Local Emergency Medical Services Plan Toolkit for Municipalities

State of Connecticut
Department of Public Health

Office of Emergency Medical Services
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Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

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Preface

A municipality that puts effort and detail into a Local EMS Plan may benefit greatly from both the process and the final product. When the municipal leaders and the EMS organizations meet to discuss the plan, the discussion leads to better organizational relationships, improved system knowledge, and multi-dimensional goals and objectives for the town's EMS system development.

A municipality that fails to implement a local EMS plan essentially forfeits the ability to proactively manage its local EMS system. The organizations providing EMS to the municipality will be assessed for their provisions of services under the plan not less than every five years. In the absence of a plan, the Department will assess EMS system providers for compliance with applicable statutes and regulations, which may be lesser standards than what a municipality may have chosen.

Revised statutes which took effect October 1, 2014 also provide expanded municipal controls for towns that comply with the provisions of the local EMS planning statutes. It is, for the aforementioned reasons, in the municipality's best interest to work with its EMS system providers to develop a local EMS plan. In 2016, Public Act 16-43 was passed which requires municipalities, by October 1, 2016, to amend their local emergency medical services (EMS) plans to ensure that specified first responders are equipped with an opioid antagonist and trained in administering it (§ 1).

In the landmark publication "EMS Agenda for the Future", the National Highway Traffic Safety Administration (NHTSA) defined an EMS system as a dedicated organization for the allocation and coordination of emergency medical personnel, protocols, equipment and supplies. The report concluded that to operate as an effective EMS system, *comprehensive assessment programs must be in place for current processes to be reviewed and improved as necessary*.

To assess the effectiveness of an EMS system, municipal leadership, in collaboration with EMS system leadership and other stakeholders, should examine data consistent with current national, state and regional standards to validate existing processes and identify areas for improvement.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Local Emergency Medical Services Plans
January 2016

Purpose

- To develop a plan that satisfies the municipality's statutory requirement and provides a comprehensive local EMS plan (LEMSP) that communicates information about the local EMS system to all stakeholders
- To establish methods to monitor how well the EMS system is functioning and frames objectives and methods for improving the EMS system.

Depth of planning

The LEMSP encompasses all the components of the EMS system. Both statutorily required and recommended "best practice" components should be incorporated, and are reflected on the LEMSP check sheet included in this toolkit. Collaboration between the municipality and all the EMS stakeholders is a key factor in the development of a comprehensive plan.

Planning assistance

The Connecticut General Assembly anticipated that municipal leaders would require technical assistance during the planning process. Under CGS §19a-178(c), the Office of Emergency Medical Services (OEMS) is charged with developing model local EMS plans and performance agreements to guide municipalities in developing their plans, with advice and recommendations from the Connecticut EMS Advisory Board (CEMSAB) and the Regional EMS Councils. This toolkit and other resource documents are posted on the State Department of Public Health's website.

Technical assistance specific to a particular municipality may be obtained through the appropriate Regional EMS Council, regional medical advisory committee or sponsor hospital, and regional EMS coordinator. The OEMS has two full time health program assistants dedicated to local EMS planning. Contact information is provided in this document.

The planning process

A Local EMS Plan should be developed in collaboration with leadership from of each of the EMS system components, which would include all "traditional" responders, plus organizations not traditionally viewed as being part of the EMS system, such as dispatch centers and other stakeholders*. When a Local EMS plan is being *updated*, it is required by statute that the municipality consult with all primary service area responders.

*Stakeholders might include municipal and EMS organization leaders, EMS organization members, citizens, businesses, local, regional, and state policymakers and planners.

Local EMS Plans should be based upon a five year cycle, while goals and objectives should be targeted for one, three, and five years. Other documents attached to a LEMSP may revolve around a five years revision cycle, but may need to be reviewed annually. This would include mutual aid agreements and mass casualty plans.

State and regional EMS planning is done utilizing a five year cycle. Coordinating your planning cycle allows the municipality to take advantage of the new and evolving innovations being adopted globally in Connecticut. National changes in EMS system development flow down into the state plan, from which the municipality may also benefit.

Components of a Local EMS Plan

The local EMS plan should include basic information about the community, including such information as population, geographic square mileage, increased-risk populations, and a commercial and industrial overview. Support documents, such as Primary Service Area Responder (PSAR) certificates for responders, city ordinances affecting EMS, and a town map should be included in the plan. A suggested list follows.

Performance agreements

The planning statutes require the establishment of *performance standards* for each segment of the EMS system. This includes the Public Safety Answering Point (PSAP) and dispatch, first responder, ambulance and paramedic providers. Performance standards are a critical component of local EMS planning. Performance standards should be regularly reviewed and modified, at least annually.

The OEMS will be assessing each segment of the EMS system based on these standards. The performance of each primary service area responder will be reviewed at least once every five years based upon these performance standards. To have an objective review, the performance standards must be quantifiable and measurable.

In cases where a municipality and a service provider cannot come to agreement, the OEMS may be requested to assist in discussions between the parties to establish an agreement. If these discussions reach an impasse, the Department of Public Health may hold a public hearing to determine what the minimum performance standards will be. This will be discussed in more detail further in this document.

Written agreements between the providers and municipality, mass casualty plan, mutual aid and other agreements

The planning statutes require that *written agreements between the providers and the municipality, mutual aid agreements, and subcontracts or written agreements to provide services* be included as part of the plan. The OEMS requests that the Mass Casualty Plan be submitted as part of the Local EMS Plan. A checklist for the plan is included in this document.

Examples of other agreements would include bundle billing agreements, service area coverage for certain hours of the day, or subcontracting of the provision of emergency medical dispatch functions. Mutual aid agreements are frequently underdeveloped, citing statutory protections that inaccurately. We have included information and a checklist to assist you in reviewing your mutual aid agreements.

Current contracts or agreements already in effect may meet the requirement for the written agreement between providers and the municipality. The statute does not require that a municipality renegotiate a contract or agreement that is already in place.

Goals & Objectives

Another important part of the Local EMS Plan is the establishment of goals and objectives for the development of the system. Goals are overarching principals that guide decision making. Objectives are specific, measurable steps that can be taken to meet the goal.

The Local EMS Plan is a strategic plan that guides the development and directs the evolution of your local EMS system. An inefficient or failing EMS system may be the result of a lack of direction and planning.

"S.M.A.R.T." criteria should be utilized while crafting objectives. This process, also a standard in use by the Incident Command System, states that objectives must be specific, measurable, action oriented, realistic, and time sensitive.

Each municipality's goals and objectives will be different since the EMS system model varies from town to town. There are some common benchmarks that each municipality will want to achieve in their EMS system, such as universal coverage at each level of service and the provision of quality care inclusive of pre-arrival instructions for 9-1-1 callers. However some municipalities may want to consider additional programs for which the community has a unique need. Some suggestions for consideration are provided.

Plan submission and review

Local EMS Plans must be submitted to your regional EMS council and the Office of Emergency Medical Services for review. The regional EMS council will provide you with comments and recommendations to improve your plan. The OEMS will also review your plan utilizing the check sheets included in this document, and provide you with recommendations for improving your plan.

The OEMS must utilize the performance standards contained in your local plan to evaluate the primary area service responders in your community. Based upon these standards, each provider will be assigned a rating of "meets performance standards", "exceeds performance standards, or "fails to comply with performance standards". This will be discussed further later in this document.

It is important to review your plan and redact any sensitive information prior to submitting your plan to any person or entity other than the Office of Emergency Medical Services.

Draft reviews prior to submission

You may find it helpful to submit your plan to OEMS for a draft review during its development. The OEMS can provide recommendations that will facilitate its completion. In cases where important documents, such as your mass casualty plan or mutual aid agreements are not complete or don't exist, you may consider submitting your plan without the documents and make the completion of the document a "One-Year Objective." Once completed, the additional documents should be submitted to the OEMS for subsequent review and inclusion in your Local EMS Plan.

Your feedback to us

The OEMS would appreciate feedback as to how helpful this planning toolkit is for you, and any suggestions for making the planning process beneficial to your municipality. Please forward suggestions to your region's assigned Health Program Assistant.

Components of a Local EMS Plan

Emergency medical services systems vary across each of Connecticut's municipalities. However, despite the variation of EMS models employed, every local system should have addressed a common set of EMS system components. The following components and format for your plan are recommended:

- Composed in narrative form
- Title page with name of plan, date of plan, authors, version (as the LEMSP is updated)
- Table of contents
- Purpose statement
- Overall description of the response area / municipality, including basic demographics
  Information can be found at http://quickfacts.census.gov/qfd/states/09000.html
- Overview of the response process from 911 call to hospital arrival
- A list and description of each system component to include:
  - Each EMS organization assigned to each component
    - Public Safety Answering Point (PSAP)
    - First Responder
    - Basic Ambulance
    - Paramedic
    - Opioid antagonist equipment and training for EMS responders
  - Roles and responsibilities in the preparation and response to:
    - Ordinary day to day operations
    - Mass Casualty Incidents (Overview of the MCI plan)
    - Mass gathering events
    - Special operations
    - Special populations
      (Bariatric patients, ventilator-dependent patients, patients requiring specialized EMS care plans)
  - Geographic location of PSAP and EMS organizations
  - Chief of service and agent of business contact information
  - Resources (# of response vehicles and general staffing pattern, MCI trailers, off-road vehicles, marine units, etc.)
  - Performance standards and how they are monitored
  - Quality assurance and improvement procedures, including sponsor hospital oversight and emergency medical dispatch system medical oversight agreements
  - Community education programs designed to reduce mortality and morbidity
  - "HEARTSafe" achievement and designation by DPH
  - Community risk assessment
- Listing of 1, 3 and 5 year objectives for the EMS system: these should be distinct and include a process to periodically evaluate and ensure progression toward achievement
- Attach the town's mass casualty plan
- Attach written agreements with your emergency medical services providers and public safety answering point
- Attach written mutual aid agreements
- Attach contracts for the provision of EMS-related services
- Attach the Primary Service Area Responder certificate issued by DPH for each level of service
- Attach local ordinances affecting the provision of EMS in the community
- Attach a map of the town with PSAR boundaries
- Acknowledgements – authors and key stakeholders referenced
- List of resources/List of sources

A check sheet detailing the statutory requirements and common EMS system components to be covered as part of a local EMS plan is included in this toolkit. A check sheet is also included for mutual aid agreements, mass casualty plans, and performance standards.

Local EMS Plan Checklist

Use this checklist to assure that your plan addresses both important and required information. Please include additional information as you deem appropriate. ***Do not submit this checklist as your plan!***

Component description	Complete	Component description	Complete
Title Page			
Name of plan including town name		Date of plan	
Author/Point of Contact		Version	
Table of Contents		Purpose statement	
Desciption of response area/demographics		Overview of response process	
Required agreements/performance measures			
PSAP written agreement		PSAP performance measures	
First responder written agreement		First responder performance measures	
Basic ambulance written agreement		Basic ambulanceperformance measures	
Paramedic written agreement		Paramedic performance measures	
Mutual aid agreements		Other written agreements/subcontracts	
A list and description of EMS system components			
Each organization, including contact information, assigned as:			
PSAP		Basic Ambulance	
First responder		Paramedic	
Opioid antagonist compliance (P.A. 16-43)			
Roles and responsibilities in:			
Ordinary day-to-day response		Mass gathering events	
Mass casualty incidents		Special populations	
Special operations, including active assailants		EMS resource availability	
Quality assurance/performance monitoring			
PSAP QA policies (internal)		Basic ambulance QA policies (internal)	
PSAP performance reporting process		Basic ambulance performance reporting process	
PSAP EMS medical oversight policy		Sponsor hospital medical oversight policy for BA	
First Responder QA policies (internal)		Paramedic QA policies (internal)	
First Responder performance reporting process		Paramedic performance reporting process	
Sponsor hospital medical oversight policy for FR		Sponsor hospital medical oversight policy for Pm	
Community response			
Community education programs		HEARTSafe achievement & designation	
Goals and objectives			
One year		Five year	
Three year			
Attachments			
Mass casualty plan		PSAR certificates	
Written agreements with each provider		Local ordinances affecting EMS	
Mutual Aid Agreements		Map of the town with PSAR boundaries	
Community risk assessment		Contracts, subcontracts, and agreements for service	
Active assailant response plans			

Red *outlines* indicate information that is required pursuant to the Local EMS Planning statutes.

Performance Standards

Performance standards are paramount in providing and ensuring the provision of quality pre-hospital patient care for the residents in the State of Connecticut. The Local EMS Plan statute requires the development, organization, collection, evaluation and implementation of performance standards as part of every LEMSP.

Local EMS Plan performance standards defined

The Statute requiring the establishment of performance standards does not include a definition. The OEMS is therefore basing its model documents and recommending standards utilizing both the legislative intent and performance standards which are referenced in relevant Connecticut EMS statutes.

The origin of local EMS plan requirements in Connecticut stems from a Legislative Program Review & Investigation Committee report published in May of 1999 as part of an extensive EMS system review. Objectives delineated in the report included requiring performance standards to be developed in local EMS plans; adopting a more realistic approach for towns to remove a PSAR if the provider was performing poorly; building an accountability loop that includes providers, municipalities, and the Department of Public Health, and; establishing a common basis to compare performance and begin evaluation of the system.

Performance indicators may be clinical, operational, or administrative. As the following EMS processes are mentioned in the EMS statutes relative to primary service area responders and municipalities, the OEMS recommends that they be considered for inclusion in performance standards:

- Percentage of first-call responses met, reported in 3-month and 12-month rolling periods;
- Response times, separation of "hot" and "cold" responses recommended;
- Quality of patient care, including internal and external quality assurance procedures;
- Complaint resolution procedure, including reporting policy and procedure;
- Policy on reporting adverse events, both internal and external reporting; and
- Policy on communication of changes to EMS organization structure or services provided to a municipality.

A municipality may want to include more performance standards than those listed above. The National EMS Management Association presented suggested EMS Core Measures for consideration by the *National EMS Performance Measures Project*. The names of the top level processes in the index were hybridized from the categories of the NHTSA EMS Agenda for the Future, Malcolm Baldrige Criteria for Healthcare Excellence, and the criteria used by the Commission on the Accreditation of Ambulance Services (CAAS).*

Top level recommended EMS *Process Performance Indicator Index* (PPII)*

- Administration / Leadership
- Field Operations
- Clinical Care
- Medical Direction
- Human Resources
- Fleet Management
- Supply Management
- Dispatch & Communications
- Information Services
- Support Services
- Prevention, Community Education & Access
- Special Events & Services
- Financial Services
- Safety & Risk Management
- Research
- System Measures

These EMS processes, and any associated sub-processes, should be examined for inclusion in the Local EMS Plan in collaboration between the leadership of the primary service area responders and municipality. In addition to model performance agreements available on the OEMS website, you may consult with OEMS staff, your regional EMS council, regional medical advisory committee, and local sponsor hospital for advice.

An EMS system performance indicator should answer:*

• What are you measuring?	Example: response time for "hot" response calls
• Who is the target of the measurement?	Example: basic ambulance
• What is the target's requirement or goal?	Example: response time is less than agreed maximum times
• What measurement is to be used to gauge for how well (quality) or how efficiently (cost) the goal is being met?	Example: responses standards agreed to with town and basic ambulance in LEMSP
• What data is needed to measure it	Example: time of dispatch, time of arrival at scene
• What are the sources for the data?	Example: dispatch computer system
• How do you determine if the goal is achieved?	Example: response standards minus actual response time
• What format should be used to display the results?	Example: fractal response matrix model

(See sample on the next page)

*Source: EMS CORE MEASURES: SUGGESTIONS FOR CONSIDERATION BY THE NATIONAL EMS PERFORMANCE MEASURES PROJECT, National EMS Management Association, September 21, 2004.

Sample performance standard

Response Time means the total measure of time from notification to the PSAR that an emergency exists, to arrival at the patient's side, *including the activation time.*

Percentage of responses where the response time was:

Less than or equal to four minute:	Standard: 5%	Actual:_____
Greater than four minutes but less than or equal to five minutes:	Standard: 10%	Actual:_____
Greater than five minutes but less than or equal to six minutes:	Standard: 70%	Actual:_____
Greater than six minutes but less than or equal to eight minutes:	Standard: 10%	Actual:_____
Greater than eight minutes:	Standard: 5%	Actual:_____

Clinical performance standards

Clinical performance measures are a standardized, quantitative way to examine an EMS system or treatment of an identified patient illness or injury. The measures are based on scientific evidence about the processes and treatments that are known to achieve optimal results. Performance measures help EMS organizations begin to evaluate and benchmark their performance, perform evidence-based treatments, and transport patients to the most appropriate hospital.

Under Connecticut regulation §19a-179-12, the sponsor hospitals are responsible for quality assurance for the EMS organizations which they sponsor. PSAPs providing Emergency Medical Dispatch (EMD), as required by Connecticut General Statute §28-25b, are required to have a physician oversight for the purposes of quality assurance.

Recognizing the sponsor hospitals, through their appointed EMS Medical Director, as being subject matter experts on EMS patient care and emergency physicians as subject matter experts in the medical oversight of Emergency Medical Dispatch, the OEMS recommends that performance measures within their purview be included as an attachment to the LEMSP. Municipalities may want to codify their PSARs' compliance with sponsor hospital oversight or EMD physician oversight in the municipality's written agreements with their providers.

If a municipality chooses to incorporate clinical performance measures as part of their performance standards, the OEMS recommends collaboration with the regional medical advisory committee or the sponsor hospital for the associated EMS organizations. For clinical performance measures that are system-wide and not specific to a particular EMS organization, the OEMS recommends collaboration with each EMS organization and any sponsor hospital that provides medical oversight for an EMS organization within the municipality.

Sample performance standards document

Sample performance standard documents are included in this toolkit, and as part of the sample LEMPS posted on the OEMS website.

NHTSA Recommended Performance Measures (2009)

NHTSA published a project report in 2009 that provides 35 consensus-based performance measures along with the formulas and data elements necessary to implement them. This document may assist you in creating your baseline performance measures if you do not currently have any in place. The document, EMS Performance Measures: Recommended Attributes and Indicators for System and Service Performance, may be downloaded from their website. (Link: http://www.ems.gov/pdf/811211.pdf)

Legally Sufficient Mutual Aid Agreements

Mutual aid agreements and memorandums of understanding (MOU) are written documents describing how personnel, equipment, facilities, and/or supplies will be requested, made available, and utilized by or between organizations, agencies, or jurisdictions. Anytime assistance from other organizations, agencies, or jurisdictions is incorporated into your Local EMS Plan, a written mutual aid agreement or MOU should be signed by authorized representatives from **both** the entity providing and receiving the resources.

The key difference between a mutual aid agreement and an MOU is that mutual aid agreements pledge reciprocal assistance of a particular type and definition between two or more organizations, agencies, or jurisdictions. An MOU can be reciprocal in nature, with parties agreeing to help one another under certain terms, or an MOU can pledge assistance to an organization, agency, or jurisdiction without mutual benefit.

Two Connecticut General Statutes regarding mutual aid are frequently, and *mistakenly*, referred to as "covering" an EMS organization for mutual aid.

The first, CGS §7-310 Operation of fire equipment in and provision of personnel and assistance to other municipality, applies to day-to-day emergencies, but has limited complexity and detail. It also refers to the mutual aid as "being mutually agreed upon between departments", which infers there is more to mutual aid than just the statute itself. The statute essentially encourages a department to address topics that may be of concern by creating a specific agreement.

The second, CGS §28-22a Intrastate Mutual Aid Compact is frequently referred to as being a replacement for traditional mutual aid agreements; however it *only* applies when there is a ***declared*** *local civil preparedness emergency*. While when activated it does address some of the legal concerns of importance, since it applies in limited circumstances it won't cover EMS organizations with day-to-day operations.

A plan to use external organizations, agencies, or jurisdictions is a routine part of Emergency Medical Services system planning and forms the basis of surge response strategy. To ensure that there is clear understanding by all parties agreeing to provide mutual aid or external assistance in cooperation with outside agencies, a written mutual aid agreement or MOU should be executed by authorized representatives from both the agency providing and the agency receiving the resources.

As plans and agreements are developed or refined, a detailed review of all applicable Federal, State and local statutes must be undertaken with the assistance of expert legal counsel.

Connecticut General Statutes (Emphasis added)

Sec. 7-310. Operation of fire equipment in and provision of personnel and assistance to other municipality. Any city, town, borough, fire district, independent fire department or independent fire company may locate, use, man and operate fire stations, fire apparatus, ambulances, rescue trucks, radio and fire-alarm systems and other fire equipment and provide personnel and other assistance for the investigation of the cause and origin of fires, in any other city, town, borough or fire district, upon such terms respecting the location, use, management and operation **as may be mutually agreed upon** between the boards of fire commissioners or other persons having the management and control of the fire departments or fire companies. Any officer or member of a fire department or fire company while operating outside the jurisdictional limits of his fire department or fire company in accord with such an agreement shall have the same rights, privileges and immunities that are granted him when operating within the jurisdictional limits of his fire department or fire company.

Sec. 28-22a. Intrastate Mutual Aid Compact.
Intrastate Mutual Aid Compact.
Article I. Purposes

This compact shall be known as the Intrastate Mutual Aid Compact and is made and entered into by and between the participating political subdivisions of this state. The purpose of this compact is to create a system of intrastate mutual aid between participating political subdivisions in the state. Each participant of this system recognizes that emergencies transcend political jurisdictional boundaries and that intergovernmental coordination is essential for the protection of lives and property and for best use of available assets. The system shall provide for mutual assistance among the participating political subdivisions in the prevention of, response to, and recovery from, **any disaster that results in a *declaration of a local civil preparedness emergency*** in a participating political subdivision, subject to that participating political subdivision's criteria for declaration. The system shall provide for mutual cooperation among the participating subdivisions in conducting disaster-related exercises, testing or training activities.

Mutual Aid Agreement Check Sheet

Elements of a legally sufficient mutual aid agreement/MOU

The following elements or provisions should be *considered* for inclusion in your mutual aid agreements and MOU's;

- Consistent with NIMS and State level Incident Management Systems. ☐
- Describes each organization's location. ☐
- Definitions of key terms used in the agreement. ☐
- Roles and responsibilities of individual parties. ☐
- Requires minimum levels of training based on roles. ☐
- Provides for recognition of qualifications and certifications. ☐
- Describes procedures for requesting and providing assistance. ☐
- Describes a system for mobilization and deployment of resources. ☐
- Describes resources available for daily mutual aid response by day and time. ☐
- Describes resources available for Mass Incident response by day and time. ☐
- Describes resources other than EMS agencies (Red Cross, bus system, etc.). ☐
- Define a system for determining which resources will be used in which order. ☐
- Describes jurisdictional specifics (demographics, resources, risks, etc.). ☐
- Describe seasonal and temporal factors that impact the agreement. ☐
- Addresses coverage of the assisting agency area while providing mutual aid. ☐
- Addresses interoperable communication between organizations while providing mutual aid. ☐
- Addresses personnel safety and worker's compensation. ☐
- Addresses liability and immunity. ☐
- Addresses procedures, authority, and rules for payment and reimbursement for services. ☐
- Addresses protocol and clinical oversight if applicable. ☐
- Addresses post incident critical stress management. ☐
- Addresses the use of After Action Review to improve the agreement. ☐
- Requires review of the agreement annually or as needed. ☐
- Defines a method for updating the agreement to maintain operational relevance. ☐
- Describes a method for communicating changes in the agreement. ☐
- Requires authorized officials from each of the participating jurisdictions to collectively approve all mutual-aid agreements/MOU's. ☐

Mutual Aid Agreement Sources:

- Connecticut General Statutes http://www.cga.ct.gov/current/pub/titles.htm
- FEMA ***Operational Templates and Guidance for EMS Mass Incident Deployment***
  https://www.usfa.fema.gov/downloads/pdf/publications/templates_guidance_ems_mass_incident_deployment.pdf

Mass Casualty Incident Management Planning

Purpose

The purpose of a Mass Casualty Incident Plan is to provide a uniform response to a mass casualty incident, whether it is from a natural or man-made cause. Local planning will improve the capability for jurisdictions and regions to provide EMS triage, treatment, and transport during a mass casualty event. The plan should be designed as an extension of normal day-to-day services.

General MCI planning objectives

- Your plan should *meet the needs of your community* and be based on available resources and capabilities.
- Your plan should provide for *mutual aid agreements* with other local or regional jurisdictions.
- Your plan should be *integrated* with regional and state plans.
- Your plan should define *training requirements* and develop a training program consistent with the standards set forth in this document and based on the needs of your community.
- Your plan should be a *coordinated interagency effort*.
- Your plan should be *tested, reviewed and revised* regularly.

Basic MCI management principles

As you are developing your MCI management plan, please keep the following principles in mind:
1. Do the greatest good for the greatest number.
2. Make the best use of personnel, equipment and facility resources
3. Do not relocate the disaster.

MCI plan standards and references

MCI Plans are highly "local." The variety of emergency response system models employed and the variability of resources available within each municipality require that the plan be tailored to that specific municipality. However, in spite of the need for local customization, all MCI plans should be consistent with state and federal guidelines and standards so that the plan can be integrated in the larger community for any regional, state, or national response.

You should be familiar with, and craft your plan consistent with the following standards:

- National Response Framework
  http://www.fema.gov/national-response-framework
- National Incident Management System
  http://www.fema.gov/national-incident-management-system
- Incident Command System
  http://www.fema.gov/incident-command-system-resources
- Connecticut OEMS Triage Standards (Currently SMART triage for primary triage and patient tagging)
  http://www.ct.gov/dph/lib/dph/ems/pdf/communication_statements/2007_04_SMART_Triage_System_for_Connecticut.pdf
  http://www.ct.gov/dph/lib/dph/ems/pdf/communication_statements/2009_07_SMART_Triage_Training_Memo.pdf
  http://www.smartmci.com/products/triage/smart_triage_pac.php
- Homeland Security Exercise & Evaluation Program (for drilling and exercising the plan)
  http://www.fema.gov/media-library-data/20130726-1914-25045-8890/hseep_apr13_.pdf

Mass gathering pre-planning and MCI management

Connecticut General Statutes §19a-435 through §19a-443 govern the requirements for mass gathering events. A mass casualty incident management plan should be integrated into, not take the place of, mass gathering event pre-planning.

Mass casualty incident plan development

An MCI plan should be a comprehensive, operational document that is regularly reviewed and *exercised*. Specific guidance in writing an MCI plan is outside the scope of the Local EMS Plan Toolkit. The toolkit does include a checklist of recommended MCI plan components on the next page. The list was adopted by the Connecticut EMS Advisory Board Emergency Preparedness Committee in 2013. The recommendation of performing a baseline analysis, hazard analysis, and risk assessment was added by the OEMS.

As with Local EMS Planning, mass casualty incident management planning should be done with all the appropriate EMS system stakeholders. Remember to include emergency management, local health departments, and non-governmental organizations (NGOs) for logistical support and recovery phases of the plan.

Mass Casualty Plan Checklist

Preface	
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Community "Response"

Prevention and public education are tools that are typically overlooked in EMS planning processes. This is despite the fact that the cost both financially to our healthcare system and the burden on our emergency response system are well known.

As communities look to decrease financial expenditures on public safety, and thus, EMS response, they may want to consider working with other community partners to educate the public and reduce preventable injuries by implementing some of these programs. Some EMS organizations are already performing some of these services in their local communities. Other areas are looking at developing pilot programs in collaboration between healthcare providers.

The OEMS has provided the following list as a starting point for municipal leaderships to consider implementation of with their EMS system partners. The list will be updated with more programs, but more importantly, local contact information as we receive it.

AED/CPR – HEARTSafe Community

Being a HEARTSafe Community can save lives. If someone in your community suffers a sudden cardiac arrest tomorrow, how likely is he or she to survive due to rapid access to life-saving treatment? How many ordinary citizens in your community can recognize the signs and symptoms of a sudden cardiac event and know how to render care and get help "on the way, right away?"

Who knows cardiopulmonary resuscitation (CPR) in your community and is prepared to administer it when necessary? Where are automated external defibrillators (AEDs) located, and who has been trained to use them appropriately? The answers to these questions could determine whether or not your community qualifies as a Connecticut HEARTSafe Community.

LINK: http://www.ct.gov/dph/cwp/view.asp?a=3135&q=387024

Bike Safety

NHTSA encourages all road users, including motorists and bicyclists, to respect each other and foster a safer transportation environment. Bicycles on the roadway are, by law, vehicles with the same rights, and responsibilities as motorized vehicles. NHTSA's bicycle safety program focus is on research, education, and enforcement of bicyclists' and motorists' behavior to enhance roadway safety and reduce bicycle injuries and fatalities in our nation.

LINK: http://www.nhtsa.gov/Bicycles

Car Seat Registration

Following largest car seat recall in U.S. history, NHTSA, Safe Kids Worldwide and safety advocates urge parents to register car seats and take action during a recall

LINK: http://www.nhtsa.gov/About+NHTSA/Press+Releases/2015/nhtsa-safekids-urge-child-seat-registration-09102015

Car Seat Installation

Find a child car seat inspection station nearest you. Certified technicians will inspect your child car seat, in most cases, free of charge - and show you how to correctly install and use it.

LINK: http://www.safercar.gov/cpsApp/cps/index.htm

Community Emergency Response Team (CERT)

The **Community Emergency Response Team (CERT)** Program educates people about disaster preparedness for hazards that may impact their area and trains them in basic disaster response skills, such as fire safety, light search and rescue, team organization, and disaster medical operations. Using the training learned in the classroom and during exercises, CERT members can assist others in their neighborhood or workplace following an event when professional responders are not immediately available to help. CERT members also are encouraged to support emergency response agencies by taking a more active role in emergency preparedness projects in their community.

LINK: http://www.fema.gov/community-emergency-response-teams/

Distracted Driving

Distracted driving is a dangerous epidemic on America's roadways. In 2013, there were ***3,154*** people were killed in distracted driving crashes. The U.S. Department of Transportation is leading the effort to stop texting and cell phone use behind the wheel. Since 2009, we have held two national distracted driving summits, banned texting and cell phone use for commercial drivers, encouraged states to adopt tough laws, and launched several campaigns to raise public awareness about the issue.

LINK: http://www.distraction.gov/

Fall Prevention

Falls, a major cause of unintentional injury, can lead to moderate to severe injuries, such as hip fractures and head traumas, and can even increase the risk of early death. In March 2014, the DPH Commissioner unveiled the Healthy Connecticut 2020 State Health Improvement Plan and announced that falls prevention was one of the top seven priorities for DPH in the next five years.

LINK: http://www.ct.gov/dph/cwp/view.asp?a=3137&q=567730

Home Safety

Many accidental injuries occur in the home. Common causes are falls, fires, drowning, choking, and poisonings. Young children and older adults are often the most likely to be injured. Accidental injuries can result in hospitalizations, surgeries, and long-term disabilities. They are among the leading causes of death in the home.

LINK: http://www.ct.gov/dph/lib/dph/environmental_health/eoha/pdf/healthy_home_safe.pdf
LINK (Checklist): http://www.usfa.fema.gov/downloads/pdf/home_safety_checklist.pdf

Proper Use of 9-1-1

In an emergency, call 911 or your local emergency number immediately from any wired or wireless phone. An emergency is any situation that requires immediate assistance from the police, fire department or ambulance. Examples include: A fire, A crime, especially if in progress, A car crash, especially if someone is injured, A medical emergency,

Important: If you're not sure whether the situation is a true emergency, officials recommend calling 911 and letting the call-taker determine whether you need emergency help. When you call 911, be prepared to answer the call-taker's questions, which may include: The location of the emergency, including the street address, the phone number you are calling from, the nature of the emergency, and details about the emergency.

LINK: http://www.911.gov/whencall.html

Prevention

"In the future the success of EMS systems will be measured not only by the outcomes of their treatments, but also by the results of their prevention efforts. Its expertise, resources, and positions in communities and the health care system make EMS an ideal candidate to serve linchpin roles during multi-disciplinary, community-wide prevention initiatives. EMS must seize such responsibility and profoundly enhance its positive effects on community health." (EMS Agenda for the Future)

Theodore R. Delbridge MD, MPH

Public Education

"EMS has not yet begun to realize its potential as an important public educator. It should accept the challenge to explore innovative ways for educating the broadest possible spectrum of society with regard to prevention, EMS access and appropriate utilization, and bystander care. EMS must also educate the public and those that purchase services as consumers, so they are enabled to make informed EMS-related decisions for their communities." (EMS Agenda for the Future)

Patricia J. O'Malley, MD

Goals & Objectives

There are many different ways to approach setting goals and objectives for your municipality. However, with the use of various sources we have we have assembled a few tips to help you write your goals and objectives.

Definition of goals and objectives

A goal is an overarching principle that guides decision making. A goal is *what we want to accomplish*. Objectives are specific, measurable steps that can be taken to meet the goal. An objective is *how much of what will be accomplished by when*.

For example

Goal: Develop an increased level of community EMS response
Objectives: Train 500 citizens in CPR and the use of Automatic External Defibrillators (AED) by October 2016
Place a public access AED in the elementary school, high school, and senior center by November 2016
Educate all students in grades 2 through 8 in the proper use of 9-1-1 by March 2017

A common way of describing goals and objectives:

Goals are broad	Objectives are narrow
Goals are general intentions	Objectives are precise
Goals are intangible	Objectives are tangible
Goals are abstract	Objectives are concrete.
Goals are generally difficult to measure	Objectives are measurable

Clear goals and measurable objectives are essential for evaluating progress. A useful way of making goals and objectives more powerful and measurable is to use the SMART mnemonic.

As recommended in the Incident Command System, objectives should be:

S Specific: Precise and unambiguous language in describing the objective.
M Measurable: The design and statement should make it possible to conduct a final accounting as to if it was achieved.
A Action Oriented: It must have an action verb that describes the expected accomplishments.
R Realistic: Must be achievable with the resources the agency can allocate to its achievement.
T Time sensitive: The timeframe should be specified (if applicable).

To set goals, you will have to complete a baseline community assessment and determine what benchmarks you want to meet (perhaps a national standard or a locally determined need). Upon setting clear goals and SMART objectives, you can develop realistic strategies, which are *how you are going accomplish it*, and determine *who will be responsible for accomplishing what* through action plans. Action plans are not part of the LEMSP. They should be constantly evolving and might include:

Action step(s): What will happen
Person(s) responsible: Who will do what
Date to be completed: Timing of each action step
Resources required: Resources and support (both what is needed and what's available)
Barriers or resistance, and a plan to overcome them
Collaborators: Who else should know about this action and be a part of it

Topics for goals and objectives

Some of the easiest and potentially most important goals and objectives can come from the associated agreements and planning documents that are part of the Local EMS plan. Mutual aid agreement reviews and updates are important and frequently overlooked. The regular review, update, and exercising of your MCI management plan is invaluable.

Any of the top level EMS processes outlined in the performance measure section on page 5, or their associated sub-processes, may present an opportunity for improvement. Prevention, community education and response are frequently under-developed. Goals to address the prevention of unintentional injuries in a community may have significant financial ramifications within a community. Fall prevention programs may decrease the volume of "public assist" responses by emergency responders. Utilize the expertise of your EMS providers, local hospitals, and other stakeholders in determining your specific goals and objectives.

The ability of EMS to optimally meet communities' and individual patients' needs in the future is dependent on evaluation processes that assess and improve the quality of EMS Continuous evaluation is essential and should pervade all aspects of every EMS system. (EMS Agenda for the Future)

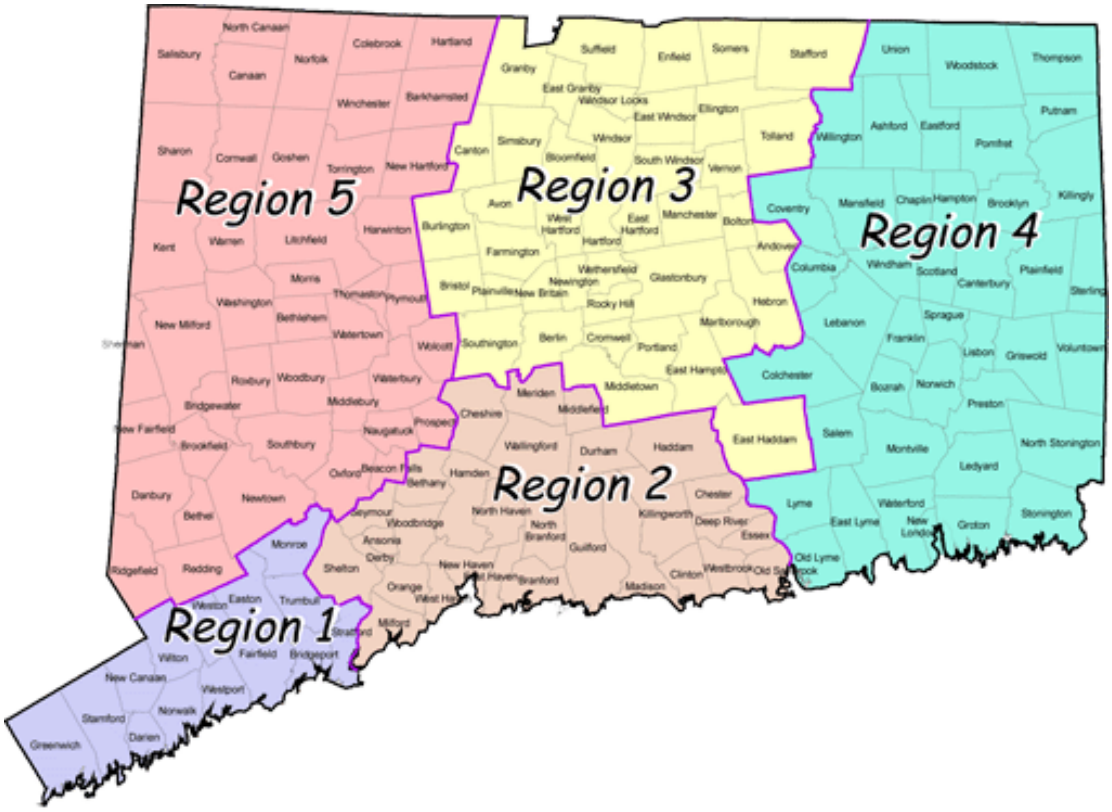
-Theodore R. Delbridge MD, MPH

OEMS Staff Contact Information

The primary contacts within the Office of Emergency Medical Services for Local EMS Planning are the Health Programs Assistants (HPA) assigned to planning. Additionally, each of the Regional EMS Coordinators, Regional EMS Councils, and Regional Medical Advisory Committees are available to provide support for their respective areas.

Regions 1, 2, & 5
Steven Hotchkiss, HPA1
Phone: 860-509-7832
Email: steven.hotchkiss@ct.gov

Regions 3 & 4
Jonathan Lillpopp, HPA1
Phone: 860-509-7813
Email: jonathan.lillpopp@ct.gov



Region 1 EMS Coordinator
[Judi Reynolds/Jean Speck]
Phone:
Email:

Region 2 EMS Coordinator
Judi Reynolds
Phone: 860-509-7721
Email: judith.reynolds@ct.gov

Region 3 EMS Coordinator
John Spencer
Phone: 860-509-7981
Email: john.spencer@ct.gov

Region 4 EMS Coordinator
Michael Rivers
Phone: 860-509-8135
michael.rivers@ct.gov

Region 5 EMS Coordinator
Jean C. Speck
Phone: 860-509-7829
Email: jean.speck@ct.gov

Regional EMS Council and Regional Medical Advisory Committee Contact Information

Contact information for the Regional Councils, the Regional Medical Advisory Committees and the Sponsor Hospitals may be obtained by going to the regional councils' website at: ctemscouncils.org.

Local EMS Planning Statutes

Sec. 19a-181b. Local emergency medical services plan.

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

(1) The identification of levels of emergency medical services, including, but not limited to:
(A) The public safety answering point responsible for receiving emergency calls and notifying and assigning the appropriate provider to a call for emergency medical services;
(B) the emergency medical services provider that is notified for initial response;
(C) basic ambulance service;
(D) advanced life support level; and
(E) mutual aid call arrangements;
(2) The name of the person or entity responsible for carrying out each level of emergency medical services that the plan identifies;
(3) The establishment of performance standards for each segment of the municipality's emergency medical services system; and
(4) Any subcontracts, written agreements or mutual aid call agreements that emergency medical services providers may have with other entities to provide services identified in the plan.

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

(c) Each municipality shall update the plan required by subsection (a) of this section as the municipality determines is necessary. The municipality shall consult with the municipality's primary service area responder concerning any updates to the plan. The Department of Public Health shall, upon request, assist each municipality in the process of updating the plan by providing technical assistance and helping to resolve any disagreements concerning the provisions of the plan.

(d) Not less than once every five years, said department shall review a municipality's plan and the primary service area responder's provision of services under the plan. Such review shall include an evaluation of such responder's compliance with applicable laws and regulations. Upon the conclusion of such evaluation, the department shall assign a rating of "meets performance standards", "exceeds performance standards" or "fails to comply with performance standards" for the primary service area responder. The Commissioner of Public Health may require any primary service area responder that is assigned a rating of "fails to comply with performance standards" to meet the requirements of a performance improvement plan developed by the department. Such primary service area responder may be subject to subsequent performance reviews or removal as the municipality's primary service area responder for a failure to improve performance in accordance with section 19a-181c.

(P.A. 00-151, S. 9, 14; P.A. 10-117, S. 55; P.A. 14-217, S. 19.)

History: P.A. 00-151 effective July 1, 2000; P.A. 10-117 amended Subsec. (b)(1) by substituting reference to Sec. 19a-186a for reference to Sec. 19a-185, effective July 1, 2010; P.A. 14-217 added Subsec. (c) re municipality to update plan and added Subsec. (d) re department review of municipality's plan.

Sec. 19a-181c. Removal of responder. Revocation of responder's primary service area assignment.

(a) As used in this section and section 19a-181f:

(1) "Responder" means any primary service area responder that (A) is notified for initial response, (B) is responsible for the provision of basic life support service, or (C) is responsible for the provision of service above basic life support that is intensive and complex prehospital care consistent with acceptable emergency medical practices under the control of physician and hospital protocols.
(2) "Performance crisis" means (A) the responder has failed to respond to at least fifty per cent or more first call responses in any rolling three-month period and has failed to comply with the requirements of any corrective action plan agreement between the municipality and the responder, or (B) the sponsor hospital refuses to endorse or provide a recommendation for the responder due to unresolved issues relating to the quality of patient care provided by the responder.
(3) "Unsatisfactory performance" means the responder has failed to (A) respond to at least eighty per cent or more first call responses, excluding those responses excused by the municipality in any rolling twelve-month review period, or (B) meet defined response time standards agreed to between the municipality and responder, excluding those responses excused by the municipality, and comply with the requirements of a mutually agreed-upon corrective action plan, or (C) investigate and adequately respond to complaints related to the quality of emergency care or response times, on a repeated basis, or (D) report adverse events as required by the Commissioner of Public Health or as required under the local emergency medical services plan, on a repeated basis, or (E)

communicate changes to the level of service or coverage patterns that materially affect the delivery of service as required under the local emergency medical services plan or communicate an intent to change such service that is inconsistent with such plan, or (F) communicate changes in its organizational structure that are likely to negatively affect the responder's delivery of service, and (G) deliver services in accordance with the local emergency medical services plan.

(b) Any municipality may petition the commissioner for the removal of a responder. A petition may be made (1) at any time if based on an allegation that a performance crisis exists and that the safety, health and welfare of the citizens of the affected primary service area are jeopardized by the responder's performance, or (2) not more often than once every three years, if based on the unsatisfactory performance of the responder. A responder for whom a municipality seeks removal pursuant to a petition under this section shall not transfer its responsibilities to another responder while the petition is pending. A hearing on a petition under this section shall be deemed to be a contested case and held in accordance with the provisions of chapter 54.

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

(d) The commissioner, or the commissioner's designee, shall open any petition for the removal of a responder (1) not later than five business days after receipt of a petition where a performance crisis is alleged and shall conclude the investigation on such petition not later than thirty days after receipt of such petition, or (2) not later than fifteen business days after receipt of a petition where unsatisfactory performance is alleged and shall conclude the investigation on such petition not later than ninety days after receipt of such petition. The commissioner may redesignate any petition received pursuant to this section as due to a performance crisis or unsatisfactory performance based on the facts alleged in the petition and shall comply with the time requirements in this subsection that correspond to the redesignated classification.

(e) The commissioner may develop and implement procedures to designate a temporary responder for a municipality when such municipality has alleged a performance crisis in the petition during the time such petition is under the commissioner's consideration.

(f) The commissioner may hold a hearing and revoke a responder's primary service area assignment in accordance with the provisions of this section, although a petition has not been filed, where the commissioner has assigned a responder a rating of "fails to comply with performance standards" in accordance with section 19a-181b and the responder subsequently failed to improve its performance.
(P.A. 00-151, S. 10, 14; P.A. 14-217, S. 20.)
History: P.A. 00-151 effective July 1, 2000; P.A. 14-217 amended Subsec. (a) by adding reference to Sec. 19a-181f, designating existing provision defining "responder" as Subdiv. (1), redesignating existing Subdivs. (1) to (3) as Subparas. (A) to (C) therein, and adding new Subdiv. (2) defining "performance crisis" and new Subdiv. (3) defining "unsatisfactory performance", substantially revised Subsec. (b) re removal of responder, amended Subsec. (c) by replacing "an emergency" with "a performance crisis" in Subdiv. (1) and, in Subdiv. (2), replacing former provisions with "responder has demonstrated unsatisfactory performance", added Subsec. (d) re petition for removal of responder, added Subsec. (e) re procedures to designate temporary responder and added Subsec. (f) re hearing to revoke responder's assignment.

Sec. 19a-181d. Hearing re performance standards. (a) Any municipality may petition the commissioner to hold a hearing if the municipality cannot reach a written agreement with its primary service area responder concerning performance standards. The commissioner shall conduct such hearing not later than ninety days from the date the commissioner receives the municipality's petition. A hearing on a petition under this section shall not be deemed to be a contested case for purposes of chapter 54.

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

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

(d) If, after a hearing authorized by this section, the commissioner determines that the performance standards adopted in the municipality's local emergency medical services plan are unreasonable, the commissioner shall provide performance standards

considered reasonable based on the state-wide plan for the coordinated delivery of emergency medical services adopted pursuant to subdivision (1) of section 19a-177, model emergency medical services plans and the standards, contracts and written agreements in use by municipalities of similar population and characteristics. If the municipality refuses to agree to such performance standards, the primary service area responder shall meet the minimum performance standards provided in regulations adopted pursuant to section 19a-179.
(P.A. 00-151, S. 11, 14.)
History: P.A. 00-151 effective July 1, 2000.

Sec. 19a-181f. Change in primary service area responder. Submission of alternative local emergency medical services plan. (a) For purposes of this section, "primary service area responder" has the same meaning as in section 19a-175. A municipality that seeks a change in a primary service area responder shall submit an alternative local emergency medical services plan prepared pursuant to section 19a-181b to the Department of Public Health when: (1) The municipality's current primary service area responder has failed to meet the standards outlined in the local emergency medical services plan, established pursuant to section 19a-181b; (2) the municipality has established a performance crisis or unsatisfactory performance, as defined in section 19a-181c; (3) the primary service area responder does not meet a performance measure provided in regulations adopted pursuant to section 19a-179; (4) the municipality has developed a plan for regionalizing service; or (5) the municipality has developed a plan that will improve or maintain patient care and the municipality has the opportunity to align a new primary service area responder that is better suited than the current primary service area responder to meet the community's current needs. Such plan shall include the name of a recommended primary service area responder for each category of emergency medical response services.

(b) Not later than forty-five days after a municipality submits an alternative local emergency medical services plan pursuant to the provisions of this section, each new recommended primary service area responder who agrees to be considered for the primary service area designation shall submit an application to the commissioner, on a form prescribed by the commissioner.

(c) (1) The Commissioner of Public Health shall conduct a hearing on any alternative local emergency medical services plan submitted pursuant to subsection (a) of this section, including the proposed removal of a primary service area responder and the proposed designation of a new primary service area responder. Not later than thirty days prior to the hearing, the commissioner shall notify the municipality's current primary service area responder, in writing, of the hearing. Such primary service area responder shall be given the opportunity to be heard and may submit information for the commissioner's consideration.

(2) In order to determine whether to approve or disapprove such plan, the commissioner shall consider any relevant factors, including, but not limited to: (A) The impact of the plan on patient care; (B) the impact of the plan on emergency medical services system design, including system sustainability; (C) the impact of the plan on the local, regional and state-wide emergency medical services system; (D) the recommendation from the sponsor hospital's medical oversight staff; and (E) the financial impact to the municipality without compromising the quality of patient care. If the commissioner approves the alternative plan and the application of the recommended primary service area responder, the commissioner shall issue a written decision to reassign the primary service area in accordance with the alternative plan and indicate the effective date for the reassignment. A primary service area responder shall deliver services in accordance with the local emergency medical services plan prepared pursuant to section 19a-181b until the effective date of the reassignment stated in the commissioner's written decision approving the alternative plan.
(P.A. 14-217, S. 22.)

Sec. 19a-181g. Primary service area responder sale or transfer of ownership. A primary service area responder, as defined in section 19a-175, shall notify the Department of Public Health and the chief elected official or the chief executive officer of the municipality to which it is assigned not later than sixty days prior to the sale or transfer of more than fifty per cent of its ownership interest or assets. Any person who intends to obtain ownership or control of a primary service area responder in a sale or transfer for which notification is required under this section shall submit an application for approval of such purchase or change in control on a form prescribed by the Commissioner of Public Health. The commissioner shall, in determining whether to grant approval of the sale or transfer, consider: (1) The applicant's performance history in the state or another state; and (2) the applicant's financial ability to perform the responsibilities of the primary service area responder in accordance with the local emergency medical services plan, established in accordance with section 19a-181b. The commissioner shall approve or reject the application not later than forty-five calendar days after receipt of the application. The commissioner shall consult with any municipality or sponsor hospital in the primary service area, as such terms are defined in section 19a-175, in making a determination on the application and may hold a hearing on the application.
(P.A. 14-217, S. 21.)
History: P.A. 14-217 effective June 13, 2014.

Public Act 16-43 (§ 1).
Section 17a-714a of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(e) Not later than October 1, 2016, each municipality shall amend its local emergency medical services plan, as described in section 19a-181b, to ensure that the emergency responder, including, but not limited to, emergency medical services personnel, as defined in section 20-206jj, or a resident state trooper, who is likely to be the first person to arrive on the scene of a medical emergency in the municipality is equipped with an opioid antagonist and such person has received training, approved by the Commissioner of Public Health, in the administration of opioid antagonists.

Sample EMS Organization Mutual Aid Agreement

This agreement is entered into between _____**(EMS Organization)** and the EMS Organizations listed on the attached signatures page that executes and adopts the terms and conditions contained herein based on the following facts:

Purpose:
An automatic aid agreement for EMS organizations where one service agrees to respond automatically in return for the other jurisdiction agreeing to respond to another area in return. For assistance when they need additional staffing and equipment to a specific problem at a specific time. This mutual aid can be long or short term, with the latter being the more common. An example of long-term aid would be EMS units being sent to a large incident that goes on for many days. Short term would be an event lasting less than eight (8) hours.

This agreement is only for special occurrences, not to augment normal staffing. Departments must staff for the normal activities during a given time, day, and day of week. When other than normal situations occur and the staffing levels and\or equipment are no longer sufficient to deal with a specific incident, the requesting service will elicit mutual aid assistance from the other. This assistance is given gratis to the receiving jurisdiction for the duration of the specific incident.

Each service will make every attempt to supply additional staffing and\or equipment when requested. In the event that any party feels that they are being exclusively utilized to augment the services of another without equal retribution, grounds may exist for termination of the mutual aid agreement in accordance with this contract.

WHEREAS, the State of Connecticut is geographically vulnerable to hurricanes, flooding, ice storms and other natural and technologic disasters that could have caused severe disruption of emergency medical services; and

WHEREAS, the Parties to this Agreement recognize that additional human resources and equipment may be needed to mitigate further damage and restore vital services to the citizens of the affected community should such disasters occur; and

WHEREAS, to provide the most effective mutual aid possible, each agency, intends to foster communications between the personnel of the other agencies, exchange of information and development of plans and procedures to implement this Agreement;

NOW, THEREFORE, the Parties agree to agree as follows:

SECTION 1. DEFINITIONS

A. "AGREEMENT" means the EMS Mutual Aid Agreement.
B. "REQUESTING PARTY" means the participating EMS entity requesting aid in the event of an emergency. Each service must coordinate requests for state or federal emergency response assistance through its county.
C. "ASSISTING PARTY" means the participating EMS entity furnishing equipment, services and/or human Resources to the requesting Party.
D. "AUTHORIZED REPRESENTATIVE" means an employee of a participating EMS entity or 911 center contracted with the Requesting Party authorized to request, offer or provide assistance under the terms of this Agreement.
E. "AGENCY" means the participating entity.
F. "EMERGENCY" means any occurrence or condition manifesting itself by acute symptoms of such severity (including severe pain) that the absence of immediate medical attention could result in placing the patient's health in jeopardy; cause serious impairment to bodily functions; or cause serious dysfunction of any bodily organ or part.
G. "DISASTER" means any natural, technological, or civil emergency that causes damage of sufficient severity and magnitude to result in a proclamation of a local emergency by a city/county, a declaration of a State of Emergency by the Governor, or a disaster declaration by the President of the United States.
H. "MAJOR DISASTER" means a disaster that will likely to exceed local capabilities and require a broad range of state and federal assistance.
I. "PARTICIPATING AGENCY" – Any service which executes this mutual aid agreement and supplies a completed executed copy to the Agency.

J. "PERIOD OF ASSISTANCE" – the period of time beginning with the departure of any personnel and equipment of the assisting Party from any point for the purpose of traveling to the Requesting Party in order to provide assistance and ending upon the return of all personnel and equipment of the Assisting Party, after providing the assistance requested, to their residence or regular place of work, whichever occurs first. The period of assistance shall not include any portion of the trip to the requesting Party or the return trip from the Requesting Party during which the personnel of the Assisting Party are engaged in a course of conduct not reasonably necessary for their safe arrival at or return from the Requesting Party.

K. "WORK OR WORK-RELATED PERIOD" - any period of time in which either the personnel or equipment of the Assisting Party are being used by the Requesting Party to provide assistance and for which the requesting Party will reimburse the Assisting Party. Specifically included within such period of time are rest breaks when the personnel of the Assisting Party will return to active work within a reasonable time. Specifically excluded from such period of time are breakfast, lunch, and dinner breaks.

Nothing should be derived from the above statement that excludes Assisting Party personnel from being considered "on the job" for purposes of workers' compensation injuries or accidents during these periods.

SECTION 2. PROCEDURES

When a Participating Agency either becomes affected by an emergency, disaster, or major disaster, Participating Agency or its Authorized Representative may request emergency related mutual aid assistance by orally communicating a request for mutual aid assistance to Assisting Party or to the Agency.
Mutual aid shall not be requested by Participating Agency or its Authorized Representative unless resources available within the stricken area are deemed inadequate by that Participating Agency. Municipalities shall coordinate requests for state or federal assistance with their county Emergency Management Agencies. All requests for mutual aid shall be transmitted by the Authorized Representative or the Director of the Local Emergency Management Agency. Request for assistance may be communicated either to the Agency or directly to an Assisting Party.

A. REQUESTS DIRECTLY TO ASSISTING PARTY: The Requesting Party may directly contact the Authorized Representative of the Assisting Party and shall provide them with the information in paragraph C below. All communications shall be conducted directly between the Requesting and Assisting Party. Each party shall be responsible for keeping the Agency advised of the status of the response activities. The Agency shall not be responsible for costs associated with such direct requests or assistance unless it so elects. However, the Agency may provide, by rule, for reimbursement of eligible expenses from a Disaster Assistance fund.

B. REQUESTS ROUTED THROUGH, OR ORIGINATING FROM, THE AGENCY: The Requesting Party may directly contact the Agency, in which case it shall provide the Agency with the information in paragraph C below. The Agency may then contact other Participating Governments on behalf of the Requesting Party and coordinate the provision of mutual aid. The Agency shall not be responsible for costs associated with such indirect requests for assistance, unless the Agency so indicates in writing at the time it transmits the request to the Assisting Party. In no event shall the Agency be responsible for costs associated with assistance in the absence of appropriated funds. In all cases, the party receiving the mutual aid shall be primarily responsible for the costs incurred by any Assisting Party providing assistance pursuant to the provisions of this Agreement.

C. REQUIRED INFORMATION: Each request for assistance shall be accompanied by the following information, to the extent known:

1. A general description of the situation;
2. The amount and type of personnel, equipment, materials, and supplies needed and a reasonable estimate of the length of time they will be needed; a specific place for a representative of the requesting Party to meet the personnel and equipment of any Assisting party. This information may be provided by any available means.

D. ASSESSMENT OF AVAILABILITY OF RESOURCES AND ABILITY TO RENDER ASSISTANCE: When contacted by a Requesting Party or the Agency, the Authorized Representatives of any Participating Agency agree to assess their agencies situation to determine available personnel, equipment and other resources. All Participating Agencies shall render assistance to the extent personnel, equipment and resources are available. Each Participating Agency agrees to render assistance in accordance with the terms of this Agreement to the fullest extent possible. When the Authorized

Representative determines that his Participating Agency has available personnel, equipment or other resources, they shall so notify the requesting Party or the Agency, whichever communicated the request. The Agency shall, upon response from sufficient Participating Parties to meet the needs of the Requesting Party, notify the authorized representative of the Requesting Party and provide them with the information to the extent known. The Assisting Party shall acknowledge receipt regarding the assistance to be rendered, setting forth the information transmitted in the request, and shall transmit it by the quickest practical means to the Requesting Party or the Agency, as applicable.

E. SUPERVISION AND CONTROL: The personnel, equipment and resources of any Assisting Party shall remain under operational control of the Requesting Party for the area in which they are serving. Direct supervision and control of said personnel, equipment and resources shall remain with the designated personnel of the Assisting Party. Representatives of the Requesting Party shall assign work tasks to the personnel of the Assisting Party. The designated personnel of the Assisting Party shall have the responsibility and authority for assigning work and establishing work schedules for the personnel of the Assisting Party, based on task or mission assignments provided by the Requesting Party and the Agency. The designated personnel of the Assisting Party shall: maintain daily personnel time records, material records and a log of equipment hours; be responsible for the operation and maintenance of the equipment and other resources furnished by the Assisting Party; and shall report work progress to the requesting Party. The Assisting Party's personnel and other resources shall remain subject to recall by the Assisting Party at any time, subject to reasonable notice to the Requesting Party and the Agency. At least twenty-four (24) hours advance notification of the intent to terminate mission shall be provided to the Requesting Party, unless such notice is not practicable, in which case such notice as is reasonable shall be provided.

G. FOOD; HOUSING; SELF-SUFFICIENCY - Unless specifically instructed otherwise, the Requesting Party shall have the responsibility of providing food and housing for the personnel of the Assisting Party from the time of their arrival at the designated location to the time of their departure. However, Assisting Party personnel and equipment should be, to the greatest extent possible, self-sufficient for operations in areas stricken by emergencies or disasters. The Requesting Party may specify only self-sufficient personnel and resources in its request for assistance.

H. RIGHTS AND PRIVILEGES - Whenever the employees of the Assisting Party are rendering outside aid pursuant to this Agreement, such employees shall have the powers, duties, rights, privileges, and immunities, and shall receive the compensation, incidental to their employment.

I. COMMUNICATIONS: Unless specifically instructed otherwise, the requesting Party shall, during long term events, have the responsibility for coordinating communications between the personnel of the Assisting Party and the Requesting Party. Assisting Party personnel should be prepared to furnish communications equipment sufficient to maintain communications among their respective operating units.

SECTION 3. REIMBURSABLE EXPENSES

The terms and conditions governing reimbursement for any assistance provided under this Agreement shall be in accordance with the following provisions, unless otherwise agreed upon by the Requesting and Assisting Parties and specified in the written acknowledgment executed in accordance with Section 2D of this Agreement. The Requesting Party shall be ultimately responsible for reimbursement of all eligible expenses. The Assisting Party shall submit reimbursement documentation to the Requesting Party.

A. PERSONNEL - During the period of assistance, the Assisting Party shall continue to pay its employees according to its then prevailing ordinances, rules, and regulations. The Requesting party shall reimburse, if reimbursed by the State of Connecticut or the Federal Emergency Management Agency (FEMA), the Assisting Party for all direct and indirect payroll costs and expenses including travel expenses incurred during the period of assistance, including, but not limited to, employee pensions and benefits as provided by Generally Accepted Accounting Principles (GAAP). However, the Requesting Party shall not be responsible for reimbursing any amounts paid or due as benefits to employees of the Assisting Party due to personal injury or death occurring while such employees are engaged in rendering aid under this agreement. Both the Requesting Party and the Assisting Party shall be responsible for payment of such benefits only to their own employees.

B. EQUIPMENT - The Assisting Party shall be reimbursed by the Requesting Party, if reimbursed by the State of Connecticut or the FEMA, for the use of its equipment during the period of assistance according to either a pre-

established local or state hourly rate or according to the actual replacement, operation, and maintenance expenses incurred. For those instances in which costs are reimbursed by the FEMA, the eligible direct costs shall be determined in accordance with 44 CFR 206.228. The Assisting Party shall pay, if reimbursed by the State of Connecticut or the FEMA, for all repairs to its equipment as determined necessary by its on-site supervisor(s) to maintain such equipment in safe and operational condition. At the request of the Assisting Party, fuels, miscellaneous supplies, and minor repairs may be provided by the Requesting Party, if practical. The total equipment charges to the requesting Party shall be reduced by the total value of the fuels, supplies, and repairs furnished by the Requesting Party and by the amount of any insurance proceeds received by the Assisting Party.

C. MATERIALS AND SUPPLIES - The Assisting Party shall be reimbursed, if the requesting party is reimbursed by the State of Connecticut or the Federal Emergency management Agency, for all materials and supplies furnished by it and used or damaged during the period of assistance, except for the costs of equipment, fuel and maintenance materials, labor and supplies, which shall be included in the equipment rate established in 3.B. above, unless such damage is caused by gross negligence, willful and wanton misconduct, intentional misuse, or recklessness of the Assisting Party's personnel. The Assisting Party's Personnel shall use reasonable care under the circumstances in the operation and control of all materials and supplies used by them during the period of assistance. The measure of reimbursement shall be determined in accordance with 44 CFR 206.228. In the alternative, the Parties may agree that the Requesting Party will replace, with like kind and quality as determined by the Assisting Party, the materials and supplies used or damaged. If such an agreement is made, it shall be reduced to writing and transmitted to the Agency.

D. RECORD KEEPING - The Assisting Party shall maintain records and submit invoices for reimbursement by the requesting party or the Agency using format used or required by FEMA publications, including 44 CFR part 13 and applicable Office of Management and Budget Circulars. Requesting Party and Agency finance personnel shall provide information, directions, and assistance for record keeping to Assisting Party personnel.

E. PAYMENT - Unless otherwise mutually agreed in the written acknowledgment executed in accordance with paragraph 2.I. or a subsequent written addendum to the acknowledgment, the reimbursable expenses with an itemized Notice as soon as practicable after the expenses are incurred, but not later than sixty (60) days following the period of assistance, unless the deadline for identifying damage is extended in accordance with 44 CFR part 206. The Requesting Party shall pay the bill or advise of any disputed items, not later than sixty (60) days following the billing date. These time frames may be modified by mutual agreement. This shall not preclude an Assisting Party or Requesting Party from assuming or donating, in whole or in part, the costs associated with any loss, damage, expense or use of personnel, equipment and resources provided to a Requesting Party.

F. PATIENT BILLING PRACTICES - The services providing care for patient s outside of their assigned PSA here by agree to honor the current billing practices and contracts within the specified PSA that the service is provided. The Assisting Party will maintain a separate billing system and submit claims for re-imbursement for all patients treated by the Assisting Party.

SECTION 4. IMMUNITY
To the extent permitted by law, the Parties shall not be liable for actions to the extent provided by Section 33-15-21(a). This immunity may be waived by the Parties in a manner provided by law to the extent that adequate insurance coverage is in effect.

SECTION 5. LENGTH OF TIME FOR EMERGENCY
The duration of such Local emergency declared by the Requesting Party is limited to seven (7) days. It may be extended, if necessary, in seven (7) day increments.

SECTION 6. TERM
This Agreement shall be in effect for one (3) years from the date hereof and shall automatically be renewed in successive one (3) year terms unless terminated upon sixty (60) days advance written notice by the participating organization. Notice of such termination shall be made in writing and shall be served personally or by registered mail by either party. Notice of termination shall not relieve the withdrawing Party from obligations incurred hereunder prior to the effective date of the withdrawal and shall not be effective until sixty (60) days after notice thereof has been set by any Participating Party.

SECTION 7. EFFECTIVE DATE OF THIS AGREEMENT
This Agreement shall be in full force and effect upon approval by the Participating Agency and upon proper execution hereof.

SECTION 8. ANNUAL RENEWAL CYCLE
This agreement shall be renewed on an annual basis during the second quarter of the calendar year.

SECTION 9. SEVERABILITY; EFFECT ON OTHER AGREEMENTS
Should any portion, section, or subsection of this Agreement be held to be invalid by a court of competent jurisdiction, that fact shall not affect or invalidate any other portion, section or subsection; and the remaining portions of this Agreement shall remain in full force and affect without regard to the section, portion, or subsection or power invalidated.

EMS organization:
Authorized name & title:
_____

Signature: _____ *Date:* _____

EMS organization:
Authorized name & title:
_____

Signature: _____ *Date:* _____

EMS organization:
Authorized name & title:
_____

Signature: _____ *Date:* _____

EMS organization:
Authorized name & title:
_____

Signature: _____ *Date:* _____

EMS organization:
Authorized name & title:
_____

Signature: _____ *Date:* _____

NOTE: This is a SAMPLE document only. The content has not been vetted by legal counsel. You should consult with your legal counsel regarding any legal document you are developing.

Sample Written PSAP Agreement

This Agreement is entered into as of the _____ day of _____, 2016, by and between the **Town of _____**, a municipal corporation organized and existing under the laws of the State of Connecticut (hereinafter called the Town), and the **_____ Emergency Communications** (hereinafter called the Dispatch Center), a corporation organized and existing under the laws of the State of Connecticut, operating as the designated Public Safety Answering Point for the **Town of _____.**

WITNESSETH

WHEREAS, Chapter 368d, Section 19a-181b requires each municipality in the State of Connecticut to establish a local emergency medical services plan; and

WHEREAS, the plan shall include a written agreement, between the municipality, its emergency medicals services providers, and the public safety answering point; and

WHEREAS, the plan shall include performance standards for each segment of the municipality's emergency medical services system; and

NOW THEREFORE, the parties hereby agree as follows:

1. The Dispatch Center shall provide any and all PSAP services as required pursuant to all applicable State of Connecticut General Statutes and Agency Regulations.

2. The Dispatch Center shall dispatch emergency response units for 911 calls within the Town and shall implement mutual aid procedures as agreed to by the emergency responders as assigned within the Town.

4. The Dispatch Center shall provide a policy by which quality assurance is monitored as well as a method of reporting performance to the Town. Both the QA policy as well as the reporting methods will be mutually agreed upon by the Town and the Dispatch Center.

3. The Town agrees to provide compensation to the Dispatch Center in the amount and installments allocated in the Town's budget as approved according to local ordinance and state statute.

TERM
This Agreement shall continue for a period of sixty (60) months from the date of signing.
The agreement may be extended by the mutual written consent of both parties.

TERMINATION
Either party may terminate this agreement for cause at any time after providing a minimum of sixty (60) days written notice of its intent to terminate. Cause shall be defined as:
a) Failure to provide services defined in this agreement; or
b) Failure to provide compensation as defined in this agreement.
Upon receipt of notice the party receiving notice shall have ten (10) business days to remedy the causative factor(s). If remedied to the satisfaction of both parties as indicated by follow-up written notice, the agreement shall endure. If the causative factor(s) cannot be remedied to both parties satisfaction, the termination date will stand.

REPRESENTATIONS
Each party represents to the other that:

a) It is in compliance with all federal, state, and local laws in order to allow it to operate as a Public Safety Answering Point or Municipality;
b) It has corporate authority to enter into this agreement; and
c) It has disclosed to the other party any material violations of any laws specified in subparagraph (a) that have occurred within the past five (5) years.

WAIVER
No failure or delay by any party in exercising any right, power, or privilege hereunder shall operate as a waiver there of nor shall any single or partial exercise thereof preclude any other or further exercise thereof or the exercise of any right, power, or privilege. The rights and remedies herein provided shall be accumulative and not exclusive of any rights provided by law.

ASSIGNMENT
The rights and obligations contained herein shall not be assigned by either party without a minimum of sixty (60) days prior written notification and prior approval of the other.

This constitutes the entire agreement between the parties with regard to the provision of emergency medical services and supersedes any and all other agreements, verbal or written. Any amendments to this agreement must be done in writing and agreed to by the authorized representatives of both parties.

Signed this _____ day of _____, 2016.

By: _____

[First Selectman/Mayor]
Town of _____

By: _____

Administrator
_____(Name)_____ Emergency Communications

In cases where a Municipal Department is serving as a PSAP it is understood that there may not be a Service Agreement between the Town and its Department. The ordinance that creates the Department should be included in lieu of the Service Agreement. If the ordinance fails to address to the specific functions of the Department then the Standard Operating Procedures defining those functions should also be included.

NOTE: This is a SAMPLE document only. The content has not been vetted by legal counsel. You should consult with your legal counsel regarding any legal document you are developing.

Sample EMS Organization Agreement

This Agreement is entered into as of the _____ day of _____, 2016, by and between the **Town of _____**, a municipal corporation organized and existing under the laws of the State of Connecticut (hereinafter called the Town), and the **_____(EMS Organization),** a corporation organized and existing under the laws of the State of Connecticut (hereinafter called Provider) certified to operate at the **[First Responder/Basic Ambulance/Paramedic]** level of care by the State of Connecticut Department of Public Health pursuant to §CGS 19a-177 and designated as the Primary **[First Responder/Basic Ambulance/Paramedic]** Responder (PSAR) within the Town of _____ pursuant to Connecticut Agency Regulations §19a-179-4.

WITNESSETH

WHEREAS, Chapter 368d, Section 19a-181b requires each municipality in the State of Connecticut to establish a local emergency medical services plan; and

WHEREAS, the plan shall include a written agreement, between the municipality, its emergency medical services providers, and the public safety answering point; and

WHEREAS, the plan shall include performance standards for each segment of the municipality's emergency medical services system; and

WHEREAS, the Town and the Provider are committed to providing the highest quality emergency medical services to the Town's resident and visitors;

NOW THEREFORE, the parties hereby agree as follows:

1. The Provider shall provide **[First Responder/Basic Ambulance/Paramedic]** service to the Town for residents and visitors. All vehicles necessary to carry out such services shall be equipped and staffed pursuant to all applicable State of Connecticut General Statutes and Agency Regulations. The Provider agrees to follow state, regional, and sponsor hospital guidelines.

2. The Provider shall be dispatched by the _____ Emergency Communications, Responding vehicles will be dispatched per the protocol enacted jointly between the Provider and the Dispatch Center.

3. If more requests for **[First Responder/Basic Ambulance/Paramedic]** service are received than the Provider has resources with which to respond, it is understood that mutual aid resources will be deployed to the Town and that "system overload" will be in effect. During *"system overload*" it is recognized and agreed that emergency response could be delayed to some 911 callers.

4. The Provider shall provide stand-by coverage, in cooperation and conjunction with the other emergency service organizations, at public events as requested, or in other situations in which medical emergencies are believed likely to occur.

5. The Town shall provide worker's compensation coverage for all members of the Provider through existing Town policies and shall provide evidence of coverage to the Provider annually.

6. The Provider shall provide the necessary insurance coverage of the type and amounts at a minimum set forth by law. These include, but are not limited to, general liability, vehicle insurance of no less than $1,000,000 per occurrence, and errors and omissions liability.

7. The Town shall review, endorse, and provide supporting documentation, as appropriate, applications for grants or financial assistance submitted by the Provider to public or private agencies for the purpose of maintaining or improving emergency services within the Town.

8. The Provider shall provide a policy by which quality assurance is monitored as well as a method of reporting performance to the Town of _____. Both the QA policy as well as the reporting methods will be mutually agreed upon by the Town and the Provider.

TERM

This Agreement shall continue for a period of sixty (60) months from the date of signing.
The agreement may be extended by the mutual written consent of both parties.

TERMINATION

Either party may terminate this agreement for any cause at any time after providing a minimum of sixty (60) days written notice of its intent to terminate. Cause shall be defined as, but not limited to:

a) Failure to provide services defined in this agreement
b) Failure to provide compensation as defined in this agreement
c) Failure to provide insurance as defined in this agreement

Upon receipt of notice the party receiving notice shall have ten (10) business days to remedy the causative factor(s). If remedied to the satisfaction of both parties as indicated by follow-up written notice, the agreement shall endure. If the causative factor(s) cannot be remedied to both parties satisfaction, the termination date will stand.

REPRESENTATIONS

Each party represents to the other that:

a) It is in compliance with all federal, state, and local laws in order to allow it to operate as an **[First Responder/Basic Ambulance/Paramedic]** service or municipality;
b) It has corporate authority to enter into this agreement; and
c) It has disclosed to the other party any material violations of any laws specified in subparagraph (a) that have occurred within the past five (5) years.

WAIVER

No failure or delay by any party in exercising any right, power, or privilege hereunder shall operate as a waiver thereof nor shall any single or partial exercise thereof preclude any other or further exercise thereof or the exercise of any right, power, or privilege. The rights and remedies herein provided shall be accumulative and not exclusive of any rights provided by law.

ASSIGNMENT

The rights and obligations contained herein shall not be assigned by either party without a minimum of sixty (60) days prior written notification and prior approval of the other.

This constitutes the entire agreement between the parties with regard to the provision of emergency medical services and supersedes any and all other agreements, verbal or written. This agreement shall not be viewed as altering or amending any agreement in place for fire control or suppression services. Any amendments to this agreement must be done in writing and agreed to by the authorized representatives of both parties.

Signed this ___ day of _____, 2016.

By: _____

[First Selectman/Mayor]
Town of _____

By: _____

[Chief/President]
_____(Name)_____ Department

In cases where a Municipal Department is serving as a Provider it is understood that there may not be a Service Agreement between the Town and its Department. The ordinance that creates the Department should be included in lieu of the Service Agreement. If the ordinance fails to address to the specific functions of the Department then the Standard Operating Procedures defining those functions should also be included.

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Sample EMS Organization Performance Standards

Sample Local EMS Plan Performance Standards
Public Safety Answering Point

MEDICAL DISPATCH CENTER PERFORMANCE STANDARDS

I. PURPOSE

The purpose of this document is to establish the minimum standards for the _____(Name)_____ Emergency Communications, Inc. dispatch center serving the Town of _____ Emergency Medical Services system.

II. POLICY

Only Medical Dispatch Centers designated by the Town of _____ EMS System may provide emergency medical dispatching for designated Basic or Advanced Life Support EMS Organizations.

Advanced Medical Priority Dispatch System® (AMPDS) [Or other Priority EMS dispatch program] is the designated Emergency Medical Dispatch Priority Reference System authorized for use within the Town of _____ EMS System.

III. REQUIREMENTS

Be designated as a Medical Dispatch Center by demonstrating compliance with applicable State and Federal statues, codes and regulation through written internal policies and procedures and by allowing announced or unannounced audits and on-site inspections.

Maintain a written agreement with the ____(Name)_____ Department [PSARs] and _____ (Sponsor) Hospital to provide emergency medical dispatch services.

Have a current Federal Communications Commission (FCC) license.

Have internal policies for the retention of medical dispatch call logs, records, and tapes for a minimum of 180 days, or as required by the Town of _____ EMS System record retention and destruction policies, whichever is greater.

Every dispatcher must have current certification as an Emergency Medical Dispatcher (EMD).

At least one certified Emergency Medical Dispatcher must be available to perform dispatching at all times.

Have available at all times a Dispatch Supervisor for the Emergency Medical Dispatchers.

Provide a structured training program for dispatchers that minimally include:

- Certifying call taking personnel as Emergency Medical Dispatchers.
- Orientation to the EMS System including any current or updated revisions to applicable EMS Organization policies and procedures.

Medical Dispatch Centers must use the AMPDS Card Set or the Pro QA computerized system. Each on-duty call taker workstation must be provided with an AMPDS Card Set or properly enabled computer terminal for AMPDS.

AMPDS must be used on every request for medical assistance. This includes:

- The standardized caller interrogation and response assignment protocols; and
- Pre-arrival instructions when appropriate for a call.
- Use of AMPDS may be suspended during disaster situations or during periods of unusual extreme call demand. The Medical Dispatch Center must notify the _____ (Sponsor) Hospital Medical Director of all incidents that trigger suspension of AMPDS. Notification must occur within 1 business day after the suspension.

Have a Quality Improvement program that meets the standards listed in Section IV of this policy.

Provide a dedicated web enabled computer to display EM System on a continuous 24-hour per day basis.

Have designated representative(s) that participate in the relevant EMS Organization committee meetings.

Participate in research studies on prehospital care approved by the _____ (Sponsor) Hospital Medical Director.

Participate in EMS system-wide disaster training exercises as determined by the EMS Organizations.

Maintain a disaster plan that defines medical dispatch center actions to assure continuous operations during a disaster that includes:

- Personnel disaster response roles;
- Call-back procedures for staff;
- Disaster training and exercise plan;
- Coordination with other disaster response organizations; and
- Contingency plans for off-site medical dispatch operations in the event the Medical Dispatch Center is rendered inoperable.

IV. QUALITY IMPROVEMENT PROGRAM REQUIREMENTS

Appoint at least one quality improvement (QI) coordinator(s) to implement and manage the Medical Dispatch Center's QI program.

Have a QI Plan approved by the _____ (Sponsor) Hospital EMS Medical Director that describes the following:

- Methods for evaluating dispatch services using objective structure, process, and outcome indicators.
- Identifies the QI feedback methods (e.g. tape review, documentation or training) for individual dispatchers, dispatch management, internal medical dispatch review committees, other EMS organizations.
- Internal policy and procedures for submitting QI data reports and Sentinel Event and Exception Reports to the EMS Organizations.
- Internal policy and procedure for providing tapes or call logs to the EMS Organizations, the Town of _____ or other external organizations for quality improvement review.

The provisions of this agreement will be assessed regularly and revised not less than annually or as needed based on results of the clinical findings, system status measurements and state and national recommendations for performance measurements.

This constitutes the entire agreement between the PSAP and the municipality with regard to performance standards of the provision of emergency medical services and supersedes any and all other agreements, verbal or written. Any amendments to this agreement must be done in writing and agreed to by the authorized representatives of both parties.

Signed this _____ day of _____, 2016.

By: _____

[First Selectman/Mayor]
Town of _____

By: _____

Administrator
_____(Name)_____ Emergency Communications

*Adaptation of California EMS Authority Publication #132: Emergency Medical Services Dispatch Program Guidelines, March 2003

Sample Local EMS Plan Performance Standards
First Responder Level of Service PSAR

The following performance measure agreement, required pursuant to Section 19a-181b of the Connecticut General Statutes is being entered into between the ____(Name)_____ Department, the first responder PSAR, and the Town of _____.

Minimum response data reporting

The basic ambulance PSAR shall report activation and response times in the following format and schedule. Each fractal response category may vary +/- 5% for any given reporting period:

Activation Time means the measure of time from notification to the PSAR that an emergency exists, to the beginning of the response of PSAR personnel.
Percentage of responses where activation time was:
- Less than or equal to two minutes: ..... Standard: 5%
- Greater than two minutes but less than or equal to four minutes: ..... Standard: 10%
- Greater than four minutes but less than or equal to six minutes: ..... Standard: 70%
- Greater than six minutes but less than or equal to eight minutes: ..... Standard: 10%
- Greater than eight minutes: ..... Standard: 5%

Response Time means the total measure of time from notification to the PSAR that an emergency exists, to arrival at the patient's side, *including the activation time.*
Percentage of responses where the response time was:
- Less than or equal to four minute: ..... Standard: 5%
- Greater than four minutes but less than or equal to five minutes: ..... Standard: 10%
- Greater than five minutes but less than or equal to six minutes: ..... Standard: 70%
- Greater than six minutes but less than or equal to seven minutes: ..... Standard: 10%
- Greater than seven minutes: ..... Standard: 5%

First call responses:
PSAR must respond to at least fifty percent or more first call responses in any rolling *three-month* period.
Rolling average - Mo 1: _____%. Mo 2: _____%. Mo 3: _____%. Standard: 50% or greater
PSAR must respond to at least eighty percent or more first call responses, excluding those responses excused by the municipality in any rolling *twelve-month* review period.
Rolling average - Mo 1: _____%. Mo 2: _____%. Mo 3: _____%. Standard: 80% or greater

Reporting period: The PSAR shall submit written reports based on the total EMS responses quarterly to the Office of the [First Selectman/Mayor].

Due: First quarter – April 30, Second quarter – July 31, Third quarter – October 31, Fourth quarter – January 31

The reports shall be generated from data collected from a combination of sources including (PSAP/Dispatch) Emergency Communications, Inc., and _____ Software. [Note: Reported times may not be based on hot and/or cold responses if the Emergency Communications does not document calls as such.]

The PSAR must meet defined response time standards agreed to with the municipality, excluding those responses excused by the municipality under the criteria listed below.
- *Delayed response times due to inclement weather*
- *Mechanical failure enroute*
- *Unsafe scene or difficult scene access*
- *Second calls (A call that is received while the department is currently responding to another call)*

The PSAR's failure to respond to a *first call* shall be excused by the municipality.
- *Response is halted due to catastrophic weather, in consultation with the [First Selectman/Mayor]*
- *Mechanical failure of ambulance, provided*
- *Second calls (A call that is received while the department is currently responding to another call)*

Clinical Measures / Patient Outcomes:

The PSAR will generate reports on currently collected e-PCR data points if required to submit data electronically to OEMS.

Reporting period: The PSAR shall submit written reports on currently collected data points quarterly to the Office of the [First Selectman/Mayor]. The development of the reporting mechanism for the clinical measurements below will be completed within

twelve months of acceptance of this agreement. Subsequent to the development of the reporting mechanism, statistical data will be reported on the following schedule:

Due: First quarter – April 30, Second quarter – July 31, Third quarter – October 31, Fourth quarter – January 31

Performance measures based on 2009 NHTSA EMS Model Performance Measures

Description	Question	Objective	Clinical need addressed
Cardiac Arrest/Chest Pain	Time to initiation of CPR in Cardiac Arrest	Reduce	Survival from Cardiac Arrest
Cardiac Arrest/Chest Pain	What percentage of patients experiencing cardiac arrest experience ROSC prior to transport	Increase Survival Rates	Successful resuscitation from cardiac arrest
Patient Satisfaction With Care	What percentage of patients does your EMS organization survey to measure patient satisfaction?	Increase	Patient satisfaction with care
Pain Assessment	What percentage of patients presenting with signs and symptoms of pain are being assessed for level of pain using a 0-10 scale	Increase	Assessment of Pain
Review Of Services Provided	What percentages of clinical cases are reviewed for adherence to protocol, guidelines and standard of care?	Increase	Appropriate delivery of care

The provisions of this agreement will be assessed regularly and revised not less than annually or as needed based on results of the clinical findings, system status measurements and state and national recommendations for performance measurements.

This constitutes the entire agreement between the PSAR and the municipality with regard to performance standards of the provision of emergency medical services and supersedes any and all other agreements, verbal or written. Any amendments to this agreement must be done in writing and agreed to by the authorized representatives of both parties.

Signed this _____ day of _____, 2016.

By: _____ By: _____

[First Selectman/Mayor] [Chief/President]
Town of _____ _____(Name)_____ Department

Sample Local EMS Plan Performance Standards
Basic Ambulance level of Service PSAR

The following performance measure agreement, required pursuant to Section 19a-181b of the Connecticut General Statutes is being entered into between the ____(Name)_____ Department, the basic ambulance PSAR, and the Town of _____.

Minimum response data reporting

The basic ambulance PSAR shall report activation and response times in the following format and schedule. Each fractal response category may vary +/- 5% for any given reporting period:

Activation Time means the measure of time from notification to the PSAR that an emergency exists, to the beginning of the response of PSAR personnel.
Percentage of responses where activation time was:

- Less than or equal to two minutes: ..... Standard: 5%
- Greater than two minutes but less than or equal to four minutes: ..... Standard: 10%
- Greater than four minutes but less than or equal to six minutes: ..... Standard: 70%
- Greater than six minutes but less than or equal to eight minutes: ..... Standard: 10%
- Greater than eight minutes: ..... Standard: 5%

Response Time means the total measure of time from notification to the PSAR that an emergency exists, to arrival at the patient's side, *including the activation time.*
Percentage of responses where the response time was:

- Less than or equal to four minute: ..... Standard: 5%
- Greater than four minutes but less than or equal to five minutes: ..... Standard: 10%
- Greater than five minutes but less than or equal to six minutes: ..... Standard: 70%
- Greater than six minutes but less than or equal to seven minutes: ..... Standard: 10%
- Greater than seven minutes: ..... Standard: 5%

First call responses:
PSAR must respond to at least fifty percent or more first call responses in any rolling *three-month* period.
Rolling average - Mo 1: _____%. Mo 2: _____%. Mo 3: _____%. Standard: 50% or greater
PSAR must respond to at least eighty percent or more first call responses, excluding those responses excused by the municipality in any rolling *twelve-month* review period.
Rolling average - Mo 1: _____%. Mo 2: _____%. Mo 3: _____%. Standard: 80% or greater

Reporting period: The PSAR shall submit written reports based on the total EMS responses quarterly to the Office of the [First Selectman/Mayor].

Due: First quarter – April 30, Second quarter – July 31, Third quarter – October 31, Fourth quarter – January 31

The reports shall be generated from data collected from a combination of sources including (PSAP/Dispatch) Emergency Communications, Inc., and _____ Software. [Note: Reported times may not be based on hot and/or cold responses if the Emergency Communications does not document calls as such.]

The PSAR must meet defined response time standards agreed to with the municipality, excluding those responses excused by the municipality under the criteria listed below.

Delayed response times due to inclement weather
Mechanical failure enroute
Unsafe scene or difficult scene access
Second calls (A call that is received while the department is currently responding to another call)

The PSAR's failure to respond to a *first call* shall be excused by the municipality.

Response is halted due to catastrophic weather, in consultation with the [First Selectman/Mayor]
Mechanical failure of ambulance, provided
Second calls (A call that is received while the department is currently responding to another call)

Clinical Measures / Patient Outcomes:

PSAR will generate reports on currently collected e-PCR data points if required to submit data electronically to OEMS.

Reporting period: The PSAR shall submit written reports on currently collected data points quarterly to the Office of the [First Selectman/Mayor]. The development of the reporting mechanism for the clinical measurements below will be completed within twelve months of acceptance of this agreement. Subsequent to the development of the reporting mechanism, statistical data will be reported on the following schedule:

Due: First quarter – April 30, Second quarter – July 31, Third quarter – October 31, Fourth quarter – January 31

Performance measures based on 2009 NHTSA EMS Model Performance Measures

Description	Question	Objective	Clinical need addressed
Cardiac Arrest/Chest Pain	Time to initiation of CPR in Cardiac Arrest	Reduce	Survival from Cardiac Arrest
Cardiac Arrest/Chest Pain	What percentage of patients experiencing cardiac arrest experience ROSC prior to transport	Increase Survival Rates	Successful resuscitation from cardiac arrest
Cardiac Arrest/Chest Pain	What percentage of cardiac arrest patients have ROSC at time of ED admission	Increase Survival Rates	Successful resuscitation from cardiac arrest
Cardiac Arrest/Chest Pain	What percentage of patients over the age of 35 with suspected cardiac chest pain received aspirin?	Increase rate in appropriate patients	Definitive care for ACS
Patient Satisfaction With Care	What percentage of patients does your EMS organization survey to measure patient satisfaction?	Increase	Patient satisfaction with care
Pain Assessment	What percentage of patients presenting with signs and symptoms of pain are being assessed for level of pain using a 0-10 scale	Increase	Assessment of Pain
Field Trauma Triage	What percentage of patients who meet the current CT guidelines for field triage criteria for transfer to a trauma center are transported to a trauma center?	Increase rate in appropriate patients	Definitive care for major trauma
Anaphylaxis / Allergy Care	What percentage of patients with suspected anaphylactic reaction received epinephrine	Increase rate in appropriate patients	Definitive care for suspected Anaphylaxis
Opiate Overdose Care	What percentage of patients with suspected opioid overdose received Naloxone	Increase rate in appropriate patients	Definitive care for suspected Opioid Overdose
Review Of Services Provided	What percentages of clinical cases are reviewed for adherence to protocol, guidelines and standard of care?	Increase	Appropriate delivery of care

The provisions of this agreement will be assessed regularly and revised not less than annually or as needed based on results of the clinical findings, system status measurements and state and national recommendations for performance measurements.

This constitutes the entire agreement between the PSAR and the municipality with regard to performance standards of the provision of emergency medical services and supersedes any and all other agreements, verbal or written. Any amendments to this agreement must be done in writing and agreed to by the authorized representatives of both parties.

Signed this _____ day of _____, 2016.

By: _____ By: _____

[First Selectman/Mayor]
Town of _____

[Chief/President]
_____(Name)_____ Department

Sample Local EMS Plan Performance Standards
Paramedic Level of Service PSAR

The following performance measure agreement, required pursuant to Section 19a-181b of the Connecticut General Statutes is being entered into between ____(Name)_____ Department, the paramedic PSAR, and the Town of _____.

Minimum response data reporting

The basic ambulance PSAR shall report activation and response times in the following format and schedule. Each fractal response category may vary +/- 5% for any given reporting period:

Activation Time means the measure of time from notification to the PSAR that an emergency exists, to the beginning of the response of PSAR personnel.
Percentage of responses where activation time was:
- Less than or equal to two minutes: ..... Standard: 5%
- Greater than two minutes but less than or equal to four minutes: ..... Standard: 10%
- Greater than four minutes but less than or equal to six minutes: ..... Standard: 70%
- Greater than six minutes but less than or equal to eight minutes: ..... Standard: 10%
- Greater than eight minutes: ..... Standard: 5%

Response Time means the total measure of time from notification to the PSAR that an emergency exists, to arrival at the patient's side, *including the activation time.*
Percentage of responses where the response time was:
- Less than or equal to four minute: ..... Standard: 5%
- Greater than four minutes but less than or equal to five minutes: ..... Standard: 10%
- Greater than five minutes but less than or equal to six minutes: ..... Standard: 70%
- Greater than six minutes but less than or equal to seven minutes: ..... Standard: 10%
- Greater than seven minutes: ..... Standard: 5%

First call responses:
PSAR must respond to at least fifty percent or more first call responses in any rolling *three-month* period.
Rolling average - Mo 1: _____%. Mo 2: _____%. Mo 3: _____%. Standard: 50% or greater
PSAR must respond to at least eighty percent or more first call responses, excluding those responses excused by the municipality in any rolling *twelve-month* review period.
Rolling average - Mo 1: _____%. Mo 2: _____%. Mo 3: _____%. Standard: 80% or greater

Reporting period: The PSAR shall submit written reports based on the total EMS responses quarterly to the Office of the [First Selectman/Mayor].

Due: First quarter – April 30, Second quarter – July 31, Third quarter – October 31, Fourth quarter – January 31

The reports shall be generated from data collected from a combination of sources including (PSAP/Dispatch) Emergency Communications, Inc., and _____ Software. [Note: Reported times may not be based on hot and/or cold responses if the Emergency Communications does not document calls as such.]

The PSAR must meet defined response time standards agreed to with the municipality, excluding those responses excused by the municipality under the criteria listed below.
Delayed response times due to inclement weather
Mechanical failure enroute
Unsafe scene or difficult scene access
Second calls (A call that is received while the department is currently responding to another call)

The PSAR's failure to respond to a *first call* shall be excused by the municipality.
Response is halted due to catastrophic weather, in consultation with the [First Selectman/Mayor]
Mechanical failure of ambulance, provided
Second calls (A call that is received while the department is currently responding to another call)

Clinical Measures / Patient Outcomes:

PSAR will generate reports on currently collected e-PCR data points if required to submit data electronically to OEMS.

Reporting period: The PSAR shall submit written reports on currently collected data points quarterly to the Office of the [First Selectman/Mayor]. The development of the reporting mechanism for the clinical measurements below will be completed within twelve months of acceptance of this agreement. Subsequent to the development of the reporting mechanism, statistical data will be reported on the following schedule:

Due: First quarter – April 30, Second quarter – July 31, Third quarter – October 31, Fourth quarter – January 31

Performance measures based on 2009 NHTSA EMS Model Performance Measures

Description	Question	Objective	Clinical need addressed
Cardiac Arrest/Chest Pain	Time to initiation of CPR in Cardiac Arrest	Reduce	Survival from Cardiac Arrest
Cardiac Arrest/Chest Pain	What percentage of patients experiencing cardiac arrest experience ROSC prior to transport	Increase Survival Rates	Successful resuscitation from cardiac arrest
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Opiate Overdose Care	What percentage of patients with suspected opioid overdose received Naloxone	Increase rate in appropriate patients	Definitive care for suspected Opioid Overdose
Review Of Services Provided	What percentages of clinical cases are reviewed for adherence to protocol, guidelines and standard of care?	Increase	Appropriate delivery of care

The provisions of this agreement will be assessed regularly and revised not less than annually or as needed based on results of the clinical findings, system status measurements and state and national recommendations for performance measurements.

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Signed this _____ day of _____, 2016.

By: _____ By: _____

[First Selectman/Mayor] [Chief/President]
Town of _____ _____(Name)_____ Department

References & Resources

The information and content of this toolkit were compiled and adapted from the following documents:

- Connecticut General Statutes, Chapter 368d
  http://www.cga.ct.gov/current/pub/titles.htm
- Regulations of Connecticut State Agencies
  https://eregulations.ct.gov/eRegsPortal/
- NHTSA (August 1996), *EMS Agenda for the Future*
  http://www.ems.gov/pdf/2010/EMSAgendaWeb_7-06-10.pdf
- NHTSA (Dec. 2009). *EMS Performance Measures. Recommended Attributes and Indicators for System and Service Performance*.
  http://www.ems.gov/pdf/811211.pdf
- FEMA, *Operational Templates and Guidance for EMS Mass Incident Deployment*
  https://www.usfa.fema.gov/downloads/pdf/publications/templates_guidance_ems_mass_incident_deployment.pdf
- Virginia Department of Health, Office of Emergency Medical Services (June 2001), *EMS Agency Management Series. EMS Strategic Planning*.
- Commonwealth of Massachusetts, Emergency Medical Care Advisory Board (May 2004), *Statewide Multiple Casualty Incident Standards for Local Planning*.
  http://www.mass.gov/eohhs/docs/dph/emergency-services/ambulance-mass-casualty-planning.pdf
- Rhode Island Emergency Management, Rhode Island MCI Working Group (January 2005), *Rhode Island Mass Casualty Incident Disaster Plan*.
- Broome County Emergency Medical Services System (December 2010), *Mass Casualty Incident Response Plan*.
- CEMSA (2013). *California EMS System Core Quality Measures.*
  http://www.emsa.ca.gov/ems_core_quality_measures_project
- NEMSMA (Sept. 2004). *EMS Core Measures: Suggestions For Consideration by the National EMS Performance Measures Project.*
- NCEMSC (Jun. 2010). *North Central Connecticut EMS Regional Medical Advisory Committee Regional Benchmarks.*
- Multiple authors. (2007). Evidence-Based Performance Measures for Emergency Medical Services Systems: A Model for Expanded EMS Benchmarking, A Statement Developed by the 2007 Consortium U.S. Metropolitan Municipalities' EMS Medical Directors' Consensus Panel on Evidence-Based Performance Measures (Appendix). *Prehospital Emergency Care Journal of NAEMSP*.
  http://www.naemsp.org/SiteAssets/Pages/2014%20Annual-Meeting-MDC/Myers%20Benchmarking%20in%20EMS.pdf
- University of Kansas (2015), *An Overview of Strategic Planning or "VMOSA" (Vision, Mission, Objectives, Strategies, and Action Plans)*
  Work Group for Community Health and Development
- United State Census Bureau, *Connecticut Quick Facts*
  http://quickfacts.census.gov/qfd/states/09000.html

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Comments, recommended additions or corrections may be forwarded to the Health Program Assistants (see contact page) assigned to Local EMS Planning at the OEMS.