**From:** Dana Johnson

**To:** [DPH-Testimony, Reg (DPH)](mailto:RTestimony@MassMail.State.MA.US)

**Subject:** Emergency Medical Services System

**Date:** Wednesday, December 7, 2022 4:28:17 PM

William Anderson

Office of the General Counsel Department of Public Health 250 Washington Street

Boston, MA 02108

RE: Comments on proposed amendments to 105 CMR 170.000: Emergency Medical Services System To Whom It May Concern:

As not only the Commonwealth but virtually every state in the nation we are experiencing a shortage of trained people to staff ambulances at all levels and it’s time for us to open the possibilities of other resources and people to continue to provide the much-needed ambulance services across the state.

Simply put we are not keeping up with the demand and placing people in jeopardy of not getting much-needed health care. With ambulance services, so understaffed it has created a backlog of calls for service as we try to obtain backup ambulances to fill our needs. All to find out they are all strained and can’t in many cases supply or spare an ambulance or crew to help out their neighbors. This is no longer a rural Massachusetts issue it is affecting the entire nation.

1. Our community has an aging population with few job opportunities for younger people. It is a bedroom community.
2. Our resources are very limited and with the requirement to travel a distance of twenty to fifty miles away for work, it leaves little time for a lot of people to volunteer. The aging population also has an impact on available people to volunteer.
3. Our nearest hospital can be up to 22.2 miles from our most distant location with an estimated travel time of 45 minutes pending on weather conditions. Our nearest backup ambulance service which is also volunteer is about 8 miles from the Center of our town with the nearest full-time 22 miles away. The distance to travel to the hospital results in a long run time for ambulance calls. The normal ambulance calls from the time of notification to being back in the station routinely can be over two hours, and it is not uncommon for it to be three hours.
4. Many states across the country, including those in New England, support the use of a first responder / Basic EMT in transporting patients, and this has been the practice for many years.
5. A reason for Massachusetts not allowing this practice was given in a conference with a ranking official of OEMS in 2005 was that the EMT providing patient care in the back of the ambulance needs to be able to ask the operator a question if he or she was unsure of a situation or was requesting advice. This is a practice that can only be described as extremely dangerous to all parties involved. If the operator has to be trying to listen to the EMT in the rear and answering questions, their focus on driving becomes impaired. It will become very similar to TEXTING AND DRIVING. The EMT attending the patient also has direct radio communication with their medical control doctor if they should need assistance in deciding on patient care.
6. In the cases when we only have one first responder and one EMT, and we were unable to get a two-person EMT crew which resulted in a delay of transporting patients of ten to thirty minutes depending on our location. As a result, the patient is denied definitive care in a most timely manner resulting in undue stress and a lot of concerns for their health. They had called the ambulance because they felt the overwhelming need to go to a hospital and do not understand or care that the ambulance, they see is not allowed to transport them even though while on the scene the EMT can provide care, he or she is trained to. It is very hard for them to comprehend how the EMT can treat and help them on the scene. However, can’t continue it while driving down the road without the second EMT. I have yet to be able to explain it to a patient in a manner they can understand or accept as I can’t fathom it myself. So, you sit there with them as they call you every name in the book and try to console them and say I know I agree. However, it’s the regulations and we are required to follow them.
7. OEMS has said changes are made based on fact-based research. They now have that fact-based information. On March 20, 2020, Director W. Scott Cluett issued an emergency waiver allowing the staffing of ambulances to be one EMT and a first responder. We now have the evidence-based research to show that the use of one First Responder and one EMT is a safe and practical way to staff an ambulance. It also should be noted on October 4, 2005 OEMS Director Guyette issued Charlemont a letter allowing for the use of an EMT and First Responder to initiate transport to meet another EMT or Ambulance while en route to a hospital. On limited bases, we have done so out any issues or adverse outcomes.

Not only is there data from Charlemont’s seventeen years now there are two years and eight months of data from statewide ambulance services to support the change in the protocols to allow an EMT and First Responder permanently. During the first hearing dated October 18, 2022, on proposed amendments to 105 CMR 170.000: Emergency Medical Services System it was stated the Department had received no reports of any problems with the use of a First Responder and an EMT.

1. It is my opinion having been involved in pre-hospital care and transporting the sick and injured to a hospital starting in 1970 and as an Emergency Medical Technician at the Basic level since 1975, we have come so far in pre-hospital care, and sadly we have begun to lose sight of what is truly in the best interest of all patients that being the ones that need pre-hospital care and assistance in getting to definitive care.

Sincerely,

Dana H. Johnson, EMT-B Director

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