bill regarding data collection are as follows:

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- Funding for the development of the data collection process is to be derived from the E9-1-1 Telecommunications Fund.
- The cost for the collection of this data is capped at \$250,000 per fiscal year. It is unknown as to how much the development of the data collection system would cost. Additionally, this requirement places new mandates on PSAPs. The PSAP community may not have the resources to gather the required data.
- The \$250,000 equates to less than one cent per month added to the current E9-1-1 surcharge. The FY99/00 E9-1-1 surcharge rate was set at 31 cents per month per phone line.
- Without a clear understanding of the magnitude of written versus electronic data submissions it is difficult to estimate staffing requirements for aggregation of the data. This could add to the cost of implementation of the data collection process.

Additionally, SB164 and HB 5287 require that PSAPs provide Emergency Medical Dispatch (EMD) no later than 7/1/2004. The Department of Public Safety - Office of Statewide Emergency Telecommunications will provide funding for the initial training for EMD and the purchase of pre-arrival emergency medical dispatch card systems. DPS-OSET shall provide, by 7/1/2001, an emergency medical dispatch training course or approve any EMD training that meets the requirements of the US Department of Transportation. National Highway Traffic Safety Administration EMD national standard curriculum. The Department of Public Safety endorses the concept of providing EMD to the citizens of the State of Connecticut. EMD is a proven process that allows dispatchers/call takers to initiate emergency medical assistance immediately. EMD training has been provided for under the DPS Public Safety Telecommunicator Certification program since 1996. Issues related to the implementation of this program are as follows.

- No costs are identified in the proposed bills for the implementation of EMD training and priority reference cards sets.
- Significant cost variance exists between providers of EMD cards and training. Four major vendors currently provide EMD training and priority reference cards. The DPS would contract for the provisioning of training and cards utilizing a bid process.
- Assuming that a set of call guides (priority reference cards) would be required for each state funded answering position, the State would purchase approximately 300 sets of cards. This would include 256 for all State funded E 9-1-1 answering positions and additional sets for training purposes. Assuming a cost of \$50 for a set of reference cards, the total cost for EMD cards would be \$15,000 in year one. Additional sets could be purchased by any PSAP off the State contract.

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- Training cost per year may be phased in due to the three-year implementation period. Again, a bid process would be used to purchase a training program. This would be bundled with the purchase of the cards. Vendors would only train on their respective priority reference cards.
- Implementation and monitoring of the mandated EMD program would require additional staff resources for the Office of Statewide Emergency Telecommunications. An estimated ½ person would be required to monitor implementation, monitor training and provide quality assurance oversight.
- Assuming that 500 people would have to be trained annually, for the first three years, at an estimated cost of \$300 each, the total cost would be estimated at \$150,000 for training each year. Year one costs are estimated at \$150,000 for training plus \$15,000 for priority reference cards, plus staff resources of \$30,000 for a total of \$195,000. At current E9-1-1 surcharge rates this would equal approximately one cent. Cost would be limited to the categories sited in the bill.
- PSAPs may not have the resources to provide the required quality assurance program that is an integral part of an EMD program.

Sincerely,

by *Col. J. P. Marshall* Deputy Comm.  
Dr. Henry C. Lee  
COMMISSIONER

001566

Testimony of Michael Zacchera, AS, NREMT-P regarding Raised Bills 5650 and  
5287, before the Connecticut General Assembly, Committee on Public Health.

Hartford, March 2, 2000.

001567

**Testimony Regarding Raised Bill No. 5650**

Good afternoon Mr. Chairman, Ladies and Gentlemen of the Public Health Committee. My name is Michael Zacchera, I am a Nationally Registered paramedic and an Emergency Medical Services (EMS) Educator at Hartford Hospital. I have been involved in EMS for the last 13 years, in Massachusetts, Connecticut and Pennsylvania. I have experience in all aspects of EMS, from street level provider of care to administrator to educator.

I am before you today to discuss Raised Bill No. 5650, An Act Concerning the Scope of Practice of Paramedicine. I would like to address each of the three sections of the bill.

Section 1. Discusses allowing paramedics to utilize AED's without online or "simultaneous communication" with a physician. I support this section of the bill.

I feel that it is in the best interest of the public at large by removing a potential time delay. The AED units are designed for lay public to use and as such all of the decision making is within the machine and leaves nothing to the individual's discretion. Therefore there is no need to have "simultaneous communication"

001571

Testimony Regarding Raised Bill No. 5287 "An Act Concerning Emergency  
Medical Services Data Collection and Emergency Medical Dispatch."

Good Afternoon Mr. Chairman, Ladies and Gentlemen of the Committee. My name is Michael Zacchera and I am a Nationally Registered Paramedic and an EMS Educator at Hartford Hospital. I would like to speak with you today regarding Raised Bill No. 5287.

In general I would like to applaud your efforts in this important area of Emergency Medical Services (EMS). I support this bill and would like to offer a few items that you might wish to add to the bill. Under Section 8, Subsection A, the bill describes information that should be collected. I would suggest including all times from each ambulance call, not just "response times," other types of information that you might wish to consider collecting would include gender, patient age, as well as information that is required by the state trauma regulations (for example, mechanism of injury and whether or not safety devices were used, such as seat belts, etc.) The importance of a centralized data collection system can not be overemphasized. The information collected can be used for a variety of purposes, among them are: 1. To identify weaknesses in the EMS system that can

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then be focused on and improved. 2. For EMS, Public Health and other research that can then be used to improve patient care. 3. To allow comparisons between services within the state.

There are those that may tell you that the time frame you specify is too short for implementation. It is my opinion that such a system could be implemented in the delegated time frame, if the proper support is in place and if the person entrusted with the project is willing to work very hard to bring it to fruition. The funding designated (up to \$250,000) is a reasonable amount although initial start up costs may run higher, maintenance of the system should fall within the \$250,000 allocated.

The Emergency Medical Dispatch (EMD) program to provide pre-arrival instructions described in Section 5, d, (2) has become a standard of care nationwide. Most members of the public assume that when they call 9-1-1 they can be given instructions over the phone. When I conduct classes, many of my students are surprised to learn that this is not the case. Many times their answer to that is "But that's what happens on TV!" Which is true, Rescue 911 and shows like it have brought EMD programs into everyone's livingroom on a weekly basis

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for years now. It is what the public expects. I've heard people and organizations say that they can't afford the liability insurance to have the program. It is my opinion that they can't afford not to have the program. I can go and find 10 national leaders in EMS and I'd probably get all of them to say that EMD is the expected standard of care across the country.

The remainder of the bill discusses the implementation of a training program for EMD. This should not be a difficult process, there currently exist numerous courses that are used nationwide. The American Public Safety Communication Officers (APCO) program, Powerphone, Dr. Clawson's program in Salt Lake City as well as the EMS Telecommunicator Program sponsored by the Southern Alleghenies EMS Council are all examples of such programs. Any one are all of these programs could be adopted by Connecticut and fit the requirements of the bill.

Mr. Chairman, Ladies and Gentlemen I'd like to thank you for your time this afternoon. Thank you.

Respectfully submitted,

Michael Zacchera III, AS, NREMT-P

JOINT  
STANDING  
COMMITTEE  
HEARINGS

PROGRAM  
REVIEW  
AND  
INVESTIGATIONS  
PART 2  
300-612

2000

scp PROGRAM REVIEW & INVESTIGATIONS February 29, 2000  
10:30 a.m.

000306

PRESIDING CHAIRMAN: Senator Fonfara  
Representative Wasserman

COMMITTEE MEMBERS PRESENT:

SENATORS: Daily, Guglielmo, LeBeau,  
Nickerson, Smith Jr.

REPRESENTATIVES: Jarjura, Landino

SENATOR NICKERSON: We will open the hearing as we  
always do with the opportunity for the legislators,  
agency heads and municipal officials. I have the  
sign-up sheet and we have DPS, who we invite you to  
start the morning.

GEORGE POLTORILAK: Good morning, Representative  
Wasserman and Senator Nickerson and members of the  
Committee.

My name is George Poltorilak and I am the Director  
of the Office of Statewide Emergency  
Telecommunications, which is part of the Department  
of Public Safety, and I'm here representing Dr.  
Henry Lee --

SEN. NICKERSON: Is your mic on?

GEORGE POLTORILAK: I believe it is. Can you hear me  
now?

SEN. NICKERSON: That's better, thank you.

GEORGE POLTORILAK: Okay, I'll lean forward a little  
bit.

I'm representing Dr. Henry Lee. He has submitted  
written testimony. And I won't read that testimony  
verbatim. I will just summarize his comments. And  
then if you have any questions, by all means.

And we're testifying on SB 164, AN ACT IMPLEMENTING  
THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM

REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE REGULATION OF EMERGENCY MEDICAL SERVICES, PHASE TWO. Additionally, a bill that's not being heard today, which is similar, is HB 5287. So our comments apply to both of those bills.

The Department wishes to address the provisions of both bills and I'll address them in two separate areas. The issues related to the provisions of SB 164 regarding data collection are, first of all, the funding for the data collection would be derived from the enhanced 911 telecommunications fund. The cost within the bill, apparently, are capped at \$250,000.00 a year. It's really unknown as to how much the development of the data collection system would cost. And this 250,000 would equate to approximately one cent added to the 911 surcharge on everybody's phone bill. Without a real clear understanding of the magnitude of the task in terms of data collection, that cost figure may increase.

Additionally, SB 164 and 5287 require that Public Safety Answering Points provide emergency medical dispatch to people calling 911. The Department endorses the concept of providing emergency medical dispatch. You know we've been training people in our certification program since 1996 in that regard and it's definitely a very positive thing to do for the public.

No costs are identified within the bill for the provision of EMD, as it's called, for the training and the purchase of the priority reference cards. We estimate that -- we've done some gross estimates and we estimate that it would probably cost in year one about \$195,000.00 to implement that program. And then in subsequent years for the three-year phase-in, there would be an additional \$150,000.00 for training costs. That cost additionally as well would add about a penny to the surcharge each year.

One of the main concerns is that the Public Safety Answering Points may not have the resources required to provide quality assurance for an emergency medical dispatch program.

That's a summary of the written testimony that was submitted and I'll gladly answer any questions you might have.

SEN. NICKERSON: Okay, thank you.

REP. WASSERMAN: I have no questions.

SEN. NICKERSON: Questions?

REP. WASSERMAN: I have no questions.

SEN. NICKERSON: Okay, thank you very much for your testimony.

GEORGE POLTORILAK: Thank you.

SEN. NICKERSON: We move on to DPH.

COMM. JOXEL GARCIA: Good morning, Senator Nickerson and Representative Wasserman. My name is Joxel Garcia and I'm the Commissioner of Public Health.

The reason of my presentation here is I'm going to testify regarding Senate Bills 164 and 417 implementing Phase One and Phase Two of this Committee's review of EMS. We already submitted written testimony, so I'm not going to go through the entire written testimony. So, I'm just going to go through -- if I may, through the recent history of EMS in our state and in our agency and go through some of the changes that we have been doing in our agency and then comment on the Phase One and Phase Two implementation bills.

In July 1995, OEMS consolidated into the Bureau of Regulatory Services in my agency. In February of 1997 this Program Review and Investigations Committee voted to change OEMS. In September of 1997 there was regulation consolidating OEMS into the Health System Regulation, which is part of my Bureau of Regulatory Services in my agency. In December of 1997 this committee endorsed the DPH organization effort. In May of 1998 the Public Act 987-195 qualifies DPH organizational structure. In May 1999, Phase One of the EMS study was completed.

REP. WASSERMAN: The next person is Fred Rosa. Fred, where are you -- (inaudible, microphone off) --

FREDERICK ROSA: Good afternoon, how are you. I've provided some written testimony besides a few other comments that I have.

I'm a little early on Bill 5287. I was preparing myself for Thursday for being back up here at 1:00. But as far as the bills that are up here on 164 and 140 -- excuse me 417 -- 417 we're in complete agreement with. We can't agree strong enough as far as the data collection system and the idea of emergency medical dispatch. We certainly know the importance of it and we favor it wholeheartedly.

What we're looking for as far as Bill 164, the only tweaking that we would look for is -- it was recommended that there be no constraints whatsoever as far as licensed providers being able to open up branch offices, get any number of vehicles, and any category, as long as they didn't come back and then seek to try and recoup that by raising their rates the next year, and it basically put a fiscal constraint on the providers.

We're also looking besides that fiscal constraint to limit the number of either branch offices or vehicles that any one provider could go for within a year, using a calendar year time period, basically because -- again, we're looking to prevent one over-saturation of the market in any particular service without it being easily recognizable and being able to do something about it.

Those were the only comments that we saw negatively on this bill. As far as everything else goes, it is what Program Review has been offering for the past two years, both in Phase One and Phase Two, and we've been up here strongly supporting it. We believe that they're going in the right direction.

We're certainly supporting the Commissioner, who we believe is going in the right direction also and means to make EMS a priority and also tie it in

000358

State of Connecticut



## DEPARTMENT OF PUBLIC SAFETY

Dr. Henry C. Lee  
Commissioner

February 29, 2000

Senator John W. Fonfara  
Representative Julia B. Wasserman  
Co- Chairmen  
Program Review and Investigations Committee  
Legislative Office Building  
Hartford, CT 06106

***RE: SB 164 - An Act Implementing the Recommendations of the  
Legislative Program Review and Investigations Committee Concerning the  
Regulation of Emergency Medical Services, Phase Two and HB 5287 -  
AAC Emergency Medical Services Data Collection and Emergency  
Medical Dispatch***

The Department of Public Safety wishes to address provisions of both bills related to the collection of data for EMS response times and the implementation of Emergency Medical Dispatch (EMD) pre-arrival instructions. Provisions of SB 164, related to rate increases for ambulance services, ambulance service licenses and certification do not impact the Department of Public Safety directly and will not be commented on.

Both SB 164 and HB 5287 address the collection of Emergency Medical Service (EMS) data, by directing EMS organizations and Public Safety Answering Points (PSAPs) to collect and submit data related to the delivery of emergency medical services. The data includes, number of EMS calls, level of service provided, response times, number of passed calls, canceled and mutual aid calls. The data will be collected monthly and can be written or electronic in format with the Commissioner (DPH) submitting an annual report to the General Assembly. Requirements for data collection for EMD purposes dictate that quarterly reports will be submitted to Department of Public Safety (DPS) Office of Statewide Emergency Telecommunications (OSET) for aggregation and dissemination. Issues related to the provisions of this bill regarding data collection are as follows:

P. O. Box 2794, 1111 Country Club Road  
Middletown, CT 06457-9294  
An Equal Opportunity Employer

- Funding for the development of the data collection process is to be derived from the E9-1-1 Telecommunications Fund.
- The cost for the collection of this data is capped at \$250,000 per fiscal year. It is unknown as to how much the development of the data collection system would cost. Additionally, this requirement places new mandates on PSAPs. The PSAP community may not have the resources to gather the required data.
- The \$250,000 equates to less than one cent per month added to the current E9-1-1 surcharge. The FY99/00 E9-1-1 surcharge rate was set at 31 cents per month per phone line.
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Additionally, SB164 and HB 5287 require that PSAPs provide Emergency Medical Dispatch (EMD) no later than 7/1/2004. The Department of Public Safety - Office of Statewide Emergency Telecommunications will provide funding for the initial training for EMD and the purchase of pre-arrival emergency medical dispatch card systems. DPS-OSET shall provide, by 7/1/2001, an emergency medical dispatch training course or approve any EMD training that meets the requirements of the US Department of Transportation, National Highway Traffic Safety Administration EMD national standard curriculum. The Department of Public Safety endorses the concept of providing EMD to the citizens of the State of Connecticut. EMD is a proven process that allows dispatchers/call takers to initiate emergency medical assistance immediately. EMD training has been provided for under the DPS Public Safety Telecommunicator Certification program since 1996. Issues related to the implementation of this program are as follows.

- No costs are identified in the proposed bills for the implementation of EMD training and priority reference cards sets.
- Significant cost variance exists between providers of EMD cards and training. Four major vendors currently provide EMD training and priority reference cards. The DPS would contract for the provisioning of training and cards utilizing a bid process.
- Assuming that a set of call guides (priority reference cards) would be required for each state funded answering position, the State would purchase approximately 300 sets of cards. This would include 256 for all State funded E 9-1-1 answering positions and additional sets for training purposes. Assuming a cost of \$50 for a set of reference cards, the total cost for EMD cards would be \$15,000 in year one. Additional sets could be purchased by any PSAP off the State contract.

000360

- Training cost per year may be phased in due to the three-year implementation period. Again, a bid process would be used to purchase a training program. This would be bundled with the purchase of the cards. Vendors would only train on their respective priority reference cards.
- Implementation and monitoring of the mandated EMD program would require additional staff resources for the Office of Statewide Emergency Telecommunications. An estimated ½ person would be required to monitor implementation, monitor training and provide quality assurance oversight.
- Assuming that 500 people would have to be trained annually, for the first three years, at an estimated cost of \$300 each, the total cost would be estimated at \$150,000 for training each year. Year one costs are estimated at \$150,000 for training plus \$15,000 for priority reference cards, plus staff resources of \$30,000 for a total of \$195,000. At current E9-1-1 surcharge rates this would equal approximately one cent. Cost would be limited to the categories sited in the bill.
- PSAPs may not have the resources to provide the required quality assurance program that is an integral part of an EMD program.

Sincerely,

  
Dr. Henry C. Lee  
COMMISSIONER



**NORTHWEST CONNECTICUT  
EMERGENCY MEDICAL SERVICES COUNCIL, INC.**

000376

February 25, 2000

Legislative Program Review and Investigation Committee  
Legislative Office Building  
Room 506  
Hartford, Ct. 06106-1591

To: All Committee Members

These comments are from the Housatonic Valley EMS sub- region ( HVEMS ), and the Northwest Connecticut EMS Regional Council ( NWCEMSRC, Inc. ). ( HVEMS ) is the advisory body for the twelve towns in the Danbury catchment area, and the NWCEMSRC, Inc. is the advisory body for the forty three towns in Northwest Connecticut.

Both the Housatonic Valley EMS subregion, and the Northwest Connecticut EMS Regional Council approve of House Bill 5287, An act Concerning Emergency Medical services Data Collection And Emergency Medical Dispatch, with this exception:

That the data provided to the Dept. of Health, by the EMS providers, in turn, be provided to all EMS agencies that provide this information in a manner that will be useful to them. If the EMS services must collect this data, then it should be noted in the legislation that they receive this information in return, in order to use this information as a gauge to measure their proficiency in the EMS field.

Also that reporting time be changed to quarterly instead of the monthly requirement that is now currently in the bill.

The other bill is Senate Bill # 164, An Act Implementing The Recommendations Of the Legislative Program Review And Investigations Committee Concerning The Regulation Of Emergency Medical Services II.

Under Sec. 3 Section 19a-180, (f) the only change that we request, is that the following be eliminated from this legislation, " and any number of branch locations as such person or emergency medical service organization deems necessary to provide adequate service ", be eliminated from this legislation. Therefore an EMS service will be required to go through the need for service process in order to place a branch office in another area. This section will , if approved, will be deleterious to certified providers and will undermine the 911 response system. The rest of this bill has been approved by both agencies.



P.O. Box 627 Southbury, Connecticut 06488 Telephone 1(203) 264-0460

000377

Senate Bill #417, An Act Implementing The recommendation Of The Legislative Program Review And Investigations Committee Concerning The regulation Of Emergency Medical Services, Phase One.

The Northwest Connecticut EMD Regional Council supports this bill. We find that this legislation will define the responsibility needed in EMS.

The following EMS Services are located within the Northwest Ct. EMS Region V.

**American Medical Response:**

Bantam Vol. Fire Dept. ( Waterbury / Watertown )  
Beacon Falls Vol. Fire Dept.  
Bethlehem Vol. Fire Dept.  
Bethlehem Vol. Amb.  
Bridgewater Vol. Fire Dept.  
Brookfield Vol. Fire Dept.  
Bethel Vol. Fire Dept.  
Campion Ambulance ( Torrington )  
Campion Ambulance ( Waterbury )  
Campion Ambulance ( Cheshire )  
Campion Ambulance ( Prospect )  
Cornwall Vol. Fire Dept.  
Danbury Fire Dept.  
Falls Village Vol. Fire Dept.  
Georgetown Vol. Fire Dept.  
Goshen Fire Dept.  
Harwinton Vol. Amb  
Heritage Village Ambulance  
Kent Vol. Fire Dept.  
Lime Rock Race Track Amb.  
Litchfield Vol. Amb.  
Middlebury Vol. Fire Dept.  
Morris Vol. Fire Dept.  
Naugatuck Amb. Service  
New Fairfield Vol. Fire Dept.  
New Hartford Amb.  
Newtown Vol. Amb.  
New Milford Vol. Amb.  
North Canaan Vol. Amb.  
Norfolk Vol. Amb.  
Northfield Vol. Fire Dept.  
Oxford Vol. Amb.  
Redding Ridge #1 Vol. Fire Dept.  
Ridgefield Fire Dept.  
Roxbury Vol. Amb.  
Salisbury Vol. Amb.

Warren Vol. Fire Dept.  
Watertown Vol. Fire Dept.  
Washington Vol. Fire Dept.  
Winsted Vol. AAA  
Woodbury Vol. Amb.  
West Redding Vol. Fire Dept.  
Sharon Vol. Fire Dept.  
Sherman Vol. Fire Dept.  
Thomaston Vol. Ambulance  
STS Fire Dept  
Stony Hill Vol. Fire Dept.  
Wolcott Vol. Ambulance

Dear Committee Members,

I would like to take this opportunity to address the committee on the two bills being brought before it today.

The first is Raised Bill No. 5287. We find the bill to be reasonable in both what it requires of the services and the time frame to implement the changes it calls for. The only item that might be investigated by this committee is the continuance of the current subsidy to cities and towns who are using the C-Med system for frequency coordination. This will help continue the regionalization of dispatch centers and provide them with a revenue source for upgrades to the system as new technology becomes available, other than raising their rates to the cities and towns they now serve.

The second bill is Raised Bill No. 164. Again, we concur with almost all elements of the bill, with the exception of Sec. 3. Section 19a - 180 paragraph (f). While the fiscal constraints placed on existing providers who are expanding their services, either through adding vehicles or branch locations, may be enough to prevent one provider from exerting undue influence over the EMS system, we would also like to suggest that a numerical limit, on the amount of vehicles acquired in each category, be set at three(3), and the number of branch locations, be set at one(1) per calendar year. These limits, we believe, would continue to stabilize our EMS system in Connecticut.

I would like to thank Program Review and Investigations and the Members of this Committee for all of the hard work put forth by both groups, to promote the availability of excellent pre-hospital care to the residents and visitors to, our great state.

If I can answer any questions, or be of any assistance to this committee, please do not hesitate to contact me.

Sincerely,



Frederick V Rosa

**Waterbury**

**Torrington**

**Cheshire**