Connecticut Emergency Medical Services Primary Service Area Task Force
Meeting Minutes

Monday, December 09, 2013 at 2:30pm
Connecticut Department of Public Health
OCHA Hearing Room, 410 Capitol Avenue, Hartford

Task Force Committee Members Present:

Caroline Baisley, Raphael Barishansky, Bruce Baxter, Joseph Danao, Paul Fitzgerald, Matthew Galligan, Mary-Ellen Harper, Vincent Landisio, David Lowell, Thomas Ronalter, Charlee Tufts, Seth Roberts,

Guests in Attendance:

Greg Allard, Gary Allyn, James Brown, Carmine Centrella, Randy Collins, Brian Courmoyer, Michael Demicco, Michael Donohue, Jill Kentfield, Gary O'Connor, Ken Przybysz, Judith Reynolds, Ted Schroll, Brian Sullivan, Chelsey Worth, Wayne Wright

1.0 Call to Order

The meeting was called to order at 2:33PM by Co-Chair Barishansky.

A. Introduction/Roll Call of Members
The Task Force members introduced themselves and their affiliations.

B. Introduction of Audience
The members of the audience introduced themselves and their affiliations.

C. Approval of Minutes of Previous Meeting
A Motion was made to approve the minutes of the November 25, 2013 meeting, (Baxter/Galligan).

D. Public Comment
Co-Chair Barishansky read into the record three public comment submissions:
1. Received from Jack Casner, Chief of Cheshire Fire Department, dated December 9, 2013.
2. Received from Robert Shea, Chief of the Portland Fire Department and President of the Connecticut Fire Chief's Association. Position statement from the Connecticut Fire Chief's Association, undated.
3. Received from Jeffrey J. Hogan, Chairman, Farmington Town Council, dated December 9, 2013.

Wayne Wright, President ASM-Aetna, expressed concern with the proposed recommendations not addressing regionalization, noting that regionalization as it has evolved works well and provides optimal coverage. Additionally he expressed concern with PSA's being withdrawn upon sale.

Gary O'Connor of Pullman and Comley, representing AMR, informed the group Chuck Babson was unable to attend today's meeting due to travel delays. He distributed a position paper from American Medical Response, dated December 9, 2013 and reviewed highlights of the document.

Randy Collins, Senior Legislative Associate with CCM, distributed a document titled "CCM 2013" Testimony dated December 9, 2013, supporting Co-Chair Harper's recommended changes. He also commented on contracts and PSA assignment reviews supporting the modification removing the 3 year limit.

2.0 Old Business

A. DPH Proposed Regulations – Modified Proposal from Co-Chair Harper
A motion was made to approve the "Proposed Task Force Recommendations to Modify OEMS PSA Regulations Presented by Mary-Ellen Harper", (Galligan/Ronalter). Galligan supports the recommendations commenting they are well crafted and give the ability to seek better service. He also commented on the time limitations of the task force. Co-Chair Harper reminded the group there are three planned meetings left, two to construct the report and one for finalization.

David Lowell expressed concern over the removal of a PSA without cause, noting this would not promote stability which has been established through statutes. There is a lack of communications between all parties and statutes that have not been moved on like the EMS Plans. He feels change should be made for cause.

Co-Chair Barishansky clarified for the group that in the document he handed out the text in bold type is new for conversation purposes, the italicized bold are previous comments from Co-Chair Harper.

There was discussion on determination of economic feasibility, reassignment based on equal or overall improvement of health care quality and safety or economic efficiency, compliance review and municipalities being locked into providers and the bidding process required by municipalities entering into contracts. Several members of the group stated the changes they are proposing should not affect the small service providers.

Bruce Baxter spoke on cost efficiencies possibly driving the need to have one type or provider, not the current designations of licensed or certified, so all could compete equally. In order for the non-profits to buy into a change of this substance non-profits would have to be allowed to compete in the non-emergency market.

Discussion followed on language changes to the document after which the original Motion was amended to accept the language changes suggested by Co-Chair Barishansky and the addition of a time frame to Section 2, para. 3. (Galligan/Ronalter). During discussion Charlee Tufts noted patient care needs to be the priority. David Lowell stated he did not expect a vote today, his understanding was these documents were to be used as a framework for consensus development. A Motion was made (Baxter/Tufts) to table, a show of hands vote was taken, Motion to table failed (4 in favor, 7 against, 1 abstain). Discussion continued. Paul Fitzgerald commented the goal is to give the municipality some control and the provision of service in an economical manner.

Gary O'Connor requested and was granted the floor, he noted there were no action items on the agenda and he feels a vote taken would be flawed. Discussion followed with David Lowell asking that items be combined and presented at the next meeting for consideration. After further discussion the Motion was repeated and a vote was taken, 8 were in favor, 4 were opposed (Tufts, Baxter, Baisley and Lowell), Motion passed.

B. Task Force SWOT final document
The document is now considered final and will be included in the final report as an appendix.

3.0 New Business

A. ACAP proposal (3 documents) presented by David Lowell
David Lowell reviewed the documents and references distributed. He commented that whatever the group decides will impact delivery of care statewide. He asked the status of his request for a summary of EMS Plans on file and the template that was used in the past for planning. Co-Chair Barishansky will distribute a copy of the template to the group prior to the next meeting, he also is working on the summary requested.

David noted the document focuses on performance as the group was assigned and calls into question some regulatory language. It answers a number of concerns municipalities have and he agrees with. Vincent Landisio feels it is a good document but doesn't address allowing municipalities to change PSA's, he suggested merging Co-Chair Harper's document and this one. Seth Roberts questioned how it allows municipalities to affect change, David Lowell answered that is addressed in a number of statutes already in place he stated again his concern with relinquishing of PSA's for no cause.

Joe Danao complimented David Lowell on the documents noting the importance of an inventory of plans, the importance of a five year review, transferability should not be automatic and the importance of pushing for permanency of the Regional Coordinator's positions with the possibility of additional duties being added to their current responsibilities with changes that may be made. He only sees # 4 in two page

document as an issue.

A Motion was made (Harper/Danao) to accept the two page document titled "PSAR Task Force Recommendations" authored as a consensus document by David Lowell, Bruce Baxter, Gary Wiemokly and Charlee Tufts, with # 4 wording changed with the addition of the word *automatically*, "The "review" is not associated with a provider *automatically* relinquishing their PSA." Motion passed unanimously.

A Motion was made (Baxter/Fitzgerald) to accept the section beginning with "Proposal" in the document titled "Association of CT Ambulance Providers – Task Force Recommendation EMS Plan December 2013" ending at the bottom of page 2, with changes discussed and agreed on, (page 2, para. 3, the word "develop" changed to "facilitate the development of a plan submitted to the municipality for their approval", and page 2, para. 7, addition of the word" Medical"), Motion approved unanimously.

Co-Chair Harper would like to use the documents moved on tonight as the foundation for the final report. Everything will be compiled, updated and distributed for review.

The next meeting is scheduled for December 23, 2013 at 2:30PM, OCHA Conference Room, State of Connecticut, Department of Public Health, 410 Capitol Avenue, Hartford.

4.0 Adjournment

A Motion to adjourn was made at 4:40PM (Galligan/Lowell) and approved unanimously.

Respectfully Submitted:

Judi Reynolds
DPH/OEMS
Region 2 Coordinator

Connecticut Fire Chiefs Association

To: **Mary-Ellen L. Harper**
Director of Fire and Rescue Services
Town of Farmington Fire Department
Re: Proposed Task Force Recommendations to Modify OEMS PSA Regulations

Mary-Ellen,

The CFCA strongly supports recommendations presented today by the task force to modify OEMS PSA regulations. Our position suggests that the current PSA regulation be revised to adopt critical changes allowing municipality and/or state agencies an option in delivering EMS service within their own municipality *or* a choice in the selection of a private provider.

Every five years the DPH reviews EMS delivery services in each Connecticut municipality, it is essential that there is local agency involvement in this review so that a determination can be made that will benefit all involved.

Career chiefs as well as volunteers are required, within their local EMS plans, to deliver critical EMS services to their communities as well as timely and sufficient transport at a level which relates to the needs of their specific community. Making these changes will provide the opportunity for those tasked, (i.e., Fire Chiefs, local EMS coordinators, etc.) in making these decisions, to be part of the discussions related to their PSA holder and develop the right plan for their communities by assigning or reassigning providers based on current needs.

We thank you for your work on the task force and hope our position and that of the Task force is supported.

Thank you ,

Robert Shea

Robert Shea
Chief ,Portland Fire Department
President, Connecticut Fire Chiefs Association

250 Maple Avenue
Cheshire, CT 06410
(203) 272-1828
(203) 272-7314 Fax
jcasner@cheshirect.org

Cheshire Fire Department

From the Desk of Jack Casner, Chief of Department

December 9, 2013

To: Members of the task force to modify OEMS PSA regulations
Legislative Members

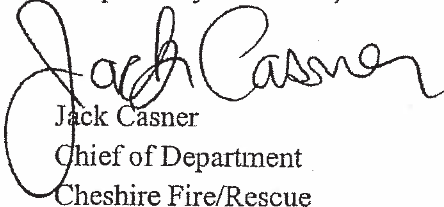
I am writing this letter in support of the task forces four recommendations (attached) to modify the current regulations which are not realistic and also not municipality friendly. As you all know, these regulations are limiting and restricting to cities and towns and we are held hostage by these archaic regulations that have been in need of revision for many years.

While I am a Fire Chief that **does not provide EMS** services I am in total agreement that the current PSA/EMS system is dysfunctional and must be addressed, sooner than later.

Currently, the Town of Cheshire has an outstanding relationship with an EMS provider that is second to none however, if the relationship or the standard of care were to change, it is next to impossible to make a change to another provider or service. I am more than willing to meet or be contacted to answer any questions that anyone may have.

My email is jcasner@cheshirect.org or by phone at 203-272-1828.

Respectfully submitted,



Jack Casner
Chief of Department
Cheshire Fire/Rescue

Attachments

CONNECTICUT CONFERENCE OF MUNICIPALITIES
THE VOICE OF LOCAL GOVERNMENT
CCM 2013 Testimony
900 CHAPEL STREET, 9th FLOOR, NEW HAVEN, CT 06510-2807 PHONE (203) 498-3000 FAX (203) 562-6314
Your source for local government management information www.ccm-ct.org

DEPARTMENT OF PUBLIC HEALTH
EMS TASK FORCE
December 9, 2013

RECOMMENDED CHANGES TO OEMS PSA REGULTIONS

The Connecticut Conference of Municipalities (CCM) is Connecticut's statewide association of towns and cities and the voice of local government. Our members represent over 92% of Connecticut's population. We appreciate the opportunity to submit comments on issues of interest to towns and cities.

Below are CCM's comments on the recommended changes to the current laws and regulations regarding the assignment of Primary Service Area Responders (PSAR) as submitted by Mary-Ellen Harper, Director of Fire and Rescue Services for the Town of Farmington to the EMS Task Force established pursuant to PA 13-306.

CCM would ask the members of the EMS Task Force to support the recommendations, giving towns and cities additional control in delivery of an important and vital local service.

CCM supports the recommended changes to the state statutes and regulations dealing with the Local Emergency Medical Services Plan, in order to give towns and cities greater flexibility to respond to the changing needs of their town and its residents. Included in the recommendations is the provision that would allow a town or city, upon updating their Local Emergency Service Plan, to demonstrate that they are better positioned to deliver or contract for EMS Service than the currently designated provider. Following that update, the DPH shall re-assign the PSA contract in accordance with the approved Local EMS Plan, so long as the EMS provider recommended by the town complies with both Connecticut General Statues and OEMS Regulations.

CCM and its members are adamant that the delivery of any public service including the delivery of EMS service within their town is not a commodity that may be bought and sold.

CCM strongly supports the recommended changes that would result from the sale of an existing EMS service provider to a third party to serve as cause for DPH to withdraw any current PSA assignments currently granted to that provider.

A municipality is entitled to review any contract which it enters into and if a third party acquires a provider that currently holds a PSA assignment; the acquiring entity must be required to reach a new agreement with the town or city.

CCM supports the modification of CGS 19a-181c (b) to allow a municipality to petition the DPH Commissioner "as warranted", for the removal of an assigned responder without time or frequency restrictions.

The recommended changes will allow for greater municipal authority and control when determining the provider of local EMS service as well as the level of service the municipality believes is in the best interest of the town and its residents. Not only does the statute no allow for this, the current language is a hindrance to enhancing EMS services for municipalities.

Municipalities are continually being asked to do more with less, and the recommended changes will give towns the ability and select the provider that best enhances the needs of their town and encourages EMS providers to offer the best and most cost effective service available.

If you have any questions, please contact Randy Collins, Senior Legislative Associate for CCM at rcollins@ccm-ct.org or (860) 707-6446.

Barishansky, Raphael

From: Mary-Ellen Harper <HarperM@farmington-ct.org>
Sent: Monday, December 09, 2013 10:49 AM
To: Barishansky, Raphael
Subject: FW: Proposed Task Force Recommendations to Modify OEMS PSA Regulations Presented by Mary-Ellen Harper

First email public comment submission.

Mary-Ellen L. Harper
Director of Fire and Rescue Services
Town of Farmington Fire Department
1 Monteith Drive • Farmington, CT • 06032 •

Phone: 860.675.2322
Email: HarperM@Farmington-CT.org

The Town of Farmington Fire Department is dedicated to providing for the safety and welfare of the community through the preservation of life, property, and the environment, by maintaining a constant state of readiness through fire fighter training and public education.

From: Jeffrey Hogan
Sent: Monday, December 09, 2013 10:48 AM
To: Mary-Ellen Harper
Cc: Kathy Eagen
Subject: Proposed Task Force Recommendations to Modify OEMS PSA Regulations Presented by Mary-Ellen Harper

Dear Task Force Members:

I write to enthusiastically support the proposed task force recommendations to modify OEMS PSA regulations as presented by Mary Ellen Harper.

Personally, I've spent 30 years in Police, Fire and EMS. I worked as a Police Officer for 12 years early in my career and then spent 16 years involved in both Fire and EMS in Farmington. I'm intimately familiar with the operations of first response systems in municipalities. I currently serve as the chief elected official for the town of Farmington. I formerly served as an Assistant Fire Chief in Farmington.

The recommendations presented by task force co-Chair Mary Ellen Harper support best practice, transparency and home rule; all of which are rudimentary elements of good public policy. The recommendations allow us to draft our own plan for EMS delivery. OEMS would ensure that the plan complies with the law and that our selected provider meets the required criterion. Home rule is a fundamental aspect of the laws and traditions of every New England state. Our towns are totally capable of and desirous of creating our own EMS delivery plan.

The recommendations presented also support the whole notion of transparency in government. No provider should ever feel entitled to keeping a PSA. Competition for services keeps providers alert and attuned to their own costs and quality. Please note that national healthcare reform supports the whole notion of accountability via the creation of large Accountable Care Organizations (ACOs). Large hospital and multi-specialty doctor systems are now being forced to become directly accountable for their costs and for the quality that they drive

through their system. I'd argue that the proposed task force recommendations to modify OEMS PSA regulations creates a higher level of accountability. Towns and cities are acutely aware of their vendors and will do a better job ensuring accountability. Good healthcare policy relies upon competition and local management.

Thank you for considering my thoughts. This is a big deal. I hope that you support these changes. Thank you for your service on this task force. Sincerely, Jeffrey J. Hogan

Jeffrey J. Hogan
Chairman, Farmington Town Council
Farmington, Connecticut 06032
860-424-2600

MEMORANDUM

TO:	Connecticut Emergency Medical Services Primary Service Area Task Force
FROM:	American Medical Response
DATE:	December 9, 2013
SUBJECT:	EMS PSA Task Force

Background:

The Emergency Medical Services system in Connecticut is a comprehensive, highly regulated system which delivers quality pre-hospital emergency medical care efficiently and cost effectively. It is a system that the National Highway Traffic Safety Administration Technical Assistance Team, in its 2013 "Assessment of Emergency Medical Services," refers to as one that is "rich in talent" and that "has been tried by real life events and passed the test each time." Nevertheless, all stakeholders recognize that there are always areas for improvement especially considering that EMS is a relatively new field and has only been regulated in Connecticut since 1967. Since 1974, when the General Assembly instituted primary service areas, there has been some concern from certain municipal officials and other stakeholders as to the amount of input and control municipalities have over emergency medical services within their jurisdictions. Over the years, the state legislature has responded to these particular concerns by amending Connecticut's EMS statutes. In 2013, in response to additional concerns raised, the legislature passed Public Act No. 13-306, which established the Connecticut Emergency Medical Services Primary Service Area Task Force (the "Task Force"). The Task Force was charged with reviewing:

1. The current process for designating and changing primary services areas;
2. local primary services area contract and applicable subcontract language and emergency medical services plans as such language and plans vary among municipalities and as such contracts and plans pertain to performance and oversight measures;
3. methods to designate emergency medical services providers that are used by other states that have populations, geography and emergency medical services systems that are similar to those of this state; and
4. the process by which municipalities may petition for a change or removal of a primary service area responder.

Task Force Initiatives:

The Task Force has held a number of meetings in which there have been general discussions and/or reviews of: (a) existing EMS statues and regulations, (b) the statutes and regulations of at

least one other state, (c) performance metrics, (d) OLR Reports, and (e) Legislative findings and recommendations. At the very outset, some Task Force members offered specific changes to the current EMS statutes and regulations, particularly as they relate to primary services areas. At subsequent meetings, the Task Force reviewed additional language changes.

AMR respectfully suggests that proposing specific statutory or regulatory language changes goes beyond the Task Force's statutory charge. More importantly, AMR believes that the Task Force has not sufficiently focused on the tools already existing under Connecticut law to address the recent concerns of municipal officials and other stakeholders.

Existing Legislation:

In 1999, the Legislative Program Review and Investigations Committee conducted a comprehensive review of EMS in Connecticut. The committee made a number of recommendations to improve the EMS system, including several recommendations relating to PSAs, including the requirement for local EMS plans, a mechanism to resolve PSAR and municipal differences over Performance Standards, the creation of model guidelines for local EMS Plans and Agreements and the enhancement of municipalities ability to remove PSARs for unsatisfactory performance.

These recommendations were codified in Public Act 00-151. AMR believes that the statutory changes address most, if not all of the issues raised by municipalities and other stakeholders. They provide a clear mandate for developing specific service requirements and performance standards tailored to each municipality. They provide a mechanism to resolve any impasse between a provider and a municipality with respect to such municipal plan or performance standards. The statues also require OEMS, the EMS Advisory Board and the regional EMS councils to develop guides and model local EMS plans and agreements. Finally, the statutory changes empower municipalities to petition for the removal of PSARs, once every three years, based on unsatisfactory performance as measured against the local EMS plans and other agreements between the providers and the municipalities. Excerpts of the relevant statues are attached as **Exhibit A**.

Unfortunately, DPH, the municipalities and the EMS providers have failed to implement and take full advantage of these legislative improvements. Education and outreach initiatives to municipalities have not been adequate. Enforcement of statutory requirements for local EMS plans has not occurred. Municipalities and providers in many cases have failed to negotiate local EMS plans and/or contracts. Ironically, despite the concerns for increased municipal control over PSARs, AMR is not aware of any municipality that has exercised its right to seek the removal of a PSAR based on poor performance.

Recommendations:

The Task Force should focus on how to achieve increased utilization of the existing statutory tools as opposed to the creation of new laws or regulations, which may have unintended consequences on a system that performs well and is cost effective. To that end, AMR recommends the following:

1. Establish an outreach and education program at OEMS. Personnel dedicated exclusively to this task should be assigned by the Commissioner. OEMS should utilize the resources of the regional EMS councils to reach each municipality and EMS provider. The regional EMS coordinators should be assigned the responsibility to revise the model local EMS plan and guidelines as well as the model municipal/provider agreement for their respective regions. These model plans and guidelines can be tailored to the particular needs and challenges of each municipality. The regional EMS coordinators should follow up with each municipality in their region to insure compliance.

2. Sufficient personnel should be assigned by the Commissioner to handle disputes among municipalities and providers regarding the local EMS plans as well as any revocation hearings. It is critical that the hearing process be quick, streamlined and inexpensive.

3. Establish, by regulation, penalties for those municipalities and providers who have failed to comply with the statutory process for creating local EMS plans. The Association of Connecticut Ambulance Providers has suggested an alternative approach requiring the regional EMS coordinator to develop the local plan if the municipality fails to do so. AMR finds this approach acceptable as well.

4. Establish a working group to create evidence based performance metrics. Although AMR believes that sufficient minimum standards currently exist which can be incorporated in any local EMS plan, it respectfully submits that these standards must and should be refined to ensure that the metrics are reasonable, applicable to providers serving different geographic areas and designed to improve the quality, effectiveness and efficiency of the entire EMS system. Please see AMR's Performance Benchmarks statement attached as **Exhibit B**.

EXHIBIT A

RELEVANT STATUTES

Sec. 19a-177. (Formerly Sec. 19-73w). Duties of commissioner. The commissioner shall:

(1) With the advice of the Office of Emergency Medical Services established pursuant to section 19a-178 and of an advisory committee on emergency medical services and with the benefit of meetings held pursuant to subsection (b) of section 19a-184, adopt every five years a state-wide plan for the coordinated delivery of emergency medical services;

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

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

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

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(6) Establish such minimum standards and adopt such regulations in accordance with the provisions of chapter 54, as may be necessary to develop the following components of an emergency medical service system: (A) Communications, which shall include, but not be limited to, equipment, radio frequencies and operational procedures; (B) transportation services, which shall include, but not be limited to, vehicle type, design, condition and maintenance, life saving equipment and operational procedure; (C) training, which shall include, but not be limited to, emergency medical technicians, communications personnel, paraprofessionals associated with emergency medical services, firefighters and state and local police; and (D) emergency medical service facilities, which shall include, but not be limited to, categorization of emergency departments as to their treatment capabilities and ancillary services;

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

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

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

Sec. 19a-178. (Formerly Sec. 19-73z). Office of Emergency Medical Services. State-wide coordinated delivery plan. Model local emergency medical services plans and performance agreements. (a) There shall be established within the Department of Public Health an Office of Emergency Medical Services. The office shall be responsible for program development activities, including, but not limited to: (1) Public education and information programs; (2) administering the emergency medical services equipment and local system development grant program; (3) planning; (4) regional council oversight; (5) training; and (6) providing staff support to the advisory board.

(b) The Office of Emergency Medical Services shall adopt a five-year planning cycle for the state-wide plan for the coordinated delivery of medical emergency services required by subsection (a) of this section. The plan shall contain: (1) Specific goals for the delivery of such emergency medical services; (2) a time frame for achievement of such goals; (3) cost data and alternative funding sources for the development of such goals; and (4) performance standards for the evaluation of such goals.

(c) Not later than July 1, 2001, the Office of Emergency Medical Services shall, with the advice of the Emergency Medical Services Advisory Board established pursuant to section 19a-178a and the regional emergency medical services councils established pursuant to section 19a-183, develop model local emergency medical services plans and performance agreements to guide municipalities in the development of such plans and agreements. In developing the model plans and agreements, the office shall take into account (1) the differences in the delivery of emergency medical services in urban, suburban and rural settings, (2) the state-wide plan for the coordinated delivery of emergency medical services adopted pursuant to subdivision (1) of section 19a-177, and (3) guidelines or standards and contracts or written agreements in use by municipalities of similar population and characteristics.

Sec. 19a-181b. Local emergency medical services plan. (a) Not later than July 1, 2002, each municipality shall establish a local emergency medical services plan. Such plan shall include the written agreements or contracts developed between the municipality, its emergency medical services providers and the public safety answering point, as defined in section 28-25, that covers the municipality. The plan shall also include, but not be limited to, the following:

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

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

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

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

(b) In developing the plan required by subsection (a) of this section, each municipality: (1) May consult with and obtain the assistance of its regional emergency medical services council established pursuant to section 19a-183, its regional emergency medical services coordinator appointed pursuant to section 19a-186a, its regional emergency medical services medical advisory committees and any sponsor hospital, as defined in regulations adopted pursuant to section 19a-179, located in the area identified in the plan; and (2) shall submit the plan to its regional emergency medical services council for the council's review and comment.

Sec. 19a-181c. Removal of responder. (a) As used in this section, "responder" means any primary service area responder that (1) is notified for initial response, (2) is responsible for the provision of basic life support service, or (3) is responsible for the provision of service above basic life support that is intensive and complex pre-hospital care consistent with acceptable emergency medical practices under the control of physician and hospital protocols.

(b) Any municipality may petition the commissioner for the removal of a responder. A petition may be made (1) at any time if based on an allegation that an emergency exists and that the safety, health and welfare of the citizens of the affected primary service area are jeopardized by the responder's performance, or (2) not more often than once every three years, if based on the unsatisfactory performance of the responder as determined based on the local emergency medical services plan established by the municipality pursuant to section 19a-181b and associated agreements or contracts. A hearing on a petition under this section shall be deemed to be a contested case and held in accordance with the provisions of chapter 54.

(c) If, after a hearing authorized by this section, the commissioner determines that (1) an emergency exists and the safety, health and welfare of the citizens of the affected primary service area are jeopardized by the responder's performance, (2) the performance of the responder is unsatisfactory based on the local emergency medical services plan established by the municipality pursuant to section 19-181b and associated agreements or contracts, or (3) it is in the best interests of patient care, the commissioner may revoke the primary service area responder's primary service area assignment and require the chief administrative official of the municipality in which the primary service area is located to submit a plan acceptable to the commissioner for the alternative provision of primary service area responder responsibilities, or may issue an order for the alternative provision of emergency medical services, or both.

Sec. 19a-181d. Hearing re performance standards. (a) Any municipality may petition the commissioner to hold a hearing if the municipality cannot reach a written agreement with its

primary service area responder concerning performance standards. The commissioner shall conduct such hearing not later than ninety days from the date the commissioner receives the municipality's petition. A hearing on a petition under this section shall not be deemed to be a contested case for purposes of chapter 54.

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

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

(d) If, after a hearing authorized by this section, the commissioner determines that the performance standards adopted in the municipality's local emergency medical services plan are unreasonable, the commissioner shall provide performance standards considered reasonable based on the state-wide plan for the coordinated delivery of emergency medical services adopted pursuant to subdivision (1) of section 19a-177, model emergency medical services plans and the standards, contracts and written agreements in use by municipalities of similar population and characteristics. If the municipality refuses to agree to such performance standards, the primary service area responder shall meet the minimum performance standards provided in regulations adopted pursuant to section 19a-179.

EXHIBIT B

PERFORMANCE BENCHMARKS

Development of performance metrics to evaluate the performance of the EMS system and its providers is a commendable goal. Development of such metrics, however, must be thoughtful to ensure that the metrics are reasonable, applicable to providers serving difference geographic areas and ultimately improve the quality, effectiveness and efficiency of the entire EMS system.

The task of evaluating EMS systems and pre-hospital care is difficult due to the number and complexity of variables in uncontrolled pre-hospital environments. Traditionally, EMS performance measures have been divided into three categories: (i) input measures that assess the capabilities of the system (e.g., number of ambulances per capita); (ii) process measures to evaluate the procedures and protocols implemented by EMS systems (the best known example is a measure of response times); and (iii) outcome measures of EMS operations (e.g., mortality rates of cardiac arrests attended to by EMS providers).

Typically, response time as a performance metric is used because it is easily quantifiable, objective and easily understood by the public and policymakers. Recent studies have shown a lack of conclusive evidence supporting solely shorter response times and a correlation with better outcomes in cardiac arrest, trauma and medical life threatening emergencies. The role of solely measuring response times in evaluating EMS system performance, therefore, is of limited value.

The questionable value of response time alone should prompt EMS systems to consider and implement comprehensive evidence based performance metrics that are shown to improve outcomes, efficiency and effectiveness. The performance metrics should consider the overall EMS system design that includes: communications infrastructure; first responder support; response, scene activity and care; destination transport; performance specifications; level of provider and scope of practice outlined by state and local protocols; and prospective and retrospective medical direction. Operational success of an EMS system is based on such design and its interrelated components. Thus, performance metrics must be developed for each of these components to ensure improvement within the EMS system.

Performance metrics should be evidenced based. Evidence based performance metrics are quantifiable, valid, useful and usable, and have a high likelihood, if met, of improving outcomes and improving or enhancing the efficiency and effectiveness of processes, procedures and protocols. Evidence based performance metrics can be adopted from those currently existing or can be developed by a task force charged with the duty to do so. Adopting or developing evidenced based performance metrics, however, is an enormous undertaking in both time and money. For instance, the State of California has spent a number of years creating performance metrics and data regarding these metrics with the goal of ultimately establishing evidenced based performance metrics for EMS. The project is still a work in progress. Whether evidenced based performance metrics are adopted from existing metrics or are newly developed, significant consideration must be given to selecting the appropriate and reasonable metrics for each component in the EMS system, as well as considering the geography in which EMS systems provide services, fiscal constraints and potentially labor issues. Development of thoughtful and meaningful performance benchmarks cannot be reasonably completed by this task force within the next six weeks. It is strongly recommended that the development of performance benchmarks be delegated to a separate committee or deferred for future review by this Task Force so that appropriate consideration and thoughtfulness can be devoted to such an important task that has a far reaching impact on the EMS system of Connecticut and the public.