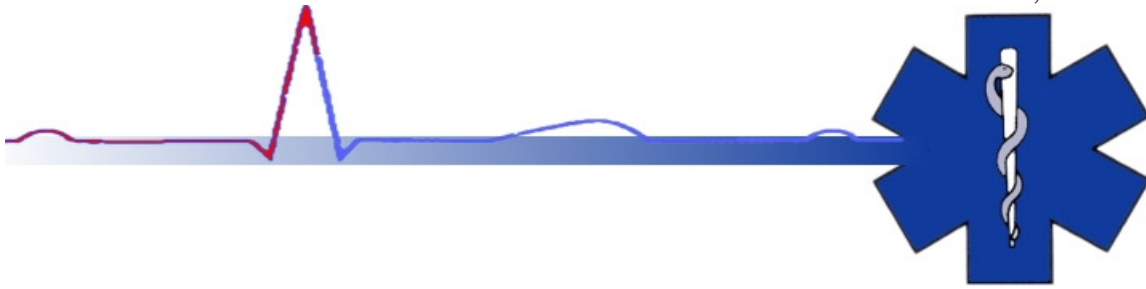




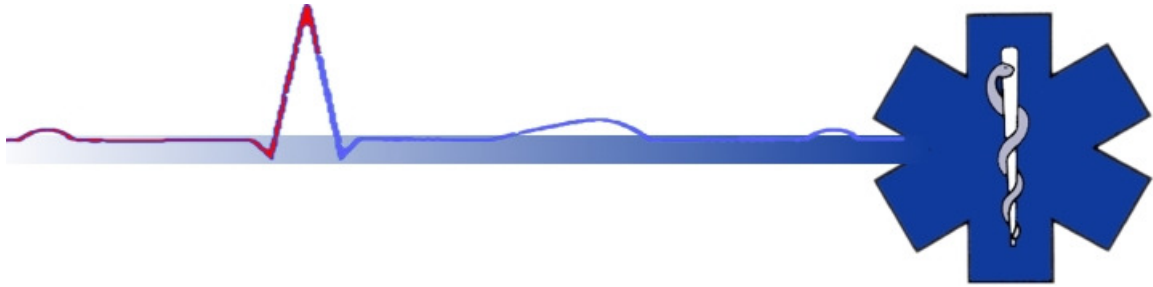
# **Connecticut Emergency Medical Services Plan**

A System to Save Lives



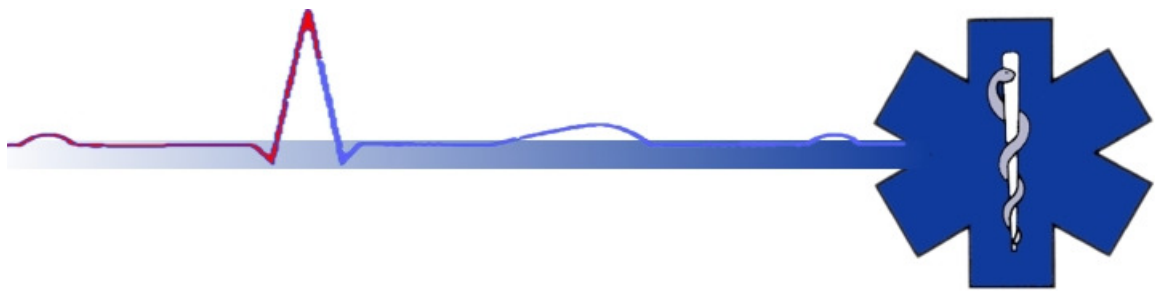
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## **Dedication**

**This plan is dedicated to the courageous men and women who selflessly serve the public by providing on site immediate and high quality pre-hospital emergency medical care in an effort to save lives and ameliorate injury.**



## What People are Saying About Us

It is only now, a month later that I can start to gather some thoughts on the accident that took place on October 15<sup>th</sup> at the intersection of Godfrey and Route 53. It is a scene that will be with me forever, and one that me and my family will be forever grateful to all of you for being a part of.

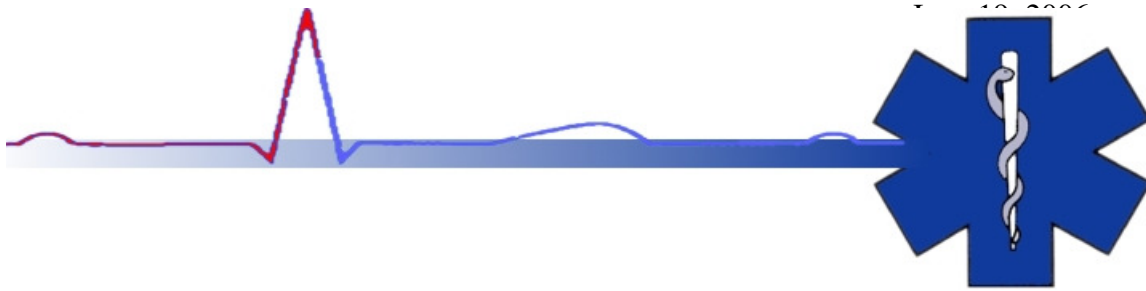
I remember running upon the scene, not only knowing all of the young ladies in the accident, but somehow knowing all of you, Weston's emergency response team. The confidence with which you all worked, the knowledge, skill and compassion you showed each of the nine girls, as well as how you calmed and managed all of us, the parents, friends, and on lookers, for all of this, and so much more, we thank you.

I suppose it is always the way. You don't realize how special something is, until you either need it, or loose it. We will struggle the rest of our days trying to find a way to truly show you our appreciation for your role and care in getting Gwen safely out of the car and to the hospital. She spent 16 days there, recovering from surgery and a variety of injuries. We are now home, continuing to stay the course of healing and life ahead.

To those of you that volunteer your time, we pray that you feel our appreciation and that your personal rewards in serving our community are many. It truly takes a special person that can in a seconds time, be there to assess the trauma, know the victims, and to perform the needed care. We are grateful to you for your commitment. To our wonderful Police force, your responsibilities in keeping our community safe are many. Our requests and requirements are endless. You are always there, problem big or small. You too, are in our prayers of gratitude and good wishes. For all of you, our community is blessed.

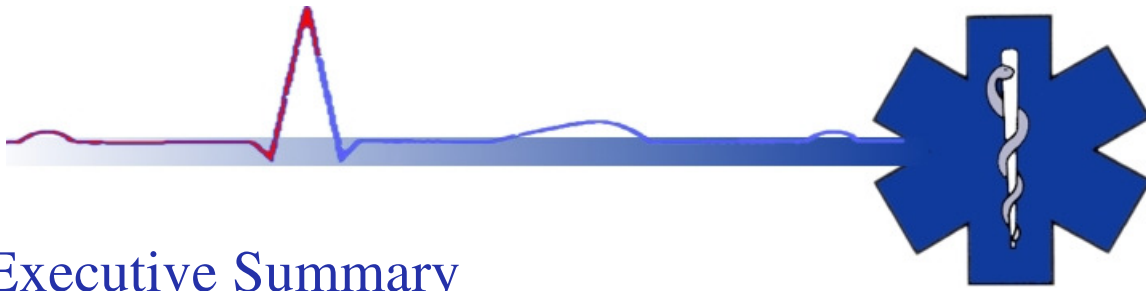
With heartfelt appreciation,  
G and B K

Note: See additional patient comments on the cover pages of other sections of this plan.



## Mission Statement

**The Mission of the Connecticut Emergency Medical Services System is to save lives and minimize disability through the creation of regional networks of Emergency Medical Services providers. Such a system will insure that consistent and high quality pre-hospital emergency medical care is available throughout the state 24 hours per day, seven days per week.**



## Executive Summary

Any one of Connecticut's residents can experience the need for Emergency Medical Services (EMS). This need can happen at anytime and in any place. Consequently there are no off hours, no down times. The "store" is never closed and that makes EMS different from a lot of other services. That's a fact that needs to be remembered. There are no open or closed hours, there are no holidays and no time off. The demand can be predictable, around the holidays when people may mix alcohol and driving, often with deadly results; or unpredictable, as on a bright clear day when a truck loses its brakes on a hill and slams into a line of waiting vehicles killing four and sending scores to the hospital. Some of those victims never knew what happened during the accident on Avon Mountain in July 2005. For the lucky ones who survive, some of their first memories are of being pulled out of a burning vehicle or that of an emergency medical staff person kneeling over them reassuring them that everything will be all right. Fact of the matter is that they may not really know for sure that everything is going to be all right. In the EMS business HOPE is a huge commodity, and hoping out loud is a lot like praying and since prayers can be answered, you just do it.

A spectacular accident, like the kind that happened in Avon is the kind of stuff that makes national news, the kind that gets people calling their family and friends and going home to hug their kids because they are healthy and alive and in one piece. To be sure there are other less spectacular accidents or emergencies that happen on a day-to-day basis. Many of them too are critical and many of them result in saved lives.

No one organization can be available to every person in every area of the state everyday of the year 24 hours a day 7 days a week. It's a daunting task, but that the job of the EMS system. It requires highly skilled staff that are trained in both interpersonal skills and high tech equipment. They have to be willing to jump out of bed in the middle of the night and rush off to the scene of an accident or some other life-threatening emergency. What's truly remarkable is that many of them are volunteers and without these people the EMS system wouldn't work. It just wouldn't work. Pause for a moment and think about that. The fact that this business of life and death wouldn't work without volunteers! That is truly, truly remarkable and something that needs to be supported. Oh, and finally let's not forget that they often have to get there in six minutes or less, otherwise, the mission turns into a "recovery" rather than a "rescue".

To provide Emergency Medical Services all across the state of Connecticut requires a collaborative, coordinated network of providers. When one EMS team can't make it to a scene then another is called in through a system of mutual aid. The State of Connecticut Department of Public Health seeks to coordinate these efforts via regulations and regional coordination. It is in light of the necessity to coordinate and work together to insure the best service in the quickest timeframe that this plan has been conceived and

brought to fruition. *This plan seeks to identify what needs to be accomplished when it needs to get done and who will do it.* In this regard the plan serves as a management tool to maintain focus, assess progress toward goals and, when necessary, shift resources to insure their accomplishment. It could not have been accomplished without the dedicated effort of each of the EMS Advisory Boards and its committees and each of the regional EMS coordinators and the staff of the Department of Public Health.

## **Essential Findings**

- The likelihood of the occurrence of public health emergencies has increased dramatically. Natural and man-made disasters related to climatic changes and other conditions have been forecast to increase in number. Terrorism related to political and social instability demands a larger and larger share of governmental and private sector resources. Emerging new diseases and the possible ease of their spread is a current and ongoing concern. All of these issues will make the need for emergency medical services an essential and increasing reality in the years ahead.
- The provision of emergency medical services requires a competent and highly skilled workforce that is trained to deliver care to people of all ages in a myriad of adverse circumstances. Additional education and training opportunities will be required to keep pace with technological advances.
- Communication is essential to the delivery and coordination of efforts that respond to public health emergencies. Multiple communication system must be in place and be interoperable to insure command and coordination of services.
- Federal, state and local governments must work cooperatively particularly in responses to mass casualty care in order to maximize scarce fiscal resources.
- Data must be continually collected and analyzed to assess program effectiveness and design programs that are most effective in meeting needs for emergency medical services.

## **Map Information**

A series of six maps are presented on the following pages. These maps provide information on the availability of various levels of Emergency Medical Services to towns throughout the State of Connecticut. These maps are as follows:

**Note: Maps will be provided at a later date as well as information related to DMHAS and the volunteer committee.**





**DRAFT**  
June 19, 2006

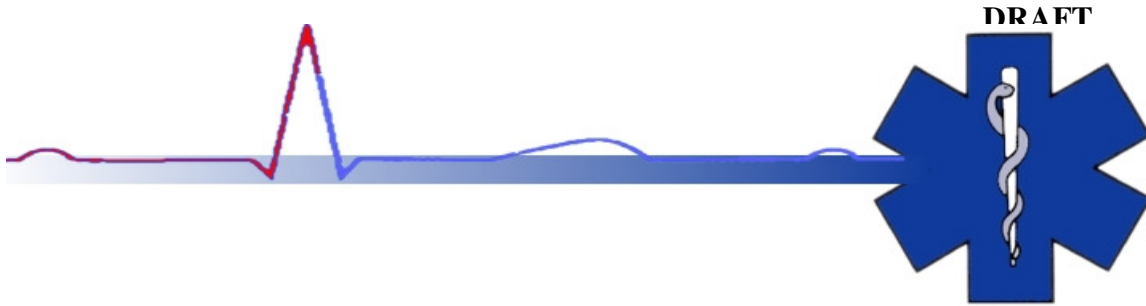
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# Priority Areas

With Goals and Objectives

# model EMS system



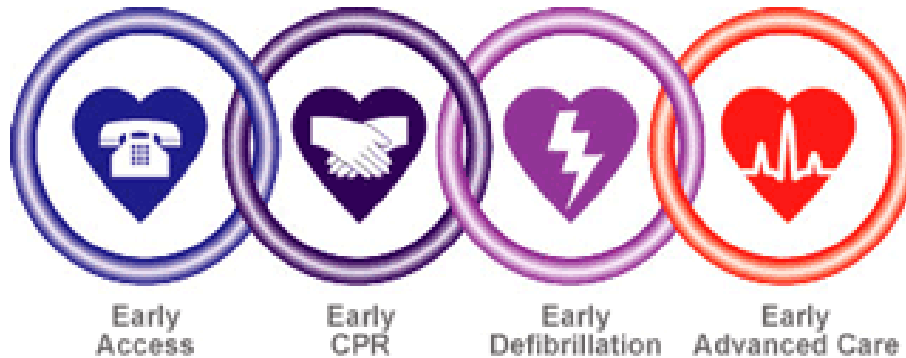
**I have used EMS twice for myself and previously for my late wife on several occasions. They are the greatest! One reason that I am staying in the town of Greenwich, in my retirement, is the Greenwich Hospital and the EMS Service. They are both outstanding. I feel quite secure here.**

**K.M.**





# MODEL EMS RESPONSE SYSTEM



The "Model EMS Response System" has been developed to assist the reader of this plan in understanding what constitutes a coordinated and comprehensive emergency medical response system. Each of the components should be addressed appropriately in order to achieve maximum effectiveness from the EMS system by strengthening the "*Chain of Survival*".

## PREVENTION

**Prevention is a "response" to the fact that many medical emergencies are indeed preventable. The two most prominent medical emergencies in the United States are traumatic injury and sudden cardiac death.**

- Traumatic injury is a preventable public health problem
  - It is the leading cause of death between the ages of 1 and 44 years
  - A reduction in mortality and morbidity can be accomplished through coordinated public information/education and prevention programs include:
    - Providing programs designed to alter behavior or guide decision making (e.g. drunk driving campaigns, seatbelt education, gun safety programs);
    - Enacting laws to protect-the individual (seatbelt law, motorcycle helmet law, child bicycle helmet law);
    - Providing environmental protection devices (e.g. smoke detectors, air bags, anti-lock braking systems).
    - Providing programs for conflict resolution education are needed to help mitigate potentially volatile situations.

- Cardiovascular disease is the overall highest cause of death in the general population,
  - promotion of smoking cessation programs,
  - exercise programs,
  - proper diet and weight control.

## **CITIZEN RECOGNITION AND ACTION**

**Through public information and education programs, the general population must know several factors with regard to the EMS System. First, they must know what the system is and must appreciate what the system is not.**

- EMS is a system to deliver fast and effective medical care in emergency situations.
  - It is not a replacement for primary care.
  - It should be used when an individual believes that a time critical, potentially life-threatening health crisis has occurred.
- At least 25% of the public should be trained in "bystander EMS" which includes:
  - Recognition of life threatening injuries and illness,
  - Access the enhanced 9-1-1 system immediately.
  - Learn to perform CPR,
  - Learn to control hemorrhage, and
  - Understand when not to move a patient unnecessarily.

## **NOTIFICATION**

**Rapid citizen access to emergency care is greatly facilitated by the statewide availability of an enhanced 9-1-1 (E 9-1-1) system that immediately pinpoints the address and telephone number of the calling party on a computer screen at the appropriate public safety answering point (PSAP).**

- Educate the public on the proper use of 911
- Assure cell phone and cable phone users accurate access through 911
- Ensure that all streets are clearly identifiable by responding emergency services and that all businesses and residences are properly numbered.

## **DISPATCH**

**In order to realize the maximum effectiveness of the statewide E 9-1-1 system, the public safety answering point should be designed so that minimal time is lost between the receipt of the call and the dispatch of emergency medical help to the incident location.**

- All dispatch centers must be staffed by properly trained emergency medical dispatchers (EMDs).

- To perform medically appropriate interrogation to determine the best utilization of emergency personnel and equipment.
- To provide pre-arrival instructions to callers based on established protocols. Trained EMDs can effectively guide untrained callers to:
  - Perform CPR over the telephone.
  - Perform Heimlich maneuver
  - Or simply to tilt the victims head to open an airway,
- Medical Direction **must** be incorporated to provide quality assurance review and continuous quality improvement.

## SCENE CARE

### **Successful intervention in medical and traumatic emergencies is time critical, and dependent upon a multi-disciplinary organized system.**

- First responders must be identified in each community with sufficient units strategically deployed to ensure a 4 minute response to all life-threatening calls with personnel:
  - Trained and certified at least to the Medical Response Technician (MRT) level
  - Trained and equipped to provide early defibrillation through the use of an automatic external defibrillator (AED)
- BLS ambulance dispatched simultaneously with the first responders to meet a 6-8 minute response time.
  - Staffed by two Emergency Medical Technicians (EMTs) or EMT-Is.
  - Equipped BLS vehicle certified by DPH
  - Equipped with radio communication to EMS communication centers (CMEDs) to provide the recorded coordination between the field providers and hospital medical direction.
- Paramedic level service should be available to all communities with a maximum response time of 10 minutes to provide Advanced Life Support care.
  - Endotracheal intubation,
  - IV therapy,
  - Medications,
  - Cardiac defibrillation,
  - Cardiac pacing
  - Transmitting of patient assessment data to the hospital

### **This plan recognizes that geographic, environmental and other site-specific variables may present impediments to the realization of the time frames set forth above.**

- An emergency medical response system can be configured in a number of ways as long as it meets medical and regulatory requirements.
- Rural, urban, and suburban modifications are included in the appendices.

## TRANSPORTATION AND CARE EN ROUTE TO HOSPITAL

**All transportation should be directed to the facility that has the capability for providing the care necessary in accordance with the patient's condition.**

- Determination is made based on written protocol and/or from medical control via radio.
- Transportation of a patient is usually by ground ambulance
- Aeromedical EMS service, with its rapid transport and sophisticated medical care capability may be summoned according to established protocol.
- In most cases, the patient destination is the nearest emergency medical facility.

**All determinations of patient destination should be in compliance with established guidelines and subject to medical control and peer review.**

## FACILITIES

**All emergency facilities should be categorized in accordance with their capabilities in the area of emergency and critical care medicine.**

- All emergency departments should have the capability to initially treat all patients according to accepted standards.
  - Physician and nursing personnel staffing these facilities should have specialized emergency medical training in:
    - advanced cardiac,
    - trauma life support
    - pediatric life support
  - The proper equipment necessary to provide for the basic emergency care and advanced resuscitative needs of both the pediatric and adult patient.
  - Daily inventories of critical areas, including ICU and CCU, so that patients can be directed to where critical care capability exists at any given time.

**Specific specialty care centers that treat cases such as burns, pediatric, TBI, etc., should be designated so that the two to four percent of the patient population requiring the sophistication of a specialty care center will have such availability.**

## MEDICAL DIRECTION

**Standardization of medical direction should allow pre-hospital personnel certified by the state to function statewide.**

**Medical direction should be provided for all pre-hospital care levels.**

- First responders at BLS level with AED capability,
- Basic level and advanced level ambulance services should be in conformance with written state medical guidelines, and under medical control.
- On-line medical direction should be specifically responsible for:
  - Authorizing advanced care beyond standard protocols
  - Directing patients to appropriate facilities based upon the assessment by field personnel and by the use of approved guidelines.
- Off-line medical direction responsible for ongoing medical evaluation of the performance of EMS personnel under their control.
  - Post-event medical audits of patients treated,
  - Identification of educational or technological weak areas, and the implementation of corrective measures.

**A tracking system should be in place at the state level that allows for the identification of individuals who have had their medical direction privileges**

#### INTERFACILITY TRANSFER

**Critical patients requiring transfer to specialty care centers must be handled appropriately according to State-wide standard guidelines.**

- Transferring facility must communicate with the receiving facility to ensure that it is able to accept the patient and provide the necessary care.
- Transfer of patients must assure continued acute medical care during the transport. This may require the mobilization of a specialized transport team.

#### REHABILITATION

**Rehabilitative care is critical to achieving optimal patient outcomes that includes family education, involvement, and support, as well as peer support**

- Rehabilitation medical consults,
- Physical therapy,
- Occupational therapy, and
- Speech/language/therapy.

# human resources education and training

**Dear EMS Heroes -**

**I'm taking a guess that you are somewhat accustomed to being heroes, but we are not used to having you fine people perform your heroic duties in our home.**

**Your very professional and well-trained response to the emergency at 24 Lords Highway last Saturday night October 25, is something that everyone at our son's birthday party will never forget (except the unconscious victim of a very severe asthma attack).**

**As you know, the victim was very close to losing her life that night, and we witnessed that only your extraordinary efforts saved her.**

**We want you to know that the victim is recovering at home after a two-night stay at Norwalk Hospital, and she seems to be as lucid in her thoughts as she has always been.**

**Thank you from the bottom of our hearts from both the family and the victim and her family for your unforgettable efforts.**

**J&M. B.**

## **Human Resources Education and Training**

### **Goal**

All EMS Training programs will conform to uniform national and statewide standards. Training programs will be available to ensure an approved proficiency level for every class of EMS personnel (citizen CPR, dispatchers, MRT, EMT, paramedics, emergency nurse, through to medical director.)

### **Objective 1 of 10**

Complete the integration of the new DOT EMT-B curriculum into the initial and refresher training programs.

#### **Action Steps**

- Formal EMT-B Education Program Evaluation in progress (curriculum compliance in terms of outcomes);
- Data collection in progress (record keeping improvements to confirm instructor / curriculum awareness);
- Course inspection program in development (confirm curriculum compliance);
- EMS Education CQI system in development (assure ongoing curriculum development / implementation).

#### **Staffing**

State EMS Education Coordinator

### **Objective 2 of 10**

Include early defibrillation training in all MRT, EMT, EMT-I, initial and refresher courses.

#### **Action Steps**

Regulatory intervention is suggested to fully accomplish this objective by January 1, 2007. Once approved it is to be mandated in all regions with a full complement of the required equipment.

#### **Additional Action Steps**

- Reminder letter from OEMS with T-1 Approval letter that AED Awareness (at minimum) is a required component of MRT Programs. By April 1, 2007.
- Assure curriculum needs of MRT class met by existing curricula. By September 1, 2008.
- Inclusion of AED related questions on certification examinations. By January 1, 2007.
- Enhance Data Collection for competencies (didactic and psychomotor) for AED curriculum components.
- Mandatory addition of Automatic External Defibrillators to EMS transport units will require Regulatory change.

- Distribute AED Module inclusion into MRT Program requirements reminder letter by March 2007.
- Implement curriculum compliance verification procedure by January 2007.

**Staffing**

Refer to Regulations Review Committee

**Objective 3 of 10**

Streamline the administrative functions of the OEMS training section. Introduce new technologies such as voice mail service, enhanced computerization for testing, test results distribution, certification verification and database maintenance.

**Action Steps**

Department of Public Health training division is to take the lead in streamlining the OEMS training functions and introducing the new technologies cited above. Staff is now in place to accomplish these goals.

**Additional Action Steps**

- Ongoing organizational role clarification and interpersonal communication
- OEMS Education Web page Development & Implementation expected by July, 2007
- EMS Education Program Evaluation with collection and analysis of existing data and identification of additional data needs with an initial progress report due in January, 2007

**Staffing**

EMS Education Coordinator & OEMS Training Division staff

**Objective 4 of 10**

Develop a standardized operating procedures manual for the OEMS Training Section. Include in this manual training requirements for all certification levels, practical/written testing process and a quality improvement program for EMS training programs.

**Action Steps**

Department of Public Health training division is to take the lead in standardizing the operating procedures manual for the OEMS training section. Staff is now in place to accomplish these goals.

**Additional Action Steps**

Work on this objective will be on going.



- Collection and analysis of current manual components with a preliminary analysis by January, 2007
- Assess Information and Data management needs is on going
- Continuation of evaluation process is on going;
- Development of electronic format with initial access of selected material by August 2007.

**Staffing**

EMS Education Coordinator & OEMS Training Division staff

**Objective 5 of 10**

The OEMS Training Division, in conjunction with the Regional Coordinators, will develop a plan to provide oversight of EMS courses and evaluate course test results. They will identify problems and develop a process of checks and balances to monitor course content.

**Action Steps**

- Define Roles and responsibilities within OEMS Training and clarify reporting structure, on an on-going basis.
- Complete EMT-B Evaluation (including EMS education Data Base system), initial assessments to be completed by January 2007.
- Implement effective OEMS web page with “Procedure Manual” and integrate instructors into direct data entry of course information, the initial phase of which should be implemented by July, 2007 with on-going refinements.

**Staffing**

EMS Education Coordinator  
Regional Coordinators  
CSEMSI  
Web page and Data Management Experts

**Objective 6 of 10**

In conformance with the trauma regulations, integrate pre-hospital field triage training into all EMS provider initial and refresher training.

**Action Steps**

Assign the tasks necessary to accomplish the outcomes of this objective to the training committee and the trauma coordinator. They will work with together in addressing this objective.

Additional Action Steps

- Revisit the Pre-Hospital Field Triage lesson plan and revise to current standards by the completion date of Trauma Regulation re-write date
- Update EMS-I's & other EMS / Trauma system instructional settings; distribute revised lesson plan / curriculum by the completion date of Trauma Regulation re-write date.

- Develop a compliance and competence process by the completion date of Trauma Regulation re-write date
- Investigate use of TRAIN, or other comparable system, for instructional / validation process by July, 2007

**Staffing**

EMS Education Coordinator  
State Training Committee  
CSEMSI  
Clinical Care Coordinators  
State Trauma Committee.

**Objective 7 of 10**

By September 1, 2009, every emergency vehicle operator will have successfully completed an Emergency Vehicle Operations Course which meets or exceeds the National Standard Curriculum – EVOC standards and which is approved by the State Office of Emergency Medical Services.

**Action Steps**

Refer to the training committee for minimum standards or adopt a specific approved program. Standards will need to be reviewed and approved prior to implementation.

- Complete State Training Committee Initiative by allocating necessary labor resources to meet February 2007 timeline
- Evaluate programs submitted for conformance to NSC expectations and feasibility; make recommendations by June, 2007
- Undertake Regulatory changes requiring OEMS approved EVOC before September 2007.
- Explore auxiliary funding options for EVOC (Grants, municipal / agency partnerships, insurer support, etc) before September 2007.

**Staffing**

EMS Education Coordinator  
State Training Committee  
Regulatory Review Committee

**Objective 8 of 10**

Annually conduct a statewide EMS educational conference for statewide education, information dissemination and team building.

**Action Steps**

Refer to OEMS training committee to advocate on behalf of necessity for state sponsored conference. Committee will explore required resources for statewide conference.

**Additional Action Steps**

- Investigate more official or formal connection to or investment in the annual EMS Seminar / Conference immediately after the 2007 conference; create a letter of understanding describing possible roles and responsibilities.
- Annually consider and develop an education agenda to coincide with each year's conference

**Staffing**

OEMS Training Division

**Objective 9 of 10**

Develop and maintain effective and efficient procedures for the dissemination of training information, policies and procedures to the regional councils and EMS providers.

**Action Steps**

The Department of Public health training division is to take the lead in streamlining the OEMS training functions and introducing the new technologies cited above. Staff is now in place to accomplish these goals.

**Staffing**

OEMS Training Division

**Objective 10 of 10**

Develop a joint certification program, with EMS involvement, to establish CPR, MRT and EMT as part of the public school curriculum focusing on students age 10 and above.

**Action Steps**

Research existing high school programs (in-state and out-of-state) to evaluate possible benefit to students and communities by July 1, 2007

Research Connecticut education districts to determine interest by January 1, 2007

Clarify objective to determine if other alternatives may already exist (Community Colleges, youth group sponsors such as Scouting organizations, local fire and EMS services receptive to "Junior" programs) by January 1, 2007

Research alternative funding sources to support any and all options by January 1, 2007

Explore Regional Council interest in sponsoring region wide (as opposed to state wide), school district shared participation in high school aged EMS programs by January 1, 2007.

**Staffing**

EMS Education Coordinator  
Regional Coordinators

# communications

**October 3, 2004**

**To EMS of Stratford,**

**On September 12, 04, Sunday about 9:30 pm I was having severe chest pain and my husband called 911. Within minutes your ambulance was here. I wish to commend and thank the group that came to my aid that night. I was having a heart attack and in much pain but you folks were so very professional and kind that, in spite of how I felt, I knew I was in good care.**

**I wish I could recall the names of your people and thank them personally. I know a young woman was tending to the intravenous and EKG hook-ups and 2 or 3 men were also about me. All spoke calmly and respectfully, which I so appreciated in such a humble and painful situation.**

**Your work, I know, aided the Bridgeport Hospital emergency doctors to continue where you left off. As best as I understand, I received an Angio-Seal Vascular closure device and coronary stent. I was in the hospital for one week and now am recovering at home and feeling stronger everyday and so thankful to God to be here. For me, you were “Angles in the Night” and I thank you from the bottom of my now healing heart for your dedication to such meaningful and blessed service.**

**I am sincerely grateful,**

**M.L.**

## **Communications**

### **Goal**

Develop a technologically effective and comprehensive emergency medical communications network to facilitate rapid access to care by the patient and provide the communications pathways between the field and the emergency medical facility necessary to enhance on-line medical direction/control.

### **Objective 1 of 6**

Maintain the requirement that all EMS vehicles be equipped to communicate over the state approved EMS communications system.

#### **Action Steps**

All ambulances are inspected once every two years by a certified DPH inspector. These inspections insure that, among other things, that the EMS radio communication equipment is installed in each vehicle and that these systems are in good working condition and fully operational.

In addition to state efforts, each of the regions will be strongly encouraged to review vehicles as needed to insure that these systems are fully operational as well. Both state and regional efforts will be ongoing. To assess effectiveness of these efforts the DPH/OEMS will issue a report that will be distributed to each of the EMS regional coordinators by January 1, 2007 (and each year thereafter) summarizing compliance with this objective.

#### **Staffing**

DPH/OEMS inspectors and related staff  
EMS Regional staff

### **Objective 2 of 6**

Develop a comprehensive State EMS Communications Plan and annually update that plan. This plan will address coordination issues and provide standards and operating procedures for the statewide EMS communications system. Further, the plan will promote the implementation of an approved EMS communications concept paper as the basis for the replacement of the existing communications system.

#### **Action Steps**

The statewide EMS communications committee will be re-established and a plan will be written which will include specific and measurable objectives. **The first draft of the plan will be due on January 2007.**

#### **Staffing**

OEMS communications staff  
Statewide communications committee

### **Objective 3 of 6**

Support the efforts of the State 9-1-1 Commission and the OSET in updating the capabilities of the statewide E 9-1-1 system and provide technical assistance as needed.

#### **Action Steps**

Support 9-1-1 Commission efforts and maintain the OEMS liaison to the 911 Commission. This activity will be conducted on an ongoing basis

#### **Staffing**

OEMS Communication Liaison

### **Objective 4 of 6**

Adopt comprehensive Emergency Medical Dispatch (EMD) standards and promulgate regulations to ensure implementation, maintenance, training and quality assurance statewide.

#### **Action Steps**

The Regional office will coordinate with OSET and OEMS in producing an evaluation tool and then conduct the evaluation and produce a report. An evaluation tool will be completed by January 1, 2007 and the actual evaluation will be completed by May 1, 2007. A final report on the status of EMD in CT will be completed by July 1, 2007.

#### **Staffing**

Combined effort of the Regional EMS Councils and the OEMS Communications Coordinator.

### **Objective 5 of 6**

Support the adequate funding of and resources for the existing EMCCs.

#### **Action Steps**

Through the Communications Committee, the EMS Advisory Board will track and support efforts to provide funding of and resources for existing EMCC's. These efforts will be ongoing.

#### **Staffing**

OEMS Communications Coordinator.

**Objective 6 of 6**

Develop the communications portion of the medical directors course. Implement a mandatory medical director's course with bi-annual medical director's training.

**Action Steps**

OEMS staff to work with CEMSMAC toward accomplishment of this objective. Development of the communications portion of the medical directors course will be accomplished by the EMS Communications Coordinator. Implementation of the mandatory medical director's course with bi-annual medical directors training will be accomplished by the OEMS Medical Director. These will be completed by January 2007.

**Staffing**

DPH/ OEMS Communications Coordinator.

# EMS for children

Dear EMS Service,

I just wanted to put into writing how I feel about the EMS service, in particular the Storms ambulance crew. Unfortunately for me, we have had to use their services frequently the past few years. When my son was critically injured in a bicycle accident, there was an immediate response to me, someone was on the phone with me until the ambulance came, the crew did an excellent job getting my son where he needed to be in a quick and efficient manner and seeing to it my needs as a frantic mother were met. Our best friends were right there with me in the hospital until his condition stabilized. I don't think they were there because we were friends. In fact I know that if it were someone else who needed them they would be there. Many times during family parties or being out to dinner they were called away to an emergency. There isn't a more precious gift than giving up one's time when a person is in need of emotional support.

Living in Derby and knowing the people from the Storms gives me a great reassurance that should someone in my family need their help, a well educated caring team of individuals will respond to the call. At the most tragic time of my life when I lost my son, the whole company was there to lend their support. I can't put into words how much that meant to me. I have seen them in action at the football games, all levels, from Pop Warner to High School games. Derby is one of the very few towns that have their ambulance at the fields. It just goes to show you how committed they are to community service. You can always count on The Derby Storms to be out at Christmas time throwing popcorn balls to the children and throwing candy at the Memorial Day Parade. They go into the school and talk about child safety. They do a boot drive for people in need. They have to be ready to place their own life on the line to take care of someone else. That requires the utmost courage.

I could go on and on about the many wonderful things the Storms do but you said it had to be brief. In closing EMS services are the front line hero's and they deserve more recognition for the excellent service they provide.

J. G.



## EMS for Children

### Goal

Optimize the level of emergency care for children within the existing structure of the statewide EMS system.

### Objective 1 of 7

Develop a comprehensive 5-year plan that will address the needs of children within the EMS system.

#### **Action Steps**

These goals will be accomplished by a collaborative effort among various State EMS Committees that can affect change in the area of pediatric prehospital care. The committees include EMS-C Advisory Committee (subcommittee of the State EMS Advisory Board), The State EMS Clinical Coordinators Group, CT. EMS Medical Advisory Committee and the State Trauma Committee

#### **Staffing**

The EMS-C coordinator will facilitate this groups toward the goal of sharing ideas, policies and protocols.

### Objective 2 of 7

In conjunction with the Advisory Board Funding Committee, explore and develop funding sources for continued implementation of the EMS-C plan.

#### **Action Steps**

EMS-C coordinators will continue to communicate with the national office, on all EMS-C related issues. On going basis as information becomes available from the federal level this information regarding funding and other important information will be shared with the EMS-C committee

#### **Staffing**

The EMS-C coordinator will facilitate this process.

### Objective 3 of 7

Standardized statewide data collection of pediatric prehospital care as well as the pediatric trauma patient.

#### **Action Steps**

At the present time OEMS-DPH collects data from prehospital providers in a hard copy form, with limited pediatric information.

Computer data collection of prehospital PCRs is presently being Beta testing(May 2007) Implementation of Statewide data collection targeted for (July 2007).

Computer data collection for the Statewide Trauma Registry implementation targeted for 01/06

**Staffing**

EMS-C coordinator, OEMS/DPH Epidemiologist to facilitate this process

**Objective 4 of 7**

Training /Guidelines: The prehospital care providers will continue to have standardized pediatric education i.e. PALs and PEPP. Prehospital providers will have sound evidence based and consistent protocols/guidelines.

**Action Steps**

This will be accomplished as a collaborative effort with the EMS-C subcommittee of the state EMS Advisory Board, EMS Clinical Coordinators Group, CEMSMAC, and the state Trauma Committee.

**Staffing**

Facilitated by the EMS-C Coordinator/Clinical Coordinator OEMS

**Objective 5 of 7**

Prehospital provider agencies will have the essential pediatric equipment and supplies needed. As outlined in the American Academy of Pediatrics/ American College of Emergency Physicians Joint Guidelines for BLS and ALS providers. As well as State of Connecticut EMS Regulations. Will know the status of all BLS/ALS provider ambulance services equipment by December, 2007 to be able to make recommendations to services.

**Staffing**

EMS-C coordinator will facilitate this process.

**Objective 6 of 7**

Coalition building to enhance the care of the pediatric patient. To bring together other groups interested in the health and well being of the pediatric population. Coordinated with in the EMS-C program. This group could include cooperate sponsors, to enhance current pediatric initiatives, As well as family representatives on the EMS-C Advisory Group.

**Action Steps**

EMS-C/OEMS will work with EMS-C Advisory Group to seek out family representative. Will network with other groups interested in the needs of children i.e. Family Health Division of Department of Public Health and Safe Kids of CT.

**Staffing**

EMS-C coordinator will facilitate.

**Objective 7 of 7**

Integrate EMS-C into EMS/Trauma regulations

**Action Steps**

Representatives from Pediatric Subcommittee of the State Trauma Committee as well as EMS-C representation. Will have input as to new regulations. Trauma Regulation revision process will start in Fall 2007.

**Staffing**

EMS-C coordinator, representative State Trauma Committee to name representative.

# medical direction



Dear Coordinator Eastern CT EMS Council,

I wanted to share with you something that happened recently regarding a call that we responded to at Foxwoods Casino. In October 2005, our EMS crew responded along with the First Responders to a report of a man in cardiac arrest at Foxwoods Casino. Upon arrival, the first responders found a 52-year-old male in Cardiac arrest, with bystander CPR being performed. The First Responders applied an AED and defibrillated him. Enroute to the hospital, the patient regained consciousness and has since been released and is back to work at as an engineer at the World Financial Center in New York.

The patient contacted American Ambulance in December, looking to come up to Connecticut and meet the people who saved his life, from the First Responders to the ER and CCU staff. When he saw the paramedic, he ran over to him and enveloped him in a bear hug, saying, "I can't thank you enough!" He was very happy to meet everyone who was involved in his care, telling them "I wouldn't be alive if it weren't for all the wonderful people who took care of me!"

The patient told us that everyone he works with had taken a CPR class as a result of his experience. He asked his Doctors if he was cleared to take a CPR class and to make sure it would be safe for him to use an AED if needed. They gave him the go-ahead and he came to American Ambulance the next day and took a CPR/AED class. He was very grateful for the care that he received and very impressed with the EMS system that was in place when he went into Cardiac Arrest.

Sincerely,

J. B.

## **Medical Direction**

### **Goal**

Ensure that emergency medical care is rendered consistent with standards of quality medical practice via the involvement of the physicians in design, implementation, management and provision of emergency care.

### **Objective 1 of 11**

Define the roles, responsibilities and authority of the Office of Emergency Medical Services (OEMS) Medical Director and the Connecticut Emergency Medical Services Medical Advisory Committee (CEMSMAC). Define roles of other related providers of medical direction.

**Action Steps** Currently under discussion/update via the Regulation Review/Revision Committee. Consideration being given to statewide medical direction and CEMSMAC reporting directly to the Commissioner of DPH.

**Staffing:** Medical Director (lead), OEMS staff and Regulations Revision/Committee.

### **Objective 2 of 11**

Revise existing EMS regulations to reflect the American College of Emergency Physicians (ACEP) definition of medical direction and make recommendations related to required qualifications.

**Action Steps** Underway. Committee meets monthly after EMS Advisory Board meeting. Plan is for permissive language to reflect accepted standards of practice from organizations such as ACEP, ACS.

**Staffing:** Medical Director (lead) OEMS staff and Regulations Revision Committee.

### **Objective 3 of 11**

Develop statewide protocols for medical directors and their provision of medical control directives. Develop a training program and a handbook for medical directors.

**Action Steps** While current policy is for each sponsor hospital and its designated medical control physician to develop and promulgate their own set of protocols, there has been a move toward regionalization of protocols. This shift has opened the door to discussion of statewide EMS protocols, a much debated concept. Included in the discussions surrounding the Regulation Review process is the concept of single medical control for the State and thus a single set of protocols. While this is in its infancy, it has raised the question of statewide protocols and seems to be gaining favor. Training would

be inherent in this process and would likely involve the EMS Advisory Board's Education and Training Committee.

**Staffing** This concept is being worked on by the Regulations Review Committee.

### **Objective 4 of 11**

Develop criteria for the DPH evaluation of sponsor hospitals' responsibilities and interaction with EMS services during the inspection process.

**Action Steps** None at present.

**Staffing**

### **Objective 5 of 11**

Develop a process for pre and post evaluation of sponsor hospitals' EMS interaction and responsibilities by the EMS regional councils.

**Action Steps** None at present.

**Staffing**

### **Objective 6 of 11**

Establish "Levels of Care" protocols for all certification and licensure levels and associated standing orders for pre-hospital care.

**Action Steps** Refer to question regarding Statewide Protocols. Would apply to all levels of care. Additionally, the State OEMS is following closely the National "Scope of Practice Model" being developed. Initial review has been favorable and acceptance of this model would be the likely course of action for Connecticut.

**Staffing** As above (pending the "Scope of Practice Model"). Regulations Review Committee, and eventually the Education and Training Committee of the EMS Advisory Board.

### **Objective 7 of 11**

Require the provision of sponsor hospital medical control for all OEMS certified pre-hospital personnel including Medical Response Technician (MRT) and Emergency Medical Technician (EMT) basic personnel.

**Action Steps** None at present. May be brought up in Regulation Review. Moving toward this end naturally with the ability of all personnel to use the AED and EMT-B to use the Epi-Pen (both of which require medical control/sponsorship).

**Staffing** Regulations Review Committee, OEMS Medical Director, OEMS MIC Coordinator.

### **Objective 8 of 11**

Develop criteria for evaluating and reporting outcomes of Emergency Medical Direction (EMD).

**Action Steps** Statutory requirement for all approved EMD programs. Require internal medical direction and QA/QI.

**Staffing** Will likely fall to the Data Committee, along with the EMS Data Registry.

### **Objective 9 of 11**

Establish statewide protocols based on (EMTALA) for determining the patient destination for patients in the 911 system.

**Action Steps** The State of Connecticut supports and follows the transport rules as set forth in this federal legislation. There is currently no work toward formalizing these rules in State regulation.

**Staffing**

### **Objective 10 of 11**

Develop statewide protocols for inter-facility transfers.

**Action Steps** Currently under development through the guidance of the CEMSMAC. A critical care transport curriculum is being created and reviewed and will lead to guidance and protocols as to the appropriate movement of patients within our system. Decisions as to level of care required during transport will remain the purview of the transferring physician with/without consultation with the accepting physician.

**Staffing** CEMSMAC, EMS Advisory Board Education and Training Committee, OEMS Curriculum Development/Training personnel.

## Objective 11 of 11

Develop ethical standards of practice and establish a DPH due process review for the removal of medical control.

**Action Steps** Much discussion underway. At present this is left to the individual sponsor hospital medical control physicians. Some consideration is being given in the Regulation Review process. This has led to the consideration of a single point of medical control through the OEMS.

**Staffing** Regulations Review Committee, OEMS Medical Director, OEMS Director, OEMS legal counsel.

## **FACILITIES**

All emergency facilities should be categorized in accordance with their capabilities in the area of emergency and critical care medicine. This would include the categorization of all acute care general hospitals and freestanding emergency care facilities. All emergency departments should have the capability to initially treat all patients according to accepted standards. Physician and nursing personnel staffing these facilities should have specialized emergency medical training in advanced cardiac, trauma and pediatric life support. In addition, all facilities should have the proper equipment necessary to provide for the basic emergency care and advanced resuscitative needs of both the pediatric and adult patient. Daily inventories should be kept of critical areas, including ICU and CCU, so that patients can be directed to where critical care capability exists at any given time. Specific specialty care centers that treat cases such as burns, pediatric, TBI, etc., should be designated so that the two to four percent of the patient population requiring the sophistication of a specialty care center will have such availability.

## **MEDICAL DIRECTION**

Medical direction should be provided for all prehospital care levels. All prehospital care at both the basic and advanced level rendered by first responders, basic level and advanced level ambulance services should be in conformance with written state medical guidelines. Standardization of all elements related to medical direction should allow pre-hospital personnel certified by the state to function statewide regardless of their sponsor hospital, provider service affiliation, or location of original training program. The person providing on-line medical direction should be specifically responsible for directing patients to appropriate facilities based on the assessment by field personnel and by the use of approved guidelines.

Each first responder, basic, advanced and paramedic provider should have off-line medical direction that should be responsible for ongoing medical evaluation of the performance of EMS personnel under their control. This should include, but not be limited to, post-event medical audits of patients treated, identification of educational or technological weak areas, and the implementation of corrective measures. Based on the evaluation, a feedback mechanism will be used so that the individuals and providers of



prehospital emergency care can be kept up-to-date and corrective measures instituted according to statewide standards. A tracking system should be in place at the state level that allows for the identification of individuals who have had their medical direction privileges removed.

## **INTERFACILITY TRANSFER**

Few hospitals have the capability of handling the medical problems of all patients. Critical patients requiring transfer to specialty care centers must be handled appropriately according to standard guidelines. The transferring facility must communicate with the receiving facility and ensure that it is able to accept the patient and provide the necessary care. Transfer of patients should not involve a decrease in the ability to deliver medical care during the transport. This may require the mobilization of a specialized transport team.

## **REHABILITATION**

Rehabilitative care is frequently critical to achieving optimal patient outcomes. Rehabilitative services include rehabilitation medical consults, physical therapy, occupational therapy, and speech/language/therapy. Family education, involvement, and support, as well as peer support, is a fundamental component of rehabilitation.

# trauma system



**Dear Crew and Staff of the Deep River Ambulance:**

**My husband and I would like to make the enclosed contribution to the Ambulance Association. We also want to express how much we appreciate all that you do for our community and us personally. Your crew answered a call for help that we placed this year, which resulted in the saving of my husband's life. A day does not go by that I do not think of what happened and how lucky we are that people like you do such a challenging, stressful job day in and day out. With a blood sugar level of 8, there is no doubt that my husband's life would have been cut short in his 40<sup>th</sup> year if it were not for your compassionate crew. Your crew was kind, helpful, and professional and they responded quicker than I could have ever imagined and even carried my husband down the stairs and out the door to the ambulance.**

**When we think of how different our lives could be right now if we had to wait for assistance even five minutes farther away, it takes my breath away. Even though we don't thank you everyday, (which we should) please know that you are all in our hearts and minds and we wish you all the very best in 2005.**

**Though words cannot express all that we really feel, thank you for saving my husband's life. Because of your efforts he can hopefully look forward to another 40 years.**

**Sincerely,  
L and J W.**

## **Trauma System Goal**

Develop an organized statewide system of trauma care. Implement the necessary components of such a system in order to insure that the performance of the trauma system is cost effective, cost efficient, and provides the appropriate level of care to patients with major injuries.

### **Objective 1 of 8**

Participate in the development of the Statewide Trauma Plan Revision Process

#### **Action Steps**

The tentative deadline for the completion of the Statewide Trauma Plan is January 1, 2007. This Statewide Trauma Plan Committee will seek active participation and input from each of the EMS regions in revising the EMS sections of the Trauma plan.

#### **Staffing**

OEMS Section Chief

### **Objective 2 of 8**

Educate pre-hospital and hospital care providers regarding the system, policies, procedures and protocols.

#### **Action Steps**

Target date for the completion of this objective is planned to occur simultaneously with the rollout of the newly developed Statewide Trauma Plan. The tentative time frame for the rollout of this plan is June 30, 2007.

#### **Staffing**

OEMS Section Chief

### **Objective 3 of 8**

Provide financial opportunities to support pre-hospital trauma education programs from state, federal and private organizations and sources.

#### **Action Steps**

The state trauma coordinator will actively investigate and identify funding from state, federal and private organizations. This will be done on an ongoing basis through the regular and timely review of grant related literature, electronic notifications, announcements, etc. Once identified, financial resources for educational and related programs will be sought via grant application and other appropriate solicitations. This too will be done on a continuous basis. Information gained from the statewide

coordinator's efforts will be shared with the EMS Regional Directors on a semi-annually basis or as the funding arises. Similarly, regions are encouraged to share funding information they may have with the statewide coordinator. Such cooperation will maximize the probability of submitting successful funding applications.

**Staffing**

OEMS Section Chief

**Objective 4 of 8**

Collect and analyze statewide information related to trauma. Prepare and disseminate reports to regions and related providers that measure trauma system performance, cost, outcomes and other relevant indicators. Propose enhancements to the system based on the analysis of the data.

**Action Steps**

The initial attempt to down load the trauma data will occur in June 2007. The State Data Committee is developing queries to assist in this effort. Comprehensive, accurate and timely reports will be available for distribution to the State Trauma Committee by September 1, 2007. Reports will be disseminated to the Regional Councils on a quarterly or as needed basis.

**Staffing**

OEMS Section Chief  
Epidemiologist

**Objective 5 of 8**

Compile the trauma data that is to be gathered by the Connecticut Trauma Centers. Enter that data into the centralized Department of Public Health's trauma registry program. Prepare and distribute trauma reports to the Regional Emergency Medical Services (EMS) offices, which will include recommendations and guidance for improvement, and enhancement to existing EMS systems. Such recommendations will include injury preventions programs and other such programs that are specific to each region.

**Action Steps**

As of February 1, 2007, the Data Committee, a sub group of the State Trauma Committee is developing queries for these reports. Representatives from the EMS Advisory Board will be encouraged to collaborate with the Data Committee to assure that that the reports that are developed reflect all aspects of EMS trauma care.

The first attempt to down load the trauma data will occur in June 2005. The State Data Committee is developing queries to assist in this effort. Comprehensive, accurate and timely reports with region specific recommendations will be available for distribution to the State Trauma Committee by January 1, 2007. Subsequent reports will be disseminated to the Regional EMS Councils and others on a quarterly or as needed basis.

**Staffing**

OEMS Section Chief  
Epidemiologist

**Objective 6 of 8**

Develop a mechanism designed to collect, merge and then collate outcome data from the Department of Public Health (DPH) Trauma Data Registry and the Public Transportation Safety and Crash Data system. Such data will then be prepared in a report format that will be initially distributed to the EMS regions and utilized for planning and other related purposes.

**Action Steps**

This is a new initiative and hence the development of activities and timelines is conditional and may be based on unknown factors. Provisionally, the regions will be encouraged to discuss the feasibility of this initiative and respond with recommendations and a work plan to the statewide coordinator by April 1, 2007. Based on this regional input, the statewide coordinator will make initial planning contact with the Department of Public Safety by July 1, 2007. Collection and entry of the data will occur by November 1, 2007. A report will be prepared for dissemination by January 1, 2007.

**Staffing**

Epidemiologist (lead staff person)  
OEMS Section Chief (support)

**Objective 7 of 8**

Develop a mechanism designed to collect, merge and then collate outcome data from the Department of Public Health (DPH) Trauma Data Registry and the Public Transportation Safety and Crash Data system. Such data will then be prepared in a report format that will be initially distributed to the EMS regions and utilized for planning and other related purposes.

**Action Steps**

This is a new initiative and hence the development of activities and timelines is conditional and may be based on unknown factors. Provisionally, the regions will be encouraged to discuss the feasibility of this initiative and respond with recommendations and a work plan to the statewide coordinator by April 1, 2007. Based on this regional input, the statewide coordinator will make initial planning contact with the Department of Public Safety by July 1, 2007. Collection and entry of the data will occur by November 1, 2007. A report will be prepared for dissemination by January 1, 2007.

**Staffing**

Epidemiologist (lead staff person)  
OEMS Section Chief (support)

**Objective 8 of 8**

The Department of Public Health will identify all injury preventions programs within the State and work with them in an effort to provide effective and consistent injury prevention programming based on state and regional needs.

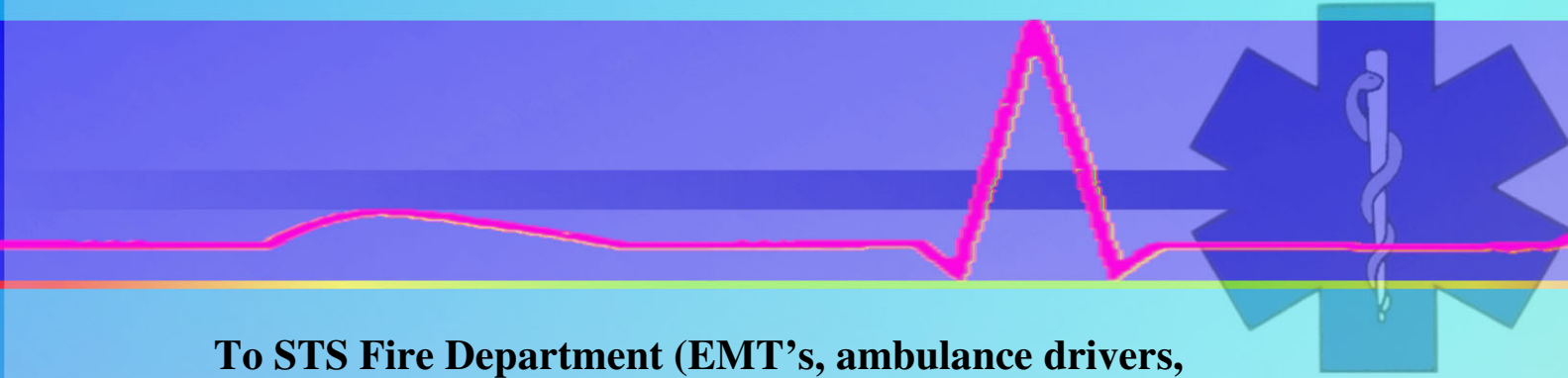
**Action Steps**

The Department of Public Health (DPH) will survey all acute care hospital and EMS agencies by September 1, 2007 and compile a list of their injury prevention programs. This list will be available for distribution upon request. Once this information is obtained a revision to the Resource Guide will begin. The revision to the resource guide is scheduled for completion by July 1, 2007. The DPH will also collaborate with other injury prevention organizations and, in cooperation with EMS, it will coordinate services as needed.

**Staffing**

OEMS Section Chief

# data and evaluation



**To STS Fire Department (EMT's, ambulance drivers,  
everyone in the Department):**

**No, it'll never be enough for you. You'll want to hear it over and over and over again. Yes, for the rest of my life, I'll be indebted to you. The cloud of indebtedness will hover over my head every day. You'll point and exclaim, "Say, what's that thing over your head?" And I'll answer, "It's my indebtedness to you." You'll pretend you're an old woman and say, "Eh, can't hear you dearie." "Me? Oh, it was nothing," you'll say in mock surprise. But that cloud will remain, an ominous testimony to the terrible power of good deeds and kindness. Oh, the horror, thank you.....**

**Thank you so much for everything you did for me. It's greatly appreciated. It's good to know that if someone gets hurt at work you ladies and gentlemen are only a few minutes away. Through your dedication, knowledge and courage I'm here able to write this thank you to you all. From the bottom of my heart, "Thank You All!"**

**God Bless you,**

**BW**



## **Data and Evaluation**

### **Goal**

Design a functional system for collecting data and evaluation system components to ensure the ongoing quality and integrity of the EMS system.

### **Objective 1 of 6**

Hire a full time data system manager. Maintain ongoing operation of the data system.

#### **Action Steps**

Hiring complete.

#### **Staffing**

Epidemiologist

### **Objective 2 of 6**

Develop a system that is “user friendly” so as to facilitate rapid integration into the daily operations of the EMS system.

#### **Action Steps**

Pilot (Beta) testing started in February 2007. Testing will last through August 2007. All EMS services will be required to send OEMS/DPH EMS data either by using the EMSDCS supplied by the State or any data system that will send compatible data in a state specified data format to OEMS.

#### **Staffing**

Epidemiologist

### **Objective 3 of 6**

Pilot test the data system and get approval from the EMS Advisory Board before formal acceptance and implementation.

#### **Action Steps**

Pilot testing is planned in four stages. The first phase will test data entry, screen flows, program logic and subjectively measure ease of use i.e. “user friendly ness”. The second phase will test data entry and sending data to the hospitals. The third phase will test sending data to OEMS in a state specified format that will be published so that services using a different data collection system can send OEMS their run data. The fourth phase will test EMS data being sent to an EMS services billing service. Additional testing will involve testing data entry on slate, and laptop computers.

#### **Staffing**

Epidemiologist



### **Objective 4 of 6**

Explore sources of long term funding, with Advisory Board funding committee, for the EMS data system.

#### **Action Steps**

This source of funding is stable and for the long-term unless it is reversed by the legislature.

#### **Staffing**

Epidemiologist

### **Objective 5 of 6**

Evaluate data system performance and make appropriate changes where necessary.

#### **Action Steps**

Ongoing

#### **Staffing**

Epidemiologist

### **Objective 6 of 6**

Disseminate reports that address EMS system performance based on the outcomes from hospital and Emergency department discharge data linked to the run reports of the EMS data system.

#### **Action Steps**

We are currently negotiating with the Connecticut Hospital Association to obtain the discharge data.

#### **Staffing**

Epidmeiologist

# mass casualty care

## **Ambulance Department:**

**This note is to extend my deep gratitude to your response to my son. I don't know who you were but I thank God for you everyday and I know that my son's fate was in your hands and his guardian angel's on that night. Thank you for your devotion and commitment to your call --- your call to help others in their time of need.**

**Thank you again,**

**E. M.**



## **Mass Casualty Care**

### **Goal**

All patients in Connecticut who are injured in an event where the patient capacity and need outweighs local resources will receive optimal emergency medical care at the scene, during transportation and at the hospital.

### **Objective 1 of 6**

There shall be a presence of the following planning components within 80% of all Connecticut towns and cities. Those components are:

- a. Written and approved local mass casualty response plans – Development of a Template.
- b. Written mutual aid protocols as part of the plan – Development of a formal evaluation for the above noted Template.
- c. Utilize formal evaluation guidelines in the evaluation of all drills and MC events.

### **Action Steps**

DPH will seek an update from the regional councils to compare plan submissions, which OEMS has on file. This will allow identification of towns that have not submitted their plan. A letter will be sent to those identified towns.

This objective will be accomplished by November 15, 2007.

### **Staffing**

OEMS Section Chief

### **Objective 2 of 6**

Train personnel who are assigned a primary or organizational role at all drills and actual MCI events. They will be trained via the Triage and Mass Casualty Scene Management course and in field evolutions. Train personnel who are assigned a secondary or support role in overview via a course in mass casualty scene management.

### **Action Steps**

Approved training materials will be made available to service providers Fall of 2007. Develop the role of the Regional Councils in both Education and Training of providers and coordinate activities with other Regional Councils by the fall of 2007.

### **Staffing**

OEMS Section Chief

### **Objective 3 of 6**

Achieve integration of all scene EMS operations to the National Incident Management System incident command structure.

**Action Steps**

Connecticut MCI Plan will integrate with NIMS – ICS.

**Staffing**

OEMS Section Chief

**Objective 4 of 6**

Achieve compliance in drills and actual field operations using Connecticut mass casualty protocols and guidelines.

**Action Steps**

Continue to support activities of the MCI Committee in the research and development of the MCI action plans.

**Staffing**

OEMS Staffing

**Objective 5 of 6**

Develop and implement an evaluation tool to be used in the evaluation of all MCI drills.

**Action Steps**

Develop and update evaluation process as related to Connecticut MCI plan and protocol, specifically note ICS component within the plan by Fall 2007. Assure compliance with National Incident Management System protocols by Fall 2007.

**Staffing**

OEMS Section Chief

**Objective 6 of 6**

Regulations will be drafted and introduced to mandate operational compliance with local EMS plans including MCI planning, PSA assignments, integration with first responders, etc.

**Action Steps**

Continue to meet with Regulation Review Committee and assure compliance of MCI Objectives. Meetings are held on a monthly basis.

**Staffing**

OEMS Section Chief

## **EMS – Roles and Responsibilities**

## **COMMISSIONER OF HEALTH**

The Commissioner of Health has overall authority and responsibility for the EMS System in Connecticut.

- Sets EMS policy and priorities
- Seeks and utilizes input from broad-based groups of providers and consumers, including comprehensive physician input
- Reports regularly to the Advisory Board on the status of the EMS system
- Promulgates regulations
- Reports to the Governor and Legislature regarding the EMS system

## **OFFICE OF EMERGENCY MEDICAL SERVICES**

The Office of Emergency Medical Services is responsible to the Commissioner for the coordination, administration, and enforcement of the state's EMS statutes, regulations, programs and policies.

- Coordinates, monitors, and evaluates the EMS system
- Develops state EMS plan in conjunction with EMS Advisory Board and Regional EMS Councils
- Reviews regional status reports and coordinates regional plan implementation
- Approves and oversees regional work contracts
- Provides technical assistance, consultation and training as needed to regional staff to facilitate regional plan implementation
- Works with the Advisory Board and Regional Councils to develop statewide programs and standards for the EMS system.

- - Coordinates with the EMS Advisory Board and the Regional Councils in developing and implementing an EMS data system that collects data from patient entry into the system through discharge from the health care system and feeds back data to the EMS providers and Regional Councils for quality assurance purposes on a timely basis
- - Approves and coordinates pilot programs
- - Develops regulations in conjunction with the EMS Advisory Board and Regional Councils and provides written interpretations of those regulations
- - Develops operational standards with written policies and procedures - Provides staffing to the EMS Advisory Board and Committees -Contracts with Medical Director to oversee medical accountability issues
- - Licenses and certifies personnel, provider organizations, facilities and approves sponsor hospital designations
- - Enforces regulations, investigates complaints and takes appropriate action
- - Collects inventory data and provides data to regional offices annually or more often as required
- - Sets rates for licensed and certified providers
- - Approves training standards
- - Inspects all regulated vehicles for compliance with federal and state standards
- - Categorizes medical facilities based on treatment capabilities
- - Coordinates the collection of inventory data by the Regional Councils and provides compiled summary reports
- - Develops criteria for the establishment of Primary Services Area (PSA) boundaries, MIC services and EMSI authorization
- - In conjunction with the State Office of Emergency Telecommunications, plans, coordinates and oversees the EMS communications system
- - Meets regularly with Regional Councils and CORC to facilitate system development, implementation and evaluation

**CONNECTICUT EMERGENCY MEDICAL SERVICES ADVISORY BOARD**

The EMS Advisory Board, utilizing its committees, serves as an advocate for EMS system development. The Board advises the Commissioner on EMS issues and develop programs and standards for the EMS system for approval by the Commissioner.

- Recommends EMS priorities
- Prepares and recommends a long term plan for the State of Connecticut -  
Reviews and recommends EMS regulations and statutes
- Develops and recommends system wide protocols, guidelines and standards  
-Make recommendations on the state EMS budget
- Develops and makes policy recommendations on EMS training programs
- Develops and recommends a statewide communications plan, provides for  
the statewide coordination of CMEDSIRCC's with accompanying standards for  
operational procedures, reporting and evaluation
- Develops and presents recommendations for statewide protocols and  
policies for mass casualty planning
- Develops and recommends a coordinated data collection system that can  
properly monitor the EMS system
- Develops and recommends a public information and education effort to  
prevent injury and increase knowledge of the EMS system for use at the local,  
regional and statewide level
- Studies, recommends, and advocates dedicated funding sources to insure  
future stability of the EMS system.
- Studies and makes recommendations on other EMS issues as necessary



## **CONNECTICUT EMS MEDICAL ADVISORY COMMITTEE**

The Connecticut EMS Medical Advisory Committee is representative of the pertinent statewide physician community and other emergency medical practitioners. It provides both the Advisory Board and the Commissioner with advice regarding medical policy for EMS system.

- Provides the other committees of the Advisory Board with advice and comment regarding the medical aspects of their projects. The Medical Advisory Committee provides comment in a timely manner
- The Medical Advisory Committee shall also have the option to report directly to the Commissioner regarding medically related concerns which have not, in the Committees opinion, been satisfactorily addressed by the Advisory Board
- The OEMS Medical Director, who serves as co-chair of the State Medical Advisory Committee, coordinates the flow of medical issues between the EMS Committees, State EMS Advisory Board, and the Regional EMS Medical Advisory Committee

## **COUNCIL OF REGIONAL CHAIRPERSONS**

The Council of Regional Chairpersons (CORC) serves as an advocate for EMS system development. CORC serves to provide coordination of the Regional EMS Councils.

- Meets regularly as a group
- Discusses planning, coordination and implementation of the statewide emergency medical services system and meets with the Director of OEMS to determine direction for EMS issues

## **REGIONAL EMS COUNCILS**

The Regional EMS Councils serve as an authorized extension of the state in implementing and evaluating state policy and programs at the regional and local level. They develop regional plans in conformance with State EMS Plan, coordinate and evaluate the delivery of EMS, and serve as a voice for the local communities in recommending continued development of the EMS system.

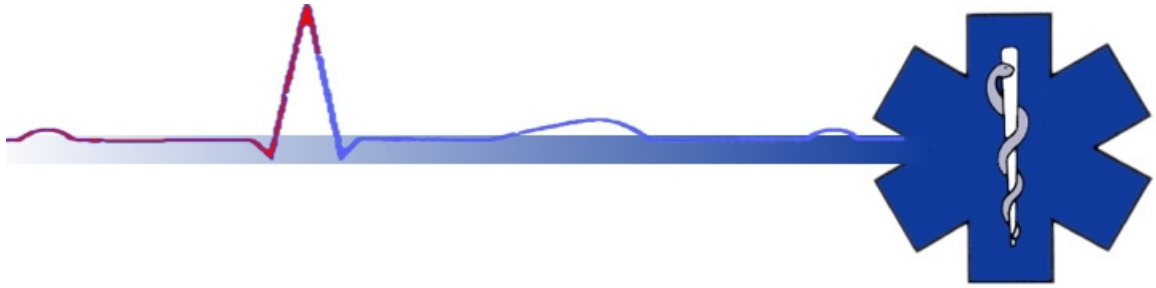
- Provide representatives to the EMS Advisory Board and its committees (also staff as needed and available)

- - Meet regularly with OEMS Director and OEMS staff
- - Review and make recommendations regarding EMS statutes and regulations -Direct regional staff in carrying out implementation plan
- - Foster close working relationship with all EMS providers
- - Work with OEMS to ensure implementation of operational policies and programs at the regional and local levels
- - Evaluate system effectiveness within their regions -Conduct regional needs assessments
- - Coordinate regional availability of training programs
- - Conduct pilot programs
- - Assist OEMS in conducting written and practical exams and approving training programs according to statewide standards
- - Work with local providers to conduct prevention activities and develop consumer participation in the EMS system
- - Foster public education regarding all aspects of EMS
- - Implement the State approved Public Information, Education and Relations (PIER) program at the regional level and encourage and facilitate implementation at the local level
- - Review and make recommendations on PSA assignments, need for service applications, mobile intensive care and EMS-I applications. Clearly define geographic boundaries for PSAs
- - Assist in the collection of local and regional data
- - Provide staff and support for all regional committees and provide liaison between the regional committees and the State EMS Advisory Board

## **SPONSOR HOSPITALS**

MIC activities shall be subject to medical direction by Sponsor Hospitals.

- Oversee MIC personnel who function under the supervision and direction of a physician at the sponsor hospital from which they are receiving medical direction
- MIC services shall be under the control of the Medical Director, or his or her authorized designee.
- Appoint an emergency department staff person as liaison to MIC personnel
- Maintain two-way radio communications interface with the capability to provide prehospital medical direction
- Appoint an MIC Medical Director who shall be responsible for appropriateness of operating protocols, medical supervision and training of MIC personnel, review of MIC medical performance and quality assurance



# **EMS – Definition of Commonly Used Terms**

## **EMS - Definition of Commonly Used Terms**

### **19a-179-1. Emergency Medical Services regulations. Definitions**

Those definitions set forth in C.G.S. Sec. 19a-175 shall govern the provisions of these regulations, in addition to the following:

- (a) "Activation time" means the measure of time from notification to the EMS provider that an emergency exists, to the beginning of the response of the emergency vehicle.
- (b) "Advertising" means the promotion or announcement of one's business name and services in a manner intended to attract members of the public to use such business services.
- (c) "Commissioner" means the commissioner of health services as defined in Sec. 19a-175 of the C.G.S.
- (d) "Council" means regional emergency medical services council.
- (e) "Director" means the director of the office of emergency medical services (OEMS).
- (f) "Dispatch Center" means the organization responsible for receiving emergency calls and notifying the appropriate emergency medical service providers of such calls for help, and assigning them to respond to such calls.
- (g) "Emergency Medical Services Provider" or "EMS Provider" mean a person, association, or organization who provides immediate and/or life saving transportation and medical care away from a hospital to a victim of sudden illness or injury, and who may also provide invalid coach services.
- (h) "Emergency Medical Services Instructor" or "EMS-I" means an individual who has successfully completed the requirements of Sec. 19a-179-16 (d) of these regulations and is certified by the office of emergency medical services to teach, supervise and conduct courses in EMS training programs.
- (i) "Emergency Medical Technician" or "EMT" means an individual who has successfully completed the requirements established by Sec. 19a-179-16 (b) of these regulations and is certified as an EMT by the office of emergency medical services.
- (j) "Emergency Medical Technician-Intermediate" or "EMT-I" means an individual who has successfully completed the requirements established by Sec. 19a-179-16 (c) of these regulations and is certified as an EMT-I by the office of emergency medical services.
- (k) "Emergency Medical Technician-Paramedic" or "EMT-P" means an individual who has successfully completed the requirements established by Sec. 19a-179-16 (c) of these regulations and is certified as an EMT-P by the office of emergency medical services.
- (l) "First Responder" means the EMS provider who is notified for initial response to a victim of sudden illness or injury.
- (m) "Invalid Coach Transportation" means transportation to or from a private home, health care facility, or hospital for examination, diagnosis treatment,

- therapy or consultation. Invalid Coach transportation is only to include the transportation of non-stretcher patients for whom the need for resuscitation, suctioning, or other emergency medical care or continuous observation is not evident.
- (n) "Medical Communications Coordination Center" means an organization responsible for the coordination of medical frequencies to ensure allocation of such frequencies on a priority basis to EMS personnel requesting communications with a medical facility.
  - (o) "Medical Control" means the active surveillance by physicians of mobile intensive care sufficient for the assessment of overall practice levels as defined by statewide protocols.
  - (p) "Medical Direction" means the provision of medical advice, consultation, instruction and authorization to appropriately trained or certified personnel by designated staff members at sponsor hospitals.
  - (q) "Medical Response Technician" or "MRT" means an individual who has successfully completed the requirements established by Sec. 19a-179-16 (a) of these regulations and is certified as an MRT by the office of emergency medical services.
  - (r) "Mobile Intensive Care" or "MIC" means pre-hospital care involving invasive or definitive skills, equipment, procedures, and other therapies.
  - (s) "Mobile Intensive Care Medical Director" means a physician on the staff of the sponsor hospital, appointed by the sponsor hospital to be medically responsible for the facility's participation in the mobile intensive care system.
  - (t) "Mobile Intensive Care Service" means the organized provision of intensive, complex prehospital care, consistent with acceptable emergency medical practices, utilizing qualified personnel supervised by physicians and hospitals as part of a written emergency medical services agreement with the mobile intensive care provider.
  - (u) "Mobile Intensive Care Unit" means an emergency vehicle equipped in accordance with Sec. 19a-179-18 (b) of these regulations and operated by a mobile intensive care provider.
  - (v) "Mutual Aid" means a written agreement between emergency medical service providers or among a group of such providers to ensure cooperative aid in times of need.
  - (w) "Office of Emergency Medical Services" or "OEMS" means the office established within the department of health services pursuant to C.G.S. Sec. 19a-178.
  - (x) "Primary Service Area Responder" or "PSAR" means the designated EMS provider for first call in a primary service area.
  - (y) "Primary Service Area" or "PSA" means a specific municipality or part thereof, to which one designated EMS provider is assigned for each category of emergency medical response services.
  - (z) "Regional Medical Advisory Committee" or "RMAC" means a committee composed of physicians and other members appointed by the regional

- emergency medical services council, for the purpose of advising the council on medical practices and medical quality assurances.
- (aa) "Regional Medical Director" means a physician licensed to practice medicine in Connecticut who is authorized by the council to develop and represent council positions on medical matters.
  - (bb) "Response Time" means the total measure of time from notification to the EMS provider that an emergency exists, to arrival of the EMS provider, at the patient's side, and is the total of "activation time" and "travel time."
  - (cc) "Sponsor Hospital" means a hospital which has agreed to maintain staff for the provision of medical control to emergency medical service providers and which has been approved by OEMS in accordance with Sec. 19a-179-12 (a) (7) of these regulations.
  - (dd) "State Medical Advisory Committee" or "SMAC" means a committee composed of the medical directors of each regional emergency medical Services council and the medical director of OEMS, for the purpose of advising the OEMS on medical matters within the emergency medical services system in the state.
  - (ee) "Travel Time" means the measure of time from the beginning of the response of the emergency vehicle to arrival on scene.  
(Effective June 14, 1988; Amended July 2, 1993.)

