**STATE OF CONNECTICUT**
**DEPARTMENT OF PUBLIC HEALTH**
**PUBLIC HEALTH HEARING OFFICE**

In Re: Declaratory Ruling Proceeding Concerning the Provision of Emergency Medical Services

February 14, 2003

## MEMORANDUM OF DECISION

On May 6, 2002, the Public Health Hearing Office ("the Office") received a Petition for a Declaratory Ruling ("the Petition") from Debra Turcotte, Director of the Division of Health Systems Regulation of the Department of Public Health ("the Department"). Rec. Exh. 1. The Petition requests a declaratory ruling with regard to seven questions concerning the provision of emergency medical services ("EMS") in Connecticut.

On May 8, 2002, the Commissioner of the Department designated the undersigned to sit as a hearing officer and to rule on the Petition. Rec. Exh. 2. Notice of the Declaratory Ruling was published in the Connecticut Law Journal on May 21 and June 11, 2002. Rec. Exh. 3 and 4.

On June 27, 2002, the following entities were granted party status following their application: American Ambulance Service, Inc. ("American"), American Medical Response of Connecticut, Inc. ("AMR"), the Association of Connecticut Ambulance Providers, Inc. ("the Provider Association"), E.F.K. of Connecticut, *d.b.a.*, Nelson Ambulance Service ("Nelson"), Hunter's Ambulance Service, Inc. ("Hunter's"), and Seymour Ambulance Association ("Seymour"). Rec. Exh. 17.

Also on June 27, 2002, the following entities were granted intervenor status following their application: the Connecticut Association of Health Care Facilities, Inc. ("CAHCF"), the Connecticut Hospital Association ("CHA"), Montowese Health and Rehabilitation Center, Inc. ("Montowese"), New Britain Emergency Medical Services, Inc. ("New Britain EMS"), South Central Connecticut Regional Emergency Communications System ("SC Communications"), and Town of East Hartford, Fire Headquarters ("East Hartford"). Rec. Exh. 17. Intervenors were not permitted to

conduct cross-examination or to raise objections, but were permitted to make opening and closing arguments, and redirect their witnesses. Rec. Exh. 17.

Following one extension of time, all parties and intervenors prefiled the testimony of each of their witnesses by July 31, 2002, as ordered. Rec. Exh. 17 and 22.

The hearing was held on August 19, 20, and 21, and October 1, 2002.[1] The hearing was conducted in accordance with the Connecticut General Statutes ("the Statutes"), Chapters 54 and 368d and the Regulations of Connecticut State Agencies ("the Regulations"), §§19a-9-1 through 19a-9-29, and 19a-180-1 through 19a-180-10, inclusive.

The parties were represented at the hearing as follows: American was represented by Milton L. Jacobson, Esq. and Jeffrey F. Buebendorf, Esq. of Brown Jacobson PC; AMR was represented by Gary B. O'Connor, Esq. and H.C. Kwak, Esq. of Drubner, Hartley & O'Connor; the Provider Association was represented by Jay B. Levin, Esq. and Patricia Shea, Esq. of Levin & Shea; Nelson was represented by Craig Lyle Perra, Esq. of Updike, Kelly & Spellacy, PC; Hunter's was represented by Alan M. Solomon, Esq. and Dianne Sargalski, Esq.; and, Seymour was represented by Frank F. Marcucio, III, Executive Director, CEO, Chief.

The intervenors were represented at the hearing as follows: CAHCF was represented by Louis B. Todisco, Esq., Martha Everett Meng, Esq., and Alan K. Ormsby, Esq. of Murtha Cullina LLP; CHA was represented by Carolyn Brady, Vice President; Montowese was represented by Jennifer L. Groves, Esq. and Ann Moore, Esq. of Updike, Kelly & Spellacy, P.C.; New Britain EMS was represented by Bruce Baxter, Executive Director; SC Communications was represented by John G. Gustafson, Executive Director; and, East Hartford was represented by David J. Dagon, Fire Chief.

Written closing arguments were received from the Provider Association, American, CAHCF, Hunter's, Nelson, Montowese, AMR, and SC Communications. Rec. Exh. 62 through and including 69, respectively.

[1] The hearing was reopened on January 3 , 2003, *sua sponte*, for the sole purpose of marking for identification and entering into the record, Hearing Officer Exhibit 3.

All parties to the proceeding waived the statutory time frame for issuance of a final decision in this matter until February 17, 2003. Tr. 8/21/02, pp. 287-88; Rec. Exh. 53.

This Memorandum of Decision is based entirely on the record and sets forth findings of fact and conclusions of law, and an order. To the extent that the findings of fact actually represent conclusions of law, they should be so considered, and vice versa. *SAS Inst., Inc. v. S & H Computer Systems, Inc.*, 605 F.Supp. 816 (Md. Tenn. 1985).

***Issues***

1. In an emergency, can ambulance services, as defined in §19a-175(4) of the Statutes, emergency medical service organizations, as defined in §19a-175(10) of the Statutes, licensed ambulance services, as defined in §19a-175(17) of the Statutes, and/or emergency medical services providers as defined in §19a-179(g) of the Regulations (hereinafter "provider") provide emergency medical services in an area in which the receiving hospital does not provide medical control including, but not limited to, ongoing quality control and assessment of practice levels of the provider, other than through mutual aid as defined in §19a-179-1(v) of the Regulations and other than as directed to do so by an authorized and recognized emergency dispatch center?

2. In an emergency, can a provider provide emergency medical services in an area in which it is not the primary service area responder, other than through mutual aid as defined in §19a-179-1(v) of the Regulations, and other than as directed to do so by an authorized and recognized emergency dispatch center?

3. In an emergency, can a provider cancel the response of a primary service area responder if it is closer to the emergency, already at the scene of the emergency or for any other reason?

4. In an emergency, is a provider required to forward an emergency call to the 911 system if it has been contacted outside of the 911 system?

5. In an emergency, can a provider dispatch its own ambulances to the emergency if it is not the primary service area responder in that area?

6. In an emergency, is a provider required to sign on immediately with an authorized and recognized emergency dispatch center prior to patient contact, treatment and initiation of transportation of a patient to a medical facility?

7. Can a provider contract with a health care facility of any type for the provision of emergency medical services in emergency situations?

***Findings of Fact***

1. Prior to the enactment of legislation creating a comprehensive EMS system in 1974 (P.A. 74-305, now §§19a-175 *et seq*.), there was no single number to call for emergencies; emergency calls were made directly to providers using seven digit phone numbers; there was no central dispatching; towns called providers on a rotation basis; providers often had insufficient equipment and supplies; the system lacked supervision and accountability; staff were not always adequately trained; and, there was very little communication between providers and destination hospitals. Tr. 8/19/02, pp. 105, 115-16; Tr. 8/21/02, pp. 202-03; Exh. P5-E, pp. 32, 85-86, 134-35, 147-48, 156-57, 185.

2. Prior to the 1974 legislation, there were allegations of widespread abuse among competitors within the emergency medical services system, including the use of radio scanners to intercept calls, races to emergencies by multiple providers, fraud, bribery, "jumping calls" (*i.e.*, intercepting and responding to a call that was made to another provider), stacked calls (*i.e*., the failure to pass a call to another provider when a provider had no available ambulance), harassment, and the practice of calling in false emergencies to keep a provider busy so another provider could respond to a legitimate call. Tr. 8/19/02, pp. 67, 97-98, 114-16; Tr. 8/21/02, pp. 202-03; Exh. P4-Q, vol. 1, pp. 5-7; P5-E, pp. 9-10, 52, 64, 68, 78, 86-87, 104, 116, 129-35, 137-38, 152-56, 158, 178, 188.

3. Prior to the 1974 legislation and the establishment of the 911 system, unnecessary deaths resulted from the inefficiencies and abuses rampant in the existing system. Additionally, residents called providers who advertised in telephone directories and were often located outside the community, which resulted in delays and further endangered patients. Exh. P5-E, p. 11; Exh. I3-A, p. 3.

4. In 1974, the Emergency Medical Services Assistance Act was passed (1) to create a statewide coordinated emergency response system to ensure that emergency calls are answered by assigning accountability to one provider within designated geographic areas; (2) to ensure that rural areas are afforded the same quality of care as urban areas; (3) to control costs by minimizing the number of providers that respond to an emergency; (4) to eliminate unsafe practices; (5) to encourage investment and market efficiency by ensuring stability; and, (6) to develop and enforce standards. Exh. P2-C, pp. 3, 10-11; P4-Q, p. 26.

5. The Emergency Medical Services Assistance Act created the basic structure of today's emergency medical services system including the designation of Primary Service Areas ("PSAs") throughout the state, with each PSA having one responder ("PSAR") at the First Responder ("FR") level, and at the Basic Life Support ("BLS") and Advance Life Support ("ALS") levels, with each such PSAR being designated by the Department. Regulations were also promulgated regarding the training of emergency personnel, the equipment and design of ambulances, advertising, the use of scanners, and rates. Tr. 8/19/02, pp. 67-68, 99-100, 116; Tr. 8/21/02, pp. 213-14; Exh. P4-Q, p. 12; Exh. I3-A, p. 7.

6. There are approximately 180 PSAs within the State of Connecticut, roughly corresponding to each of the municipalities within the State. The state is also divided into five EMS Regions, each of which has a Regional Council. Exh. P4-Q, vol. 1.

7. Designated PSARs are responsible for providing emergency services 24 hours each day, seven days each week, and are required, among other things, to (1) maintain a trained, licensed staff; (2) maintain vehicles and equipment that meet mandated standards; (3) maintain a comprehensive set of records regarding requests for service, including information regarding fractile response times; (4) coordinate medical control issues with sponsor hospitals; (5) coordinate efforts with emergency dispatch centers in compliance with state and local requirements; (6) coordinate efforts with local authorities and other PSARs within their service area; and, (7) be prepared to respond to mass casualty situations. Exh. P2-C, p. 4.

8. The PSA system gives PSARs first call priority within their service area. By ensuring that PSARs have first-call priority, PSARs are ensured a sufficient volume of calls to provide them with the financial ability to bear the cost of complying with state laws and regulations. Tr. 8/21/02, pp. 101-02, 184, 210-12, 265; Exh. P2-C, p. 5; P5-B, p. 3; Exh. I3-A, pp. 4-5; Exh. I4-A, p. 3.

9. The provision of emergency care in Connecticut is intended to be non-competitive; however, the provision of non-emergency care, remains subject to some degree of competition. Tr. 8/19/02, p. 101; Exh. P4-Q, vol. 1, p. 25, vol. 2, p. 4; P5-E, p. 177.

10. The configuration of emergency medical services varies from town to town and region to region. For example, in some locations, ambulances are staffed only with Emergency Medical Technicians ("EMTs"), and intercept vehicles are used to transport paramedics. In other locations, paramedics are part of the ambulance staffing. Tr. 8/19/02, pp. 102-103; H.O. Exh. 3; Exh. I4-A, p. 4.

11. Although PSARs are responsible for emergency service within the PSA, they may enter into agreements with other providers to provide emergency service within the PSA during certain times and in certain situations. Tr. 8/21/02, pp. 186-87; Exh. P2-C, p. 7; Exh. P3-A, p. 6; Exh. P4-Q, pp. 13-14; Exh. P5-B, pp. 2-3; Exh. I3-A, pp. 7-8.

12. When a PSAR has an agreement with another provider to provide services in the PSAR's service area, the agreement must be provided to the dispatcher. Exh. P3-A, p. 6.

13. The PSA system has improved patient care, and provided stability, organization and accountability within the emergency medical services system. Tr. 8/19/02, p. 70; Tr. 8/21/02, pp. 203-04; Exh. I3-A, p. 4.

14. Advertising was also prohibited by the Emergency Medical Services Assistance Act to prevent the public, including long term care facilities, from calling ambulances other than the PSAR to provide service. Tr. 8/19/02, p. 106.

15. Public Safety Answering Points ("PSAPs") operate twenty-four hours each day, and receive all 911 calls. PSAPs are the authorized dispatchers that, upon receipt of a 911 call, either directly dispatch the PSAR or transfer the call to a PSAR's dispatcher. PSAP/dispatchers provide service within the geographic areas where they are located as well as for other participating jurisdictions, and document the number of requests they receive for emergency assistance. §28-25(10) of the Statutes; §28-24-3(b)(4) of the Regulations.

16. If a PSAR is unable to respond to a request for service, a mutual aid responder is dispatched. Exh. P6-A, p. 5.

17. Coordinated Medical Emergency Direction ("CMED") Centers coordinate and operate the Statewide UHF Radio System and provide various services in support of the emergency medical services system, including the coordination of responses and the enabling of medical control communications. Some CMEDs are also PSAP/dispatchers and perform those responsibilities as well. If a CMED is *not* a PSAP/dispatcher, providers contact the appropriate CMED for medical control, after being dispatched by the PSAP/dispatcher. Exh. P6-A, p. 6; Exh. I3-A, p. 4; Exh. I4-A, pp. 1-2.

18. In 1999, there were 108 PSAP/dispatchers located throughout the state, eight of which were regional. There are presently thirteen CMEDs. Exh. P4-Q, vol. 2, p. 47; Exh. P6-A, p. 6; Exh. I4-A, pp. 1-2.

19. The Department has designated the CMEDs to coordinate emergency activities such as on-line medical control. Exh. P6-A, p. 6.

20. Presently, there are different standards for the daily operation of CMEDs and PSAP/dispatchers, including different protocols, different operational procedures, and different policies and procedures sanctioned by medical directors at the sponsor hospitals. Tr. 8/19/02, p. 135; Exh. P5-B, p. 5.

21. PSAP/dispatchers and CMEDs record all calls received. Exh. I4-A, p. 2.

22. The State has expended and continues to expend significant financial resources on the 911 system which is a single statewide, easily recognized emergency telephone number for EMS, fire and law enforcement. Tr. 8/19/02, p. 101; Exh. I4-A, p. 3

23. In 1989, the enhanced 911 system was established which automatically routes 911 calls to the PSAP/dispatcher, as appropriate for that location, and displays the geographic location of the call. It may also provide the PSAP/dispatcher with

information about the type of location (*e.g.*, nursing home, residence), and residents with special needs who live at the location. Tr. 8/19/02, pp. 65, 109.

24. Most, if not all providers, routinely sign on with the appropriate PSAP/dispatch center when they respond to an emergency call. Tr. 8/19/02, p. 134; Exh. P3-A, p. 7; Exh. P5-B, p. 4; Exh. I3-A, p. 7.

25. Pursuant to the policies and procedures of the North Central Connecticut CMED, providers are required to notify CMED whenever they are responding to an emergency call. Exh. I3-A, p. 4.

26. The specific manner in which providers sign on with dispatch centers varies from region to region. For example, in Hartford, the PSAP/dispatcher manages the initial dispatch and routing. Once a provider is dispatched, the North Central CMED is notified and the provider maintains contact with the CMED. In New Haven, the CMED is also the dispatcher for all 911 calls. Exh. I3-A, p. 7.

27. The City of New Britain utilizes a Department of Telecommunications that dispatches calls rather than a CMED. The CMED tracks ambulances and their availability, provides communication between the provider and the receiving hospital, and coordinates mass casualty incident responses by locating available beds and emergency response agencies, if requested by the incident commander. Tr. 8/21/02, pp. 177-78.

28. SC Communications utilizes the Incident Command System, according to national standards, and receives requests for emergency responses, dispatches the provider, allocates resources, advises EMS providers of any diversions in effect[2] and current traffic problems, relays information from units already on the scene to limit duplicate responses, coordinates multi-jurisdictional and multi-disciplinary responses, and provides for communication between the hospital and the provider. To ensure the effectiveness of its system, SC Communications requires that commercial providers contact them within three minutes after receiving a call; volunteer services must contact them within six minutes. If the provider fails to respond within these time frames, mutual aid is requested to respond. Tr. 8/21/02, pp. 204-05; Exh. P2-C, p. 9; Exh. I4-A, pp. 1, 5.

29. The authorized and recognized dispatch center must be aware of all of the EMS providers operating in a PSA in order to coordinate appropriate and necessary responses to emergencies. Therefore, providers must sign on with the authorized PSAP/dispatch center prior to responding to an emergency, or as soon thereafter as possible, if a provider unexpectedly happens upon an emergency while in transit. Tr. 8/21/02, p. 191, 264; Exh. P1-A, p. 6; Exh. P2-C, p. 9; P2-B, p. 8.

[2] Hospitals may be placed on a diversion status when, for example, they have no beds available, or are temporarily lacking particular equipment.

30. If AMR is contacted by a long term care facility for emergency care in a service area where it is not the PSAR, it contacts the local dispatch center for the PSA. Tr. 8/19/02, p. 75.

31. The term "EMD" refers to the Emergency Medical Dispatch system and involves the advanced training of dispatchers in the use of protocols to interrogate callers to determine patient needs, the level of care required, and the appropriate emergency response. Tr. 8/19/02, pp.86-89; Tr. 8/21/02, p. 106; Exh. P4-Q, vol. 2, p. 38.

32. Two concepts form the basis of EMD: (1) tiered or priority response, and (2) pre-arrival instructions. Tiered or priority response refers to gathering information in order to classify the problem and activate an appropriate response; pre-arrival instructions refer to the giving of first-aid instructions over the telephone to the caller. Both concepts depend on proper caller interrogation. Failure to utilize proper interrogation techniques may result in over-utilization of ALS, under-utilization of BLS, and inappropriate use of FRs. Exh. P4-Q, vol. 2, p. 38.

33. A proper configuration of response requires the matching of the types and number of vehicles, levels of care, capacity, and mode of response (*i.e.*, lights and sirens) with the level of assistance needed. Exh. P4-Q, vol. 2, p. 38.

34. Presently, there are State BLS Guidelines. Exh. P4-R.

35. There is insufficient evidence to establish the number of PSAP/dispatch centers that use EMD at this time; all PSAP/dispatch centers are required to implement EMD protocols by July 1, 2004, or arrange for EMD to be otherwise provided. Tr. 8/19/02, p. 90; Exh. P4-Q, vol. 2, pp. 45-46; §28-52b(g) of the Statutes.

36. Because emergency medical technicians and paramedics[3] provide invasive medical care, including starting IV lines, using defibrillators, performing endotracheal intubations, and administering medications, they operate under the medical direction of physicians at sponsor hospitals[4] who provide "medical control." Medical directors may withhold medical authorization from emergency personnel or a provider if the medical director believes the EMS staff or service has demonstrated incompetence or negligence, poses a threat to public health or safety, or has acted contrary to medical direction. Tr. 8/19/02, pp. 80, 91-92, 99;

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[3] "Emergency medical technician" (EMT) is defined in §19a-175(5) of the Statutes as "an individual who has successfully completed the training requirements established by the commissioner [of the Department] and has been certified by the Department . . . ." An EMT-I is an Emergency Medical Technician-Intermediate" which is also a certified title, as is a paramedic. *See*, §19a-179-1(I), (j), and (k) of the Regulations.

[4] The term, "sponsor hospital" is defined as, "a hospital which has agreed to maintain staff for the provision of medical control to emergency service providers and which has been approved by the Office of Emergency Medical Services ("OEMS") in accordance with Section 19a-179-12(a)(7) of these regulations." §19a-179-1(cc) of the Regulations.

Tr. 8/21/02, pp. 205-06; Exh. P2-A, p. 2; Exh. P3-A, p. 1; Exh. I3-A, pp. 2-3; §19a-179-15(b) of the Regulations.

37. The term, "medical control" includes both medical direction and quality assurance functions. Tr. 8/19/02, p. 65; Tr. 8/21/02, pp.72-73, 271; Exh. P1-A, p. 1.

38. Medical direction includes both on-line and off-line medical direction. On-line medical direction requires that an EMS provider speak with a physician by direct voice communication regarding the treatment of a specific patient. Off-line medical direction involves the use of written treatment protocols that, among other things, address common situations, permit a provider to perform clinical skills within defined parameters, specify when on-line medical direction is required, and address situations in which a patient is transported to a non-sponsor hospital, *e.g.*, based on patient preference or the need to transport the patient to a Trauma Center. Tr. 8/21/02, pp. 49-50, 61, 72-73; Exh. P1-A, p. 1; Exh. P2-B, p. 2; Exh. P3-A, p. 1; Exh. P5-B, p. 3; Exh. I1-A, p. 3; Exh. I1-A, Att. B1, p. 1.

39. The quality assurance function of medical control includes establishing criteria for credentialing, re-education, clinical monitoring, and supervision and education for EMS providers. Exh. I1-A, Att. B1, p. 1.

40. Medical directors at sponsor hospitals are responsible for all aspects of medical control and for defining their system. Tr. 8/21/02, pp. 103, 175; Exh. P5-B, p. 3; Exh. I1-A, pp. 2-3.

41. Three hundred and thirty one EMS providers in Connecticut have relationships with a total of thirty sponsor hospitals. H.O. Exh. 2.

42. The only EMS providers that do not have relationships with sponsor hospitals are 24 fire departments, 11 police departments, and one management service organization. H.O. Exh. 2.

43. Of the thirty sponsor hospitals, four are designated by the Department as Level I Trauma Centers; eight are designated as Level II Trauma Centers; and, three are designated as Level III Trauma Centers. Additionally, one hospital in Worcester, Massachusetts, is designated by the Department as a Level I Trauma Center. H.O. Exh. 1.

44. Regulations determine when a patient's condition requires that the patient be transported to a Level I or II Trauma Center. Regulations §§19a-177-5 et seq.

45. Sponsor hospitals typically enter into written agreements to provide medical control only with the PSARs in the same PSA as the hospital, or in close proximity. Tr. 8/21/02, pp. 68-69, 275; Exh. P5-B, p. 3.

46. Many hospitals also limit their medical control to specified geographic areas. Thus, providers that have a relationship with a sponsor hospital that limits its control to a geographic area, are generally limited to providing services within that geographic area, with some exceptions. Tr. 8/19/02, pp. 73, 109-110, 138; Tr. 8/21/02, pp. 47, 57, 64, 65; Exh. P2-A, p. 2; Exh. P2-B, p. 2; P2-C, pp. 1-2; Exh. I4-A, p. 2.

47. At Yale, the concept of limiting medical control to a specified geographic area applies to where the calls originate, not where the patient is transported. Tr. 8/21/02, p. 279.

48. The common practice within the industry is for providers to respond to emergencies only in areas in which they are the PSAR except (1) when directed to provide mutual aid by the authorized dispatch center; (2) when the PSAR has contracted with another provider outside of the PSAR's service area to provide emergency services at certain times and for specific situations within its PSA; and, (3) when the provider encounters an emergency while travelling through another provider's PSA. When a provider encounters an emergency while travelling through another provider's PSA, providers generally notify the appropriate dispatch center and transfer care to the PSAR upon its arrival, or take whatever other action is directed by the dispatch center. Tr. 8/19/02, pp. 82, 92-93, 131; Tr. 8/21/02, pp. 52, 263-64; Exh. P2-B, p. 3; Exh. P2-C, pp. 3, 6; Exh. P2-D; Exh. P3-A, pp. 3, 4; Exh. P5-B, p. 3; I3-A, pp. 6-7; Exh. I4-A, pp. 4-5.

49. In the majority of emergency situations, PSARs initiate service in the geographic area of its sponsor hospital, and transport patients to the sponsor hospital. When a patient's condition requires transport to a Trauma Center, or when the sponsor hospital is under diversion, the patient may be transported outside of the geographic area of the sponsor hospital. Tr. 8/21/02, pp. 268, 274-75.

50. Sponsor hospitals that limit the geographic area in which they provide medical control do so in order to exercise meaningful oversight over a provider's activities and ensure the quality of patient care. Meaningful oversight requires that the medical director have personal knowledge of the EMS personnel, have routine access to incident and run reports, and be able to examine and review the records of patients who are treated in the field. Tr. 8/21/02, pp. 58, 59, 65, 103-104, 206-07; Exh. I1-A, pp. 2, 4.

51. At least one sponsoring hospital organization (the Joint Hospital Planning Council which is comprised of Bridgeport Hospital and St. Vincent's Medical Center, hereinafter "JHPC") cannot monitor or supervise providers operating outside a specified geographic area since it cannot maintain on-line communications beyond that designated area. Exh. P2-A, p. 2.

52. When a provider is required to initiate services and/or transport a patient outside the geographic area of its sponsor hospital (*e.g.*, when providing mutual aid,

transporting a patient to a Trauma Center, or directed to transport a patient outside the geographic area by an authorized dispatch center), either the sponsor hospital extends its medical control, the destination hospital provides medical control, or the destination hospital provides on-line medical direction and the sponsor hospital continues to be responsible for quality assurance. Tr. 8/19/02, pp. 111-112, 130-131; Tr. 8/21/02, pp. 48-49, 50, 61, 73-75, 76-77, 85-86; Exh. P4-A, p. 6; Exh. P6-A, pp. 1-2; Exh. I1-A, p. 3; Exh. I3-A, p. 3. Exh. P5-B, pp. 2-3.

53. If a provider is responding to an excessive number of mutual aid calls outside the geographic area of the provider's sponsor hospital, the sponsor hospital may request that the provider obtain a sponsor hospital in the area outside of its medical control. Additionally, the PSAR for the area outside medical control may also request authorization from the Department to operate additional vehicles, upon a showing of need, in order to reduce its reliance on mutual aid. Tr. 8/21/02, pp. 85-86.

54. The percentage of mutual aid calls that require Hunters to travel outside the area of its medical control is small; a greater number, but still an insignificant number of calls, originate in the sponsor hospital's area, but require transport outside of the sponsor hospital's geographic area. Tr. 8/21/02, pp. 104-05.

55. The South Central Region requires mutual aid two to three times per day out of 85,000 calls per year, which constitutes approximately 1% of its total call volume. Tr. 8/21/02, pp. 219, 236-37.

56. Until recently, in the North Central EMS Region, on-line medical control was provided to ALS providers by sponsor hospitals without regard to the destination hospital, and the sponsor hospital received a copy of the patient's pre-hospital care record for quality assurance purposes. Exh. I3-A, p. 3.

57. In the South Central Region, the hospitals have a written agreement to notify the sponsor hospital of any problems that might arise regarding a provider when the patient is transported to a facility other than the sponsor hospital. Tr. 8/21/02, pp. 274-75.

58. Yale University School of Medicine ("Yale") only sponsors providers that have a PSAR in the twelve towns within a designated geographic area. Tr. 8/21/02, p. 275.

59. Yale exercises medical control regardless of the destination hospital, so long as the emergency service originates within the geographic area. Yale also provides medical control for mutual aid calls that originate outside of its designated geographic area, so long as they are initiated by the appropriate dispatch center. Tr. 8/21/02, pp. 268-72.

60. Yale receives reports from other destination hospitals, if there is a problem with care. Tr. 8/21/02, p. 274.

61. In potential mass casualty situations, Yale temporarily extends the geographic area of its medical control to include ambulances relocated to other areas of the state to assist with disaster operations. Tr. 8/21/02, pp. 262, 272.

62. Sponsor hospital protocols used by providers are implemented through the Regional Councils. The protocols in different Regions are similar, but not exactly the same. Tr. 8/19/02, pp. 91, 121.

63. In some instances in which sponsor hospital protocols differ from a destination hospital's protocols, the issue has been addressed through regional protocols developed by the Regional Councils, in which a number of hospitals agree to follow the same protocols. Tr. 8/21/02, pp. 75-76.

64. If a provider provides emergency services on a routine and regular basis in more than one geographic area (*i.e.*, holds multiple PSAR designations or provides mutual aid in multiple locations), the provider must either establish sponsor hospital relationships with a hospital in each such area, or have a sponsor hospital that agrees to provide, and is capable of providing medical control (*i.e.*, can ensure on-line medical direction) in each service area. Exh. I1-A, p. 4.

65. On November 20, 1987, the Department issued a statement to long term care facility administrators advising them of the most appropriate utilization of ambulance services for patients in long term care facilities ("the 1987 Statement"). The 1987 Statement distinguished between requests for emergency ambulance services and non-emergency ambulance services, and defined a medical emergency as

> . . . determined by the transferring facility and . . . characterized by. . .:
>
> The rapidly deteriorating condition of a patient,
> An accident where the patient sustains serious injury,
> A life threatening emergency.

The 1987 Statement also defined non-emergency transports as "the transportation of a patient for pre-arranged or routine appointments at another destination." Exh. P4-L.

66. The 1987 Statement also provided the following directive: "[w]hen a medical emergency exists, the local emergency medical service should be activated by calling '9-1-1' or the seven digit access number listed in the front of most telephone directories, whichever is appropriate for the community in which the

facility is located" and "[f]or non-emergency transportation, any ambulance service may be utilized." Exh. P4-L.

67. Until May 1, 2002, a small number of emergency calls were made to providers using a private seven-digit phone number. There is insufficient evidence to establish that this was a widespread practice during the twelve preceding months. Tr. 8/21/02, pp. 41, 43, 115, 135.

68. On May 1, 2002, the Department issued a letter ("the May 2002 Statement") to long term care facility operators reminding them that

> . . . the policies and regulations regarding [the appropriate utilization of ambulance services as stated in the 1987 Statement] have not changed. Your continued compliance in activating the 911 system in an emergency situation should be adhered to at all times.
>
> In determining appropriate ambulance transport, it is necessary to differentiate between routine and emergency responses.
>
> . . . a medical emergency, which requires an immediate response, as determined by appropriate licensed staff at a transferring facility necessitates the activation of the 911 response system. Examples of emergency medical situations include, but are not limited to:
>
> The rapidly deteriorating condition of a resident;
> An accident resulting in serious injury;
> A life threatening emergency;
> A medical condition/injury wherein the resident's comfort and safety are at issue ("the fourth bulleted item").
>
> When a medical emergency exists, the local emergency medical service should be activated by calling 911. If a non-emergency transportation is needed any ambulance service may be utilized."

Exh. I5-4A.

69. The May 2002 Statement further stated that

> Ambulance services for non-emergency transportation of a resident means a pre-arranged or routine appointment for evaluation of an otherwise stable condition, at another provider or facility and does not require the activation of the 911 system.

Exh. I5-4A.

70. The primary difference between the 1987 Statement and the May 2002 Statement, consists of the addition of the fourth bulleted item. While the 1987 Statement was well understood and applied by the long term care industry, the addition of the fourth bulleted item in the May 2002 Statement created confusion within the industry. Tr. 8/21/02, pp. 60-61, 142, 241; Exh. P4-A, p. 2; Exh. I2-A, pp. 3-4; Exh. I5-A, pp. 2-4.

71. On December 4, 2002, the Department issued a letter ("the December 2002 Statement") to long term care facility operators and EMS providers, deleting the fourth bulleted item of the May 2002 Statement, and reiterating that "[w]hen a medical emergency exists in the judgment of a clinician, the 911 system must be activated. If non-emergency transportation is desired, any ambulance service may be utilized." Exh. H.O. 3.

72. The December 2002 Statement also described a tiered response to medical emergencies as follows: "[w]hen 911 is accessed, first responders, typically fire or law enforcement agencies, are dispatched to provide basic intervention such a cardiopulmonary resuscitation and control of bleeding. Basic ambulances then provide more advanced skills and transportation of the sick and injured. Paramedics provide advanced life support and may function as a part of the ambulance or intercept with the ambulance." Exh. H.O. 3.

73. Generally, at this time, because EMD protocols are not available, and dispatchers are not all trained to determine the appropriate level of response, it is a common practice for dispatchers to send all levels of service (FR, BLS, and ALS), using lights and sirens. Tr. 8/19/02, pp. 98-100; Exh. P4-Q, p. 41.

74. Some dispatch centers assume that health care facilities have staff trained to respond to medical emergencies and, therefore, do not send FRs; others do not make this assumption and send FRs. I4-A, p. 6.

75. In addition to the need for emergency and non-emergency transports to and from long term care facilities, long term care facilities also request transports that are not pre-scheduled and do not require a full three tiered response with lights and sirens or even an immediate response. Tr. 8/21/02, pp. 21-22, 241-44, 255-58; Exh. P4-Q, vol. 2, p. 41; Exh. I5-A, pp. 2-4; Exh. I5-B, pp. 1-2.

76. The dispatch of three levels of response for this third category of calls from long term care facilities, traveling at high speeds, using lights and sirens, is not necessary to patient care, creates unnecessary risks on roadways, confuses staff and residents, is highly disruptive to residents, and increases Medicare and Medicaid costs. Tr. 8/19/02, pp. 202-03, 208-11; Tr. 8/21/02, pp. 145, 216, 248-

49, 255-56; Exh. P2-D, p. 4; Exh. P4-A, p. 3; Exh. P4-B, pp. 1-2; Exh. P4-Q, vol. 2, p. 41; Exh. I4-A, p. 6; Exh. I5-A, pp. 2-4; Exh. I5-B, p. 3.

77. Health care facilities employ licensed health care providers who bring specialized knowledge and skill to their determination of what constitutes an emergency, and have knowledge of the resources available to them on site. They are in the best position to determine whether an emergency exists and when to access the emergency medical services system. Tr. 8/19/02, pp. 61, 63, 75; Tr. 8/20/02, pp. 59-60; Tr. 8/21/02, pp. 18, 20, 142, 194, 216, 234-35, 240; Exh. I4-A, p. 7; Exh. I5-A, pp. 2-3; Exh. I5-B, pp. 2-3.

78. While long term care facility staff are highly skilled in assessing patient needs, they are not usually familiar with how the emergency medical services system is organized and functions, the availability of EMS providers throughout the service area, and the levels of care available at any given time in any particular community. Tr. 8/19/02, pp. 104-105; Tr. 8/21/02, pp. 195-97.

79. A small number of healthcare facilities have resorted to calling non-PSARs for emergencies, in order to avoid an extraordinary response of apparatus and personnel. Exh. I3-A, p. 6.

80. A few communities have created a reduced response of one ambulance for the majority of calls received from long term care facilities in order to avoid the disruptions associated with multiple vehicle responses. Exh. I3-A, p. 6.

81. Even when a dispatcher is trained in EMD, if the 911 call is placed by a ward secretary, clerk, or aide, they will be unable to answer the dispatcher's questions. Tr. 8/21/02, pp. 196-97.

82. The PSAP for the Town of Wallingford has developed an EMD protocol, utilizing three acuity levels each of which has an associated transport time and takes into consideration the unique capabilities of the five facilities located within the Town, *e.g.*, available equipment, staffing, etc. When a facility calls 911, the level of response is determined based on the protocols. In some instances, FRs are not necessary since the facility can provide FR care. Acuity level one requires that a transport ambulance be on the scene within zero and fifteen minutes utilizing lights and sirens; acuity level two requires transport in fifteen to thirty minutes without the use of lights and sirens, and without the FR; and, acuity level three requires a response of between 30 and 60 minutes, without an FR and without utilizing lights and sirens. These calls are all processed by the PSAP/dispatch center. Tr. 8/21/02, pp. 107-11, 124, 213.

83. Emergency transports are reimbursed at a higher rate than non-emergency transports. Tr. 8/19/02, pp. 202-03, 208-11; Exh. P4-B, pp. 1-2.

84. Within the past five years, a small percentage of requests for emergency service have been made by facilities directly to non-PSA providers for emergency service, using a seven digit phone number. Tr. 8/19/02, pp. 111, 134, 137.

85. Prior to May 2002, Nelson often provided emergency care for patients at Montowese Health and Rehabilitation Center even though it was not the PSAR or a mutual aid provider. It was often the closest provider because it stationed an ambulance at Montowese to provide non-emergency care, and had an agreement with Montowese to provide emergency care. Tr. 8/19/02, pp. 169-70; Tr. 8/21/02, pp. 161-162, 168, 170-72; Exh. P4-A, p. 1.

86. During the time period of 1997 through 1999, non-PSARs in New Britain responded to emergency calls placed directly to them via a seven-digit number, 1,915 times without the authorization of either the dispatcher or the PSAR for New Britain. During subsequent years until May of 2002, there were approximately 500 to 600 such calls each year, out of a total of approximately 11,000 calls per year. Thus, such calls constituted approximately 5% of the total call volume. Tr. 8/21/02, p. 189; Exh. I3-A, p. 4.

87. After the Department issued the May 2002 Statement, between May 1 and July 31, 2002, there were 121 private emergency calls placed to non-PSAR providers that were then referred to the PSAR for New Britain. There is insufficient evidence to establish how many of these calls were made by facilities and how many were made by private individuals. Tr. 8/21/02, p. 179; Exh. I3-A, p. 5.

88. Less than 1% of private citizens call a number other than 911 in the South Central Region; there is insufficient evidence to establish how many facilities have utilized a number other than 911 for emergency service in that Region. Tr. 8/21/02, p. 237.

89. For non-PSAR's to respond to private emergency calls without the authorization of either the designated emergency dispatch center and/or the designated PSAR is contrary to the intent and purposes of the applicable statutes and regulations and undermines the provision of emergency care in Connecticut. Such a practice hinders the effective operation of a coordinated statewide emergency telecommunications system, and interferes with the PSAP/dispatcher's ability to regulate and monitor responses. Tr. 8/21/02, p. 211; Exh. P1-A, p. 2; Exh. P2-C, pp. 5, 8; P6-A, p. 5; Exh. I3-A, p. 4; Exh. I4-A, p. 5.

90. The generally accepted practice when a non-PSAR receives a request for emergency service via a seven digit telephone number, is to forward the call to the appropriate dispatch center or PSAR. Tr. 8/21/02, pp. 263-64; Exh. P2-B, pp. 6-7; Exh. P2-C, p. 7; Exh. P3-A, p. 5; Exh. P5-B, p. 4; Exh. I3-A, p. 4; Exh. I4-A, p. 4.

91. The designated FR and BLS providers, and incident commanders (who are the senior ranking officer and representative of the 911 system), may cancel the

response of an ALS provider when there is no need for an ALS intercept, *e.g.*, the emergency is unfounded or cancelled, or there are sufficient personnel on the scene. When this occurs, the dispatcher is notified who, in turn, notifies the ALS provider. Exh. P2-B, p. 5. Exh. P3-A, p. 4; Exh. P5-B, p. 4; Exh. I4-A, p. 4 Exh. I3-A, p. 5.

92. Incident commanders may request that a non-PSAR transport a patient if the non-PSAR happens on the scene or there are multiple injuries. Tr. 8/19/02, pp. 94-95, 97.

93. There is no evidence in the record establishing that non-PSARs cancel requests for PSARs to respond to emergencies.

94. American Ambulance, AMR, and Hunter's do not enter into contracts with long term care facilities to provide emergency medical services. Tr. 8/19/02, pp. 64, 74; Tr. 8/21/02, pp. 114-115.

95. Some years ago, Montowese had a contract with Campion Ambulance to provide both emergency and non-emergency care. Pursuant to this contract, Campion stationed an ambulance at Montowese. Exh. I2-A, p. 2.

96. Montowese has called Nelson's for emergency service when they are in the area. Tr. 8/21/02, p. 143; Exh. I2-A, p. 2.

97. Long term care facilities do not enter into contracts with providers to provide emergency services outside the 911 system. If any such facility engages in this practice, it is a very isolated situation. Tr. 8/21/02, pp. 25, 30.

98. To permit non-PSAR EMS providers to contract with long term care facilities to provide emergency services, would endanger patient care, undermine the financial stability of the PSARs; circumvent and undermine the dispatch system, and could increase response times if the provider travels from outside the service area. Tr. 8/19/02, p. 69; Exh. P2-B, p. 9; Exh. P6-A, p. 7; Exh. I3-A, p. 4.

## *Discussion*

### *A. Definition of the Term "Emergency"*

In the course of the hearing, several of the parties and intervenors raised an issue regarding the definition of the term "emergency" in the context of long term care facilities.[5] Since the term appears in each of the seven questions posed in the Petition, evidence was received on this additional issue.

[5] While evidence was submitted concerning the lay person's definition of the term, "emergency," a preponderance of evidence establishes that the lay public is not confused about the definition of the term,

The term, "emergency," is not defined by the statutes and regulations enforced by the Department. The Department has defined the term, "emergency," for long term care facilities in three separate statements: the 1987 Statement, the May 2002 Statement, and the December 2002 Statement. At the time of the hearing, only the 1987 and May 2002 Statements had been issued. Thus, the testimony focused on these two Statements. A preponderance of evidence establishes that the 1987 Statement was well understood and applied within the long term care industry, but the May 2002 Statement generated a great deal of confusion.

The 1987 Statement defined medical emergencies as "determined by the transferring facility and characterized by . . . : [t]he rapidly deteriorating condition of a patient, [a]n accident where the patient sustains serious injury, [and] [a] life threatening emergency." FF 65.

The May 2002 Statement reiterated that the determination of what constitutes a medical emergency is "determined by appropriate licensed staff at the transferring facility" and listed the same examples contained in the 1987 Statement, with the following additional example: "[a] medical condition/injury wherein the resident's comfort and safety are at issue." FF 68

A preponderance of evidence establishes that staff at long term care facilities ignored the prefatory language of the May 2002 Statement and focused almost exclusively on the new fourth bulleted item in concluding that the Department was directing them to call for emergency services every time a patient experienced discomfort. This was not the Department's intent.

Therefore, the Department clarified its directive in December of 2002, when it issued another statement reiterating that clinical judgment should be used in determining whether the 911 system should be activated, and deleting the fourth bulleted item of the May 2002 Statement. FF 71. The undersigned hereby adopts the Department's December 2002 Statement as the definition of emergency as used throughout the issues posed in the Petition.

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and is effectively initiating the 9-1-1 system when appropriate. *See, e.g.*, FF 88. Moreover, the lay definition is not appropriate for long term care facilities staffed by licensed health care professionals.

In each of the 1987, May 2002, and December 2002 Statements, the Department also distinguished between emergency and non-emergency (*i.e.*, pre-scheduled) calls. A preponderance of evidence establishes that there is a third category of calls that do not require an immediate, three-tiered response (*i.e.*, an FR, BLS and ALS response). FF 76. The evidence also establishes that for these calls, as well as for many emergency calls that *do* require an immediate response, a three-tiered response is also highly disruptive and costly.

These problems will likely be resolved by July 1, 2004, when EMD protocols are implemented by PSAP/dispatchers, statewide. These protocols will enhance the ability of dispatchers to match EMS responses to patients' needs. FF 31, 32, 33. For these dispatch protocols to be effective, however, facilities must ensure that the person who calls 911 from the facility, is also familiar with the patient and capable of answering the dispatcher's questions. FF 81.

The Town of Wallingford provides an instructive example of how EMD protocols will resolve many of the issues raised by facilities during the hearing. In Wallingford, the PSAP/dispatcher has implemented an EMD protocol utilizing three acuity levels that take into consideration the unique capabilities of each of the five long term care facilities located within the Town, *e.g.*, available equipment, staffing, etc. Each acuity level has associated transport times, and identifies the level of service necessary for that patient's needs. Acuity level one requires that an FR and transport ambulance be on the scene within zero to fifteen minutes, travelling at high speeds with lights and sirens; acuity level two requires transport in fifteen to thirty minutes without the use of lights and sirens and without the FR; and, acuity level three requires a response of between thirty and sixty minutes, without an FR and without utilizing lights and sirens. All of these calls are processed by the PSAP/dispatch service. FF 82.

The Wallingford system provides a model for the types of systems that can be implemented utilizing an EMD protocol. In the meantime, the Department encourages facilities and dispatchers to communicate with one another to determine an appropriate response for each patient, to the extent possible. The evidence establishes that presently, dispatchers who are not trained in the use of EMD protocols often make assumptions about long term care facilities that may not be accurate. For example, some may assume

that the facility can provide FR care and, based on that assumption, do not send an FR even when one is needed. Conversely, some dispatchers assume that a facility cannot provide FR care and always send an FR, even when one is not needed. FF 74.

A preponderance of evidence establishes that professional staff in long term care facilities are highly skilled and capable of determining when to initiate the EMS system by calling 911, and when to call a non-emergency provider when timeliness is not an issue. FF 77. Professional staff have been making those judgments for some time and should continue to do so. Tr. 8/21/02, pp. 241-44.

At the same time, facility staff are not as familiar with the emergency medical system and its resources. FF 78. Thus, when facility staff initiate the 911 system, the dispatcher is responsible for considering the available EMS resources, and matching them to the patient needs, with information provided by the facility staff. Until EMD protocols are implemented, this task can be made more cost efficient and less disruptive when facility staff and the dispatcher communicate effectively. Until EMD protocols are implemented, the Department encourages the EMS industry to work towards identifying those situations in which "the full calvary" need not be sent in response to a request for emergency service.

***B. In an emergency, can providers provide emergency medical services in an areas in which the receiving hospital does not provide medical control including, but not limited to, ongoing quality control and assessment of practice levels of the provider, other than through mutual aid as defined in §19a-179-1(v) of the Regulations and other than as directed to do so by an authorized and recognized emergency dispatch center?***

The answer to this question is: no.

To the extent emergency medical personnel provide invasive medical care, including starting intravenous lines, using defibrillators, performing endotracheal intubations, and administering medications, they operate under the medical direction of physicians at sponsor hospitals who provide medical control. FF 36.

All mobile intensive care ("MIC") providers[6] are required to have a written agreement with a sponsor hospital. Section 19a-179-12 (a)(4) of the Regulations

[6] MIC is defined in Regulations §19a-180-1 as "service above basic life support which is intensive and complex prehospital care consistent with acceptable emergency medical practices under the control of

provides that "MIC personnel shall be under the supervision and direction of a physician at the sponsor hospital from which they are receiving medical direction;" and, subsection (5) provides that "MIC services shall be under the control of the MIC medical director, or his or her designee, such as an on-line emergency department staff member."

Medical control is defined by §19a-179-1(o) as "the active surveillance by physicians of mobile intensive care sufficient for the assessment of overall practice levels as defined by statewide protocols."[7] Medical control includes both medical direction and quality assurance. FF 37.

Medical direction is defined by §19a-179-1 of the Regulations as "the provision of medical advice, consultation, instruction and authorization to appropriately trained or certified personnel by designated staff members at sponsor hospitals."[8] The evidence establishes that medical direction may be provided either by use of written protocols (*i.e.*, "off-line" direction) or by on-line supervision consisting of actual voice communication between the provider and the physician, enabled by the CMED. FF 17. The off-line, written protocols also define when on-line supervision is necessary.

The quality assurance aspect of medical control includes establishing criteria for credentialing, re-education, clinical monitoring, supervision and education. FF 39.

There are presently three hundred and thirty one providers in Connecticut having sponsor hospital relationships with thirty sponsor hospitals, four of which are designated by the Department as Level I Trauma Centers; eight are designated as Level II Trauma Centers; and, three are designated as Level III Trauma Centers. Additionally, one hospital in Worcester, Massachusetts, is designated by the Department as a Level I Trauma Center. FF 43.

The question posed is whether providers may provide emergency medical services in an area in which the receiving hospital does not provide medical control other than

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physician and hospital protocols." *See, also,* Regulations §19a-179-1(t) which defines MIC as "pre-hospital care involving invasive or definitive skills, equipment, procedures, and other therapies."

[7] Presently, there are no statewide protocols for ALS care. Providers operate under their sponsor hospital protocols which vary from hospital to hospital and region to region. FF 62, 63.

[8] Section 19a-179-12 requires that sponsor hospitals provide the Department with a description of the sponsor hospital's role, the procedures the MIC personnel will follow in obtaining medical direction, the treatment protocols, procedures for modifying the protocols, and a description of the quality assurance functions.

when providing mutual aid and other than as directed by the PSAP/dispatch center. The evidence, statutes and regulations establish that the answer to this question is generally "no" unless the provider's sponsor hospital is providing medical control, in which case, the provider would necessarily be under the direction of the PSAP/dispatch center, as discussed herein.

One provider asserts that because authorizations to operate ambulances are valid throughout the state, this question should be answered in the affirmative. This provider also challenges the practice of hospitals to limit the geographic area in which they agree to exercise medical control, and asserts that such limits deprive it of the ability to provide emergency care statewide.

As an initial matter, the suggestion that a provider could provide emergency care and bring patients to hospitals without medical control and without being authorized to do so by the dispatch center, is completely contrary to the system of providing emergency medicine in Connecticut as established by statute and regulation. Moreover, the mere fact that authorizations to operate ambulances are valid statewide, is not justification for providing care without medical control or direction from a dispatch center. The fact that authorizations are valid statewide has more to do with the provision of non-emergency service (which is not a subject of this proceeding), mutual aid, assistance in mass casualty situations, and for providers who are PSARs in more than one PSA. It does not in any way, diminish the requirements that providers have medical control and operate under the direction of a PSAP/dispatch center.

The evidence also establishes that hospitals limit the geographic reach of their medical control for entirely rational and necessary reasons, *e.g.*, to exercise meaningful supervision over a provider's activities and ensure the quality of patient care. One medical director testified that in order to ensure adequate medical control, he needs to be familiar with the provider's personnel, have routine access to incident and run reports, and have the opportunity to examine and review the records of patients who are treated in the field. FF. 55. A representative from another sponsoring hospital organization testified that it cannot monitor or supervise providers operating outside a specified geographic area since it cannot maintain communications beyond that area. FF 51. Indeed, since CMEDs have a limited geographic area in which they are able to provide

communication services for on-line medical direction, it would seem necessary for sponsor hospitals to limit the geographic range of their medical control.

The evidence also establishes that sponsor hospitals' practice of limiting medical control to a geographic area has no bearing on a provider's ability to provide emergency care statewide. Geographic limits on a provider are the result of the PSAR system, *not hospital practices*, since PSARs have first call priority in their PSAs (as further discussed in section "C" below). Sponsor hospitals establish relationships with the PSARs within their geographic area since *they* are the providers who respond to all of the emergency calls, except when mutual aid is required – which is a very small number of calls (*e.g.*, as few as 1% of the total call volume in the South Central Region. FF 54, 55.) For example, Yale's geographic area includes twelve towns, and Yale sponsors all of the PSARs in those twelve towns. FF 58. Since Yale's geographic area includes twelve municipalities, many of the mutual aid providers have the same sponsor hospital as the PSAR. Tr. 8/21/02, p. 277.

The typical and simplest scenario of how the EMS system works is as follows: a PSAP/dispatch service receives a 911 call; the dispatcher identifies the location and calls the PSAR to respond; the PSAR initiates service within its PSA (which is part of the geographic area of its sponsor hospital); the CMED (which is either the PSAP/dispatcher, or a separate entity) provides a communication link between the PSAR and the sponsor hospital which is also the destination hospital; and, the PSAR delivers the patient to the sponsor hospital. This scenario describes the vast majority of emergency calls. FF 49.

The remaining calls, which are relatively few in number, involve (1) PSARs who transport a patient to a destination hospital that is not a provider's sponsor hospital because either the patient requests a different hospital, the patient's condition requires a transport to a Trauma Center outside the geographic reach of the sponsor hospital, or the sponsor hospital is under diversion; (2) when a dispatcher calls for mutual aid from a provider that does not have a sponsor hospital relationship in the geographic area where the emergency has occurred; [9] (3) when a provider has a formal relationship with a PSAR

[9] If a provider is responding to an *excessive* number of calls for mutual aid outside the geographic area of its sponsor hospital, one sponsor hospital testified that they would require that provider to secure a sponsor hospital relationship. More appropriately, the PSAR for the area that is passing the calls, should either request authorization to operate additional ambulances based on its passed call volume or enter into a

to provide services during certain times of day or under certain circumstances in the PSAR's service area, in which case, the dispatcher has a copy of that agreement and knows who to call (FF 12); and, (4) situations in which a provider encounters an emergency while travelling through another provider's PSA, in which case, it is the common practice in the industry for the provider to render necessary assistance and immediately contact the dispatch center, as discussed in greater detail under "G," herein.[10]

In the first instance described above, a PSAR *initiates* care within its PSA and the sponsor hospital's geographic area, and then *transport*s the patient to a hospital outside its sponsoring hospital's geographic area. In the second, third, and fourth situations, non-PSAR providers *initiate* emergency care in an area where they do not have a sponsor hospital *and* may *transport* a patient to a hospital where they do not have a sponsor hospital relationship.

A preponderance of evidence establishes that *under each of the scenarios described above, the provider is either alerted to the emergency by the PSAP/dispatcher (examples 1 – 3) or initiates contact with the PSAP/dispatcher (example 4), and provides care under medical control, enabled by CMED.* In particular, in each instance, one of the following occurs: the sponsor hospital of the geographic area where service is initiated, extends its medical control until the patient is delivered to the destination hospital, if different than the sponsoring hospital for that area; the destination hospital provides medical control; or, the destination hospital provides on-line medical direction and the sponsor hospital for that provider continues to be responsible for quality assurance, in which case, the destination hospital provides information to the sponsor hospital, as necessary. FF 52.

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formal agreement with the other provider to provide services during certain times or under certain circumstances. If a provider is operating on a regular and routine basis in another providers PSA pursuant to such an agreement, that provider should also have a sponsor hospital relationship that will provide it with medical control in that PSA. *In general, the purposes of the sponsor hospital relationship can only be accomplished if the provider's sponsor hospital has the opportunity to exercise medical control over the vast majority of the calls to which the provider responds.*

[10] In general, the evidence establishes that under this circumstance, the practice in the industry is to stop and assist, and to immediately call the authorized dispatch center to obtain direction. In some instances, the dispatcher will request that the provider provide service until the PSAR arrives; in other instances, the provider may be requested to render assistance and transport the patient, and the CMED enables medical

While there are no statutes or regulations specifically governing hospitals' practice of limiting the geographic area in which they exercise medical control, there also does not appear to be a need to regulate this practice at this time. Indeed, given that the configuration of emergency medical services varies widely from town to town and county to county, the Regional Councils[11] are in the best position to address any issues that may arise regarding this practice, and at least two Regional Councils have done so. For some time, in the North Central EMS Region, on-line medical control was provided by sponsor hospitals, without regard to the destination hospital, and the sponsor hospital received a copy of the patient's pre-hospital care record for quality assurance purposes. FF 56. In the South Central Region, the hospitals have a written agreement to notify the sponsor hospital of any problems that arise when the patient is transported to a facility other than the sponsor hospital. FF 57.

A preponderance of evidence establishes that hospitals' practice of limiting the reach of medical control is necessary to ensure quality of care and proper oversight of EMS providers. The evidence also establishes that when providers respond to calls or deliver patients to hospitals outside the geographic area of their sponsor hospital, they must do so as directed by the appropriate PSAP/dispatch center and under medical control.

***C. In an emergency, can a provider provide emergency medical services in an area in which it is not the primary service area responder, other than through mutual aid as defined in §19a-179-1(v) of the Regulations, and other than as directed to do so by an authorized and recognized emergency dispatch center?***

The answer to this question is: no, except when a provider encounters an emergency while travelling *en route* through another provider's PSA, in which case, the provider may stop and render necessary assistance, and then must contact the PSAP/dispatcher as further discussed in section "G."

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control either with the hospital that would have provided medical control for the PSAR, or the destination hospital. FF 48.

[11] Indeed, pursuant to §19a-182 of the Statutes, the Regional Councils are responsible for "area-wide planning and coordinating agencies for emergency medical services and shall provide continuous evaluation of emergency medical services for their respective geographic areas." The Regional Emergency Medical Services Coordinator is responsible for, among other things, maintaining a complete inventory of all personnel, facilities and equipment within the region related to the delivery of emergency medical services. . . ." §19a-186 of the Statutes.

Since there is no dispute as to whether a provider may respond to an emergency call as requested by a dispatch center, including mutual aid requests, the question at issue solely concerns situations in which a non-PSAR responds to an emergency call made directly to the provider utilizing a seven-digit phone number. The evidence presented at the hearing focused on two issues: (1) whether facilities may place such calls to providers, and (2) whether providers may respond to such calls.

During the hearing, the alleged practice of facilities calling providers for emergency services using a seven digit number was referred to as "the private provision of emergency services." Despite bald assertions to the contrary, a preponderance of evidence establishes that such practices are not and have not been widespread for many years.[12] FF 84, 85, 86, 87. By and large, it is the universal practice in the industry for long term care facilities to utilize 911 to call the appropriate dispatch center in the event of an emergency. FF 90.

In creating the emergency medical services system as it exists today, the legislature determined that the quality and timeliness of emergency care could best be ensured by eliminating the competition that had given rise to the outrageous conduct that marred the early days of the industry.[13] As stated by Representative Cohen, "we have now pending in the state . . . legislation which will do away with all the present competition . . . with all the problems of competition." Exh. P5-E, p. 177.

Competition was eliminated by creating a single number to be called in the event of an emergency, creating a central dispatching system, assigning PSARs, and eliminating advertising.[14] *See*, §28-24-1(b)(3) of the Regulations; Exh. P2-C, Att. Each of these components of the emergency medical services system has withstood an anti-

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[12] Such calls constitute approximately 5% of New Britain's call volume (FF86) and less than 1% of calls in the South Central Region (FF88).

[13] See, also, *Med-Trans of Conn., Inc. v. Department of Public Health & Addiction Services*, 242 Conn. 152, 165 (1997), in which the court dismissed suit on the grounds that plaintiff lacked standing, finding that "Section 19a-180, by its language, requires the department primarily 'to protect the public at large and not the interests of individual competitors' . . . in its decisions whether to grant licenses and certificates," *quoting United Cable Television Services Corp v. Dept of Public Utility Control*, 235 Conn. 334, 346, 663 A.2d 1011 (1995). *Supra*, at 165. As stated by the court, "[i] t is very clear that the legislature did not intend to protect the competitive advantage or monopoly of an existing service provider, but, rather, the legislature sought to protect the welfare of those in the community in need of those services." *Supra,* at p. 166.

[14] FF 14; §28-28(c) of the Statutes; §19a-179-19 of the Regulations.

trust challenge in the courts.[15] As stated by the court in *Professional Ambulance Service, Inc. v. Blackstone, supra,* at p. 144,

> [t]hat there exists a need for a statewide emergency medical care system is not an unreasonable assertion by the legislature, nor is the mandate that the state be broken into identifiable geographical areas to be serviced by the various responders. *In a matter of the magnitude of a medical emergency it is clearly not unreasonable to assign as goals specific geographic areas of responsibility, the designation of specifically responsible people for these areas and a limitation on the advertising of those engaged in emergency medical service as a means of assuring that the public is appropriately directed into the emergency medical services system* . . . . Emphasis added.

The 911 system is "responsible for receiving emergency calls and notifying the appropriate emergency medical service providers of such calls . . . and assigning them to respond to such calls." §19a-179-1(f) of the Regulations. It was clearly the legislative intent in creating the 911 system that the public, including long term care facilities, call 911 to connect with PSAP/dispatch centers in the event of an emergency.

Moreover, the State has expended significant resources in developing a coordinated 911 system and educating the public to use it. There are presently 108 PSAP/dispatch centers, some of which are also CMEDs, that receive all 911 calls, twenty-four hours each day. More recently, the State has developed the "enhanced 911 system" which has the capacity to route automatically a 911 call to the appropriate PSAP/dispatcher for that town or region, and display the geographic location of the caller, as well as some demographic information, *e.g*., whether the call is from a long term care facility or private individual. FF 22, 23; §§28-24 *et seq.* of the Statutes; §28-24-2 of the Regulations.

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[15]This legislation withstood an action brought under state antitrust laws in *Professional Ambulance Service, Inc. v. Richard H. Blackstone*, 35 Conn. Sup. 136 (1978), in which the plaintiff sought to enjoin East Hartford from (1) designating a provider, other than itself, as the PSAR; (2) designating the use of a single telephone number for all emergencies; and, (3) prohibiting advertising. Describing the emergency medical system as "provid[ing] for the arrangement of personnel, facilities, and equipment for the efficient, effective and coordinated delivery of health care services under emergency conditions . . . ." the court determined that "the totality of the mandate set out in these statutes furnishes an adequate basis and authority for the promulgation of regulations creating the primary service areas, assigning one responder to each such area and limiting or restricting the advertising of those who would provide emergency services or personnel." *Id*., at p. 143. The court further found that "[u]nder all of the circumstances . . . , the plaintiff simply has not proven by a fair preponderance of the evidence that the enactments . . . did not embody safeguards demonstrably protective of the public interest or that a reasonable public purpose was not served in their promulgation. *Id.*, at p. 145.

In addition to establishing the 911 system, the legislature also authorized the creation of Primary Service Areas (PSAs) for which one responder at each level of service would be responsible. Section 19a-175(23) and (24) defines PSAs as "a specific geographic area to which one designated emergency medical services provider is assigned for each category of emergency medical response services." Subsection (24) defines Primary Service Area Responders (PSARs) as, "an emergency medical services provider who is designated to respond to a victim of sudden illness or injury in a primary service area." *See also*, §19a-179-1(x) and (y). Pursuant to §19a-177(11) of the Statutes, the Commissioner of the Department is responsible for establishing PSAs and for designating the PSARs, in writing, at each level of service. Municipalities may petition the Department for removal of a PSAR, and the Department may revoke a designation and reassign a PSAR if it is in the best interests of patient care to do so, or if the PSAR has performed unsatisfactorily. §§19a-177(12) and 19-181c of the Statutes; §19a-179-4(d) of the Regulations. *There is no authority for a provider unilaterally to substitute itself for the PSAR.*

Section 19a-179-4(c) of the Regulations specifically provides that PSARs have "first call priority" in a PSA. By ensuring that the PSAR has first call priority, PSARs can rely upon an income sufficient to enable them to comply with statutory and regulatory requirements and maintain a readiness to respond. In particular, this section provides that "*[a]ny circumstances* under which another designated response service would receive first call priority, such as central dispatch sending the closest available vehicle, shall be stipulated in the assignment of the PSAR." Emphasis added. Thus, this provision clearly envisions that PSARs have first call priority. Any argument that an ambulance parked outside of a long term care facility should be sent to respond to an emergency at that facility instead of the PSAR, because it is the closest available ambulance, is directly contradicted by this regulation unless such a stipulation is included in the written assignment of a PSAR.

In support of its claim that long term care facilities should be permitted to call non-PSAR providers directly to request emergency service, one provider claimed that the practice was necessary since PSARs did not always respond to requests in a timely manner. First, if a PSAR is not performing satisfactorily, there are statutory and

regulatory provisions that can be invoked to remove a PSAR designation. Secondly, the evidence simply did not support this claim. Rosemarie Clark, R.N., N.H.A., Administrator of Norwichtown Rehabilitation and Care Center, testified that she has worked in the nursing home industry for twenty-eight years and is familiar with one chain of twenty facilities, another business having eight homes, and an additional twelve to fifteen facilities with which she has consulted. In her many years of experience, she testified that she was unaware of any problem with timeliness of an emergency response. Tr. 8/21/02, pp. 25, 30. Similarly, while Toni Fatone, Executive Vice President of the Connecticut Association of Health Care Facilities, Inc., an organization representing over 165 nursing home facilities, expressed concerns about the May 2002 Statement, she testified that she was not aware of any problems at any of the facilities she represented, in accessing the 911 system. Tr. 8/21/02, pp. 242.

Finally, the argument was made that no specific statute or regulation expressly prohibits long term care facilities from calling non-PSARs for emergency services, or that prohibits non-PSARs from providing such services. While it may be true that there is no specific statute or regulation prohibiting such conduct, there are a plethora of statutes and regulations that militate against such practices.[16] The statutes and regulations make

[16] *See*, *e.g.*, the requirement of written agreements to provide mutual aid when a PSAR is unable to respond to an emergency call (§19a-175(21) of the Statutes); the designation of PSARs (§19a-175(24); the requirement that the Department collect data from each provider and produce a report regarding the total number of 911 calls to which each provider responded, the level of service provided, response times, the number of passed, cancelled and mutual aid calls, and prehospital data (§19a-177(8) of the Statutes); the establishment of rates for emergency service (§19a-177(9) of the Statues; §19a-179-21 of the Regulations); the requirement that providers undergo a certificate of need determination prior to expanding their services (§§19a-180-1 *et seq.* of the Regulations); the requirement that the Department develop a statewide coordinated delivery plan (§19a-178 of the Statutes); the requirement that municipalities develop a local emergency plan identifying all levels of emergency medical services including, but not limited to, the PSAP responsible for receiving emergency calls and assigning the appropriate provider to respond, the provider that is notified for FR, BLS and ALS services, performance standards, any contracts or mutual aid agreements the PSAR has entered into (§19a-181b of the Statutes); the Department's ability to remove a PSAR (§19a-181c); the creation of Emergency Medical Services Regional Councils to plan and coordinate emergency services within their regions and develop a plan for the delivery of such services (§§19a-182, 19a-183, 19a-184 of the Statutes; §19a-179-2 of the Regulations); the creation of Regional Emergency Medical Services Coordinators to facilitate the work of the Councils, implement Regional plans, monitor and evaluate emergency services in their region, inventory all personnel, facilities and equipment within the region related to emergency care (§19a-186 of the Statutes; §19a-179-3 of the Regulations); the regulation of staffing and equipment in emergency vehicles and the investigation and prosecution of complaints (§§19a-195, 19a-195a, 196 of the Statutes; §§19a-179-5, 19a-179-9, 19a-179-10, 19a-179-15, 19a-179-16a of the Regulations); the requirement that each emergency medical service council and system respond to and honor calls from any municipality that participates in another council or system (§19a-196b of the

it abundantly clear that the legislature intended to occupy the field and exercise control over all emergency calls in Connecticut. It is ludicrous to imagine that, despite the complex statutes and regulations governing the EMS industry in Connecticut, the legislature intended to permit any provider who does not wish to comply with the statutes and regulations to create their own parallel, unregulated universe of emergency medical services. If numerous providers followed such a course, the emergency medical services system in Connecticut would fail.

The absolute silence of the legislature regarding so-called "private emergency services" also suggests that the legislature did not intend for providers to engage in such business practices. For example, §§19a-177(8) and 28-25b(f) of the Statutes requires that the Department collect voluminous data regarding 911 calls from both providers who respond to 911 calls and dispatchers. *There is no data reporting requirement for providers who respond to so-called private emergency calls*. It would seem that if the legislature anticipated such practices, it would have referenced such emergency calls in the statute since the stated intent of the legislature was that the Department have *complete* information "following a patient from initial entry into the emergency medical service system through arrival at the emergency room." §§19a-177(8) and 28-25b(f) of the Statutes.

Indeed, the term, "emergency medical service system," is statutorily defined as "a *system* which provides for the *arrangement of personnel, facilities and equipment* for the efficient, effective and *coordinated* delivery of health care services under emergency conditions." Emphasis added; §19a-175(1) of the Statutes. For a provider to provide emergency services where it is not the PSAR would be highly disruptive to the "coordinated delivery of health care services" and would endanger the public health and safety.

In conclusion, the preponderance of evidence and a reasonable construction of the statutes and regulations establishes that long term care facilities are required to call 911 when there is an emergency, and non-PSAR providers may *not* respond to emergency calls made directly to them. By regulation and the clear intent of the legislature, the

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Statutes); the assignment of one PSAR for each PSA, at each level of service (§19a-179-4 of the Regulations); sponsor hospital requirements, discussed *supra*;

PSAR has "first call priority" in its designated PSA. The only circumstances under which a non-PSAR may provide emergency services in a PSA having a PSAR, are those previously discussed.

***D. In an emergency, can a provider cancel the response of a primary service area responder if it is closer to the emergency, already at the scene of the emergency or for any other reason?***

The answer to this question is: no.

As stated above, dispatch centers are the only statutorily authorized entities "responsible for receiving emergency calls and notifying the appropriate emergency medical service providers of such calls . . . and assigning them to respond to such calls" (§19a-179-1(f) of the Regulations); and, providers are not dispatch centers. Since providers have no authority to dispatch, they also have no authority to cancel the appropriate PSAR dispatched by an authorized dispatch center. To permit providers to cancel PSARs of their own volition, would be to interject into the emergency medical services system the competition, chaos, and potential abuses the legislature eradicated.

A preponderance of evidence establishes that there are circumstances in which someone other than the dispatch service may determine that a PSAR should be cancelled. For example, the designated FR or BLS provider, and an incident commander (a senior ranking officer and representative of the 911 system) may determine that the ALS provider is not necessary in situations in which, *e.g.*, there is no emergency, or there are sufficient personnel on the scene, etc. Under these circumstances, the FR, BLS provider or incident commander notifies the PSAP/dispatch center which then cancels the ALS provider.

The record is devoid of evidence of any situation in which a non-PSAR may either directly cancel the PSAR, or call the PSAP/dispatch center and request that the PSAR be cancelled. Therefore, in light of the need for a coordinated system of emergency medical services to protect the public health and safety, and a preponderance of the evidence, the answer to this question is "no."

***E. In an emergency, is a provider required to forward an emergency call to the 911 system if it has been contacted outside of the 911 system?***

The answer to this question is: yes.

As discussed above, PSARs have first call priority in emergency situations; facilities are required to call 911 when there is an emergency; and, non-PSARs may *not* respond to an emergency except (1) when requested to by a dispatch center to provide mutual aid; (2) when it has an agreement with a PSAR to provide emergency services in the PSAR's service area during designated periods of time or under specified circumstances; and, (3) when a provider encounters an emergency while travelling *en route* through another provider's PSA, in which case, as discussed in section "G," it is required to notify the dispatch center as soon as possible after providing necessary care. Thus, it would follow that providers who receive so-called private emergency calls, forward them to the appropriate dispatch center.

This construction is also consistent with statutes and regulations which require, *inter alia*, that when a public safety agency[17] receives a request for emergency service outside of its service area, the public safety agency is required to forward the request to the PSAP/dispatch center or PSAR responsible for the area and render service until relieved by the PSAR (§28-28 of the Statutes), and "[e]ach response service shall maintain contact with the dispatch center concerning the location and availability of system vehicles." §19a-179-11(d) of the Regulations.

If providers fail to contact PSAP/dispatch centers when contacted outside of the 911 system, PSARs would be deprived of calls for which they are responsible and the necessary revenues those calls generate; dispatchers would have no way of knowing that the provider is unavailable for other emergency services such as mutual aid and mass casualty situations, and will be unable to dispatch additional resources, as needed; and, if the PSAP/dispatcher is also a CMED, the provider would be unable to obtain on-line medical direction, and the receiving hospital would not be alerted to the incoming patient. Additionally, as discussed above, the Department would be unable to fulfill its statutory mandate to plan, coordinate and administer the emergency medical services system (*see,*

[17] Public safety agencies are municipal or state entities that provide fire fighting, law enforcement, ambulance, medical, and other emergency services.

§19a-176), since it would be unable to collect prehospital data regarding patient care. *See*, §19a-177(g). Thus, the failure to forward a call to the appropriate PSAP/dispatch center would frustrate and undermine the legislative intent to create a coordinated emergency medical system, and would endanger the public health and safety.

Fortunately, a preponderance of evidence establishes that, in the rare occurrence of a provider receiving a request for emergency services *via* a private seven digit phone number, the standard, routine practice in the industry is to contact the appropriate dispatch center. FF 24, 25, 26, 27, 28, 29, 30.

***F. In an emergency, can a provider dispatch its own ambulances to the emergency if it is not the primary service area responder in that area?***

The answer to this question is: no.

Generally speaking, providers are not PSAP/dispatchers and, therefore, do not receive 911 calls. Thus, it is difficult to imagine a scenario in which a provider would even be aware of a 911 call and dispatch its own ambulance other than if a provider received a call through a seven digit number, as discussed above. No evidence was submitted during the hearing to establish any other scenario in which a provider would become aware of an emergency such that it could dispatch its own ambulances.

Additionally, as previously stated, the regulations establish that PSARs have first call priority within their service area. To provide emergency services in another PSAR's service area, without being directed to do so by an authorized dispatch center (unless the provider encounters an emergency while travelling through another provider's PSA, as further discussed in "G" hereinbelow), is contrary to the practices in the industry, and the regulatory and statutory scheme governing the provision of emergency medical care.

***G. In an emergency, is a provider required to sign on immediately with an authorized and recognized emergency dispatch center prior to patient contact, treatment and initiation of transportation of a patient to a medical facility?***

In situations in which the provider encounters an emergency while *en route* through another provider's service area: the answer is no, with regard to patient contact and treatment; the answer is yes, with regard to the initiation of transportation. In all other emergency situations, the provider should already be in communication with a

PSAP/dispatcher prior to initiation of treatment, since providers are dispatched by the PSAP/dispatch service.

Since previous questions have already addressed scenarios in which a provider is contacted *via* a seven digit number and is required to immediately contact the PSAP/dispatch center, this question seems to concern situations in which a provider encounters an emergency while *en route* through another provider's service area. Under such circumstances, the evidence establishes that the provider should stop to render assistance, and then immediately contact the PSAP/dispatch center so that the PSAP/dispatch center may, *e.g*., dispatch the PSAR; dispatch multiple providers, if needed; or, direct the non-PSAR to transport the patient.

Section 19-179-11(d) of the Regulations provides that "each response service shall maintain contact with the dispatch center concerning the location and availability of system vehicles." Thus, if a provider is responding to an emergency call, this provision requires that the providers contact and remain in communication with the authorized PSAP/dispatch service.

A preponderance of evidence establishes that when providers unexpectedly encounter an emergency in an area where they are not the PSAR, they routinely sign on with the appropriate PSAP/dispatch center (FF 24, 25, 26, 27, 28, 29, 30). Many PSAP/dispatchers *require* that providers sign on with them (FF 25, 26, 27, 28).

Based on the foregoing, for all of the reasons set forth under "E" above, providers are required to sign on with PSAP dispatch centers under these circumstances, after initiating necessary care to the patient. Any other determination would only raise the specter of providers once again racing to an emergency, to beat PSARs to the emergency – just as providers did before the legislature abolished such competitive practices.

***H. Can a provider contract with a health care facility of any type for the provision of emergency medical services in emergency situations?***

The answer to this question is: no.

Although one provider asserted that the practice of non-PSARs entering into contracts with long term care facilities to provide emergency care is "widespread" within the industry, the evidence regarding this claim was either entirely lacking, anecdotal hearsay, or simply to the contrary. A preponderance of evidence establishes that

providers do *not* enter into contracts with long term care facilities to provide emergency services. Rosemarie Clark, R.N., N.H.A., Administrator of Norwichtown Rehabilitation and Care Center, who is familiar with numerous facilities, testified that she is unaware of any private agreements between long term care facilities and non-PSARs for the provision of emergency services. Tr. 8/21/02, pp. 25, 30. American, AMR, and Hunter's all testified that they do not enter into such contracts. FF 96.

Not only is the evidence contrary to this claim, but for long term care facilities to enter into such agreements with providers would undermine the entire regulatory scheme creating the emergency medical services system as it exists today and the efficient, systematic provision of coordinated emergency care. As previously determined in "C," long term care facilities must call 911 when they have an emergency situation.

***Conclusion***

A preponderance of the evidence, a reasonable construction of the statutes and regulations, sound public policy, and the need to protect the public health and safety in emergency situations that threaten the very lives of patients, all mandate that the answer to each of the foregoing questions, except "E" and portions of "G," is no. To find otherwise would interject the very elements of competition that the legislature eradicated; and, those competitive practices cost lives.

In particular, (1) if providers could operate without medical control, patient safety would be gravely threatened; (2) if providers could respond to emergency calls in another provider's PSA without being requested to do so by a dispatch center, providers would once again race to calls to be the first at the scene; (3) if providers could cancel a dispatcher's call to a PSAR, providers would be able to steal another provider's business; (4) if providers could respond to emergency calls made directly to them without referring them to the PSAP/dispatch center, or contract with long term care facilities for the provision of emergency care, providers would once again be in competition to provide emergency services; (5) if providers could dispatch their own ambulances in another provider's PSA, there would again be races to the scenes of emergencies; and, (6) if providers were not required to sign on with the authorized dispatch center, dispatch centers would have no way of properly and efficiently allocating resources.

The evidence establishes that, in fact, providers do *not* engage in these activities except in isolated instances; and, since the issuance of the May 2002 Statement, even those instances have been largely eliminated.

The evidence also establishes that in the past thirty years, the emergency medical system, as created by the legislature, has evolved into a highly effective, complex, and sophisticated system that promotes the health and safety of patients in life-threatening situations; and, the success of this system continues to depend upon the dedication and cooperation of every emergency medical services professional and their adherence to the statutes and regulations governing the EMS system.

_____ _____

Donna Buntaine Brewer, Esq. Date
Hearing Officer