Approved April 27, 1988
Date

MINUTES OF THE Senate COMMITTEE ON Local Government.

The meeting was called to order by Senator Don Montgomery at
Chairperson

9:00 a.m./p.m. on March 30, 1988 in room 531-N of the Capitol.

All members were present except:

Committee staff present: Mike Heim, Theresa Kiernan, Emalene Correll and Lila McClaflin

Conferees appearing before the committee:

Representative Anthony Hensley
Terry L. Stevens, Legislative Liaison, City of Topeka
Representative Mary Jane Johnson
Fred Thorp, Division of E.M.S., Kansas City, Ks.

The Chairman opened the hearing on H.B. 2718 concerning airport authorities relating to the powers and duties. He called on Representative Hensley.

Rep. Hensley stated the Shawnee County delegation was requested to introduce this legislation; it amends the Topeka Metropolitan Airport Authority law to clarify the Authority may purchase and resell sewage services to any person. He requested that the committee pass H.B. 2718.

Terry L. Stevens representing Topeka, stated they supported the legislation, as it is necessary in order for them to provide services for Lario Enterprises, for the construction of a racetrack facility (Attachment I).

Senator Salisbury moved H.B. 2718 be passed. Senator Langworthy seconded the motion. Motion carried.

The hearing on H.B. 2865 providing for the certification of emergency medical dispatchers; and providing for the administration of the provisions of the act, was opened. The Chairman called on Representative Mary Jane Johnson.

Rep. Mary Jane Johnson presented testimony and a newspaper article supporting the importance of training and certification of emergency medical dispatchers. She believes lives would be saved by having qualified dispatchers able to describe techniques, such as the Heimlich maneuver, over the telephone. She urged the committee to pass the bill (Attachment II).

Representative Debara Schauf was unable to be present, but submitted written testimony supporting H.B. 2865 (Attachment III).

Fred Thorp, representing the division of E.M.S. of the Kansas City fire department, supported the bill, stating this legislation seeks to prepare dispatchers to maximize assistance to the calling party seeking medical assistance (Attachment IV).

The hearing on H.B. 2865 was closed.

Senator Bogina announced S.B. 734 scheduled for hearing at this time, had been amended into another bill on the floor of the Senate.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE Senate COMMITTEE ON Local Government,

room 531-Statehouse, at 9:00 a.m./p.m. on March 30, 1988

The Chairman opened the discussion on H.B. 2669.

Senator Gaines offered an amendment, a balloon of the amendment is attached to these minutes (Attachment V). Senator Gaines moved the amendment be adopted. Senator Allen seconded the motion. Motion carried. The committee report is (Attachment VI).

Senator Gaines moved H.B. 2669 be passed as amended. Senator Allen seconded the motion. The motion carried.

The Chairman stated H.B. 2797 was on the floor for action.

Senator Gaines moved to amend H.B. 2797, by striking "statute book" and inserting "Kansas Register". Senator Daniels seconded the motion. Motion carried.

Senator Gaines moved H.B. 2797 be passed as amended. Senator Salisbury seconded the motion. Motion carried. The committee report is (Attachment VII).

Attention was called to H.B. 3037.

Senator Allen moved H.B. 3037 be passed. Senator Ehrlich seconded the motion. Motion carried. The committee report is (Attachment VIII).

Attention was called to H.B. 3043.

Senator Langworthy stated she was concerned with setting a per diem cap, as John Peterson had proposed. After discussion, Senator Langworthy moved to amend H.B. 3043, on page 1, in line 44, following "basis", by inserting "for days or parts thereof related to a field audit"; and language that "unless the Secretary of State determines (1) there are substantial or material deviations from the requirements of the applicable statute or (2) the entity has failed to maintain adequate records for auditing purposes." Senator Gaines seconded the motion. Motion carried.

Senator Langworthy moved that line 45, the "$100" be struck and "$500" be inserted. Senator Salisbury seconded the motion.

During committee discussion, Senator Daniels objected to the $500 cap.

The vote was taken and the motion carried.

Senator Langworthy moved H.B. 3043 be passed as amended. Senator Gaines seconded the motion. Motion carried. The committee report is (Attachment IX).

Senator Steineger asked the committee to reconsider their action on H.B. 3037, and amend the bill so that the provisions of this section would not be applicable to KSA 60-307. He made a conceptual motion that the committee accept this recommendation. By consensus of the committee the bill was amended.

CONTINUATION SHEET

MINUTES OF THE Senate COMMITTEE ON Local Government,

room 531-N Statehouse, at 9:00 a.m./p.m. on March 30, 19__.

Attention was called to H.B. 2732, Representative Mollenkamp's bill authorizing, Trego County to levy 4 mills each for county road and bridge fund.

The committee consensus was, Trego County voters have turned this proposal down twice, the last time in July of 1987, they did not think it was a good idea to make this change in Topeka, they could do this under their home rule powers now, or through the State Board of Tax Appeals. Senator Mulich moved to table the bill. Senator Gaines seconded the motion. Motion carried.

H.B. 2981 concerning municipalities, relating to franchises.

Senator Gaines stated he was opposed to taking any quick action on this bill, it was major legislation and the committee had not had sufficient time to study the issue. He then moved to report the bill unfavorable. Senator Langworthy seconded the motion. Motion carried. The committee report is (Attachment X).

H.B. 2865 concerning the E.M.S. dispatchers. The committee consensus was to let the new board deal with this issue. The bill was tabled.

Senator Allen stated he would like to bring up H.B. 2063 the group home zoning bill. An amendment that had been drafted by Staff was distributed (Attachment XI). Senator Allen moved in the proposed amendment "restrictive covenants" be struck in all places where it appears, and the amendment be adopted. Senator Gaines seconded the motion. Committee discussion followed. Several Senators expressed concern that this was an issue best handled at the local level, several others stated it was not being done at the local level and needed stronger support from the legislature. The question was called for; motion carried.

Senator Gaines moved H.B. 2063 as amended by passed. Senator Winter seconded the motion. Motion carried. Committee Report is (Attachment XII).

The Chairman thanked members and staff for their work during the session.
He adjourned the meeting at 10:02 a.m.

Don Montgomery

Chairman, Senator Don Montgomery

Date: March 30, 1988

GUEST REGISTER

SENATE

LOCAL GOVERNMENT

NAME	ORGANIZATION	ADDRESS
Marla Howard	City of Wichita	Wichita
[illegible]		[illegible]
M. J. Johnson		
FRED THORP	KCK FIRE	KCK
[illegible]	KALPCCA	Topeka
Dave Corliss	Lg of Municipalities	"
[illegible]	"	Topeka
Jim Kaup	League of Municipalities	Topeka
John T. [illegible]	Ks. Assoc. of Counties	"
Gerry Ray	Jo Co Comm	Olathe
[illegible] McDaniel	KHD	Topeka
Richard Funk	KASB	Topeka
S. Streff	AP	Topeka

SENATE LOCAL GOVERNMENT COMMITTEE

TESTIMONY ON H.B. 2718
PRESENTED BY
TERRY L. STEVENS
LEGISLATIVE LIAISON FOR THE CITY OF TOPEKA

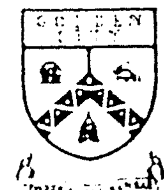
During the 1987 legislative session, The Kansas Legislature amended K.S.A. 27-331, which relates to the powers and duties of airport authorities in Kansas. This change is reflected in Chapter 132 of the 1987 Session Laws. Specifically, it allows an airport authority to own, operate, and dispose of water and sewage utility systems. Also included in the amended change to the statute is the authority to purchase and resell water and sewage utilities to a person, firm, or corporation **within** the territory owned by the respective authority.

As many of you might be aware, the City of Topeka, recently negotiated an agreement with Lario Enterprises for construction of a racetrack facility and commercial development area on a parcel of land outside the boundaries currently controlled by the Metropolitan Topeka Airport Authority (M.T.A.A.). Included in the agreement is the responsibility of the City of Topeka to provide certain "essential services" under their jurisdiction, namely water and sewer services. Currently, **sewer services** are not available from existing city sewer lines to either the proposed racetrack facility or the Lario commercial development site. It has been determined, that one short term solution to providing this necessary service would be to extend the existing sewer lines from the Metropolitan Topeka Airport Authority. This would allow for the utilization of the present sewage treatment plant operated by the Metropolitan Topeka Airport Authority.

In order to make this a viable solution, it would necessitate amending current language in the state statute, eliminating the requirement that the receiver of the utility system be located within the territory under the control of the airport authority.

In conclusion, The City of Topeka would respectfully request favorable consideration and recommendation for passage of this bill by the committee.

Memorandu



TO: Mayor Douglas S. Wright

FROM: Public Works

SUBJECT: Sewer Service to the Proposed Lario Site

DATE: December 18, 1987

The Public Works Department has been working with the proposed Lario site for the race track and associated commercial development specifically in addressing the provision of essential services.

Sanitary sewer service for ultimate development of this area will be by either extension of the City's South Branch Shunganunga Interceptor or a new regional treatment plant. Selection of the final service alternate must be coordinated through the Kansas Department of Health and Environment and be consistent with the Section 208 Water Quality Management Plan for the Topeka area. This process, as well as design and construction of these facilities, will take several months(36-48) to achieve. In order to provide sanitary sewer service for the initial development, two short term service alternatives have been identified. These include an on-site, non-discharging lagoon or connection to the existing MTAA sanitary sewer system. In order to have this second option available, Chapter 132 of the 1987 Session Laws need to be amended.

Edie L. Snethen
Director of Public Works

ELS/vsb

MARY JANE JOHNSON
REPRESENTATIVE, THIRTY-SIXTH DISTRICT
WYANDOTTE COUNTY
5321 ROSWELL
KANSAS CITY, KANSAS 66104

STATE OF KANSAS

TOPEKA

HOUSE OF REPRESENTATIVES

COMMITTEE ASSIGNMENTS
RANKING MINORITY MEMBER: LOCAL GOVERNMENT
MEMBER: ELECTIONS
COMMERCIAL AND FINANCIAL INSTITUTIONS

M-E-M-O

TO: SENATE LOCAL GOVERNMENT
FROM: REPRESENTATIVE MARY JANE JOHNSON
DATE: MARCH 29, 1988
SUBJECT: EMS DISPATCHER CERTIFICATION HB 2865

HB 2865 requires that as of 1990 any new dispatchers hired to dispatch emergency services will have to complete a course of study, not more than 24 hours, in order to aid victims in distress over the phone until the appropriate unit arrives.

The bill will grandfather in any previously hired dispatchers. The newly hired dispatchers will have 1 year to complete the course or an additional year may be added if the dispatcher can show good cause why the training was not obtained in the first year. The cost of training will be at the discretion of the employer, it could be paid by the employer or a requirement of the individual who is being considered for employment.

Many dispatchers have already completed the required course as you will probably hear from the following conferees.

I have attached a news article written January 24, 1988. This story is a prime example of the type of situation that this bill would address if passed. As you will read, a woman's life was saved by the dispatcher's aid in explaining how to do the Heimlich method of clearing the windpipe.

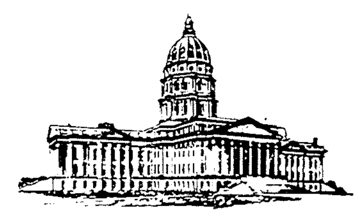
Mr. Chairman and members of the committee, I would appreciate your favorable vote on this most needed piece of legislation.

(Attachment II) Local Go 3/30/88

A II

STATE OF KANSAS

MARY JANE JOHNSON
REPRESENTATIVE, THIRTY-SIXTH DISTRICT
WYANDOTTE COUNTY
5321 ROSWELL
KANSAS CITY, KANSAS 66104



TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
RANKING MINORITY MEMBER: LOCAL GOVERNMENT
MEMBER: ELECTIONS
COMMERCIAL AND FINANCIAL
INSTITUTIONS

Fire dispatcher a real lifesaver

By JOHN CARRAS
Kansan Staff Writer

A veteran Kansas City, Kan., Fire Department emergency dispatcher helped save the life of a woman choking to death by describing over the telephone the techniques of the Heimlich maneuver to her husband.

The dispatcher, Daryl Sybrant, a 10-year veteran of the Fire Department communications center, received a call at 7:34 a.m. Friday from a man who said his wife was "choking badly" on a pill she took that apparently went down her windpipe. Sybrant immediately dispatched a KARE ambulance to the KCK residence. While the ambulance was en route, Sybrant calmly explained to the husband the Heimlich method of clearing the windpipe. The husband followed instructions and got his wife breathing normally again.

near-by fire engine

Upon arrival of the ~~KARE unit~~, rookie firefighter Matthew Muder [EMT] learned that the woman had choked on an iron supplement pill. Still showing signs of discomfort but no longer in a life-threatening situation, the woman drank a glass of water.

Sybrant's reaction to the emergency was matter-of-fact:

"The caller was very willing to cooperate and take instructions from me. He seemed to be somewhat familiar with the procedure. I spoke plainly and clearly so that he could understand me. I stayed on the line until I could hear in the background that the medical unit had arrived."

Sybrant has been trained in emergency medical dispatching

(See LIFE, page 2A)

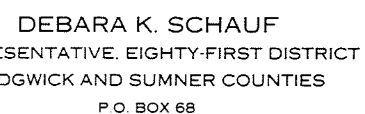
Life

(Continued from page 1)

as recently as November. All the dispatchers will eventually undergo such training, according to Fred Thorp, KCK director of emergency medical services. The training involves a course with 2½ days of instruction. To date, five of the 11 dispatchers have received the training with the remaining six set to undergo training in March. The training utilizes information cards dispatchers can immediately refer to when responding to medical emergencies. The cards provide detailed instructions on approved medical procedures such as the Heimlich maneuver and CPR.

All was fine upon arrival of the Paramedic Ambulance!

STATE OF KANSAS



DEBARA K. SCHAUF
REPRESENTATIVE, EIGHTY-FIRST DISTRICT
SEDGWICK AND SUMNER COUNTIES
P.O. BOX 68
MULVANE, KANSAS 67110
(316) 777-4608

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS

MEMBER: GOVERNMENTAL ORGANIZATION
LOCAL GOVERNMENT
INSURANCE

MEMO

TO: SENATE LOCAL GOVERNMENT
FROM: REPRESENTATIVE DEBBIE SCHAUF
DATE: MARCH 28,1988
SUBJECT: EMS DISPATCHER CERTIFICATION HB 2865

This bill simply requires that as of 1990 any new dispatchers that are hired to dispatch emergency service need to complete a course of study not more than 24 hours in order to be able to accurately assess the type of emergency, the condition of the victim, the necessary units to be dispatched, the accurate location of the need for service, and the ability to offer some basic information to aid the victim or the caller in dealing with the emergency until the appropriate unit arrives.

The bill grandfathers in any dispatcher employed prior to 1990, it allows a new dispatcher to be hired on a temporary basis for up,to one year and complete the training, and even allows an additional one year if the dispatcher can show good cause why the training was not obtained.

The course shall be approved by the EMS council, and will require recertification every three years after initial completion. The bill does not speak to who will be required to pay for the training which will cost in the area of $165.00 so at the discretion of the employer it could be paid by the employer or a requirement of the individual for consideration of employment.

I would like to discuss a potential amendment for the bill allowing any currently certified EMS technician or first responder to be allowed to accept employment as a dispatcher without being certified in the manner required by this bill. The only real opposition I have heard was that many of the rural services have this type of dispatcher which fills in on dispatching and because of their current level of training would not need the additional training. My concern would be that although they have technical attendant training, they have not been trained in the dispatch proceedures.

This bill is really needed to make the delivery of emergency services in Kansas as good as the quality of service delivered currently by the technicians. I urge your support of this bill to keep Kansas in the forefront in the field of emergency services. I would like the opportunity to visit with any of you that have questions or concerns.

(Attachment III) Local Go 3/30/88

A III

SALT LAKE CITY FIRE DEPARTMENT
Medical Division
159 East 100 South
Salt Lake City, Utah 84111

March 3, 1988

Dear Representatives Johnson and Schauf,

As the originator of Emergency Medical Dispatch training, also known as Priority Dispatching, over 10 years ago, I was very pleased to learn of House Bill 2865 - Certification of Emergency Medical Dispatchers. The Kansas legislature has the opportunity to forge important ground in professionalizing medical dispatching throughout the State of Kansas.

I have reviewed the bill and find it well written, to-the-point, and correctly organized. In 1983, the State of Utah established the first rules and standards for EMDs based on existing EMS enabling legislation that allowed for such. The increase in the numbers of individual dispatchers trained and the great leap forward in the abilities of these certified EMDs to give lifesaving pre-arrival instructions over the phone to callers in crisis, as well as in correctly prioritizing the correct level of mobile response, has been a very welcome change here since certification training was effected.

The EMD must not be the "weak link" in the chain of EMS response, but must be a trained, certified professional, who is the only person capable of impacting the victim *prior* to the arrival of the paramedics or EMTs. I have enclosed some documents that may be helpful in better understanding the currently accepted standard for medical dispatch practice nationally. I certainly laud your efforts in Kansas, and if I can be of any help personally in your efforts to effect implementation of House Bill No. 2865 please do not hesitate to call upon me at 801-530-5283.

Sincerely,

Jeff J. Clawson, M.D.
Fire Surgeon/Medical Director

JJC:wp
Enclosures
cc: Fred Thorpe

DISPATCH PRIORITY TRAINING: STRENGTHENING THE WEAK LINK

Dr. J. Clawson
Fire Surgeon
Salt Lake City Fire Department
Utah, USA

In the last fifteen years Emergency Medical Service (EMS) response throughout the world has undergone an incredible evolution. Improvement has been the general trend, exemplified by the move from untrained mortuary services and first aid vehicles, to Emergency Medical Technician (EMT) ambulances, and finally Advanced Life Support (ALS) paramedic systems. Responders' expertise has been upgraded, and the fact that EMT's now receive hundreds of hours and paramedics often over a thousand hours of intensive emergency training indicates the importance of such training in EMS. But at the centre of this well-trained specialised, and expensive EMS configuration – deciding whether or not to respond, who responds, and how they respond – is the emergency dispatcher, who likely has not been given a single hour of emergency medical instruction. For many years, emergency dispatchers have remained the weakest link in the EMS chain of response.

In November 1976, the United States Department of Transportation developed a program for converting EMT's into dispatchers. However, this type of training program was applicable neither to EMS in our area nor to many other systems of which we were aware. Most municipal public safety agencies operating EMT and paramedic services function with an established corps of dispatchers, many of whom have significant seniority and accrued benefits. This is the case in our system, and thus replacement of these dispatchers with EMTs or paramedics is neither economically nor occupationally feasible.

In addition to the problem, those few dispatchers who have completed EMT training course lack the concurrent field experience necessary to make this classroom education relevant to dispatch application.

In order to upgrade the emergency medical expertise of the dispatcher the concept of the Emergency Medical Dispatch Priority Card Protocol System was developed (Fig. 1). This reference system became the core of a 25 hour training course used to educate and certify dispatchers as Emergency Medical Dispatchers (EMD's) throughout the State of Utah. The entire course was outlined in instructor teaching format and was elapsed-time referenced for accuracy in course scheduling.

Fig. 1. Medical Dispatch Priority Card System.

Emergency Medical Dispatcher (EMD) Training Course
The 25 hour course consists first of a three-hour review of basic dispatch techniques, equipment, regulations and codes. The role of the EMD is then explained and the Medical Dispatch Priority Card System introduced (Fig. 2). At the system's core are the general concepts of key questions, pre-arrival instructions, and dispatch priorities (determinants and response). The 'Four Commandments' of medical dispatch (age, chief complaint, states of consciousness and breathing) are reinforced as an absolute baseline of information obtained and relayed on every call.

The EMD trainee is taught how to assist in co-ordinating EMT and paramedic enroute rendezvous and relaying information between agencies or units lacking common radio frequencies. Since a function of the EMD is also to prevent needless delays within the system, their leadership role in the area of unit logistics is stressed. For example, the EMD is often in the position to determine that available ALS units are so distant from the victim that, in the interest of time, basic life support personnel at the scene would be better advised to transport immediately to the nearest emergency department.

A significant improvement necessary to every medical dispatch system today is the provision of pre-arrival instructions. To prepare the EMD for the role of giving life-saving instructions to the caller, the trainees are certified in basic life support (Cardiopulmonary resuscitation and choking intervention) on the second day of the course. The heart of the course, however, is the physician-taught review of each medical symptom or incident-type priority card. This includes a basic review of the problem involved, discussion of the additional information section of the cards, the significance of instructions. The medical, as opposed to political or geographical priorities of dispatching are stressed for each caller complaint.

- I. General dispatch protocols
- 1. Abdominal pain/problems
- 2. Allergies/hives/med reactions/stings
- 3. Animal bites
- 4. Assault/rape
- 5. Back pain
- 6. Breathing problems
- 7. Burns
- 8. Carbon monoxide poisoning/inhalations
- 9. Cardiac/respiratory arrest
- 10. Chest pain
- 11. Choking
- 12. Convulsions/seizures
- 13. Diabetic problems
- 14. Drowning (near-drowning/diving accident
- 15. Electrocution
- 16. Eye problems
- 17. Falls
- 18. Headaches
- 19. Heart problems
- 20. Haemorrhage
- 21. Industrial/machinery accidents
- 22. Multiple complaints
- 23. Overdose/poisoning/ingestion
- 24. Pregnancy/childbirth/miscarriage
- 25. Psychiatric/behavioural problems
- 26. Specific diagnosis as a chief complaint (sick person)
- 27. Stab/GSW
- 28. Stroke/CVA
- 29. Traffic injury accidents
- 30. Traumatic injuries, specific
- 31. Unconsciousness/fainting
- 32. Unknown problem (mandown)
- A. Infant/child choking sequence
- B. Infant/child airway mouth-to-mouth
- C. Infant/child chest compressions
- D. Adult choking sequence
- E. Adult airway mouth-to-mouth (part 1)
- F. Adult airway mouth-to-mouth (part 2)
- G. Adult chest compressions
- H. Childbirth sequence

Fig. 2. Categorisation of Caller Complaints.

1. Red light and siren vs. routine
   a. Ask yourself the following question of each problem:
      1. Will time make a difference in final outcome?
      2. How much time leeway do you have?
      3. How much time can you save going red-light-and-siren?
      4. How much can be saved sending a closer but larger unit (engine)?
      5. When the victim gets to the hospital will the time you saved be significant to the time spent awaiting care (i.e. waiting turn, X-rays, lab tests, etc.)?

2. True time-priority items (one to five minute response required):
   a. Cardiac or respiratory arrest
   b. Airway problems
   c. Unconsciousness
   d. Severe Trauma/Hypovolaemic Shock
   e. True obstetrical emergencies

3. Other emergent medical problems should receive responses of less than 10 minutes with *all* responses* (in urban/suburban areas) within 15 minutes.

**Note: In rural areas distance can replace true medical need as an index of emergency response.*

Figure 3: Determining the Response.

The introduction of the non-red-light-and-siren response concept for many calls previously felt to be dire emergencies by untrained dispatchers is an important learning experience for the EMD trainees, and a highlight of the course. For example, after explaining that abdominal pain and fever in a 17 year old male (felt to be appendicitis) is not a pre-hospital medical emergency, and requires neither a red-light-and-siren nor paramedic (ALS) response, dispatchers often respond, 'why, after all these years, weren't we told that before?'

The importance of obtaining symptoms rather than diagnoses is stressed (for example: chest pain versus a heart problem). The physician also discusses how to adapt and localise the dispatch priorities to meet different agencies' needs, and demonstrates how to calculate and establish varied levels of response (Fig. 3) while explaining benefits of the dispatch priority system.

A practical session of medical interrogation ends the course. Using mock-case scenarios, the trainees receive practical experience using the card system and telephone treatment sequence cards. Each class member is evaluated on their ability to use the key questions and select the appropriate determinant and response. A final examination of 20 items is administered and those satisfying this requirement receive state certification and a uniform insignia. Regulations and standards developed by the Utah State Bureau of EMS require recertification every 3 years and also require use of the priority card system by all medical dispatch agencies.

The Priority Card System

Each dispatch office is provided with a flip-card file containing 32 sets of two 8 x 5 cards (Fig. 4 and 5). Each caller complaint (either symptom or incident) is listed in alphabetical order for quick-reference. The index of cards reflects either a symptom

ADDITIONAL INFORMATION

Insulin Shock/Hypoglycaemia (rapid onset)
Too much insulin has depleted the body's available blood sugar. Since the brain's only usable fuel is sugar it is first organ at risk. Serious if patient is not alert. May be confused with alcohol intoxication.

Diabetic Coma (gradual onset)
Unconsciousness or decreased level of consciousness secondary to the body's inability to use available blood sugar for fuel when sufficient insulin is not given. Without accurate history this problem may be difficult to tell from insulin shock.

Diabetic Ketoacidosis
Pre-coma state resulting from insufficient insulin. Unable to use sugar, the body burns its own tissue (fat, muscle, etc.). The ketoacids produced (acetones) are "poisonous" to the patient making him increasingly ill. This is not a **pre-hospital** medical emergency.

NOTE: Level of consciousness is the key to determining pre-hospital response selection.

KEY QUESTIONS	PRE-ARRIVAL INSTRUCTIONS
1. Conscious?	a. As per unconscious if appropriate
2. Alert?	b. Gather medicine for paramedics/ED
3. Breathing?	c. Check for medical identification tags or cards
4. Fever?	

DISPATCH PRIORITIES

	Determinant	Response	
A	Conscious & Alert	Ambulance (BLS)	Cold
B	Conscious but **not** Alert	Paramedics (ALS)	Hot
		Ambulance (BLS)	Cold
C	Unconscious (but breathing)	Closest EMTs (BLS)	Hot
		Paramedics (ALS)	Hot
		Ambulance (BLS)	Cold

Fig. 4 Medical Dispatch Priority Card for Traumatic Injuries.

or an incident categorisation of problems rather than a diagnosis-oriented system. If diagnosis is used as the index, the dispatcher must diagnose, or worse, accept the caller's diagnostic opinion before selecting the appropriate card. With diagnosis clearly the most difficult of all medical skills, requiring the least medically trained individual in the system to diagnose as an initial step for response selection is medically unsound.

The core card contains three colour-coded area: key questions, pre-arrival instructions, and dispatch priorities, sub-divided into determinant and response. The key questions represent the minimum amount of interrogation necessary to adequately establish the correct level of emergency medical response (for example EMT's versus paramedics, red-light-and-siren mode or not). Use of the key is mandatory on every call to insure standard, consistant interrogation practice and response assignment selection.

In addition to the 32 priority cards, the system contains 8 telephone treatment sequence alogrithm cards to assist the EMD in giving pre-arrival instructions to the caller. (Fig.6) These instructions are given to assist the caller in preventing the patient from further injuring himself, and to enable the caller to do as much as possible to help or resuscitate a victim in a life-threatening situation. The instructions range from basic head-tilt airway maintenance to phone-instructed CPR. Also included are control of haemorrhage by direct pressure, treatment of small burns, eye flushing, removing pillows from behind the heads of unconscious victims, and pre-hospital obstetrical do's and don'ts.

While key questions and pre-arrival instructions remain basically constant from one locality to another, the dispatch priority section of each card must reflect a given agency's varied ability to respond, ranging from single-unit volunteer squads to the multiple-level of metropolitan fire and public safety departments. Dispatch priorities become necessarily more complex for more sophisticated systems. Each problem should be studied carefully before determinants are selected and various responses assigned. Certainly these breakdowns are medical control decisions and should be made by emergency and advisory physicians in every case.

The determinant subsection reflects lines of separation between different pre-planned levels of response. For example, in an urban ALS system, chest pain in a 10 year old should not evoke the same level of response as in a 57 year old;

ADDITIONAL INFORMATION

Types of Injuries:

Fractures
Dislocations (If haemorrhage is chief complaint see "Haemorrhage")
Contusions
Abrasions
Lacerations

AREAS:

1. *** Head (if conscious**)	8. * Wrist	15. * Hip
2. *** Neck	9. * Hands	16. ** Femur (upper leg)
3. * Shoulder	10. * Fingers	17. * Knee
4. * Clavicle (collarbone)	11. ** Back	18. * Tibia (lower leg)
5. ** Chest, ribs, sternum	12. *** Abdomen	19. * Ankle
6. * Arms	13. ** Perineum (genitalia)	20. * Feet
7. * Elbows	14. ** Pelvis	21. * Toes

*** **Dangerous**
** **Possibly** Dangerous
* **Not** Dangerous

KEY QUESTIONS	PRE-ARRIVAL INSTRUCTIONS
1. Conscious?	a. **DON'T** move
2. Breathing?	b. **DON'T** splint
3. Uncontrolled haemorrhage?	c. Direct pressure for haemorrhage
4. Area injured?	d. Lay down
5. Extrication needed?	e. Locate any amputated parts or skin – place in clean plastic bag
6. Amputation? (parts found)	

DISPATCH PRIORITIES

	Determinant	Response	
A	**Dangerous**	Closest EMTs (BLS)	Hot
		Paramedics (ALS)	Hot
		Ambulance (BLS)	Hot
B	**Possibly** Dangerous	Paramedics (ALS)	Hot
		Ambulance (BLS)	Cold
C	**Not** Dangerous	Ambulance (BLS)	Cold

Fig. 5. Medical Dispatch Priority Card for Traumatic Injuries.

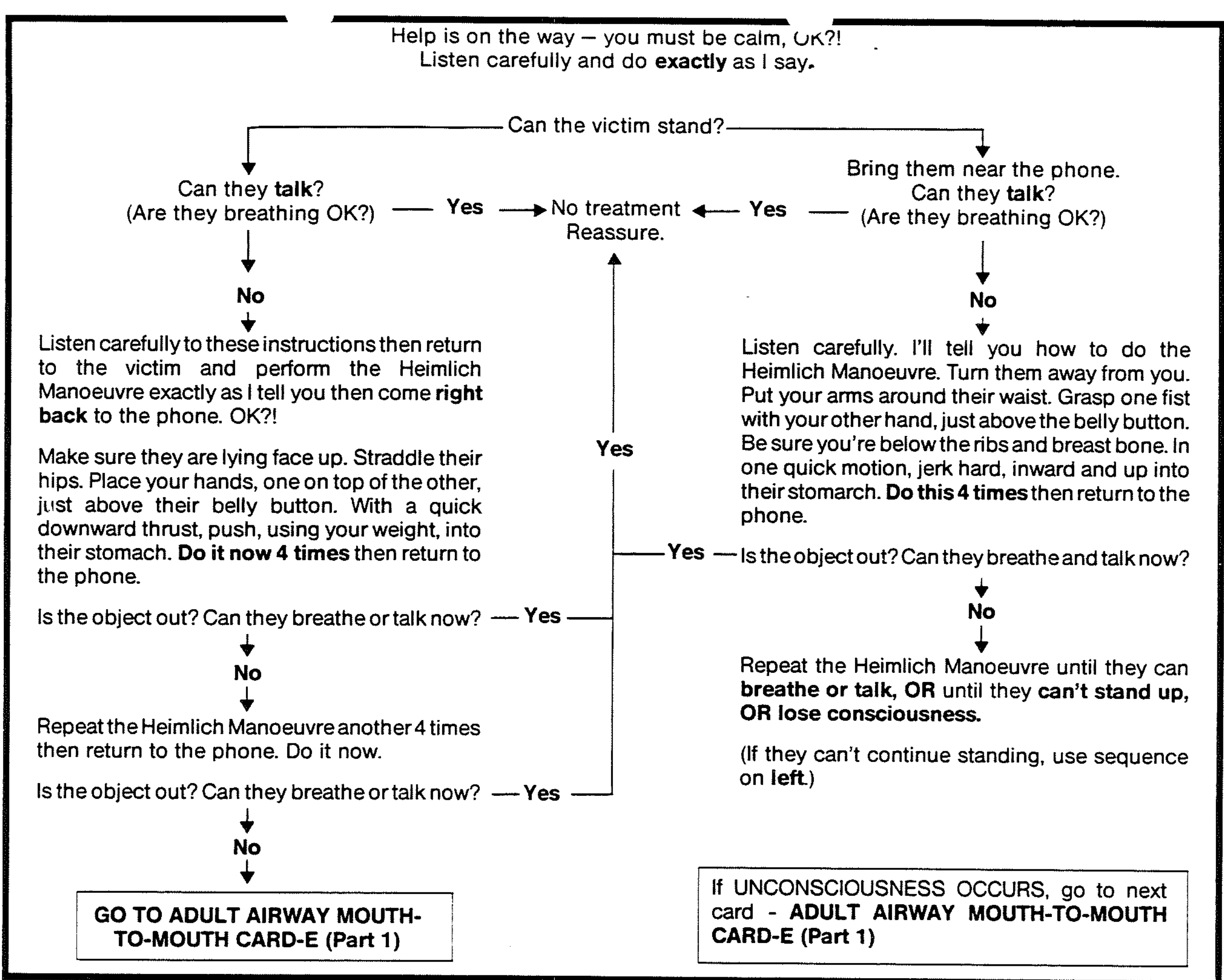


Fig. 6. Example of a telephone treatment alogrithm card.

just as hives without dyspnoea should require a less urgent response than when dyspnoea is present. For many emergency medical systems, localisation of the dispatch priority section will require an unprecedented justification of response modes and unit selection.

Results

To date over 500 public safety and private agency dispatchers have been trained and certified as EMDs by the Utah State Bureau of Emergency Medical Services. Participating agencies were surveyed both prior to training and one year after the course was administered. A comparison of these surveys showed that all six paramedic provider agencies in Utah are now using the Dispatch Priority Card System. In addition, the chief dispatchers of each agency indicated that the training course was very useful to dispatch corps. The survey also showed that, as compared with the time prior to the implementation of the course and card system, there are now fewer red-light-and-siren runs. Concurrently, the ratio of EMT to paramedic runs has increased, with the use of paramedics being limited more to life-threatening problems. The State Bureau of EMS also reports that the EMD course is the most enthusiastically accepted program that they now offer.

Since its beginning in 1979, in that time the program has spread throughout the United States and Canada with communities in 49 American states and 5 Canadian provinces adapting the system for their own use. The Dispatch Priority Card System recently won Public Technology Incorporated's 1983 award for the best technological achievement in area of health and human services in North America. The associated EMD Training Course won the International City Manager's Association award for the outstanding in-service training program for municipal employees in the world in 1983. Finally, the United States National Highway Traffic Safety Administration of the Department of Transportation has adapted the EMD priority Training Course as the core of the new National Standard Curriculum for EMDs.

Conclusion

Many dispatchers are performing in the role of Emergency Medical Dispatcher without the benefits of either basic emergency training or practical emergency experience in the problems that constitute their daily routine. In order to correctly utilise them as members of the emergency medical team, it was necessary to upgrade the dispatcher's skills by the development of the Emergency Medical Dispatch Priority concept and an associated EMD training course and certification program.

The benefits of the utilisation of this system are far-reaching. Through dispatch-specific education and practical experience, the EMD is able to more accurately interrogate the caller, cull more pertinent information, and make more sensible decisions about EMS responses. The system allows for pre-planned responses, medically appropriate responses, safer responses (fewer units responding in the red-light-and-siren mode), fuel and energy savings (smaller units and fewer units used when possible) and it saves paramedic teams for true advanced life support emergencies. It was for these reasons we have devised this program.

Dr. Jeff Clawson, the originator of the Medical Dispatch Priority concept, has recently become the full-time Fire Surgeon for the

Telephone Treatment Protocols

Reach Out and Help Someone

by Jeff J. Clawson, MD

It has only been the past few years that the telephone has started to add new dimensions to EMS. But strangely enough, as suggested from the content of Alexander Graham Bell's first call, the now important role of the telephone in emergency medical dispatching can be traced directly back to the invention of the device itself. That initial call from Bell was not a passive one in which information was obtained – it was a command! Bell told Watson to *do* something. The very earliest uses of the telephone included the summoning of aid. But to *give* aid via the phone to save lives might have taxed even Bell's remarkable foresight.

It seems incredible now to think that it took over 100 years from the telephone's invention in 1875 to 1976 when the Phoenix Fire Department began their innovative "telephone self-help" program.

But the era of "prearrival instructions" has arrived. Assertive communities are beginning to fight off the liability "scares" and to intervene through the caller on behalf of the victim. The frightening mental picture of a minimally trained or untrained dispatcher "winging it" through an attempt at phone-instructed CPR has been imagined by more than a few city attorneys. However, there is expert advice which supports such concern regarding telephone CPR. EMS legal expert James O. Page stated as early as 1981, "We feel the legal issues (or non-issues) are very clear. A person who needs CPR is pulseless and non-breathing. That is defined as clinical death. That is the state of the victim at the time the call is received by the dispatcher. The dispatcher did not cause the victim to be in a pulseless, non-breathing state. There is no way the victim can be made worse. If the effort to direct CPR by phone fails, the victim is no worse off than he was when the dispatcher received the call and offered assistance via CPR instruction. If the victim survives (even for a brief period, or even in a vegetative state), they are better off than when they were clinically dead. There can be no liability for a good faith effort that fails, or for leaving a person better off.

"If a CPR-trained dispatcher permits his knowledge and skills to deteriorate (does not engage in periodic refresher training), and if that dispatcher issues inappropriate instructions to a caller, there could be cause for concern (more medical and ethical than legal, in my opinion)."

While Phoenix (Ariz.), Salt Lake City (Utah), Aurora (Colo.), Stockton (Calif.), Baltimore County (Md.), Tualatin (Ore.), Dallas (Texas), Grand Island (Neb.), Kalamazoo (Mich.), San Diego (Calif.), and even Albany (Ore.) have organized programs to reduce these "recurring tragedies," the liability "tide" is turning. There is no question that the old cliché "there's safety in numbers" applies to adoption of prearrival telephone instruction.

In 1976, only one department in North America had such a program. In 1980 the number of agencies with official programs could be counted on one hand. Today hundreds of programs are emerging. Concerning this trend, Page prophetically continued his statement, "I personally feel that the highly successful medical self-help program introduced by the Phoenix Fire Department may have started a process which will redefine a municipality's duty to its citizens. Similarly, the Emergency Medical Dispatch (EMD) Priority Card System, created by Clawson in association with the Salt Lake City Fire Department, may have further advanced the municipality's duty. In other words, I can foresee a day when a citizen might allege that the municipality (which maintains a full-time public safety dispatching service) was negligent for failing to implement and operate such a service."

Unfortunately, the norm is still not to advise that hysterical caller who "is in no condition to do something as complicated as CPR," who "can't be brought under control" or who might prevent the dispatcher from handling "the next call." Indeed, it is interesting how the *next* call is considered more important than the one that's there needing immediate help.

But "what ifs" abound, and most communities, when initially exploring the possibilities of such programs, have usually met resistance from a dubious city or county attorney. As with most areas of EMS, these municipal legal consultants have little, if any, expertise in prehospital care issues, much less the even more

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Jeff J. Clawson, MD, is a fire surgeon for the Salt Lake City Fire Department and the developer of the priority dispatch concept. He has co-authored with Kate Dernocoeur, "Principles of Emergency Medical Dispatch," to be published by Brady.

obscure area of medical dispatching. Few legal experts have offered any intelligent advice as to the real legal issues, or non-issues as they often turn out to be, regarding dispatch telephone intervention. But the little advice that exists can be an extremely valuable tool in convincing local legal officials that it might even be criminal if such programs were not implemented – and soon.

Roadblocks to program implementation can take many forms. However, experience has identified seven misconceptions that perpetuate the fears surrounding important issues of emergency medical dispatching. They are:

1. The caller is too upset to respond accurately.
2. The caller doesn't know the required information.
3. The medical expertise of the dispatcher is not important.
4. The dispatcher is too busy to waste time asking questions, giving instructions, or flipping through card files.
5. More personnel and more units at the scene are always better.
6. It is dangerous not to maximally respond or to not respond red-light-and-siren.
7. Phone information from dispatchers cannot help victims and may even be dangerous.

Although the last item may seem to be an obvious misconception, don't be fooled. Because for every one that believes in or practices the art of pre-arrival intervention, there are 10 that "misconceive."

EMS legal expert James E. George, editor of the *EMT Legal Bulletin*, wrote in his Fall 1981 issue on EMS triage, "An 'upfront' clearly articulated written policy in support of telephone screening of emergency calls, coupled with sound guidelines and protocols for use by dispatchers, would provide a ray of legal light in an otherwise murky area of heavy potential liability. A reasonable system of call screening can provide a good legal defense for both the EMS dispatcher and his employer should a charge of negligent handling of emergency calls be raised by a plaintiff.

"EMS dispatchers must always avoid the appearance of responding to or categorizing emergency calls in a haphazard or arbitrary manner. A unified procedure will provide an excellent method of safeguarding against arbitrary decision making. Without a unified system, one dispatcher may decide that a crucial situation exists primarily on the level of emotion he detects in the caller's voice, while another may depend on his own gut reaction, without being able to articulate a clear reason for his decision.

"Where reasonable guidelines are in effect, the EMS dispatcher's conduct will be less vulnerable to charges of careless or wreckless judgment. Similarly, EMS employers can point to such guidelines as a system of risk management in an area where human error and its dire consequences are clearly foreseeable."

Trained dispatchers operating from sound guidelines and protocols provide not only a "ray of legal light," but a glimmer of hope for callers who, prior to telephone intervention programs, just stood and watched as precious minutes ticked by! The result, in many cases, was clearly foreseeable. And that end result was often death to countless North Americans.

Stated Page about these often tragic deaths, "After years of arriving 'too late' at the scenes of hundreds of life-threatening emergencies, it is difficult for me to offer a detached and unemotional opinion. Throughout the U.S., we have spent billions of dollars constructing systems to respond to medical emergencies and we have done little to cure the deadly four minute gap at the front of the system. While we race through city traffic to get to the scene, a brain dies for lack of CPR (oxygen). Frankly, I don't understand how any public safety or health care worker can accept these recurring tragedies without actively seeking a solution to the 'response time' problem which proves fatal in so many cases.

"I feel that the concerns which have been expressed over supposed legal hazards are little more than a 'red herring' issue. Of greater concern to me is the collective attitude which places such unwarranted fear on a higher plane than the compulsion for human service – especially saving lives."

The provision of prearrival instructions is not only appropriate but necessary as long as the dispatcher is well-schooled in basic life support and has immediate access to approved telephone treatment sequence protocols which he is required to follow.

While the actual impact of the telephone to give prearrival instructions may be only a fraction of an overall reduction in morbidity and mortality secondary to prehospital care in general, the new-found value of Bell's old communications device should not be overlooked, discounted, or further delayed. While its normal use is commonplace, the telephone has a great potential contribution yet to make in prehospital care. Remember, even the incredible lifesaving feats of Superman often began in a phone booth! □

The following treatment sequence cards are currently approved by the state of Utah for use by certified EMDs. Any use of these cards outside Utah should be carefully reviewed and approved by local medical control, and the dispatchers using them trained in CPR and the Heimlich Maneuver.

This is the first in a series of four articles by Dr. Jeff Clawson on medical dispatching. Each article will be accompanied by two Utah Treatment Sequence Cards in cutout form. These articles and cards will appear in jems *every other month.*

STATE OF UTAH - DEPARTMENT OF HEALTH

EMERGENCY MEDICAL DISPATCHER RULES AND STANDARDS

OF THE

UTAH EMERGENCY MEDICAL SERVICES SYSTEM ACT

Title 26, Chapter 8

Utah Code Annotated 1953, as amended

ADOPTED BY THE
EMERGENCY MEDICAL SERVICES COMMITTEE

EFFECTIVE JULY 1, 1983
REVISED: December 31, 1985

EMERGENCY MEDICAL DISPATCHER RULES
OF THE
UTAH EMERGENCY MEDICAL SERVICES SYSTEMS ACT
Title 26, Chapter 8

SECTION 1. PURPOSE

I. Scope of Rules

A. The purposes of these Rules are:

1. To provide for the establishment of minimum standards to be met by those providing Medical Dispatch services in the State of Utah so as to promote the health and safety of the people of this state; and

2. To establish training and certification standards for dispatchers who voluntarily request certification as Emergency Medical Dispatchers.

SECTION 2. DEFINITIONS

As used in these Rules:

1. Department — The State Department of Health

2. Emergency Medical Dispatcher — A person certified by the Department who has successfully completed a Department approved Emergency Medical Dispatch Course.

3. Local Medical Authority — A person recognized by The Department who assumes medical leadership for the provision of basic and/or advanced life support services in the dispatch agencies geographical area.

4. Person — Any individual, firm, partnership, association, corporation, company, group of individuals acting together for a common purpose, agency, or organization of any kind.

5. Selective Medical Dispatch System — A Department approved reference system used by a local dispatch agency to dispatch aid to medical emergencies which includes: (a) systemized caller interrogation questions, (b) systemized pre-arrival instructions, and (c) protocols matching the dispatcher's evaluation of injury or illness severity with vehicle response mode and configuration. Vehicle Response Mode is the use of emergency driving techniques, such as red-light-and-siren vs. routine driving response. Vehicle Response Configuration is the specific vehicle(s) of varied types, capabilities, and numbers responding to render assistance.

SECTION 3 REQUISITES FOR PROVIDING MEDICAL DISPATCH SERVICE

A. All agencies who routinely accept calls for EMS assistance from the public and dispatch emergency medical personnel shall have in effect a Selective Medical Dispatch System.

B. The Department shall assist local dispatch agencies in implementing Selective Medical Dispatch System by:

1. Providing technical assistance.

2. Making available standard Selective Medical Dispatch System caller interrogation questions, pre-arrival instructions and vehicle response mode protocols.

C. The State standard questions, instructions and protocols may be used intact or modified by dispatch agencies with the approval by Local Medical Authority and the Department.

D. Dispatch agencies shall provide for quality assurance by initiating an ongoing medical call review procedure.

SECTION 4 PERSONNEL

Dispatchers serving medical providers are not required to be certified as Emergency Medical Dispatchers, but are encouraged to voluntarily seek training and certification through a Department approved course. Certification allows the dispatcher to fall under the liability immunity coverage provided in 26-8-11 (2).

SECTION 5 - CERTIFICATION

The Department shall develop an Emergency Medical Dispatch training and certification program. Curriculum standards shall be established by the Department with certification standards as follows:

A. Initial Certification.

To be certified as an Emergency Medical Dispatcher (E.M.D.) an individual must:

1. Successfully complete a State approved E.M.D. Course.

2. Be currently certified in cardiopulmonary resuscitation (CPR) through a Department approved course.

3. Successfully pass the Department's written examination.

B. Recertification

Recertification is required every three (3) years to maintain State certification. This period may be modified by the Department. To recertify an E.M.D. must:

1. Submit to the Department a completed application form provided by the Department.

2. Submit to the Department a current cardiopulmonary resuscitation card meeting standards approved by the Department.

3. Successfully complete the Department's E.M.D. written examination.

4. Complete thirty-six (36) hours of Department approved continuing medical dispatch education or in-service during the three year recertification period.

C. Certification and Recertification for the Handicapped

These Rules and Rules shall not preclude any physically handicapped individual from certifying or recertifying who can demonstrate proficiency in verbally describing the treatment methods outlined in the Department approved E.M.D. Course to a caller.

D. Lapsed Certification

Those individuals who permit their certification to lapse may be recertified by completion of the recertification requirements and personal interview with a Department designated interviewer.

E. Instructor Standards

Those who teach emergency medical dispatchers, must meet certification standards established by the Department.

F. Prohibitions

The Department may, in its own determination, for good cause, deny, suspend or revoke for a specified period of time, the certification of any emergency medical dispatcher where the facts submitted to it justify such action.

NAEMSP Consensus Document on EMERGENCY MEDICAL DISPATCHING

I. General Statement: The trained Emergency Medical Dispatcher (EMD) is an essential part of today's EMS system. Medical control for the EMD and the dispatch center is also part of the EMS physician's responsibilities. The basic functions of emergency medical dispatching should include predetermined interrogation questions, pre-arrival telephone instructions, and pre-assigned response levels and modes. The EMD must understand the philosopy and psychology of interrogation and telephone intervention, basic emergency medical priorities and be versed in basic life support. Training should be standardized and EMDs certified by governmental authority.

Rationale for Document: Medical Dispatching has been the last major area in the EMS system to be identified and developed. The "health" of many EMS systems can be gauged by the appropriateness of training, protocol, and medical control of dispatchers. The involvement of EMS physicians in the world of dispatch is relatively new but unquestionably essential. For this purpose our involvement is outlined and the position of NAEMSP stated regarding the significant issues of EMD.

II. The Issues:

1) **Basic Telecommunication Skills** are a requisite to becoming an EMD.

2) Understanding the **Philosopy of Medical Interrogation** and the **Psychology of providing Pre-Arrival Instructions** are integral parts in the training of EMDs.

3) **Pre-Arrival Instructions** are a mandatory function of the EMD. In essence the EMD is the "first" first responder and through immediate action can effectively eliminate the deadly "four-minute" plus gap at the beginning of the response.

4) **Dispatch Prioritization** requires careful attention by both the EMD, his/her supervisor, and the physician responsible for medical control. The necessity to prioritize response is evident in the majority of EMS systems today.

5) **Training of EMDs** requires unprecedented cooperation between the diverse disciplines of telecommunications and emergency medicine necessary to provide this unique teaching forum.

6) **Quality Assurance, Risk Management, and Medical Control** are an absolute necessity for the ongoing well-being of any EMS system. Emergency medical dispatching requires such attention and guidance.

7) **Certification and Authorization by government entities** are the next logical steps to assurring that the EMD is a well-trained EMS professional. An ever increasing number of states, regions, counties, and municipalities certify or require standard training of EMDs.

III. Discussion

1) **Basic Telecommunication Skills** are a requisite to becoming an EMD. The training and certification of the EMD is then built upon this baseline of knowledge. NAEMSP encourages this training for all public safety dispatchers.

2) Understanding the **Philosopy of Medical Interrogation** and the **Psychology of providing Pre-Arrival Instructions** are integral parts in the training of EMDs. The ability to interact with anxious, uncooperative, and at times, hysterical callers rests upon the ability of the EMD to anticipate the actions of the caller, control them, and convert the caller into a calmer first responder. This requires training that is not part of EMT or paramedic curricula but is specific to medical dispatch training.

3) **Pre-Arrival Instructions** are a mandatory function of the EMD. In essence the EMD is the "first" first responder and through immediate action can effectively eliminate the deadly "four-minute" plus gap at the beginning of the response. Standard telephone instructions by <u>trained</u> EMDs are safe to give and in many instances a moral necessity. Training and recertification in BLS, as is appropriate to application by medical dispatchers, is necessary to maintain and improve this unique, and at times, life-saving, non-visual skill.

4) Dispatch Prioritization requires careful attention by both the EMD, his/her supervisor, and the physician responsible for medical control. The necessity to prioritize response is evident in the majority of EMS systems today. In order to prioritize calls properly the EMD must be well versed in understanding the medical conditions and incident types that constitute their daily routine. The training in these priorities must be dispatch-specific (not EMT or paramedic training per se) and provided in a straightforward way to the EMD, who in most situations has had little more training than the average layperson. The development of dispatch priorities for an agency or locality must be carefully thought out and ultimately be approved by those responsible for medical control. These priorities must reflect the level of appropriate response including types of personnel (ALS vs. BLS vs. first responder), numbers of vehicles responding, and mode of response (red-light-and-siren vs. routine). EMDs must always avoid the appearnace of responding to or categorizing calls in a haphazard or arbitrary manner. A unified procedure will provide an excellent method of safeguarding against arbitrary decision making. Without a unified system, one dispatcher may decide that a crucial situation exists primarily on the level of emotion he detects in the caller's voice, while another may depend on his own "gut" reaction, without being able to articulate a clear reason for his decision. Where reasonable guidelines are in effect, the emergency medical dispatcher's conduct will be less vulnerable to charges of careless or reckless judgment. Similarly, EMS employers can point to such guidelines as a system of risk management in an area where human error and its dire consequences are clearly foreseeable. The appropriate prioritization of responses and therefore appropriate reduction of responding vehicles and vehicles traveling red-light-and-siren, will assure that unnecessary emergency medical vehicle accidents do not occur, that emergency crews will not be inappropriately committed to non-emergent cases, and that the "right care will be sent in the right way to the right patient at the right time".

5) Training of EMDs requires unprecedented cooperation between the diverse disciplines of telecommunications and emergency medicine necessary to provide this unique teaching forum. Instructor requirements should include line dispatch experience as an EMD for the Primary Dispatch Instructor and a minimum of advanced life support training and experience for the Medical Dispatch Instructor who is responsible for teaching the core course material especially the medical dispatch priorities. All instructors should have attended and passed an EMD course prior to assuming a teaching role.

6) Quality Assurance, Risk Management, and Medical Control are an absolute necessity for the ongoing well-being of any EMS system. Emergency medical dispatching requires such attention and guidance. NAEMSP believes that routine medical review of the activities of EMDs and medical dispatch centers is vital to the health of the EMS system in general. Dispatch review committees are a significant step toward providing this assurance. The EMS physician must be intimately familiar with the medical dispatch process and involved in an on-going way with its function.

7) Certification and Authorization by government entities are the next logical steps to assurring that the EMD is a well-trained EMS professional. An ever increasing number of states, regions, counties, and municipalities certify or require standard training of EMDs. NAEMSP stands behind this effort as not only laudable but a future prerequisite to practice by medical dispatchers. The ASTM process is currently defining a national standard for medical dispatch practice that will be translated into a national standard training curriculum. EMS physicians should actively participate in its development as well as others that insure the professionalism of pre-hospital care in the streets. The emergency medical dispatcher is no exception to this process.

IV. Resolutions

RESOLVED: **Basic Telecommunication Skills** are a requisite to becoming an EMD. The training and certification of the EMD is then built upon this baseline of knowledge. NAEMSP encourages this training for all public safety dispatchers.

RESOLVED: Understanding the **Philosopy of Medical Interrogation** and the **Psychology of providing Pre-Arrival Instructions** are integral parts in the training of EMDs. The ability to interact with anxious, uncooperative, and at times, hysterical callers rests upon the ability of the EMD to anticipate the actions of the caller, control them, and convert the caller into a calmer first responder. This requires training that is not part of EMT or paramedic curricula but is specific to medical dispatch training.

RESOLVED: **Pre-Arrival Instructions** are a mandatory function of the EMD. The EMD is the "first" first responder and through immediate action can effectively eliminate the deadly pre-arrival gap at the beginning of the response. Standard telephone instructions by trained EMDs are safe to give and in many instances a moral necessity. Training and recertification in BLS, as is appropriate to application by medical dispatchers, is necessary to maintain and improve this unique, and at times, life-saving, non-visual skill.

RESOLVED: **Dispatch Prioritization** requires careful attention by both the EMD, his/her supervisor, and the physician responsible for medical control. The necessity to prioritize response is evident in the majority of EMS systems today. In order to prioritize calls properly the EMD must be well versed in understanding the medical conditions and incident types that constitute their daily routine. The training in these priorities must be dispatch-specific (not EMT or paramedic training per se) and provided in a straightforward way to the EMD. The development of dispatch priorities for an agency or locality must be carefully thought out and ultimately be approved by those responsible for medical control, EMS physicians. These priorities must reflect the level of appropriate response including types of personnel (ALS vs. BLS vs. first responder), numbers of vehicles responding, and mode of response (red-light-and-siren vs. routine).

The appropriate prioritization of responses and therefore appropriate reduction of responding vehicles and vehicles traveling red-light-and-siren, will assure that unnecessary emergency medical vehicle accidents do not occur, that emergency crews will not be inappropriately committed to non-emergent cases, and that the "right care will be sent in the right way to the right patient at the right time".

RESOLVED: **Training of EMDs** requires unprecedented cooperation between the diverse disciplines of telecommunications and emergency medicine necessary to provide this unique teaching forum. Instructor requirements should include line dispatch experience as an EMD for the Primary Dispatch Instructor and a minimum of advanced life support training and experience for the Medical Dispatch Instructor who is responsible for teaching the core course material especially the medical dispatch priorities. All instructors should have attended and passed an EMD course prior to assuming a teaching role.

RESOLVED: **Quality Assurance, Risk Management, and Medical Control** of emergency medical dispatch are an absolute necessity for the ongoing well-being of any EMS system. NAEMSP believes that routine medical review of the activities of EMDs and medical dispatch centers is vital to the health of the EMS system in general. Dispatch review committees are a significant step toward providing this assurance. The EMS physician must be intimately familiar with the medical dispatch process and involved in an on-going way with its function.

RESOLVED: **Certification and Authorization by government entities** are the next logical steps to assurring that the EMD is a well-trained EMS professional. NAEMSP stands behind this effort as not only laudable but a future prerequisite to practice by medical dispatchers.

NAEMSP encourages the completion of these important improvements in emergency medical dispatching throughout North America and beyond.

October 20, 1987

DIVISION OF EMERGENCY MEDICAL SERVICES
Assistant Chief Fred Thorp, Director
March 30, 1988

H.B. 2865 Emergency Medical Dispatchers

I endorse the Bill as amended before us today. Approximately 60 Kansans have been trained as Emergency Medical Dispatchers in accordance to the State of Utah Regulations. Almost all of these people agree that Kansas should have a similar requirement. I am pleased to share with you the names and county of these course participants.

Those involved with the delivery of pre-hospital emergency medical services on a daily basis are cognizant of time and its value to the preservation of life. This Bill recognizes the value of time and seeks to prepare dispatchers to maximize assistance to the calling party seeking medical assistance. Specifically, time here-to-fore being wasted is that segment from when the dispatcher answers the phone and hangs up to when the emergency response units arrive at the location of the caller seeking medical assistance.

This Bill encourages the training of dispatchers to follow locally pre-approved and a medically relevant set of questions to assess the medical need, and to provide pre-arrival instructions. Time, in this setting, amounts to ten (10) minutes on the state-wide average. Think of that - a person calls for help....then waits an average of ten minutes in Kansas for help to arrive. We must do better!

One of the common arguments against this Bill is an old one. The myth that callers are too hysterical simply cannot be substantiated. When the calling population is scrutinized it has been demonstrated (Phoenix, Salt Lake, Seattle, etc.) that actually only about 4% are truly "hysterical." Certainly, many people are very excited and almost hysterical, but a skilled dispatcher knows how to control this. The primary response by the dispatcher is not to quickly hang up! After all, once you hang up, your opportunity to provide the caller with medically appropriate pre-arrival instructions and/or aid is gone. Thus, "programming" the dispatcher means that each caller is asked the appropriate questions without deviation by a dispatcher or someone asking "their" questions. Being consistent in approved procedures with the caller results in decreased costs of operating the service and decreases everyone's liability while improving the service to the public.

One legislator told me he was against the Bill because "some of our dispatchers were not too bright." I do not agree with him because frequently our dispatchers do one heck of a job with little formal instruction from their employers. In my view, this should alert us all the more to providing our dispatchers with training and locally approved relevant procedures to do the task assigned to them.

The cost of implementing a proven program is dependent upon local procedures for handling the training of public safety personnel. The course can be taught locally once an instructor has been identified which could be anyone who has already had the course. Course materials consist of a manual which costs $15.50. Any other expense is how the local agency deals with the time factor of employees or volunteers.

Regardless, the results of implementing an emergency medical dispatch program are:

1) Cost-effective to the community
   a) fewer "emergency" calls red light & siren
   b) equipment travels at normal traffic
   c) less disturbance of the community
   d) fewer emergency vehicle accidents
   e) less demand on volunteers

2) Improves quality of service

3) Saves time in receiving assistance

4) Reduces liability
   a) community
   b) agency
   c) employee

5) Reduces stress on the dispatchers

The bottom line - everyone benefits!

State of Kansas
Emergency Medical Dispatchers

March 19-21, 1988

Name	County
Chris Alexander	Shawnee County
Max Biggerstaff	Jackson County (Mo)
Jerri Brewster	Johnson County
Loretta Childs	Marion County
Jerry Deckert	Grant County
Georgie Eggleston	Coffey County
Dorothy Faulkner	Ford County
Rodney Grabner	Saline County
Stanley Honeycutt	Johnson County
Michael Meyers	Wyandotte County
Sheila Peterman	Clay County (MO)
Teresa Roberts	Lynn County
Maryann Rohr	Wyandotte County
Dave Schoenrock	Pottawotomie County
William Schwarzenholz	Wyandotte County
Connie Sterbenz	Shawnee County
Rita Swenson	Wabaunsee County
Marguerite Underhill	Shawnee County
Donald Vochatzer, Jr.	Wyandotte County
Claude Warren	Wyandotte County
George White	Johnson County
George Hoar	Brown County
Joseph Wilcox	Wyandotte County
Marilyn D. Watson	Leavenworth County
Mark Laemmli	Johnson County
Erna Dickinson	Reno County
Rhonda L. Jones	Franklin County
Joey Bolelander	Shawnee County
Maureen Eggleston	Coffeey County
Gerry Ross	Lynn County

REGION IV EMERGENCY MEDICAL SERVICES COUNCIL

INSTRUCTOR: DR. JEFF CLAWSON, M.D. SALT LAKE CITY FIRE DEPARTMENT

Course Coordinator: Fred Thorp, Kansas City, Kansas Fire Department

Asst. Course Coordinator: E.J. Wilkinson, Johnson County Emergency Communications Center, Sherry Coyer, Region IV Administrative Assistant

State of Kansas
EMERGENCY MEDICAL DISPATCHERS
November 15-17, 1987

Telecommunicator:	County:
Mark Addington	Shawnee County
Kenneth Briscoe	Wyandotte County
Scott Campbell	Riley County
Debbie Chalender	Douglas County
Dean Cochran	Johnson County
Greg Dahlem	Douglas County
Matthew Dicky	Johnson County
Charmian Davis	Miami County
Dale Fickle	Miami County
Mike Halleran	Douglas County
John Hayworth	Shawnee County
Rita Hoffman	Johnson County
Allen Humphrey	Douglas County
Lori Jackson	Douglas County
Donald Jones	Wyandotte County
Andrea Kaesler	Douglas County
Gary Luduke	Douglas County
Donald Matthews	Miami County
Paula McAlister	Johnson County
Ted McCurdy	Franklin County
Rosemary Morgan	Miami County
Herbert F. Nye	Leavenworth County
Jim Peterson	Miami County
Dwight Purtle	Johnson County
Rose Rozimarek	Miami County
Elsie Schley	Wabaunsee County
Lee J. Shouse	Leavenworth County
Raymond Simonich	Wyandotte County
Richard Smith	Wyandotte County
Selma Southard	Douglas County
Ron Spradling	Shawnee County
Daryl Sybrant	Wyandotte County
Vikie Warburton	Finney County
Mark Whelan	Johnson County
David Wooten	Wyandotte County

Instructor: Dr. Jeff Clawson, M.D., Salt Lake City Fire Department, Salt Lake City, Utah

League of Kansas Municipalities

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Session of 1988

HOUSE BILL No. 2669

By Representatives Fuller, Baker, Borum, Bowden, Cribbs, Dean, Foster, Francisco, Gjerstad, Grotewiel, Helgerson, Kennard, Pottorff, Sawyer, Schauf, Spaniol, Webb and Williams

1-19

0020 AN ACT concerning cities; relating to the acquisition of fee title
0021 to certain realty; amending K.S.A. 1987 Supp. 12-16,103 and
0022 repealing the existing section.

0023 *Be it enacted by the Legislature of the State of Kansas:*
0024 Section 1. K.S.A. 1987 Supp. 12-16,103 is hereby amended to
0025 read as follows: 12-16,103. (a) The governing body of any city
0026 may acquire by condemnation, dedication, gift or purchase the
0027 ~~underlying~~ fee interest in any real estate in which it ~~holds~~ [could acquire] a
0028 permanent easement [.] ~~in order to merge the title and sell such real~~
0029 ~~estate or in which it intends to acquire a permanent easement.~~
0030 (b) The governing body of any city may sell real estate
0031 acquired or held in fee simple when it is no longer needed for
0032 public purposes, including, but not limited to, real estate ac-
0033 quired for the construction of municipal water supply structures
0034 or reservoirs and land adjacent thereto, street, sanitary and storm
0035 sewer systems. A record of all sales authorized herein shall be
0036 maintained in the office of the city clerk.
0037 Sec. 2. K.S.A. 1987 Supp. 12-16,103 is hereby repealed.
0038 Sec. 3. This act shall take effect and be in force from and
0039 after its publication in the statute book.

(Attachment V) Local Go 3/30/88

AV

REPORTS OF STANDING COMMITTEES

MR. PRESIDENT:

Your Committee on Local Government

Recommends that House Bill No. 2669

"AN ACT concerning cities; relating to the acquisition of fee title to certain realty; amending K.S.A. 1987 Supp. 12-16,103 and repealing the existing section."

Be amended:

On page 1, in line 27, by striking "underlying"; also in line 27, by striking "holds" and inserting "could acquire"; in line 29, by striking all before the period;

And the bill be passed as amended.

____________________________Chairperson

CRH2797j1

REPORTS OF STANDING COMMITTEES

MR. PRESIDENT:

Your Committee on Local Government

Recommends that House Bill No. 2797 (As Amended by House Committee of the Whole)

"AN ACT relating to political and taxing subdivisions of the state; concerning procedures for the consolidation of operations, procedures and functions of offices and agencies of such subdivisions; amending K.S.A. 12-3903 and 12-3904 and repealing the existing sections."

Be amended:

On page 3, in line 100, by striking "statute book" and inserting "Kansas register";

And the bill be passed as amended.

_____________________________Chairperson

REPORTS OF STANDING COMMITTEES

MR. PRESIDENT:

Your Committee on Local Government

Recommends that House Bill No. 3037 (As Amended by House Committee)

"AN ACT relating to certain legal notices, advertisements and publications; validating action taken or authority exercised by political and taxing subdivisions upon failure to comply with publication requirements under certain circumstances."

Be amended:

On page 1, following line 34, by inserting a paragraph as follows:

"The provisions of this section shall not be applicable to K.S.A. 60-307, and amendments thereto.";

And the bill be passed as amended.

____________________________Chairperson

CRH3043j1

REPORTS OF STANDING COMMITTEES

MR. PRESIDENT:

Your Committee on Local Government

Recommends that House Bill No. 3043

"AN ACT relating to the audit of cemetery corporations and other entities offering prearranged funeral agreements; concerning payment and disposition of the expenses thereof; establishing the cemetery and funeral audit fee fund in the state treasury; amending K.S.A. 17-1312a and K.S.A. 1987 Supp. 16-310 and 16-325 and repealing the existing sections."

Be amended:

On page 1, in line 44, following "basis", by inserting "for days or parts thereof related to a field audit"; in line 45, following the period, by inserting "Such per diem charges shall not exceed a total of $500 in any one calendar year unless the secretary of state determines (1) there are substantial or material deviations from the requirements of the applicable statute or (2) the entity has failed to maintain adequate records for auditing purposes.";

And the bill be passed as amended.

______________________________Chairperson

Attachment IX Local Go 3/30/88

REPORTS OF STANDING COMMITTEES

MR. PRESIDENT:

Your Committee on Local Government

Recommends that House Bill No. 2981 (As Amended by House Committee of the Whole)

"AN ACT concerning municipalities; relating to franchises; amending K.S.A. 1987 Supp. 12-824 and 12-2001 and repealing the existing sections."

Be not passed.

________________________________Chairperson

Attachment X Local Go 3/30/88

[As Amended by House Committee of the Whole]

As Amended by House Committee

Session of 1987

HOUSE BILL No. 2063

By Representative Douville

1-15

0021 AN ACT concerning zoning; relating to group homes.

0022 *Be it enacted by the Legislature of the State of Kansas:*

0023 Section 1. (a) It is hereby declared to be the policy of the
0024 state of Kansas that physically handicapped, mentally retarded or
0025 other developmentally disabled persons shall not be excluded
0026 from the benefits of single family residential surroundings by
0027 any municipal zoning ordinance, resolution, regulation or re-
0028 strictive covenant. It is also declared to be the policy of the state
0029 of Kansas to encourage the dispersion of group homes within ~~a~~
0030 ~~municipality~~.

0031 (b) For the purpose of this act:

0032 (1) "Group home" means any dwelling occupied by ~~six~~
0033 [eight] or fewer physically handicapped, mentally retarded or
0034 other developmentally disabled persons who need not be related
0035 by blood or marriage and ~~also may include~~ two staff residents
0036 who need not be related by blood or marriage to each other or to
0037 the physically handicapped, mentally retarded or other devel-
0038 opmentally disabled residents of the home[, which dwelling is
0039 licensed by a regulatory agency of this state];

0040 (2) "municipality" means any city or county located in Kan-
0041 sas;

0042 (3) "developmental disability" means a severe chronic dis-
0043 ability of a person, other than mental illness, which:

0044 (A) Is attributable to a mental or physical impairment or
0045 combination of mental and physical impairments;

0046 (B) is manifested before the person attains age 22;

0047 (C) is likely to continue indefinitely;

AMENDMENT	EXPLANATION
and restrictive covenants (line 21)	The bill concerns restrictive covenants as well as zoning. See line 60.
areas zoned exclusively for single family residences (lines 29-30)	The bill relates to the dispersion of group homes within single family residential areas, not "within a municipality." See lines 74:75.
not more than 10 persons, including (line 32)	As written, the bill would apparently permit an unlimited number of persons within a group home, provided there are not more than eight handicapped, etc., or two staff persons.
not to exceed (line 35)	
, township (line 40)	Some townships in Kansas have authority to enact zoning regulations, and have done so.

(Attachment XI) Local Go 3/30/88

	AMENDMENT	EXPLANATION
0048 (D) results in substantial function limitations in three or 0049 more of the following areas of major life activity: (i) Self-care, (ii) 0050 receptive and expressive language, (iii) learning, (iv) mobility, 0051 (v) self-direction, (vi) capacity for independent living and (vii) 0052 economic self-sufficiency; and		
0053 ~~(4)~~ (E) reflects the person's need for a combination and se- 0054 quence of special, interdisciplinary, or generic care, treatment or 0055 other services which are of lifelong or extended duration and are 0056 individually planned and coordinated.		
0057 (c) Except as hereinafter provided, no municipality shall 0058 prohibit the location of a group home in any zone or area where 0059 single family dwellings are permitted. Any zoning ordinance, 0060 resolution, regulation or restrictive covenant which prohibits the 0061 location of a group home in such zone or area in violation of this 0062 act is invalid. Notwithstanding the provisions of this act, group 0063 homes shall be subject to all other regulations applicable to other 0064 property located in the zone or area that are imposed by any 0065 municipality through its building regulatory codes, subdivision 0066 regulations~~; special or conditional use permit regulations~~ or	, special or conditional use permit regulations	Restoration of this stricken language would permit the local governing body to respond to community and neighborhood concerns that can be legitimately addressed and still preserve the intent of state preemption of local control. Note that such regulations would have to be "nondiscriminatory"--see line 67.
0067 other nondiscriminatory regulations. For the purpose of ~~protect-~~ 0068 ~~ing the development~~ of the area, the governing body of the 0069 municipality ~~shall~~ require the physical structure of the group 0070 home to be generally compatible with other physical structures 0071 in the surrounding neighborhood.	preserving the single family residential character	In most instances, the group home will probably be located in an area that is already developed. The term "single family residential character" makes this provision more consistent with the language used in line 26.
In order to avoid excessive 0072 concentration of group homes, from and after the effective date of 0073 this act, no such group home may be located within 1,000 feet of 0074 another such group home in areas zoned exclusively for single 0075 family dwellings, unless the governing body of the municipality 0076 approves a closer location by a majority vote thereof.	may	We suggest "may" is a better word. If the legislature is going to invalidate local zoning regulations, it seems inconsistent to mandate remedial local action. Without the authority of imposing special or conditional use permit regulations (line 66), how does a municipality accomplish lines 67:71?
0077 Sec. 2. This act shall take effect and be in force from and 0078 after its publication in the statute book.		

CRH2063j1

REPORTS OF STANDING COMMITTEES

MR. PRESIDENT:

Your Committee on Local Government

Recommends that House Bill No. 2063 (As Amended by House Committee of the Whole)

"AN ACT concerning zoning; relating to group homes."

Be amended:

On page 1, in line 27, by striking all after "resolution" and inserting "or regulation"; in line 28, by striking all before the period; in line 29, by striking "a"; in line 30, by striking "municipality" and inserting "areas zoned exclusively for single family residences"; in line 33, before "eight", by inserting "not more than 10 persons, including"; in line 35, by striking "also may include" and inserting "not to exceed"; in line 40, before "city", by inserting "township,";

On page 2, in line 60, by striking the comma and inserting "or"; also in line 60, by striking "or restrictive covenant"; in line 66, before "or", by inserting ", special or conditional use permit regulations"; in line 67, by striking "protec-"; in line 68, by striking "ing the development" and inserting "preserving the single family residential character"; in line 69, by striking "shall" and inserting "may";

And the bill be passed as amended.

Attachment XII Local Go.
3/30/88

____________________Chairperson